

C.24. Population Health Management (PHM) Program

- a. Provide a comprehensive description of the Contractor's proposed Population Health Management (PHM) Program, including the following at a minimum:
 - i. Innovations and program elements the Contractor proposes to incorporate into this Program to support the overall goals of improving health outcomes for the population and empowering individuals to improve their health and engage in their healthcare.
 - ii. If the Contractor, holds NCQA PHM Accreditation, describe the Contractor's implementation of related models, lessons learned, challenges and successes.
 - iii. Plan to ensure high levels of Enrollee participation across all priority populations and conditions, including innovative methods for contacting and engaging Enrollees to initiate completion of Health Risk Assessments and Enrollee Needs Assessments.
 - iv. The Contractor's approach to each of the three PHM Program defined risk levels: health promotion and wellness, management of chronic conditions, and complex care management. Include information about the following for each risk level:
 - a. Tools the Contractor will use to identify Enrollees and their risk levels and to support services provided.
 - b. Risk stratification methodology and descriptions of the types of data that will be used.
 - c. Methods to identify Enrollees for each of Kentucky's priority conditions or populations.
 - d. Services and information available within each risk level.
 - e. Description of the care planning process, including methods to ensure individualized and person-centered care plans, and summary of how the Contractor will include Enrollees, their caregivers, and multi-disciplinary teams.
 - f. Stakeholder engagement strategies, including involvement of community resources to meet social needs.
 - g. Technology and other methods for information exchange, as applicable.
 - h. Frequency of provision of services.
 - i. Priority areas (e.g., specific health risks, conditions, social determinants of health, etc.).
 - j. Description of staffing for each risk level, including staff to Enrollee ratios, modes of interface with Enrollees, and use of care managers.
 - k. If applicable, value-based payment (VBP) or incentive models the Contractor will include in Provider agreements to support involvement in the PHM Program.
 - l. Methods for evaluating success of services provided.
 - m. Methods for communicating and coordinating with an Enrollee's primary care provider or other authorized providers about care plans and service needs.

- n. Role, if any, the Kentucky Health Information Exchange (KHIE) will play in the Contractor's PHM Program as a resource.
- v. Provide the Contractor's proposed approach to coordination with other authorized providers such as the WIC program and others.
- vi. Describe the Contractor's approach to ongoing review of its PHM Program, including potential real-time measurement, and how the Contractor will use results to address identified issues.

Passport Highlights: Population Health Management (PHM) Program

How We Are Different	Why It Matters	Proof
First and only NCQA-accredited PHM program	<ul style="list-style-type: none"> NCQA is the gold standard of how to deliver and support coordinated care effectively. Being the first and currently only national PHM program holding this accreditation showcases our leading technology and processes that are setting the standard across the country 	<ul style="list-style-type: none"> Passport's PHM program received NCQA accreditation in September 2019 for three years
Closed-loop social determinants of health (SDoH) model	<ul style="list-style-type: none"> Locally driven, community-based model that tracks referrals to ensure that members receive the services they need to improve their health 	<ul style="list-style-type: none"> Health care costs dropped by approximately twenty percent (22%) in the six months following a successfully closed referral to a community resource
Leading-edge predictive analytics	<ul style="list-style-type: none"> Intervening with members before they incur costly services and guiding them to the right evidence-based intervention to prevent those avoidable events is critical to an effective PHM program 	<ul style="list-style-type: none"> Our machine learning models use over twenty distinct sources of data to predict an adverse event accurately before it occurs Our c-statistic is 0.82, meaning the model correctly predicts the outcome eighty-two percent (82%) of the time, significantly higher than the rest of the industry
Robust statistical methods to evaluate the effectiveness of our PHM model and adjust as needed to maximize impact	<ul style="list-style-type: none"> Longitudinal observational studies with matched controls are the most effective way to assess impact, short of a randomized controlled study. Without this tool and the expertise behind it, an organization does not know the true effect of their PHM efforts 	<ul style="list-style-type: none"> Using propensity-matched, case-control studies, Passport programs have shown to reduce costs by twenty percent (20%), inpatient admissions by thirty-two percent (32%) and emergency department (ED) visits by thirty-five percent (35%)

Introduction

Passport's model of care integrates sources of data related to physical and behavioral health (BH), SDoH and medication services that impact our members' health status. We recognize medical and BH issues are tightly interwoven, while the effects of chronic medical conditions, prolonged stress, poverty and trauma can have direct and devastating effects on members as well as their families. Unmet SDoH needs contribute to physical and BH complications.

Health plans face challenges to bridge gaps in fragmented, local health care and service delivery systems across the Commonwealth. Our Population Health Management (PHM) program represents new ideas to address traditional barriers in support of *whole-person care* that improves outcomes and quality of life for our members. Through our PHM program, we offer a new level of support for our members, providers, and community-based organizations through paradigm shifts such as,

- From the use of reactive, lagging claims indicators to the use of leading, early indicators that increase the accuracy of predictive modeling
- From a focus on condition-specific programs to connecting the dots for whole-person care for our members and their families
- From members with complex conditions who participate long-term in health plan case management to providing customized education and support for self-management of chronic health conditions
- From a health plan only to a convener of on-site services through the proposed Passport Health and Well-Being Campus in west Louisville to tackle health disparities

The evolution of Passport's PHM program has contributed to significant reductions in cost and avoidable utilization. A recent 2018 case-control study of our Complex Care Management showed a reduction in costs by twenty percent (20%), inpatient admissions by 32% and emergency department (ED) visits by 35% (n=1,322).

To achieve these results, we have leveraged a distinct, evidence-based PHM model, that adapts to each member's unique combination of physical, behavioral, functional and social needs. We deliver our program through a local, community-based framework in which we strive to motivate members to participate in their own health care. Our relationships with local community organizations allow us to offer a closed-loop referral model for SDoH interventions that addresses significant underlying causes of avoidable utilization and costs. Through targeted wellness and prevention programs, we empower our members and their families to increase the quality of their daily lives.

We have been and remain fully committed to our members in improving their health and quality of life. It is our mission.

C.24.a.i. Innovations and program elements the Contractor proposes to incorporate into this Program to support the overall goals of improving health outcomes for the population and empowering individuals to improve their health and engage in their healthcare.

Innovations and Program Elements to Improve Health and Empower Members

Passport has have taken steps over the last few years to more precisely target interventions for members with whom we can have the greatest affect. We also propose innovations to further improve health outcomes for the population and empowering individuals to better their health and engage in their health care. We describe our proposed innovations below:

1. **Real-Time Risk Stratification:** To identify high-risk members using timely encounter data
2. **Cloud-Based Recovery Community:** For members with substance use disorders (SUDs) and codependency
3. **Social Needs Index (SNI):** To power Passport’s Care Compass program
4. **Passport Health & Well-Being Campus:** To address local health disparities
5. **Precision Pathways:** To identify the most effective, least harmful and least expensive cancer treatment options for Passport members

Real-Time Stratification Pilot Results

Average days between last encounter and outreach reduced by 93:

Claims-based stratification: 96

Real-time stratification: 3

In addition, member engagement rates improved by 44% with timelier outreach

Real-Time Risk Stratification

Goal: Accelerate time-to-intervention for high-risk members prior to an adverse event to improve health outcomes and empower members to engage in their care.

The health of members with multiple chronic diseases can deteriorate in a matter of weeks, even days. For such members, there is a specific window of opportunity to intervene and change course to improve their outcomes. The population health programs face a major disadvantage in keeping tabs on members’ changing health because of the outdated information from claims. Most managed care organizations (MCOs) rely on claims-based stratification. In this process, it takes three months after a member’s hospitalization or ED visit to get detailed information about the visit to include in stratification models. By the time a care manager reaches out to the member, that person may have already had additional hospitalizations or other encounters. In an analysis of thousands of high-risk members in Complex Care, Evolent Health found that roughly \$19,000 per member was spent in the three (3)-month span between the clinical encounter and the reporting of claims data.

Innovation: Real-time stratification will solve this time lag by leveraging real-time data sources, such as hospital ADT, utilization management (UM) notifications, lab results and prescriptions in stratification

processes. By rescoring members **daily** through this process, we can quickly reprioritize our Care Advisors' work lists to direct them to the highest-need individuals on a given day. Reaching members at the right time is also effective in improving member engagement and empowerment. Oftentimes, when support is offered to a member in a time of need, it leads to higher rates of engagement and empowerment because members are given specific guidance on how to take control of their health. A national pilot on real-time risk stratification showed that the total number of members engaged and assessed for clinical programs increased by forty-four percent (44%) after real-time stratification was piloted. Improved engagement rates were related to identifying the members with the highest need in real time when the support was most needed.

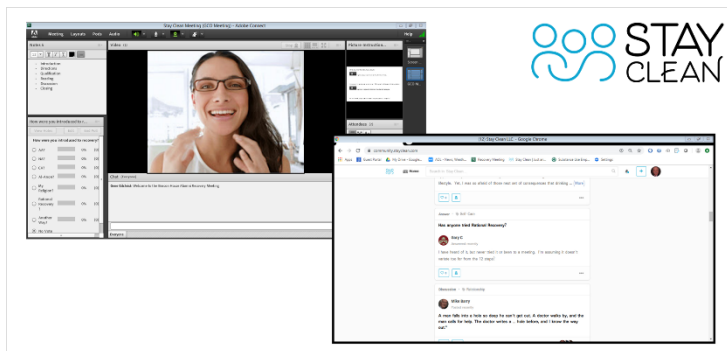
Proposed Implementation: Passport will be launching real-time stratification once Kentucky HIE connection goes live in 2020.

Cloud-Based Recovery Community for Members with SUD

Goal: Improve member access to SUD and addiction services and empower members to engage in their health through education and peer support.

Innovation: Passport is currently working with a Kentucky-based company called Stay Clean to expand SUD services and support Passport members. Members living with medical and behavioral comorbidities often receive fragmented care and experience workforce shortages, coupled with limited resources in the primary care setting, can make it difficult to connect with members. Specific issues facing members in need of treatment include shortage of providers within their communities, resulting in long wait times for initial and follow-up appointments and concerns about privacy and confidentiality related to stigma. Stay Clean was developed to expand the primary care system's capacity to support the treatment of mild-to-moderate BH

Exhibit C.24-1: Screenshot of Stay Clean Telehealth Platform



conditions at their usual site of care and increase member choice. Linking members to a peer network in real time will improve the likelihood that members will engage in treatment services and be successful.

Stay Clean is a web-based app that facilitates direct virtual care for members from a provider; provides online access to informal peer support groups, such as Alcoholics Anonymous (AA), Narcotics

Anonymous (NA), Cocaine Anonymous and AL-ANON; and offers a repository of information related to SUD (see **Exhibit C.24-1**). Stay Clean offers a clinical treatment protocol completely delivered online, including a tested, reliable and secure telehealth network and an electronic health record (EHR). All clinical treatment is delivered by certified and licensed alcohol and drug counselors working directly with those living with substance abuse disorders, as well as with codependents—a recognized diagnosis in itself. Members are

connected to peer support after treatment to receive guidance as needed. Clinical services, including an assessment, can be delivered individually or where appropriate in groups, scheduled at times convenient for the client or received in the security of their homes, and it is intended to augment not replace current treatment or 12-step programs. Passport has partnered with Stay Clean as a means to not only improve access to clinical services but also empower our members by giving them the knowledge, skills and peer support to stay healthy while recognizing community and cultural differences that are unique to Kentucky.

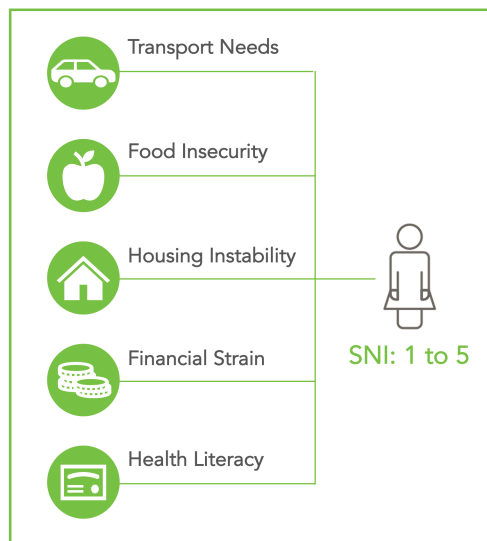
Proposed Implementation: Passport has worked closely with Stay Clean to provide feedback about its program and business model as it completed development and moved into production this year. The developers of Stay Clean are currently piloting the program and will have over 1,000 local active users (including many Passport members) by Q3 2020. At the completion of the pilot in 2020, Passport will work with Stay Clean to provide increased access to treatment and much-needed supportive services to members in the SUD recovery process.

SNI to Power Passport’s Care Compass Program

Goal: To proactively identify and address social needs of our members so that they are empowered to improve their health and able to engage in their health care.

The lack of member-specific insights and data creates a challenge to proactively identify and support members with social needs. Sources of SDoH data are disaggregated and lack standardization, and the health care industry predominately relies on screening members to understand their needs. Members who have their basic needs met, such as adequate food, stable housing and employment, are better able to focus on the activities necessary to improve their health outcomes. **Innovation:** To address this, Passport relies on the SNI, a unique, easily understandable “score” that quantifies a member’s SDoH risk level correlated to adverse health outcomes. As shown in **Exhibit C.24-2**, a single score indicating an individual’s severity of social needs across five domains (housing, finances, food, transportation and health literacy) allows Passport to better prioritize members who most need resources and provides Care Advisors an easy mechanism to integrate social support into clinical care management (CM).

Exhibit C.24-2: Five (5) Domains of the SNI That Produce a Score from one (1) to five (5) based on level of need



The SNI is updated as often as new SDoH information is generated through health risk assessments (HRAs) or acquired from external data sets. It uses machine learning algorithms to combine the following two components to determine risk of an adverse health outcome:

1. *Community strain*, which is represented by an aggregated score indicating the social strains for the community that a member lives in, serves as the foundation of the overall SNI for a member. It is determined using public data sources such as the following:
 - U.S. Census Bureau’s American Community Survey (ACS) that tracks more than 100 data elements regarding education, poverty and housing status by specific neighborhoods
 - U.S. Department of Transportation encapsulates its affordability index, walkability index, food access and supermarket availability by location
 - Environmental Protection Agency’s (EPA) Smart Location Database provides air quality and pollution information
 - U.S. Department of Agriculture (USDA) records on food scarcity and deserts
2. *Individual social needs*, which are extracted from consumer data, HRA, member eligibility files, claims, UM notes and care notes. For developing individual (and household) profiles, we use two 200-plus data elements to evaluate housing situation (renter or homeowner), household income, education level (e.g., high school, college), household composition (living alone vs. family), access to automobile and job profile and occupation.

In 2019, Passport conducted a pilot demonstrating that the SNI was able to accurately predict those with the highest social needs and conduct outreach. Among the members with an SNI of five (5) (highest score) who were outreached and assessed, one hundred percent (100%) reported at least one (1) SDoH need and ninety percent (90%) reported multiple needs. Food (thirty-four percent [34%]), employment (twenty-three percent [23%]) and housing (sixteen percent [16%]) were the most reported social needs.

Proposed Implementation: In Q3 2020, the SNI will be available to all members of the care team across programs, but it will especially power the Care Compass program, which is designed to support member needs comprehensively through care coordination, support and customer service. This program is fully developed, with implementation planned for mid- to late 2020. Members who do not stratify into one of our other PHM programs but have identified care coordination needs owing to barriers or SDoH will receive support and assistance through our Care Compass program. Members engaged in one of our other programs can also receive assistance through Care Compass as a supplement to other program interventions. Care Compass will help to address the stressors in a member’s life that are affecting the member’s short- and long-term health outcomes.

The Care Compass program will help members navigate the complexity of the health care system while empowering them through building self-management skills to manage their needs. The Care Compass team, including care coordinators, community health workers (CHWs) and social workers connect the member with resources and services and then follow up to ensure that the referral was completed and adequately met the member’s health and social needs. Specific services include the following:

- Identifying needs and available resources
- Resolving barriers
- Facilitating referrals
- Scheduling and coordinating appointments
- Supporting gap closure
- Coordinating transportation

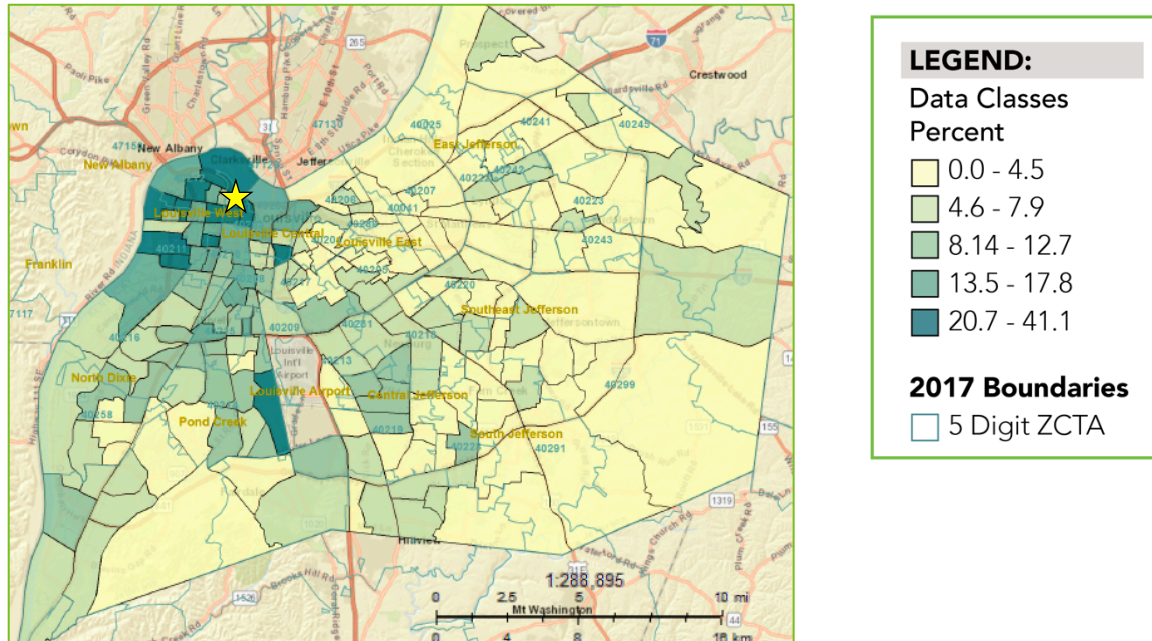
Passport's Health & Well-Being Campus to Address Health Disparities

Goal: Improve access to high quality care and reduce disparities for members living in west Louisville by increasing access to comprehensive health and wellness services where members live.

Residents in west Louisville have a life expectancy that is as much as 12 years shorter than the Louisville average (source: Louisville Health Equity Report 2017). Passport is addressing these disparities in local health care and social services delivery systems through innovative approaches, such as the Passport Health & Well-Being Campus.

Innovation: As a member of this community, Passport knows that one of the greatest impacts we can make on it is to invest in it, literally. We intend to do so by working with a developer to build the Health & Well-Being Campus at 18th and Broadway (see **Exhibit C.24-3**). This campus will house Passport's corporate headquarters, along with other community partners who are invested in revitalizing west Louisville. Passport has secured commitments from other service providers to address identified needs of this population, such as AbsoluteCARE (providing ambulatory care and pharmacy services), Family Scholar House (providing educational support, supportive housing and participant advocacy) and University of Louisville (providing education and other health-specific supportive services) to co-locate on the campus and provide services that benefit the holistic needs of Passport members and the surrounding community. In particular, University of Louisville (UofL) Health is committed to developing a health care presence on the Health & Well-Being Campus that is focused on primary care and post-acute, follow-up services with the goal of reducing utilization of high-cost inpatient and ED-based care in acute settings. Several of the other potential service provider partners interested in co-locating on the campus focus on workforce development initiatives to provide job training and placement assistance to empower members in finding sustainable employment.

Exhibit C.24-3: Percent of Families and People with Income (Past Twelve (12) Months) Below the Poverty Level by Census Tract 2013-2017. Yellow Star Denotes Location of Passport Health and Well-Being Campus in west Louisville



Legend indicates Map of Unemployment rate; Estimate; Population 16 years and over (2013-2017 American Community Survey 5-Year Estimates; U.S. Census Bureau)

The majority of Passport members, approximately 200,000, or two-thirds, reside in west Louisville, of which 75,000 live within 10 miles of the site location. Passport coordinates care for roughly one in every 2.4 west Louisville residents. Passport envisions the Health & Well-Being Campus will provide whole-person care for Passport members and the surrounding community, fuel economic development by bringing jobs and workforce initiatives to west Louisville and create an innovation lab that can pilot and identify promising models that Passport can replicate in other parts of the Commonwealth. To evaluate the impact that Passport's Health & Well-Being Campus is having on west Louisville and determine which partnerships, programs and initiatives implemented within the campus are most effective to replicate in other parts of the Commonwealth, Passport has engaged the UofL Center for Health Organization Transformation (CHOT). CHOT will conduct a multilevel longitudinal study to understand the impact on key focus areas (e.g., health care, workforce development, education, housing, poverty) targeted by service offerings provided on the campus.

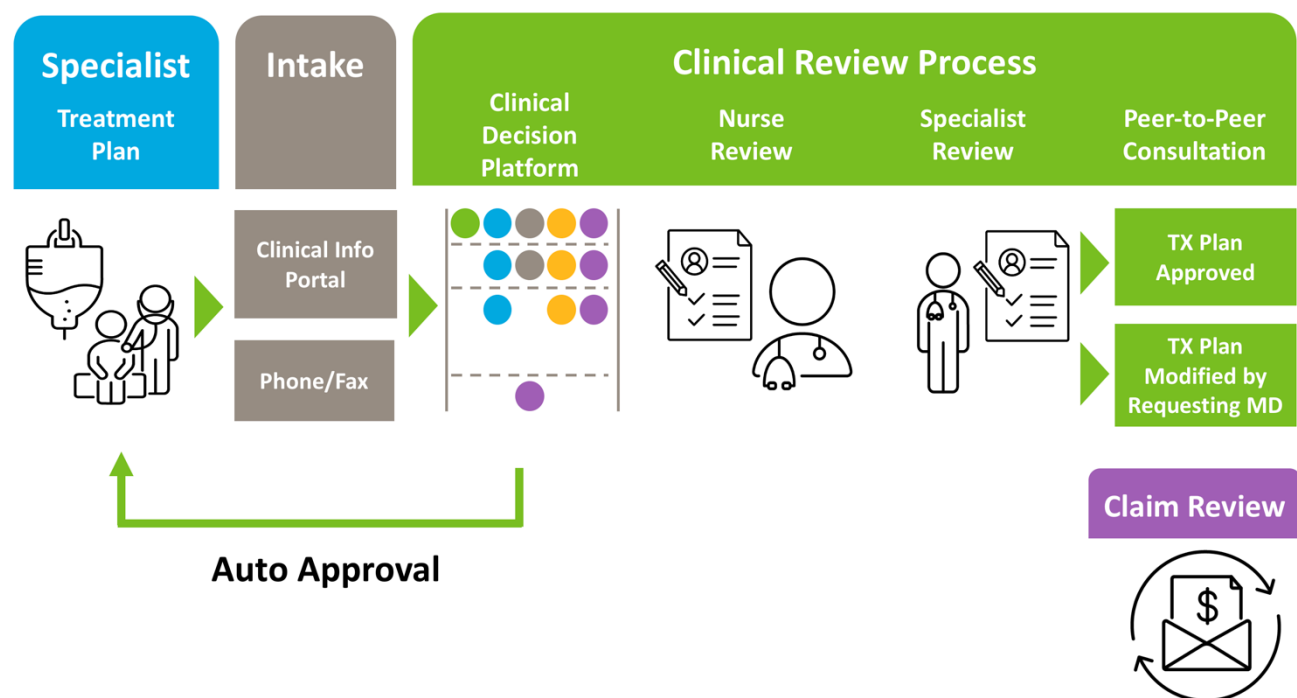
Proposed Implementation: Passport released the first stage of a developer request for proposal (RFP) process in January 2020 to identify a developer whose qualifications, vision and experience are acceptable to Passport for the campus.

Precision Pathways^(SM) to Ensure Effective and Safe Treatment

Goal: Empowers providers with the latest evidence-based pathways to improve health outcomes for members with cancer and heart disease, the top-two leading causes of death in Kentucky in 2017. Both conditions are also the Commonwealth’s priority conditions for the PHM program.

Innovation: To support our providers in treating these pervasive conditions, we will offer Precision Pathways, a web-based, point-of-care tool that empowers providers with the latest science, innovative new therapies and clinical compendia to identify the most effective, least harmful and least expensive treatment options for Passport members (see **Exhibit C.24-4**).

Exhibit C.24-4: Precision Pathways Workflow for Oncology and Cardiology Treatment

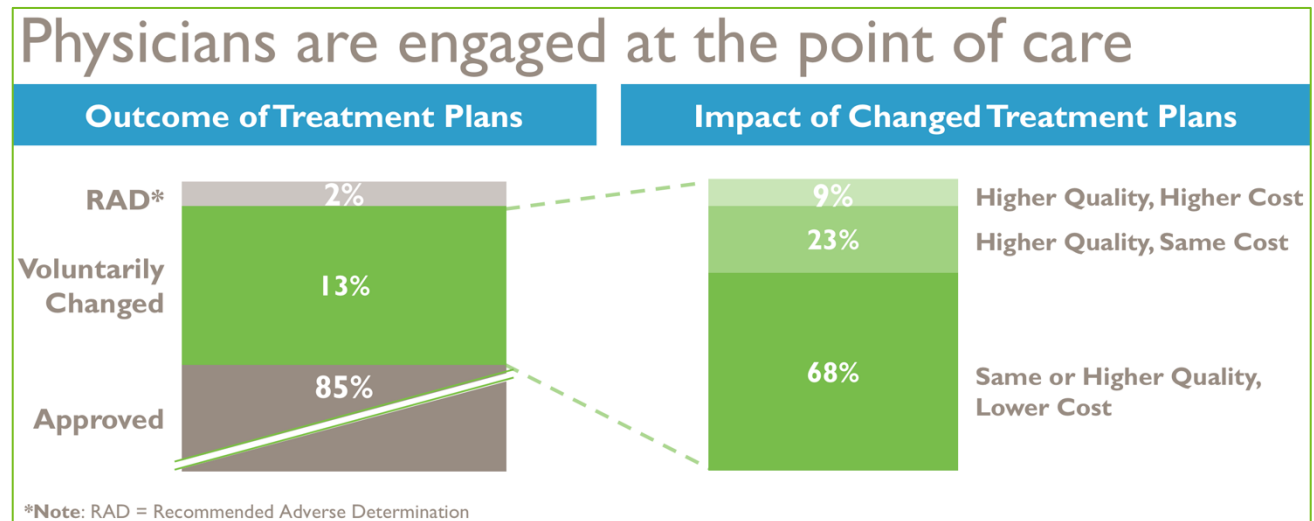


Value-based clinical pathways reduce friction with both the member and provider because they prioritize regimens that will be most effective, with the fewest side effects. It is only when comparing two equally effective regimens that the less-expensive option is preferred. When this pathway is selected, the regimen is automatically approved. This eliminates the need for prior authorization hoop-jumping that can lead to long waits for treatment or, in other cases, denial of reimbursement to specialists for drugs that were already administered. Yet physicians remain independent: They can select a different evidence-based regimen if they think it is best given the member’s circumstances and engage in peer-to-peer consultation with our specialists at any point in the process and treatment of a member.

Both our Oncology Care and Cardiology Care Programs empower providers to make evidence-based, individualized treatment decisions. Our oncology program addresses the main pillars of clinical variation and cost in oncology: drug utilization, ED and hospital admissions, as well as end-of-life care. In an evaluation of 250,000 annual treatment plan reviews, the Oncology Care Program achieved eight-five percent (85%)

approval of initial treatment plans and less than two percent (2%) recommended adverse determinations (see **Exhibit C.24-5**). Of those voluntarily changed (withdrawn or modified and resubmitted by the physician), all resulted in higher-quality treatment, with only nine percent (9%) increasing cost, twenty-three percent (23%) maintaining the anticipated cost of the initial treatment plan and fully sixty-eight percent (68%) achieving lower cost while delivering higher-quality care to the member.

Exhibit C.24-5: Oncology Care Outcome of Treatment Plans and Impact on Cost and Quality



The Cardiology Care Program addresses total cost of care through evidence-based clinical delivery for ninety-eight percent (98%) of all cardiovascular care services, including clinical cardiology, cardiovascular interventions, electrophysiology and cardiac and vascular surgeries. Our national solution reduced cardiology service utilization by 14.3% for professional services, 23.6% for hospital and emergency medical services, 26.1% for hospital elective procedures and twenty-two percent (22%) for hospital emergency procedures.

Proposed Implementation: Passport is currently in the process of implementing Precision Pathways for Passport’s oncology and cardiology providers. We have trained over 1,000 providers to date and will continue to in-service more than 500 additional providers over the course of 2020.

C.24.a.ii. If the Contractor, holds NCQA PHM Accreditation, describe the Contractor’s implementation of related models, lessons learned, challenges and successes.

Passport Uses the Clinical Program Structure from the Nation’s First NCQA-Accredited Population Health Program

Passport Health Plan is fortunate to use the clinical program structure from the nation’s first National Committee for Quality Assurance (NCQA)-accredited Population Health program through its relationship with Evolent Health. Evolent is the first organization in the country to receive NCQA accreditation of its PHM program for three years. In 2016, Passport partnered with Evolent Health, a leader in population health that is mission focused on provider-driven and community-based care as the most effective strategy for engaging vulnerable populations. Evolent enhanced Passport’s ability to expand our capabilities to provide *value-based care* using technology and strategies to pinpoint member needs and predict potential health problems. Over the last eight years, Evolent has successfully implemented PHM programs in 40 markets across the nation.

This relationship has enhanced Passport’s capabilities with leading-edge analytics and technology that use machine learning and artificial intelligence to assess risk levels across the member population and execute on early interventions to prevent adverse events. Evolent’s focus on population health makes it a natural partner for a provider-oriented health plan, such as Passport. This partnership helps members engage in their health and receive high quality care that is cost-effective, evidence-based and highly integrated.

Passport’s oversight of Evolent will be no different than its oversight of any of its other subcontractors. Passport retains full responsibility for oversight and monitoring of all activities delegated to Evolent and, ultimately, for compliance with Department of Medicaid Services (DMS) and Centers for Medicare & Medicaid Services (CMS) regulations and requirements, just as it does for all of its subcontractors.

Evolent programs are integrated into Passport’s day-to-day clinical management. The PHM program is under the direct supervision of the quality improvement director who reports directly to the chief medical officer (CMO). The staff members are a blend of Passport and Evolent staffs, who are co-located and all work in the same member management system. The staff members are listed in **Exhibit C.24-6**.

Exhibit C.24-6: Staff Responsible for Managing and Delivering PHM Program

Population Health Management		
• VP, Clinical Operations	• Program Coordinators	• Population Health Manager
• Embedded RN Care Advisor	• Care Coordinators	• Managers, Clinical Operations
• Telephonic RN Care Advisor	• Business Analysts	• Director, Clinical Operations
• Health Educators	• Project Manager	• Sr. Director, Clinical Operations
• Licensed Social Workers		

Implementation of Related Models

NCQA’s focus for population health is on four key areas that are new standards for all health plan accreditations: (1) keeping members healthy, (2) managing members with emerging risk, (3) member safety

and outcomes across settings and (4) managing multiple chronic illnesses. As such, each of our programs and initiatives is centered on these key areas. Passport developed a purposeful strategy to effectively incorporate the clinical program components from the PHM program during its initial development. The model and corresponding programs were implemented approximately four years ago. Upon release of the new NCQA PHM module, Passport's approach to PHM was already closely aligned to the new standards. We will be measuring the effectiveness of the program at the completion of HEDIS 2019, making adjustments as we go and identifying opportunities to implement updated strategies to ensure compliance with the standard.

Lessons Learned, Challenges and Successes

Making the shift from evaluation of single-disease state toward a whole-person focus resulted in the implementation of a suite of new PHM programs in 2016. Replacing an outdated siloed approach with an integrated model was embraced but required major upgrades and resulted in challenges, lessons learned and successes in the following key areas:

- Clinical training
- Enhancements to the population health platform
- Communications with providers
- Data collection and analytics

Clinical Training

The PHM program presented a paradigm shift from traditional disease management programs to whole-person care. For example, risk stratification using predictive modeling was a new concept, replacing disease-based criteria stratification and requiring knowledge of advanced statistical methods.

Challenge: The leadership and front-line teams had to shift their mindset away from one based on reactive management of members who were already experiencing severe symptoms to one that was predictive in nature, identifying members who were emerging risks and did not fit the typical “case management” mold.

Lessons Learned and Successes: To make this change from reactive to proactive successfully, we required the buy-in from the teams who would rely on this advancement. We developed training to support this transition, but the traditional didactic trainings were not effective. In response, the training team developed a creative solution: a real board game. The stratification board games were used in group trainings and engaged the learners in a nonthreatening setting, breaking up the lesson into relatable manageable pieces. The key takeaways were discovered by the participants as they navigated the game, instead of being told what they were. This strategy was extremely successful, and team members' acceptance rate of cases from stratification improved significantly. Initially, a majority of cases were closed (requiring the manager to reopen and reassign them), but since the training, which is now part of new-hire training, the acceptance rate meets or exceeds the program targets. See **Attachment C.24-1_New Hire Training Participant Guide** for an example of our training materials.

Challenge: Another key component of the PHM program is the concept of member graduation. This concept was also a paradigm shift for the front-line teams who were accustomed to managing members in perpetuity, often for years. The triple aim, which is foundational to PHM, pursues three dimensions: improving member experience of care (quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. Synthesis of the the triple aim and the NCQA PHM standards resulted in identifying the need to incorporate evidence-based interventions that would lead to an improved and sustainable outcome for members. Self-management was chosen to incorporate and is core to the PHM programs to ensure that members are empowered to engage in their health and can successfully graduate from our care programs.

Lessons Learned and Successes: Passport developed additional training, but again, traditional didactic methods were ineffective and, instead, interactive sessions were created that provide the opportunity to practice the self-management techniques. Training the front-line teams was not enough to make this intervention successful. Additional support was provided to managers through the development of an encounter audit tool. This tool provides team members with constructive feedback on their use of self-management training skills, including the use of motivational interviewing. While the process was designed to support team members, ultimately, it benefits members on their path to managing their health care independently.

Enhancements to the Population Health Platform

In addition to clinical training, the technology platform (Identifi) required enhancements to support the new Population Health program strategy fully. Because the PHM program is dynamic in nature—members can move from one risk level to another as their health changes—our technology platform also needed to be dynamic.

Challenge: The clinical operations teams needed to be able to manage members who were being stratified for multiple interventions or programs without relying on traditional paper-based reports, which can result in duplicative touch points or members “falling through the cracks.”

Lessons Learned and Successes: Identifi was improved to assign members who are identified for multiple programs to the highest acuity program. As a result, the platform provided the users with a single queue or work list to track and manage all members in one place.

Challenge: The amount of data gathered and available for every member was significant, and we needed to find a way to display it in a meaningful and useful manner. Team members were recruited to participate in product development sessions and time studies. Through this research, we found that nurses, in particular, were spending on average 30-60 minutes reviewing a member’s record and synthesizing information before doing any outreach.

Lessons Learned and Successes: A “Persistent Member Details” dashboard was created within Identifi to improve efficiency, synthesize information and provide the user with a comprehensive understanding of the member in just minutes. Information such as predictive risk scores, number of inpatient stays and ED visits in the current and past year, laboratory data, SDoH, active programs, conditions, best time and way to reach

the member and other pertinent data are included. Also, real-time dashboards assist the individual in prioritizing activities to ensure critical timelines are not missed and for tracking the team's performance.

Communications with Providers

The shift to the PHM program also required our providers to undergo meaningful behavior changes in how they thought about high-risk, high-need members. It involved moving away from focusing solely on members who were high cost or high users while also creating room for proactive management of emerging risk members.

Challenge: Providers were used to referring only members who were extremely complicated. While those members still require support, other critical parts of the population have been largely overlooked. For example, the members who were complicated but did not present to the primary care provider (PCP)/specialty office would be missed. Members at high risk of an avoidable hospital stay, readmission or ED visit in the next six to 12 months who were not symptomatic (which is typical) were not referred because of the lack of visibility.

Lessons Learned and Successes: Supporting the provider's transition from fee-for-service management of members to a value-based philosophy required a team effort. Communications, presentations and in-person meetings were developed specifically for this audience to help providers understand the paradigm shift from disease management to population health. Passport's CMO, physician leaders and population health managers who provide dedicated practice support, played key roles in disseminating the information and obtaining buy-in on the new risk-scoring methodology. The providers are pleased with the results: Fewer members have been admitted or readmitted, and more gaps in care are addressed by their extended care team at Passport.

Data Collection and Analytics

True population health requires a broad focus on the whole person rather than his/her disease, which requires a holistic picture of clinical, behavioral, mental and social data to fuel member identification and risk stratification for a program or initiative.

Challenge: Developing this whole-person view requires that data from numerous disparate sources are aggregated on a member level, and advanced statistical methods are applied routinely and in as real time as possible. This process supports timely identification and intervention with our at-risk members.

Lessons Learned and Successes: As we made the shift to population health, we identified the need for advanced analytics to conduct routine in-depth population health assessments, identify areas of disparity within the populations and subpopulations, highlight gaps in care and assess opportunities for quality improvement. Data were aggregated in a single enterprise data warehouse, and a team was put in place to manage and apply analytics to support the population health strategy. The team proactively monitors for trends, identifies areas of opportunity and conducts rigorous program evaluations, including propensity-

score, matched, longitudinal case-control studies to quantify the effect of our PHM initiatives. For example, we have quantified the success of our Complex Care Management program, demonstrating a twenty percent (20%) reduction in total medical expenses, thirty-two percent (32%) reduction in inpatient admissions and thirty-five percent (35%) decrease in ED visits (n = 1,322).

While Passport's model was already centered on an integrated continuum of care, NCQA's recognition of the importance of this approach provides additional validation of integrated, whole-person PHM. In anticipation of our health plan reaccreditation in the summer of 2020, Passport updated our PHM program and implemented changes in 2018. Our CM programs have been operating under the NCQA Population Health program standards since that time.

C.24.a.iii Plan to ensure high levels of Enrollee participation across all priority populations and conditions, including innovative methods for contacting and engaging Enrollees to initiate completion of Health Risk Assessments and Enrollee Needs Assessments.

Ensuring High Levels of Member Participation for Priority Populations and Conditions

Regardless of how successful our programs may be in driving outcomes, if members do not engage in the programs, we will not achieve success. Our provider-driven structure combined with our history in Kentucky has provided insight into specific strategies we can use that will resonate with our membership. Across our organization, we leverage multiple strategies to ensure high levels of member participation, focusing on priority conditions and populations identified by the cabinet and by Passport. Priority conditions include asthma, heart disease, diabetes, obesity, tobacco use, cancer, infant mortality, low birth weight, BH, SUDs and chronic obstructive pulmonary disease. Priority populations include all members with special health care needs and high-risk pregnant women. Passport identifies additional priority conditions and populations as needed based on our annual population assessment.

Innovative Methods for Contacting and Enrolling Members

We outreach to members using a variety of methods, which depend on risk level, population or condition; social circumstance; and member preference. Prior to outreach, care team members review a member's whole-person profile, including clinical, behavioral and social data to ensure a tailored approach to meet members where they are. The following is a sample of strategies to contact members and innovative ways to tailor our approach for each member.

- **Member Texting and Emailing:** As a best practice in communicating health-related information, Passport leverages a new communication platform and a secure member portal. Messages regarding care gaps, appointment reminders and other health information is sent via text message or email. Outreach is done in collaboration with provider offices to reinforce the provider as the key relationship with the member.

- **Provider Engagement and On-Site Support:** Passport leverages its close provider relationships to train providers in the benefits of Passport’s PHM program, share direct contact information for the care team and encourage eligible members to participate in population health services. We also attempt to enroll members face-to-face at high-volume primary care practices.
- **CHWs in the Community:** In 2018, Passport added CHWs to our PHM team. These community-based team members conduct face-to-face visits in member’s homes, provider offices and elsewhere in the community.
- **Homeless and Refugee Services:** Passport provides ongoing face-to-face member/benefits education sessions throughout the year at various transitional and homeless shelters throughout the Commonwealth. Local refugee resettlement agencies are provided with face-to-face support for newly arrived refugees to help ensure that they can navigate, access and receive quality health care in the communities where they now live.
- **Health Outcome Campaigns:** Passport uses interactive voice response (IVR) calls and follow-up live calls for health outcome campaigns, brochures to encourage working with PCPs to address the management of chronic conditions rather than seeking care in the ED and regular feedback about the effectiveness of our communication practices.
- **Targeted Telephonic Outreach:** Passport uses on-hold telephonic messages and automated outbound call technology. If we do not have a good phone number on record, we’ll check with providers and pharmacies for updated information.

In addition, Passport sends eligible members **evidence-based member education materials**, culturally sensitive **postcard** reminders for specific overdue screenings and the **New Member Handbook**, which contains information about our special programs and their contact information.

As part of our outreach efforts, Passport makes at least three attempts by telephone to enroll identified members into our programs, and we later recontact members who have previously declined participation to attempt enrollment again. Members who request to not be contacted again are placed on a “do not call” list.

If we are unable to reach members telephonically, **Passport deploys a “boots on the ground”** approach, which sends specially trained care coordinators and CHWs into the community to knock on doors, visit shelters and encampments, talk to local law enforcement and community service providers, etc., to locate difficult-to-find individuals and enroll them in services. Based on our long-standing history working closely with Kentucky Medicaid members as a community-based plan created *by Kentuckians for Kentuckians*, Passport has learned that reaching and engaging members often requires a collaborative effort with various community partners across the Commonwealth. See **Exhibit C.24-7** for examples of locations or events where we outreach, educate and enroll members into care services, showcasing the deeply embedded relationships Passport has across the Commonwealth not only within the geography but also *within* each community.

Exhibit C.24-7: Examples of Community Outreach and Community Engagement

Locations/events in our community where we outreach, educate and enroll members into care services:	
<ul style="list-style-type: none"> Community area ministries Homeless shelters City and community development centers (such as the Neighborhood Place) SUD recovery centers (such as the Healing Place) Prisons Community kitchens (especially in the western counties where rural areas provide additional help for those members needing nutritional assistance) Community centers Libraries Pregnancy centers 	<ul style="list-style-type: none"> Health departments and other health care facilities Community action agencies Apartment complexes Mental health and substance abuse facilities Churches Reentry facilities Extension offices Colleges Career centers Goodwill and other thrift centers and food pantries Salvation Army Numerous other advocate locations

Innovative Methods for Engaging and Activating Members in Their Health

Passport is the first in the country to have NCQA Population Health accredited programs, and as a leader in this space, we are setting the standards for member engagement and delivery of services and care for the country. As part of this new standard, we have redefined how we measure member engagement. While most MCOs consider members “engaged” if they receive a flyer about an available clinical program or made contact of any kind with members, we understand what really matters in improving health outcomes is the true activation of our members in their health.

As such, we only consider a member engaged in our PHM program once they have agreed to enroll in the program *and completed a comprehensive program-specific assessment*. A member’s active participation signals that he/she is truly engaged in his/her health care. So, while we may have successfully interacted with sixty-two percent (62%) of our high-risk membership, we believe that our true engagement rate of more than forty percent (40%) is not only the best in Kentucky but also across the country. Examples of engagement methods include the following:

Passport Definition of Member Engagement

A member is “engaged” in our programs once he/she has agreed to enroll in the program and *completed a comprehensive program-specific assessment*.

Even with this stringent definition, our member engagement rates are greater than forty percent (>40%), exceeding industry standards

- **Motivational Interviewing:** Once members are identified, Passport leverages proven engagement strategies that deliver results. Passport Care Advisors are trained in the Transtheoretical Model (stages of change), which helps them to assess how ready each member is to make positive health changes. When members are not yet ready for change, Care Advisors use motivational interviewing techniques to help move the member toward a greater level of activation/readiness. All PHM programs are member-centric, with members prioritizing goals for their care plans while involving their providers in the process.
- **Provider Engagement:** Passport's collaboration with the member's PCP and specialists regarding care planning helps to reinforce the forward progress to be gained from engagement. We work with practices to deliver information on identified high-risk members, care gaps and CM enrollment status. Providers who use our provider-specific technology application (Identifi Practice) can view CM enrollment status and care plans in real time. With this information at their fingertips, providers can work to engage members during routine office visits with swift follow-up from the Passport care team to activate the intake process.
- **CHW Interactions:** In 2018, Passport added CHWs to our PHM team. These community-based team members conduct face-to-face visits in members' homes, provider offices and elsewhere in the community. The CHWs serve as advocates, helping members to schedule doctor appointments, obtain the necessary resources to resolve barriers related to SDoH and assess for literacy and/or interpretation services that may be needed. CHWs teach members through self-management support to be engaged in their health care and how to take charge of making the resource arrangements.
- **Homeless Services:** Passport provides ongoing face-to-face member/benefits education sessions throughout the year. These sessions are conducted at the various transitional and homeless shelters throughout the Commonwealth. Special attention is given to those victims of domestic violence residing in emergency shelters. Passport also has a social worker embedded at a local federally qualified health center serving the homeless. The social worker interacts face-to-face with members there to resolve coordination of care needs.
- **Refugee Services:** Passport provides a Refugee Care Coordination program to help refugee members get the care they need. The refugee specialist works directly within local refugee resettlement agencies and provides face-to-face support to newly arrived refugees to help ensure that they can navigate, access and receive quality health care in the communities within which they now live. The refugee specialist assists with addressing barriers that refugees face when in the health care system. Work with members is done face-to-face or on the phone. The refugee specialist addresses transportation issues, language access problems and cultural differences, along with providing education on the local health care and social service delivery system and how to access needed services.
- **Identifi Engage:** A mobile app supported on both Android and iOS platforms that is aimed at fostering member engagement to manage care and improve outcomes effectively. Designed for members and their designated caregivers to easily interact with their care team, the secure mobile application provides bidirectional messaging (chat) capability between the care team and members to promote communication and engagement in the program.

- **Walk-In Services:** Passport members are welcome at our offices at any time. When members have questions or concerns, they sometimes stop in our offices to speak with someone face-to-face. As their concerns are being resolved, this is another opportunity to engage members to complete an HRA or even to engage in a CM program and complete a comprehensive assessment. When Passport's Health & Well-Being Campus is complete, we will be able to engage many more members in this way since the campus will be located in the community where such a large portion of Passport members reside.

Innovative Methods to Initiate Completion of HRAs and Enrollee Needs Assessments

Completion of an HRA is an important touchpoint between the member and Passport. As part of our New Member On-Boarding Plan, we provide multiple opportunities for members to complete the HRA.

- Our **Care Connector outreach representatives** conduct customer-friendly member welcome calls, introducing members to Passport. During this call, the representative conducts the HRA, asking members questions about their health and well-being status and assisting members with making an appointment with their PCPs for an initial medical assessment.
- **CHWs** assist members in completing HRAs as part of their community outreach.
- Passport's **new member web page** is tailored to meet the needs of members who are brand new to our plan and provides a straightforward checklist that members can use to take charge of their health, including completing the HRA on the web page, which is easily accessible through a link.
- Passport's **member portal** provides tools for members, including the ability to complete the HRA online.
- Passport strives to keep our new members engaged throughout their first 90 days on the plan. We have created a series of **new member online videos**—short instructional videos designed to guide our new members during this time. Our *About the HRA Form* and *7 Simple Steps for New Members to Complete During the New Member Process* videos will address the importance and ease of completing the HRA.

As required by the contract, Passport will conduct HRAs of new members who have not been enrolled with Passport in the prior 12-month period within 30 days of enrollment or earlier if the member is identified via other information or self-identifies as having specific health care or social needs. Passport will make at least three attempts to contact members in person or by telephone to complete the HRA. The three attempts will occur on different days and at different times. If we do not reach the member by telephone or in person, a letter with a number for the member to call will be mailed. If we do not have an active telephone number for the member, we will reach out to the member's PCP or other health care providers to try to obtain a usable number or other methods they have used to contact the member successfully. **Passport Go** (a proprietary Passport best practice platform used to communicate health-related information via text and IVR) is also accessed for member phone numbers.

Priority Conditions

- Asthma
- Heart disease
- Diabetes
- Obesity
- Tobacco use
- Cancer
- Infant mortality
- Low birth weight
- BH and SUD
- Other conditions, including homelessness, refugee, foster care and guardianship

Priority Populations

- Adults and children with special health care needs
- High-risk pregnant women as determined by providers
- Other populations as determined by Passport

In addition, if we have information that a member is pregnant, we will conduct an additional HRA within 30 days of notification. If determined pregnant, the member will be referred for prenatal care. HRAs will also be conducted annually to identify any new health care or social needs and at other times as deemed appropriate by Passport or DMS.

Following HRA completion, Passport will determine if the member should have a needs assessment completed.

Completion of a needs assessment is a foundational component of the care planning process and must be completed directly with a member of the care team. The needs assessment includes, at a minimum, the following:

1. Member's immediate, current and past health care, mental health and SUD needs
2. Psychosocial, functional and cognitive needs
3. SDoH, including employment and housing status
4. Ongoing conditions or needs that require treatment or care monitoring
5. Current care being received, including health care services or other CM
6. Current medications, prescribed and taken
7. Support network, including caregivers and other social supports

Once enrolled in a program, completion of the needs assessment provides the care team with a much more in-depth view of the member's conditions, barriers to care, presence of poorly managed symptoms, medication adherence issues, beliefs and preferences with regard to his/her care, assessment of health literacy and much more. The needs assessment also informs Passport of the intensity of services required.

The needs assessment is completed initially upon agreement to participate in a program and will be repeated if the member's condition changes. For example, if a member is engaged in a Condition Care program for diabetes and is admitted to the hospital, an additional assessment would be completed to assess his/her current condition and needs. Time to complete a needs assessment varies based on the program. For example, the assessment for the Transition Care program must be completed in three (3) days following notification of discharge, while the assessment for the Complex Care program allows for up to 30 days upon identification of the member.

Passport will make at least three attempts to contact members in person or by telephone to complete the HRA and enrollee needs assessment. The three attempts will occur on different days and at different times. If we do not reach the member by telephone or in person, a letter with a number for the member to call will be mailed. If we do not have an active telephone number for the member, we will reach out to the member's PCP or other health care providers to try to obtain a usable number or other methods they have used to contact the member successfully. The Passport Go database is also accessed for member phone numbers.

Passport will share the findings of the needs assessment with the member, the member's PCP or other referring provider and other Passport CM team members within 14 days of completion. The findings will only be shared following consent of the member and to the extent required by law. Findings will include Passport's recommendation for receipt of PHM program services.

C.24.a.iv. The Contractor's approach to each of the three PHM Program defined risk levels: health promotion and wellness, management of chronic conditions, and complex care management. Include information about the following for each risk level:

Passport's Approach to the PHM Defined Risk Levels

Passport uses a fully integrated, holistic, member-centric approach aimed at improving health outcomes, educating, engaging and empowering members to improve their health care and engage in their care. Our philosophy nurtures our approach to deliver high quality care, provided with compassion and respect for the member's preferences and values. Our model reveals the needs of the enrolled population across the entire health and illness continuum, including SDoH, and enables us to identify ways to provide services and supports to help members improve their quality of life. Passport's strategy is culturally sensitive and team-based, with an emphasis on medical and nonmedical drivers of health while reducing inappropriate utilization and costs. It supports the whole person, addressing physical health, BH, functional and social needs (see **Exhibit C.24-8**).

Exhibit C.24-8: Alignment of Passport Programs and Initiatives to PHM Defined Risk Levels

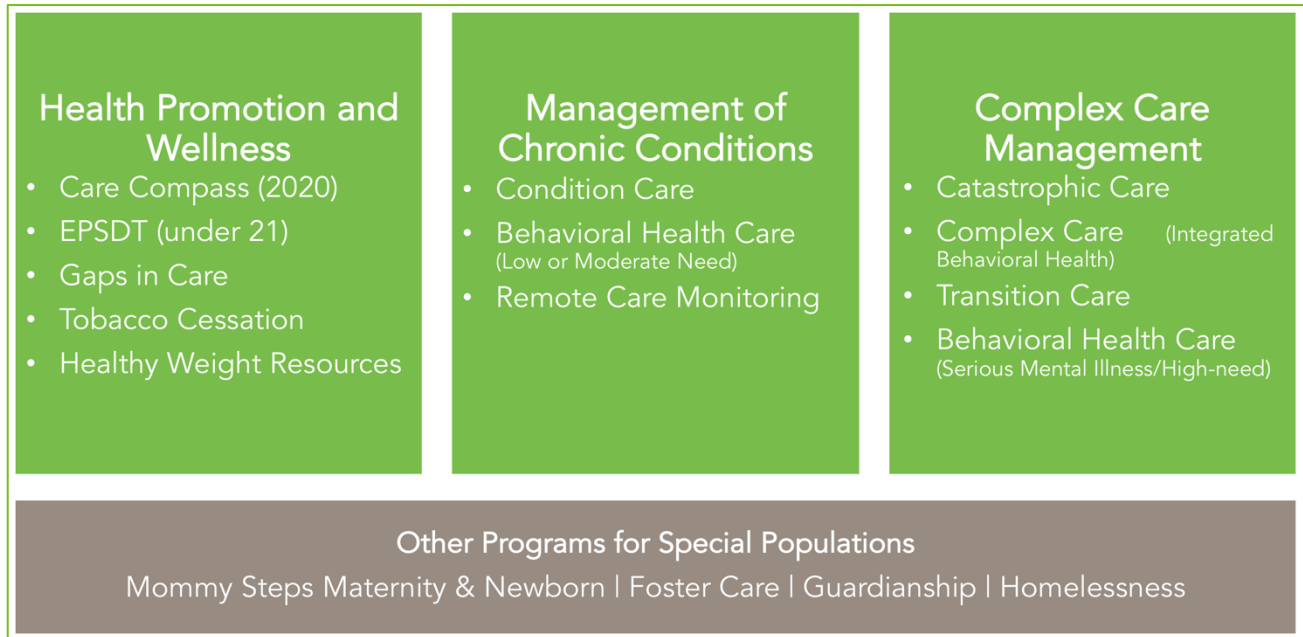


Exhibit C.24-8 shows how Passport’s program and initiatives map to the PHM risk levels. The following is a short description of each program or initiative by PHM risk level.

Health Promotion and Wellness

Passport makes all programs available to all members, regardless of their risk score. For example, an individual enrolled in Complex CM can also participate in the smoking cessation program. Health promotion and wellness initiatives underscore everything we do with a focus on prevention and healthy living.

- **Care Compass (coming in 2020):** Leverages Passport’s deep community engagement efforts to support members’ nonclinical needs through a direct focus on care coordination, support and customer service
- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (under 21):** Provides comprehensive preventive physical and mental health care, dental, developmental and specialty services to detect the early diagnosis and treatment of medical and/or behavioral conditions, which, if undetected, could become serious health care issues. This program overlays the Kentucky SKY program to provide additional services and supports
- **Gaps in Care:** Passport’s multipronged approach to identify and address gaps in care. Elements include the following:
 - **Telephone Outreach Program:** Provides text message reminders through member phones for wellness services, such as well visits or mammograms, and provides a Care Coordinator phone number for assistance in scheduling breast cancer screening. Uses **TracFone** and other available phone numbers for outreach

- **Care Messaging SMS:** Mobile texting initiative available to all members enrolled in **TracFone** or using the member's personal phone for outreach programs to support care campaigns. The Passport Go database is also accessed for member phone numbers
- **Member Incentives:** Available to all members to encourage healthy behaviors. This program includes gift cards and vouchers worth up to \$100 for use at retail stores, drug stores or a restaurant of their choice
- **Smoking Cessation Programs:** Covered benefit available to adults and adolescents who wish to quit smoking. The program includes pharmacy coverage, education and guidance and online resources. Passport offers a \$50 health incentive for tobacco users who complete a smoking cessation program
- **Healthy Weight Resources:** Support members diagnosed with overweight or obesity in reducing their weight through culturally appropriate and "body positive" education and tools

Management of Chronic Conditions

- **Condition Care:** Supports members with asthma, chronic obstructive pulmonary disease, coronary artery disease (CAD), diabetes and heart failure using condition-specific education and Action Plan development. Pregnancy care and BH programs are also available
- **BH Care:** Fully integrated program for members who experience mental health and/or SUD challenges
- **Remote Care Monitoring:** Support education of members regarding their chronic disease symptoms with Bluetooth-enabled tools to recognize worsening symptoms and apply an intervention, as warranted, before going to the ED or hospital

Complex Care Management

- **Catastrophic Care:** Coordinates services for members with catastrophic and intensive needs using a multidisciplinary care team, led by the member's PCP and overseen by a primary Registered Nurse Care Advisor (RN CA). The team-based model focuses on optimizing the health of the member using the broad skills of the PCP, RN CA, registered dietitian, licensed social worker and pharmacist to develop and implement personalized care plans
- **Complex Care:** Supports the practitioner-member relationship and plan of care, emphasizing the prevention of exacerbations and complications of co-occurring chronic diseases (BH integrated) through evidence-based practice guidelines and evaluating clinical member experience and economic outcomes on an ongoing basis with the goal of improving overall health
- **Transition Care:** Supports our members to safely and seamlessly transition back to their homes after an inpatient medical or behavioral stay and reduce readmissions for recently hospitalized members. Our care team develops a member-centric transition of care plan, including medication reconciliation and completing appropriate medical appointment follow-up and coordinates the appropriate level of care to help our members remain in their home environments and have a lower risk for hospital or ED readmissions
- **BH Care (Integrating Physician Health):** Supports members with a primary BH diagnosis, including SUD, who are at risk of an inpatient stay (behavioral or medical) through health education, self-management support and care coordination, as well as consultation with an RN CA (as needed) to address the whole health of the member

Other Programs for Special Populations

- **Mommy Steps Maternity and Newborn Program:** Supports members at *all risk levels* through pregnancy and 10 weeks postpartum, with the goal of promoting healthy pregnancies, reducing pregnancy-related complications and improving birth outcomes. These programs also focus on prevention of low birth weight and infant mortality.
- **Foster Care Program:** Passport's Foster Care team works with members, parents, Department for Community Based Services (DCBS) social service workers, foster parents and other placement-setting staff to ensure Kentucky's foster children have access to the care and services they need. Our care coordinators assist with coordination of care needs, such as scheduling appointments, closing care gaps and making connections between PCPs and specialists. Our foster care specialists intervene with more clinical needs, and they travel the Commonwealth meeting with DCBS service region staff to best understand the needs of foster children in Kentucky's diverse communities.
- **Guardianship Care:** Passport's Guardianship program is focused on ensuring individuals in state guardianship have access to the care and services they need. This is a particularly vulnerable population of members, many with severe mental illness (SMI) and/or developmental and intellectual disabilities (DID), who are often placed in the care of strangers. Our guardianship specialists travel to personal care homes across the Commonwealth, meeting with our members and their caregivers and working with members' legal guardians at Department for Aging and Independent Living (DAIL) to help ensure our members receive the care and services needed to help improve their health and quality of life.
- **Homeless Services:** Passport provides ongoing face-to-face member/benefits education sessions throughout the year. These sessions are conducted at the various transitional and homeless shelters throughout the Commonwealth. Special attention is given to those victims of domestic violence residing in emergency shelters.
- **Refugee Services:** Passport provides a Refugee Care Coordination program to help refugee members get the care they need. The refugee specialist works directly within local refugee resettlement agencies and provides face-to-face support to newly arrived refugees to help ensure that they can navigate, access and receive quality health care in the communities within which they now live. This social worker assists with addressing barriers that refugees face when in the health care system. The social worker works with the members face-to-face or on the phone, addressing transportation issues, language access problems, cultural differences and education on accessing needed services in the local health care and social service delivery systems.

C.24.iv.a. Tools the Contractor will use to identify Enrollees and their risk levels and to support services provided.

Tools Used to Identify Members and Risk Levels

A summary of tools used to identify members by PHM risk level is provided in **Exhibit C.24-9** and explained in more detail in the paragraphs that follow. Passport uses these tools to collect and aggregate various data for initial identification of members and subsequently for determining their risk level through a defined stratification methodology.

Exhibit C.24-9: Tools Used to Identify Member and Risk by PHM Risk Level

PHM Risk Level	Tools Used to Identify Members
Health Promotion and Wellness	<ul style="list-style-type: none"> • HRAs • Member needs assessment • SNI • Care gap and disease registry tools • Referrals • 24/7 free nurse advice line
Management of Chronic Conditions	<ul style="list-style-type: none"> • HRAs • Member needs assessment • UM data • Referrals • Care gap and disease registry tools • SNI • Predictive analytics/risk stratification • 24/7 free nurse advice line
Complex CM	<ul style="list-style-type: none"> • HRAs • Member needs assessment • UM data • Referrals • Care gap and disease registry tools • SNI • Predictive analytics/risk stratification • 24/7 free nurse advice line

Our PHM program brings clinical, financial and operational data together from across the organization and provides unbiased actionable analytics for us to identify members at all risk levels to improve care and reduce disparities. These data are sourced from numerous tools that capitalize on all touchpoints of the member to ensure a holistic and complete member profile and are summarized as follows:

- **HRAs:** Passport’s standardized and clinically tested HRAs may provide the first pieces of information about a new Passport member. The PHM team has developed scoring logic for the HRA to determine if a member should be referred to a PHM program based on his/her responses. If a member is flagged for outreach because of multiple responses on the HRA, it is an indication that the member’s risk level is higher, and the member may benefit from a more intensive PHM program. As stated earlier, the HRA scans for the following priority conditions and populations:

- Priority Conditions
 - Asthma
 - Heart disease
 - Diabetes
 - Obesity
 - Tobacco use
 - Cancer
 - Infant mortality
 - Low birth weight
 - BH and SUD
 - Other conditions, including homelessness, refugee, foster care and guardianship
- Priority Populations
 - Adults and children with special health care needs
 - High-risk pregnant women as determined by providers
 - Other populations as determined by Passport
- **Member Needs Assessments:** Risk level can also be determined through a comprehensive assessment, which helps us best understand our members and their unique needs. Assessment elements include the following:
 - Demographic information
 - Member's immediate, current and past health care; mental health; and SUD needs
 - Psychosocial, functional and cognitive needs
 - SDoH, including employment and housing status
 - Ongoing conditions or needs that require treatment or care monitoring
 - Current care being receiving, including health care services or other CM
 - Current medications, prescribed and taken
 - Support network, including caregivers and other social supports
 - Other areas as identified by the Contractor or Department
- **UM Data:** Passport also uses UM information to determine a member's risk level and make appropriate referrals. A member with a recent inpatient stay related to an ambulatory sensitive condition, for example, may be at high risk for a readmission and referred to the Transition Care program.

- **Referrals (Provider, Member/Family, Community):** Referrals remain an excellent method of understanding a member’s specific needs. Because of deep relationships built with providers, we regularly receive referrals from practitioners who are concerned about their members. For example, obstetricians regularly send notifications to Passport regarding new or high-risk pregnancies. Similarly, pediatricians regularly refer children with obesity for assistance from our dietitian. The member can also self-identify for program inclusion. Recommendations from the member’s family or the community are also considered.
- **SNI:** Passport uses external data to detect any SDoH risk factors affecting our members to provide better comprehensive CM services. Our system integrates dispersed SDoH data sources at different levels (e.g., individual, census block, census tract) across five main domains: housing instability, transportation barriers, food insecurity, financial stress and health literacy. While these factors are already included in our risk-stratification algorithm, late in 2020, the platform will create a distinct SNI (with five levels) to indicate SDoH-related risks, which could affect members’ health outcomes.
- **Care Gap and Disease Registry Dashboards and Reports:** Passport uses ongoing monitoring of care gaps and newly diagnosed conditions across the population to identify members in need of additional support. These reports are highly configurable, ensuring actionable information that is pertinent to the population and established care goals.
- **Care for You 24/7 Free Nurse Advice Line:** Direct clinical consultation is available 24 hours a day, seven days a week to provide advice on various health-related topics. Reasons to call include to seek help with deciding if a medical issue or need requires immediate attention, to learn about a health or medical concern or to better understand and follow doctor’s orders or prescribed treatment plan. When appropriate, 24-hour nurses refer members to Passport’s CM team for ongoing care coordination and/or CM services.
- **Predictive Analytics/Risk Stratification:** For those members with higher acuity needs, Passport employs an advanced machine learning model that uses artificial intelligence to predict the probability of an adverse event to determine risk level. A description of our stratification model is included in the following section (**C.24.iv.b**).

C.24.iv.b. Risk stratification methodology and descriptions of the types of data that will be used.

Risk Stratification Data and Methodology That Is Unbiased and Highly Accurate

A summary of risk stratification methodology and data by PHM risk level is shown in **Exhibit C.24-10** and explained in more detail in the paragraphs that follow. Passport implements a risk stratification methodology to determine risk of our overall population and to identify individual member risk levels. Based on this, we provide tiered services within each risk level. These functions are fully implemented and are regularly updated as review effectiveness of these tools.

Exhibit C.24-10: Risk Stratification Methodology and Data by PHM Risk Level

PHM Risk Level	Risk Stratification Methodology	Data Types
Health promotion and wellness	<ul style="list-style-type: none"> Rules-based criteria Referral 	<ul style="list-style-type: none"> Medical and behavioral encounters Pharmacy prescriptions Laboratory results HRA Program Needs Assessment Electronic health records Health plan UM case notes Advanced KY data sources (e.g., immunization registry) SDoH sources (census tract, household, member-level)
Management of chronic conditions	<ul style="list-style-type: none"> Rules-based criteria Advanced machine learning algorithms 	
Complex care management	<ul style="list-style-type: none"> Rules-based criteria Advanced machine learning algorithms 	

Across the country, health plans and providers use predictive models that rely heavily on past health expenditures to project future spending, rate each member's level of risk for future health problems and provide additional resources based on those risk scores. However, this cost data does not account for disparities within the population. For example, on average African American patients use health services at lower rates than Caucasian members. Based on the utilization difference, the analytical results could be detrimental for members who desperately need attention—not only do they face greater barriers to care, but those barriers often hide their true level of clinical need and deprive them of CM resources.

Choosing the right outcome is the single most important decision in constructing a model to predict a population's and member's risk of future medical needs. That outcome should focus on an event we want to avoid—not the cost—and it must be very specific. For example, Passport's models predict the likelihood of an "impactable" hospital admission within the next six months. By design, this approach avoids the structural bias inherent in using medical expenses as the primary outcome. In contrast to models that rely on past health care costs to predict future need, **Passport's models recognize that the lack of certain encounters can sometimes be a strong predictor of future hospitalization.** For example, if a member has diabetes and hypertension but does not see his PCP, that fact might actually increase the chance of an admission over a member who regularly sees their PCP. That member will have a higher risk score in our model so he does not fall through the cracks.

Passport's leading risk stratification can accurately predict an impactable adverse event *before* it occurs over 80% of the time

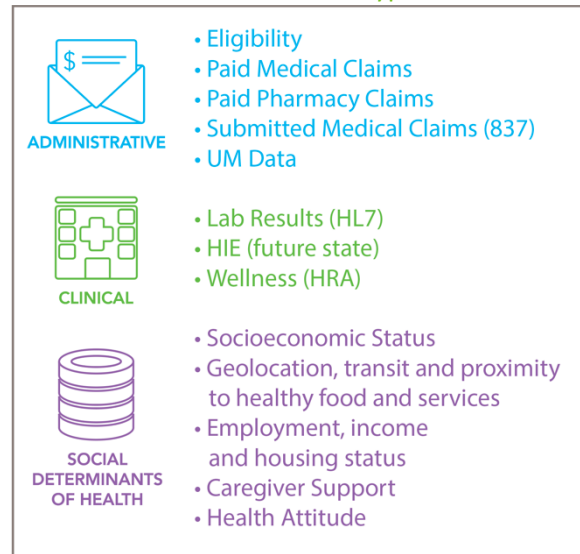
Passport employs this unbiased approach to determine risk of its overall population and to identify individual member risk levels.

Data Types Used in Stratification Methodology

Our stratification methodology starts with the data. Passport combines data from multiple sources to use in its population stratification and program eligibility process shown in **Exhibit C.24-11**. The following data are incorporated into our risk stratification algorithms:

- Medical and behavioral claims/encounters
- Pharmacy claims; laboratory results, when available
- HRA
- Electronic health records, when applicable
- Health plan UM and/or PHM case notes
- Advanced data sources, such as the Commonwealth of Kentucky immunization registry

Exhibit C.24-11: Loaded Data Types



In addition, Passport also integrates external data sources to ensure a complete picture of SDoH of our members that includes :

- U.S. Census Bureau's ACS, which tracks more than one 100 data elements regarding education, poverty and housing status by specific neighborhoods
- U.S. Department of Transportation encapsulating their affordability index, walkability index, food access and supermarket availability by location
- EPA Smart Location Database provides air quality and pollution information
- USDA records on food scarcity and deserts. Identifi continues to evaluate and add other data sources.

Passport has also invested in external data sources, including consumer data, to get a more accurate picture of the member. Through this relationship, we access member and household-level information in the following areas to ensure our outreach approach is both focused and tailored to the member's situation:

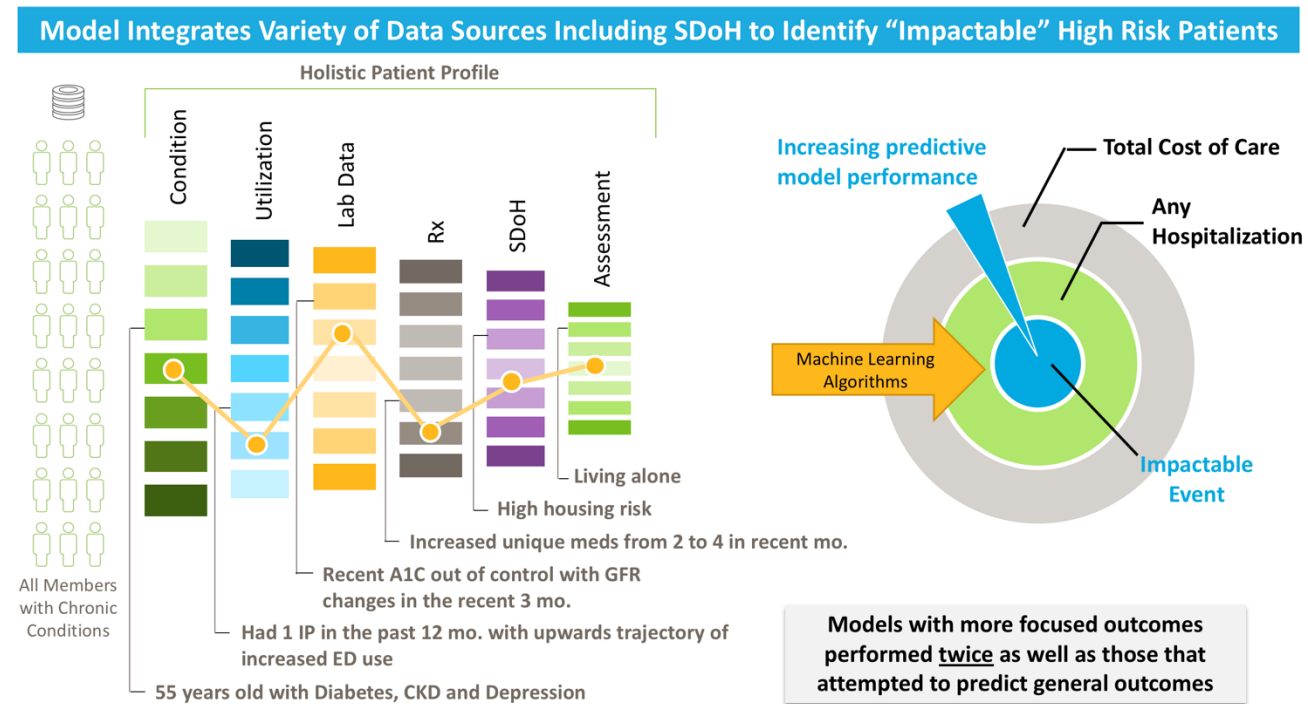
- Psychographic Behavior/Attitudes: Understanding patients' attitudes is key to influencing their behavior so we gather information on technology adoption (wizards vs. novice), preference for message channel (digital vs. face-to-face), attitude on health (indifferent vs. active), and other lifestyle preferences.
- Household profile: We use more than 200 data elements to evaluate housing situation (renter or homeowner), household income, education level (e.g., high school, college, etc.), household composition (living alone vs. family), access to automobile and occupation.

Industry-Leading Predictive Modeling Results for Improved Performance

The availability of comprehensive data sets enables our platform and analytics teams to analyze the data sets in innovative ways. Our data scientists mine millions of data points and signals for our members and identify the key risk factors that impact member outcomes across care. The team analyzes historical data

patterns that accounts for the temporal nature of different events for members and deeply understand the different member trajectories using the most advanced machine learning techniques, including neural networks, gradient boosting and clustering algorithms. This information is used to predict the probability of an adverse event incurring that is impactable through our PHM program as shown in **Exhibit C.24-12**.

Exhibit C.24-12: Data Sources to Identify Impactable Events



One of the most frequently cited measures of predictive performance is the model’s c-statistic, which is the measure of the area under a Receiver Operator Characteristic (ROC) curve. A c-statistic of 0.5 indicates a random chance at predicting a future event (e.g., a coin toss), while a value of one is a perfect predictor. A model with a c-statistic of 0.8 or higher is considered to have strong predictive ability. In 2012, the Mayo Clinic presented a meta-analysis of the performance of risk stratification methods at predicting inpatient and ED encounters at the Academy of Health Conference. Our c-statistic is 0.82, significantly higher than the rest of the industry and indicative of strong predictive ability as illustrated in **Exhibit C.24-13**.

Exhibit C.24-13: Passport's Predictive Stratification Performance for Complex Care Compared to Industry Standards

PREDICTIVE MODEL PERFORMANCE¹		
Model	ED Visits c-statistic	Hospitalization c-statistic
Johns Hopkins Adjusted Clinical Groups (ACG)	.67	.73
Charlson Comorbidity Measure	.59	.68
Passport Complex Care Predictive Model	.81	.86
	.82*	

Passport's risk stratification is fully implemented and is conducted on an ongoing basis, no less frequent than monthly and as often as daily depending on availability of data streams. Passport updates risk stratification approaches based on suggested changes in service needs of our member and providers. For example, our providers and care teams requested a way to risk stratify members based on their predicted social needs. In response, Passport developed the Social Needs Index to quantify social needs in a single score to support outreach and management efforts.

C.24.iv.c. Methods to identify Enrollees for each of Kentucky's priority conditions or populations.

Identifying Members for Kentucky's Priority Conditions or Populations

Exhibit C.24-14 is a summary of our methods for identifying members for each of Kentucky's priority conditions or populations. The information below is also an input into our risk stratification model.

Exhibit C.24-14: Methods to Identify Members for Kentucky's priority conditions or populations

Kentucky's Priority Conditions or Populations	Method(s) to Identify Member in Addition to Diagnosis
Asthma	<ul style="list-style-type: none"> Controller medication, rescue inhalers, specialist visits, self-reported, referrals
Heart disease	<ul style="list-style-type: none"> Procedures and surgery (e.g., angioplasty), medications and comorbidities, self-reported, referrals
Diabetes	<ul style="list-style-type: none"> Medications (metformin, insulin), complications (kidney, eye damage), treatments, lab results, self-reported, referrals
Obesity	<ul style="list-style-type: none"> Self-reported, biometric data (when available), UM/CM notes, referrals

Kentucky's Priority Conditions or Populations	Method(s) to Identify Member in Addition to Diagnosis
Tobacco use	<ul style="list-style-type: none"> Self-reported, UM/CM notes on tobacco cessation program, referrals
Cancer	<ul style="list-style-type: none"> Treatment and procedures, drug usage (e.g., Avastin), self-reported, referrals
Infant mortality	<ul style="list-style-type: none"> Maternity history, prenatal care regimen, demographics
Low birth weight	<ul style="list-style-type: none"> Maternity history, prenatal care regimen, demographics, UM case notes
BH and substance use disorder	<ul style="list-style-type: none"> Medications, specialists, place of service (e.g., psychiatric facility), self-reported, referrals
Additional Conditions or Populations of Focus	
Members with special health care needs	<ul style="list-style-type: none"> Treatment and procedures, specialist visits, place of service, durable medical equipment (DME), self-reported, referrals
High-risk pregnancy	<ul style="list-style-type: none"> Maternity history, prenatal care regimen, demographics, prescribed over-the-counter (OTC) medications (e.g., prenatal vitamins, folic Acid), 834 files
Foster care/guardianship	<ul style="list-style-type: none"> Eligibility files
Homelessness	<ul style="list-style-type: none"> Eligibility files (frequent address changes), geo mapping home address that reflect shelter or temporary housing, consumer data housing status (renter/homeowner)

Passport uses multiple methods for identifying members for care deeply rooted in evidence-based medicine and is purpose-built to drive improved outcomes. The platform derives insights from multiple sources, including enrollment and eligibility data, medical, pharmacy and BH claims, laboratory results, HRA information, medical assessment screening results, data collected through clinical, UM, health management or health coaching programs, electronic medical record data and information from our Care for You 24/7 free nurse advice line.

Those data are fed into our Clinical Rules Engine, which consists of over 1,400 proprietary clinical rules and measure definitions applied to each member in the Passport population. This large rule set allows us tremendous flexibility and precision in identifying members with priority conditions or populations. For example, we can identify a member with diabetes through any one of the following data points: documented diagnosis, abnormal Hemoglobin A1c (Hba1c) lab result, pharmacy claim, self-reported

condition via HRA, UM system, provider system or referral. Because of the flexibility to look for any evidence of a condition, and not just a documented diagnosis, our identification rate of these populations is exceedingly accurate.

When members with priority conditions or who are in priority populations are identified, Passport uses its risk stratification model to determine the best PHM program to fit their needs. A member with moderately managed asthma, for example, would be placed into the Condition Care Asthma program. A member with diabetes and depression at high risk of an admission in the next six (6) to twelve (12) months would stratify for our Complex Care program. A member with cancer in the hospital with a high likelihood of readmitting would stratify for our Transition Care program. Finding the best program for the member's conditions and needs is paramount to helping the member achieve better health outcomes and quality of life.

C.24.iv.d. Services and information available within each risk level.

Services and Information to Support Members Across Risk Levels

Passport connects with members on a personal level and makes every effort to ensure they are successful in completing the program and self-managing their condition. Our program approach uses interventions tailored to members' specific condition(s), individualized needs and risk level. Passport has also developed tiers of service within each risk level to address members with varying levels of intensity of care needs. For example, within Health Promotion and Wellness, our smoking cessation program is available to all members; for those who have more complex psychosocial needs, Care Compass can address those barriers.

A summary of services and information to support members across risk levels is shown in **Exhibit C.24-15** and explained in more detail in the paragraphs that follow. NOTE: EPSDT, gaps in care, tobacco cessation and healthy weight resources are available to all risk levels.

Exhibit C.24-15: Services and Information to Support Members by PHM Risk Level

PHM Risk Level	Passport Program	Information & Services
Health promotion and wellness	Care Compass	<ul style="list-style-type: none"> Care coordination assistance and support to address barriers to care (e.g., housing needs, social service needs, community and federal government benefits, immigration status, and employment protections and accommodations)
	EPSDT	<ul style="list-style-type: none"> Targeted outreach, postcard notifications for screenings, immunizations, annual care Home visits for screenings in rural areas Education on nutrition, physical activity, risky behaviors, substance use
	Gaps in Care	<ul style="list-style-type: none"> Text message reminders for wellness services with scheduling assistance IVR calls and follow-up live calls for health outcome campaigns Education on urgent care options Outreach specialists to support members in finding alternatives to the ED Host mammography and cervical cancer screening days for women Postcard reminders for preventive care Member Newsletters (MyHealthMyLife™)
	Tobacco Cessation	<ul style="list-style-type: none"> Access to smoking cessation products Education materials One-on-one health coaching Provider screening Text messaging for both smoke and smokeless tobacco, live chat support quitSTART app that provides tips \$50 health incentives for tobacco users who complete a smoking cessation program
	Healthy Weight Resources	<ul style="list-style-type: none"> Registered dietitian works with members to create individualized plans Education on nutrition, diet and exercise specific to member condition and needs Medically tailored meal planning Health educator-led sessions that include weight check, food journal review, exercise journal, review of barriers and successes
Management of chronic conditions	Condition Care	<ul style="list-style-type: none"> Education on targeted conditions, overall health Close relevant gaps in evidence-based care Self-management support CHW support to address SDoH Coordination with PCP and specialist Monitor medication adherence
	BH Care (BH/SUD only)	<ul style="list-style-type: none"> Education on behavioral health and psychotropic medication Self-management support, including relapse planning Connection to community-based and peer supports Arranging follow-up appointments with PCPs, specialists
	Remote Care Monitoring	<ul style="list-style-type: none"> Bluetooth-enabled computer tablet, blood pressure cuff, oximeter and weight scale Education taking their vital signs, using the equipment, system's flag indicators and what actions to take based on the readings

PHM Risk Level	Passport Program	Information & Services
Complex care management	Catastrophic Care	<ul style="list-style-type: none"> • Coordinate implementation of physician treatment plan, and remove barriers • Facilitate safe transitions across care settings • Support medication adherence • Ensure adequate home support • Coordinate home health care network of services and community resources • Identify and negotiate contracts with those services outside of the existing network • Support end-of-life and palliative care options
	Complex Care	<ul style="list-style-type: none"> • Care coordination across physician settings • Educate members about diagnoses and self-management, including symptom response plan • Support medication compliance • Address member/caregiver needs regarding adequate support and resources at home
	Mommy Steps Maternity and Newborn Program	<ul style="list-style-type: none"> • Educational resources, including smoking cessation, dental, importance of early and regular prenatal care (text reminders) • Community resources, including WIC, health access nurturing development services (HANDS), Healthy Start, treatment for drugs/alcohol, mental health services, domestic violence support, legal assistance, support groups, transportation assistance • Self-management support, health education, and coaching to improve knowledge • Postpartum outreach to screen for complications
	Transition Care	<ul style="list-style-type: none"> • Educate members about discharge plan including symptom response plan • Care coordination across physician settings • Post-discharge outpatient provider appointments and coordinates arrangements for any special accommodations (i.e., caregiver support, durable medical equipment, medications and referrals to community resources) • Ensure adherence to the hospital discharge plans
	BH Care (Co-occurring or serious mental illness)	<ul style="list-style-type: none"> • Facilitate access to appropriate level of care • Education and adherence to psychotropic medication • Self-management support, including relapse planning • Connection to community-based and peer supports, including virtual recovery community • Arranging follow-up appointments with PCPs, specialists; coordinating co-occurring conditions

Passport's PHM program addresses members' holistic health care needs across all risk levels and assists them in navigating the health care system. Our multi-disciplinary care team is dedicated to fully assisting the member by assessing their needs, developing an individualized care plan, creating specific interventions, evaluating their progress and referring them to needed resources, all to help our members find the path to better health and well-being. Passport's CEO, executive team and oversight committees are fully responsible for ensuring the operational effectiveness of our services, while aligning with the needs of provider partners, the community and our members. We are proud of the results of our program and the impact they have had on our members' lives. **Section C.24.iv.I** shows the results from our rigorous evaluation of our programs.

Below are more detailed descriptions of the programs that align to each level and the information and services that are offered as a part of each program.

Health Promotion & Wellness

Care Compass

Passport is acutely aware of the impact of fragmented care, as well as the effects chronic conditions, chronic stress, poverty and trauma have on members and their families. These factors result in barriers related to SDoH, disparities and literacy challenges, which are leading contributors to physical and BH morbidities. There is a vast set of needs that fall into this category including (but not limited to) housing needs and/or insecurity, social service needs, community and federal government benefits, immigration status, and employment protections and accommodations.

To address these critical needs, we will be implementing the Care Compass program in Q3 2020 to support member needs comprehensively through a direct focus on member care coordination assistance, support and customer service. Our local presence in Kentucky helps us identify and connect members with appropriate local resources to meet their needs. This program helps to lessen the impacts and future development of the illness burden and morbidity that culminates from a lifetime—and often generations—of living with challenges such as poverty, and the resulting stress and trauma experienced by most people living in poverty.

The Care Compass team, including care coordinators, community health workers and social workers, help members navigate the complexity of the health care system while empowering them through self-management skill building. Specific services include:

- Identifying needs and available resources
- Resolving barriers
- Facilitating referrals
- Scheduling and coordinating appointments
- Supporting gap closure
- Coordinating transportation

While a member may be referred to address a specific need, such as transportation, the Care Coordinator will take the opportunity to screen the member for additional SDoH needs and/or gaps and develop a

comprehensive Action Plan in collaboration with the member. Outreach occurs at a minimum of every 20 days and more frequently if needed. A Care Advisor (nurse), registered dietitian, and/or pharmacist will be consulted and/or referred to as appropriate throughout the duration of the program. Passport goes beyond merely identifying and referring members for services. Team members conduct follow up to ensure that the referral was completed and *met the member's needs—we call this a closed-loop referral*. Additional goals for all members in the Care Compass program include:

- Member has established PCP relationship
- Member is connected to necessary resources, equipment and supplies
- Member takes an active role in his/her own care

EPSDT Outreach Program

Passport wants every young child to start life being happy and healthy. Approximately forty-nine percent (49%) of our membership is under the age of 21, so it is important that we envelop them with caring and compassionate health care. One of the ways we achieve this is through our EPSDT program designed for eligible or enrolled children and adolescents, ranging from birth to age 21. The program offers comprehensive preventive physical and mental health care, dental, and developmental and specialty services to detect the early diagnosis and treatment of medical and/or behavioral conditions, which, if undetected, could become serious health care issues. This program overlays the Kentucky SKY program to provide additional services and supports.

Passport's EPSDT program is devised with specific goals to increase:

- The percentage of members receiving at least one EPSDT screen during the measurement year and all age appropriate EPSDT screens; all childhood and adolescent immunizations.
- The percentage of members receiving an annual dental visit.
- The number of members receiving a lead screening based on the periodicity schedule.
- The number of members receiving a well-child visit in the first 15 months of life, the third, fourth, fifth, and sixth years of life, and an adolescent visit.
- The number of members committed to receiving the HPV vaccine series as recommended by Bright Futures/American Academy of Pediatrics (AAP) Standard of Care periodicity schedule as adopted by the Center for Disease Control (CDC).
- Clinician adherence to documented evidence of body mass index (BMI) percentile and improving clinician adherence to documented percentile plotted on a BMI growth chart or BMI percentile documented that includes height and weight.
- Promoting counseling for nutrition; physical activity, risk behavior related to sexual activity, alcohol, substance abuse, mental health assessment/screening and tobacco use, and follow-up for special services as a result from an EPSDT screening.
- Promoting adherence to documented evidence of a depression screening based on the periodicity schedule and appropriate referral and follow up as a result from an EPSDT screening.

Passport provides targeted outreach to EPSDT-eligible members who are non-compliant with the recommended schedule of health screens, immunizations and annual participation. Our experience working with young members and their families has provided insight into the most effective outreach strategies to

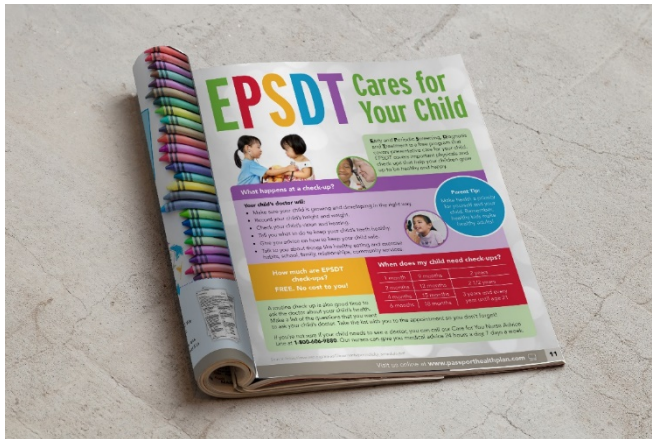
connect with and educate families on the benefits and availability of EPSDT services. The auto dialer system is utilized to contact members telephonically; postcard notifications are mailed to caregivers of all newborn members advising of EPSDT screens; where covered, home visit outreach is provided to non-compliant members unable to be reached telephonically; outreach and education is also provided at community events, (i.e., back to school events and community health fairs).

All currently enrolled Passport members, under the age of 21, are eligible for EPSDT services. Members' EPSDT status is determined through the claims system. The EPSDT application stores real-time member claims history and is utilized to produce monthly outreach efforts.

Education and guidance are a critical component of the program. Our Care Advisors teach our young members and their caregivers about proper nutrition, physical activity, risky behaviors related to sexual activity, alcohol, substance abuse and tobacco use. We also have targeted outreach efforts geared to EPSDT eligible members who have not received the recommended schedule of health screens, immunizations and annual participation. The outreach efforts inform and stress the importance of EPSDT through various means, including:

- Prenatal education and postcard notifications are mailed to caregivers of all newborn members advising of EPSDT screenings.
- Auto-dialer system is utilized to contact members regarding the availability of preventive dental care, the recommended schedule for EPSDT screens and immunizations, and the importance of follow up when referred for special services. For convenience, members have the option to speak directly to a Care Connector if they require additional information.
- Via a partnership with local health departments, home visits are provided to members in some rural regions of the Commonwealth when they are unavailable by phone.
- Outreach and education provided at community events (i.e., back to school events and community health fairs).
- Passport HealthPlus program and HealthPlus Care Conferences are used to educate and influence provider practice in EPSDT HEDIS goal movement, proper coding and ESPST education for providers within the HealthPlus program.
- Member handbook offers information on our EPSDT program, member-eligibility criteria, and an early periodic screening and diagnostic testing schedule.
- Information on our member website for EPSDT program and offerings.
- Member Newsletter, MyHealthMyLife, offers informational articles on the importance of EPSDT screenings and immunizations, as illustrated in **Exhibit C.24-16**.

Exhibit C.24-16: Member Newsletter Articles on the Importance of EPSDT for Children



The EPSDT program tracks member's adherence with all components of the health screen and follow-up related to an EPSDT screen according to the periodicity schedule based on the AAP/Bright Futures Standards of Care and Commonwealth's DMS.

Provider engagement and education are essential elements to the success of our EPSDT program. Passport conducts orientation sessions for EPSDT clinicians on a regular basis and provides ongoing support to them regarding the administration of

EPSDT preventive care, billing and claims processes, the required components of a complete EPSDT screening, the importance of outreach and education to EPSDT eligible members and their families. As a part of educational efforts, we also conduct provider outreach visits, workshops and roundtable meetings, as well as offer educational materials, such as the Quick Reference Guide, Provider Orientation Kit, EPSDT Orientation Kit, Passport Provider Manual, Provider EPSDT Education Toolkit and Passport's Provider Portal Website to support efforts to increase EPSDT participation, compliance rates and identified health outcomes. Passport also conducts EPSDT provider audits to monitor compliance around EPSDT services.

Passport continuously focuses on quality and enhances the identified areas of our EPSDT program to improve effectiveness of the EPSDT program. By doing so, we enable our young members to start their life with a healthy future, and our EPSDT program results demonstrate our firm commitment to our members' well-being. In 2018, Passport's **EPSDT compliance rates were ninety-two percent (92%)** (defined as all eligible members receiving appropriate screenings according to the periodicity schedule).

Smoking and Tobacco Cessation Programs

Smoking cessation is a covered benefit, and we encourage all members who smoke to speak with their provider about quitting. Pharmacy coverage includes smoking cessation products, available in multiple dosage formulations, without barriers such as quantity limits, maximum durations of therapy or prior authorizations. This approach is meant to encourage members to not be discouraged by multiple quit attempts and minimize additional burdens to quitting. Additionally, all products are offered at a \$0 copay to reduce the financial barriers that can be associated with quitting.

For members who reach out to Passport for additional assistance, we refer them to 1-800-QUIT-NOW, the Kentucky Quit Now Support Line. For members in Jefferson County, we provide a listing of smoking cessation classes on the member web page and refer members in other counties to their local health departments. The member web page additionally contains other smoking cessation helps and links.

Smoking cessation education and guidance is incorporated into all of Passport's clinical CM programs. When a member expresses current tobacco/nicotine use as part of the assessment, the Care Advisor or Health

Educator assesses readiness to change and utilizes motivational interviewing to attempt to help move members closer to a state of readiness to quit. Regardless of how activated the member is around smoking/tobacco cessation, educational materials will be sent to the member and referral to the above resources will be provided. If the member prioritizes smoking/tobacco cessation, then this will become a part of the care plan.

Passport also works closely with providers to screen for tobacco use and provides or refers for appropriate intervention as needed. In 2018 Passport had the highest physician screening rate of adolescent tobacco use (77.94%) among all Kentucky MCOs. Passport also had the highest screening rate (78.26%) for tobacco use at one of first two prenatal visits. Passport will continue to support our providers' efforts to screen for tobacco use and refer for interventions.

In addition, Passport is proposing a program to address smoking cessation in adolescents. In this program, 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 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, the quitSTART app that provides tips, supportive messaging and challenges, live chat support, and a supportive Instagram feed to appeal to and effectively support adolescents.

Passport offers a \$50 health incentive for tobacco users who complete a smoking cessation program. To qualify, members must be either pregnant or an adolescent (ages 13 to 17) and have a negative nicotine test performed by their doctor.

Healthy Weight Programs

Because members who are overweight or obese can often have other comorbid complications, Passport offers and encourages weight management guidance as part of our Population Health Management program. Passport's registered dietitian works with members to create individualized plans, which address the member's unique situation. The dietitian provides nutrition, diet and exercise education specific to the member's conditions, needs and preferences.

Members who are engaged in a CM program, such as our Condition Care program for diabetes, may need specific education and guidance to help address needs related to being overweight or obese. In the case, the dietitian would also assist the member in learning about a healthy diabetic diet. For every member referred, the dietitian provides education and support around healthy diet, exercise and overcoming barriers to achieving personal goals.

When members are provider-referred or self-referred with obesity as the primary condition to be addressed, the dietitian acts as the member's primary health educator and creates a unique, individual care plan specific to diet, exercise and overcoming barriers to achieving goals. Care plans focused on achievable milestones with ongoing supervision by a provider have been shown to be an effective method to stimulate

making healthier decisions and increase weight loss. Our program lasts up to three months and consists of consultation with a health educator, participation in both weight management and exercise programs, as well as keeping a daily food and exercise journal. Participation in this program requires the member to have an annual visit with his or her PCP and ensure he or she is safe for increased activity, as well as have the PCP provide oversight to his or her weight loss goals.

Upon initial outreach, the health educator will complete a dietary assessment with the member. The program will include telephonic education sessions every three weeks conducted by the health educator. The sessions will include:

- Weight check
- Food journal review
- Exercise journal review
- Barriers/successes

The health educator will be responsible for communicating the member's status with the PCP.

The goal of the health educator sessions is for the member to teach back the information shared in each meeting and verbalize the effect of the information on the member's weight loss goals. Successful completion of the program is demonstrated by the member's dedication to making healthier decisions in his or her diet and exercise habits. Members should also see their provider once they complete the program to have their weight checked and address potentially new barriers they feel may occur as they continue weight loss journeys.

In addition to CM programming, Passport offers Healthy Eating, Healthy Weight, and Physical Activity resources on the member website. The Healthy Eating resource links provide members with information on how to make healthy food choices and plan meals, and it connects members with the CDC's Healthy Weight program and the USDA's choosemyplate.gov. Members can calculate their (or their child's) BMI and can find tips on how to start a physical activity program. To encourage healthy activity for children or adolescents who are diabetic or pre-diabetic, we also offer "scholarships" to the YMCA to encourage exercise and provide them with a safe place to do so.

Passport utilizes the AAP recommendations regarding prevention, assessment, and treatment of child and adolescent overweight and obesity, and the American Heart Association (AHA), American College of Cardiology (ACC), and the Obesity Society (TOS) Guidelines (AHA/ACC/TOS) for the management of overweight and obesity in adults.

Management of Chronic Conditions

Condition Care

Passport offers members Condition Care, a highly coordinated and evidence-based disease management program focusing on asthma, diabetes, CAD, chronic obstructive pulmonary disease (COPD) and heart failure. Condition Care focuses on health education, self-management support, care coordination and close collaboration with the member's PCP and aligned, local care team.

Health educators and community health workers engage with members, their caregivers and family members, the PCP and other applicable providers, to facilitate communication across the entire care team, delivering evidence-based interventions that:

- Educate members on their targeted conditions, overall health and self-management
- Close relevant gaps in evidence-based care
- Improve medication adherence
- Reduce the incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support the provider/member relationship
- Emphasize and reinforce provider's use of clinical practice guidelines

Passport's health educator conducts an assessment and provides coaching, education and self-management education during interactions. Members will work with the Health Educator to develop an Action Plan that identifies personalized goals. If requested, members will also be mailed an educational booklet on their condition. Throughout the program, the Health Educator will provide self-management support, health education and coaching to improve the member's knowledge and self-management skills. When necessary, a local community health worker conducts an in-home assessment or other outreach visit, and coordinates access to community resources that support the member's Condition Care Action Plan. In addition to the interventions listed above, members engaged in the program can receive disease-specific interventions.

Disease specific objectives for the program are highlighted in **Exhibit C.24-17**.

Exhibit C.24-17: Condition Care Program Objectives by Condition

<p>Condition Care Asthma and COPD</p>	<p>Program objectives for the asthma program include:</p> <ul style="list-style-type: none"> • Increase the number of members with persistent asthma, ages five to 64, on controller medication for at least fifty (50) to seventy-five percent (75%) of their treatment period. • Increase the overall rate of members with persistent asthma, ages five to sixty-four (64), on controller medication that continue to refill the medication at least fifty percent (50%) of the expected number of refills. • Increase member and clinician compliance with the National Institutes of Health (NIH) Guidelines for the Diagnosis and Treatment of Asthma. • Reduce preventable inpatient admissions and ED visits. • Collaborate with members and their treating clinicians to develop an Asthma Action Plan. • Educate members on the use of an Asthma Action Plan. • Encourage members to manage their asthma day-to-day with using an Asthma Action Plan.
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	<p>Program objectives for the COPD Program include:</p> <ul style="list-style-type: none"> • Improve member and clinician compliance with the NIH global initiative for chronic obstructive lung disease (GOLD) Guidelines for medication and oxygen therapy. • Reduce the need for inpatient admissions and ED visits. • Increase the percentage of members in the COPD population knowledgeable in self-management skills. • Increase the percentage of members who receive appropriate pharmacotherapy management of COPD exacerbation. • Increase the use of spirometry testing to confirm COPD for newly diagnosed members.
Diabetes	<p>Objectives of the diabetes program include:</p> <ul style="list-style-type: none"> • During the measurement year, increase clinician adherence to American Diabetes Association (ADA) Standards of Care and the percentage of members receiving: <ul style="list-style-type: none"> — At least one HbA1c test — A Dilated Retinal Eye (DRE) Exam — Medical attention for nephropathy — Statin therapy and adherence • Increase the percentage of members with: <ul style="list-style-type: none"> — HbA1c good control of < 7% — HbA1c good control of < 8% — Blood pressure (BP) level of < 140/90 mm Hg • Decrease the percentage of members with: <ul style="list-style-type: none"> — HbA1c poor control of > 9% — Inpatient admissions — Readmissions within 30 days — ED visits • Promote healthy lifestyle, diet and nutrition, measurement of blood sugars as prescribed by the clinician, adherence to medication regimen, weight management, physical activity, smoking cessation, and adherence to recommended screenings/tests through targeted telephonic and educational mailings.
CAD	<p>Objectives for the CAD program include:</p> <ul style="list-style-type: none"> • Increase adherence to American College of Cardiology Foundation (ACCF) and the AHA Guidelines medication management protocols for coronary vascular disease. • Increase the percentage of members receiving angiotensin-converting enzyme (ACE) inhibitors post-myocardial infarction (MI).

	<ul style="list-style-type: none"> • Increase the percentage of members receiving beta-blocker treatment in all post-MI members unless contraindicated. • Increase the percentage of all adult members receiving (Lipid) Low-density lipoprotein cholesterol (LDL-C) screening. • Increase adherence to LDL-C monitoring in members with coronary vascular disease or hypocholesteremia. • Increase member adherence to the use of LDL-C lowering and antihypertensive drug therapy. • Increase member awareness of those risk factors that increase the risk of heart disease and stroke. • Promote healthy lifestyle, diet and nutrition, weight management, physical activity, smoking cessation, routine physician office visits, screenings and treatment.
Heart failure	<p>Objectives for the CHF program include:</p> <ul style="list-style-type: none"> • Increase provider adherence to the ACCF/AHA Guidelines regarding the use of ACE inhibitors, angiotensin receptor blockers (ARB), diuretics or beta blockers unless contraindicated through review and analysis of clinical and pharmacy data. • Increase member adherence with medications, sodium intake, and weight monitoring and management through risk stratification, telephonic outreach and educational mailings. • Decrease the frequency of CHF inpatient admissions, readmissions within 30 days, and ED visits through monitoring of inpatient, ED and readmission reports telephonic outreach, and educational mailings. • Promote healthy lifestyle, diet and nutrition, daily measurement of weight, physical activity and smoking cessation.

Helping Joe Gain Control of His Diabetes

Joe* is a 52-year old member who stratified for our Condition Care Diabetes program. During the needs assessment, Passport's Health Educator learned that Joe was concerned with monitoring his blood sugars and admitted that he does not routinely monitor them. His BMI is 41.0 with a HgbA1c of 9.1 and he shared that he does not know how to improve those numbers. Together they created goals to focus on symptom identification, monitoring, and management of low and high blood sugars, as well as healthy eating habits. The health educator began to work with Joe on a symptom response plan in coordination with an RN Care Advisor. They created a guide for Joe to use at home on the different ways he feels when his blood sugar may be low and when it may be high. They also began to work on routine monitoring of his blood sugars by ensuring Joe knew how to work his equipment—his goal was to begin monitoring six (6) to seven (7) times each day. Lastly, Kristy, our health educator, referred Joe to work with the Passport registered dietitian to help with healthy eating habits. Together Joe and the dietitian created grocery lists, meal plans, and healthy habits—they discussed the impact of skipping meals and discussed certain foods that he should avoid. After working together for one hundred two (102) days, Joe shared the results of his PCP appointment with his health educator.

His BMI was now 38.4, his HgbA1c was 7.6 and his oral insulin was decreased from two (2) times per day to once per day. *Member name changed for privacy.

BH Care

While BH care is integrated in all of Passport's care programs, Passport offers a targeted BH program for members with a primary behavioral health diagnosis who are at risk of an inpatient stay. A BH Care Advisor (licensed clinical social worker) provides health education, self-management support, and care coordination as well as consultation with an RN Care Advisor (as needed), to complete an assessment and create an individualized care plan to address the whole-health of the member. The BH Care Advisor works with the member, their PCP, caregivers, and community-based support services to increase the member's knowledge and understanding of his or her behavioral health conditions and improve access to BH and other specialty providers, community-based resources and support services.

The BH Care Advisor completes a comprehensive BH assessment that includes modules such as mood, personal safety, anxiety, and substance use; and evidence-based screening tools such as the patient health questionnaire (PHQ2) and 9, generalized anxiety disorder (GAD)-7 and CAGE-AID. Pediatric members are screened using tools such as the pediatric symptom checklist (PSC)-17, patient health questionnaire for adolescents (PHQ-A) or CRAFFT. Screenings are repeated within 30 days to assess improvement in functioning and symptom management.

In working with the member, the Care Advisor focuses on:

- Psychotropic medication education
- Education about the member's specific condition(s), interaction with co-morbidities, and "what to watch for"/relapse planning, including when to call the doctor; assisting the member to create a crisis plan
- Integrated care planning
- Ensuring adequate caregiver support and appropriate resources at home
- Arranging follow-up appointments, including an appointment with the PCP and BH providers
- Connection to community-based and peer supports

If the BH Care Advisor identifies any urgent care opportunities during an interaction with a member, he or she alerts the member's practitioner of the member's status via telephone, or secure email within one business day.

Remote Care Monitoring

Passport uses remote care telemonitoring to educate members about their chronic disease symptoms and provide them with the tools to recognize worsening symptoms before going to the emergency department or hospital. The technology is geared for members diagnosed with chronic conditions, such as diabetes, asthma and COPD, who would benefit from continuous health monitoring. When appropriate, the Care Advisor incorporates remote telemonitoring into their CM plan by arranging for members to obtain a specialized computer tablet, blood pressure cuff, oximeter and weight scale, which are all Bluetooth connected. The tablet transmits the member's vital sign information to our Care Advisors for monitoring any changes in their health status.

Education is an essential key to success with the remote telemonitoring program. Our Care Advisor systems flag indicators and what actions to take based on the readings. It is also important for members to complete the daily electronic health status survey that provides further insights into their condition. Should the member's condition worsen, the system indicates a red flag alert to our Care Management team, signaling changes in the member's vital signs. When appropriate, the Care Advisor calls the member, carefully listens to his or her concerns, discusses the issues and determines if additional measures are needed for health and safety.

The Care Advisor collaborates with the member's providers, keeping them fully informed about enrollment into the remote telemonitoring program, updates the member's current medical information and any interventions or actions needed for proper care continuity. By integrating telemonitoring into a member's care plan, the Care Advisor can help empower the member to better manage his or her own health. Through the use of technology and with the support of the Care Advisor, members become better educated on how to "read their numbers," what the numbers should be, and what steps they can take to bring those numbers under control.

Complex Care Management

Catastrophic Care

- The Catastrophic Care program focuses on two distinct populations:
- Members who experience a significant, potentially life-changing event or diagnosis, such as malignant cancer, degenerative neurological disease, respiratory failure, or liver diseases: Most of these members are identified through the UM authorization process for members admitted with one of the targeted conditions listed under Catastrophic Care Identification Criteria.
- Members with multiple, severe, intensive conditions: Management and support is provided to members and their caregivers in instances where a member has multiple chronic conditions with other significant comorbidities, or significant diagnoses and barriers, such as serious mental illness, cognitive and/or functional deficits, degenerative neurological diseases, etc.

The focus of the Catastrophic Care Management program is to provide members with access to quality care and services while coordinating benefits based on clinical need. Program goals and objectives include:

- Support the implementation of the member's PCP/specialist treatment plan
- Facilitate safe care transitions
- Honor the member's preferences for care
- Partner with the member, his/her caregiver(s) and the primary and specialty care providers to develop a personalized plan of care in the least restrictive setting
- Improve medication adherence
- Address member/caregiver needs regarding adequate support and resources at home
- Coordinate a comprehensive community-based and home health care network of services
- Identify and negotiate contracts with those services outside of the existing network
- Facilitate appropriate communication across the entire care team
- Support end-of-life and palliative care options with members and their physicians
- Optimize chronic CM and close relevant gaps in evidence-based care
- Educate members about diagnoses and self-management
- Lower total medical expense by avoidance of readmissions, ED visits, duplicative and unwarranted services, and specialist costs through coordinating care during acute, intensive care episodes

RN care advisors, in coordination with the PCP/specialist, member and caregiver(s) develop an individualized care plan. The care plan includes member-specific preferences, barriers, prioritized goals, self-management activities, referrals, a schedule of follow-up interactions, and a process to assess progress. The clinical teams' activities are targeted to facilitate the achievement of the member's health goals and to resolve issues/barriers.

As part of the assessment and care planning process, members may be referred to network, community or governmental support agencies to address individualized needs. The Care Advisor is responsible for ensuring members are referred to the extended care team that includes pharmacists, registered dietitians, social workers and BH Care Advisors, when appropriate. The Care Advisor determines if members are acting on referrals during follow-up care planning sessions. In addition, the Care Advisor team is responsible for identifying all relevant barriers preventing a member and/or caregiver from adhering to his/her physician's treatment plan and access to care. There are multiple forms of barriers, including physical or mental

disabilities, financial, language, hearing, motivation, culture, confidence barriers, as well as SDoH. It is a core responsibility of a Care Advisor to identify options and solutions to mitigate and remove barriers.

Complex Care

The Complex Care program consists of coordinated health care interventions and communications for members with multiple complex chronic conditions and psychosocial needs, in which member self-care efforts are significant. Program objectives are:

- Improve care coordination for members in physician settings
- Optimize chronic care management
- Educate members about diagnoses and self-management
- Implement care plans for high-risk members and members with complex care needs
- Improve medication compliance
- Address member/caregiver needs regarding adequate support and resources at home
- Improve adherence to the hospital discharge plans
- Decrease “avoidable” utilization events (e.g., readmissions)

Our predictive stratification identifies members at highest risk of avoidable acute utilization in the next six to 12 months, so the care team and providers can intervene before they require expensive care.

Once enrolled, the member works with the Care Advisor to complete a comprehensive member assessment and develop an individualized care plan with the multidisciplinary care team, member, PCP, specialist(s) and others involved in the member’s care. Any relevant condition-specific educational materials are mailed to the member, and the Care Advisor provides care coordination, including directing referrals to service providers and community-based programs and resources. As the member makes progress toward specific, personalized graduation goals, the Care Advisor offers support, reassessing and revising the care plan as appropriate.

Our local care teams work with the member’s PCP to help reinforce and support the close relationship between the member, PCP and specialty providers. In high-volume practices, we often embed Care Advisors who work closely with our members at the point of care, facilitating interactions with providers. CHWs are also assigned to certain practices. These member-focused resources are supplemented in many cases with Passport Population Health Managers, local resources who provide a population-level focus across a provider’s panel of our members. As a local health plan with local staff, we are fortunate to be able to implement this approach, which increases engagement on the part of both provider and member through the connection of our team.

Program content and interventions are specific to the individual’s condition and circumstances and are tailored to improve self-care and management of his or her condition. Content and interventions address:

- Condition monitoring, including self-monitoring (e.g., foot and skin care for patients with diabetes) and reminders about tests the member should perform themselves or complete through his or her practitioner

- Educational disease-specific booklets are available and reviewed with members. Booklet content includes disease specific education, detailed planning tools for self-management, symptom management information (e.g., managing and treatments for CAD, managing and adherence to medications, heart healthy eating)
- Communication with practitioners about member's health conditions, self-management/condition monitoring activities and care plan/goal progress (e.g., what to do before a visit to physician writing down important questions/issues)
- Additional resources external to the organization, as appropriate (e.g., community and wellness programs, ADA, American Lung Association, AHA websites)

When members show evidence of needing additional support around BH needs, appropriate referrals to our extended care team and/or BH specialty providers are made, and communication with the provider occurs when indicated.

Transition Care

Passport provides a Transition Care program for our members to safely and seamlessly transition back to their home after an inpatient medical or behavioral stay and reduces readmissions for recently hospitalized members. Our care team develops a member-centric transition of care plan and coordinates the appropriate level of care to help our members remain in their home environment and have a lower risk for hospital or ED readmissions.

Objectives of the program are to decrease avoidable readmissions, decrease ED utilization post-discharge and increase post-discharge follow up appointments in the outpatient setting, as well as supporting medication reconciliation, and adherence by creating a streamlined transition process and productive environment at home. Our clinical content in our Transition Care program is a synthesis of the Coleman Transition Model and the Project Red (Re-Engineered Discharge) Model requirements. Follow-up protocols include ensuring members have a post discharge follow-up visit with their physician, medication reconciliation, have a discharge plan, and the member can teach back his or her symptom response plan.

The Transition Care program initiates prior to a member's discharge from the hospital. Our Care Advisors and Health Educators work closely with the hospital discharge planning team to effectively coordinate and implement the discharge plan. Collectively, they provide proper continuity of care as members transition and achieve stabilized health. Every effort is made to make members and their caregiver feel respected, comfortable and at ease. Our team first takes the time to carefully listen and answer the member's questions. We then perform an assessment to identify any special needs the member may have, determine any health risks, reconcile medications for adherence and ensure the proper support resources are available. The assessment information is essential in developing the individualized care plan with the member, our team, caregiver and provider.

During the process, the Care Advisor or health educator shares all information with the member's providers to fully engage them in the development of the care plan, seek their input for treatment, and convey all information discovered through the CM outreach efforts. The team works to confirm the member is receiving the necessary care and services for health stabilization.

Other Programs for Special Populations

Mommy Steps & Newborn Care

Having a baby is a major life-changing event, filled with many physical and emotional changes. A mother's feelings and emotions can range from the highs of feeling overjoyed and excited about having a baby to the lows of feeling vulnerable and overwhelmed as the delivery and motherhood approaches. Passport's maternity program, Mommy Steps Maternity and Newborn Care, provides caring and compassionate support to our expecting members to promote healthy pregnancies and birth outcomes.

The program provides education and support for pregnant members *at all risk levels*. For moderate and high-risk members, it facilitates member understanding and responsibility of the high-risk pregnancy process as well as coordination of care between the member and/or caregiver and the practitioner. It emphasizes prevention of complications by providing support and care coordination to increase compliance with Passport's Perinatal Care Clinical Practice Guidelines which are based on the American College of Obstetricians and Gynecologists (ACOG) Guidelines utilizing member empowerment strategies. Passport has developed approaches to the management of members' high-risk obstetrical condition(s) in order to improve birth outcomes such as prematurity and low (LBW), and very low birth weight (VLBW).

The goal of the program is to improve the behavioral and physical health outcomes and quality of life of pregnant members and their newborns by using a multi-faceted approach to achieve the best possible therapeutic outcomes based on assessment of member needs, ongoing care monitoring, evaluation, and tailored member and practitioner interventions. To achieve this, Passport has specific programmatic goals that include promoting healthy pregnancies, reducing pregnancy-related complications, and improving birth outcomes. Our maternity clinical team achieves the program goals through the following objectives:

- Partner with member, their caregiver and their primary and specialty care practitioners to develop a plan of care
- Improve medication adherence
- Facilitate appropriate communication across the entire care team
- Close relevant gaps in evidence-based care
- Educate members on pregnancy complications and self-management
- Increase percentage of members who receive prenatal care within 42 days of enrollment or within the first trimester
- Increase percentage of members who receive a postpartum practitioner visit between 21 and 56 days after delivery
- Decrease the number of preterm deliveries (< 37 weeks)
- Decrease the number of LBW (1,501 grams to < 2,500 grams) babies
- Decrease the number of VLBW (≤ 1,500 grams) babies

Following delivery, mom and baby are followed in the Mommy Steps program until at least ten (10) weeks post-partum. Goals for newborns include:

- Identifying and educating members' parents on the importance of follow-up care
- Ensuring a secure and healthy transition of newborn from hospital to home

- Attendance at well baby visits and care for the newborns

Our holistic care model examines the member's behavioral and physical health status and support structure with family and/or caregiver in a systematic approach. Depending on the member's health status and caregiver support level, we offer a full range of integrated services to assist the mother during her pregnancy and post-delivery, which include:

BH: Passport knows that members with complications during or after pregnancy have a higher prevalence of postpartum depression, which can affect the mother's clinical outcomes and ability to manage her condition. We assess the mother for depression using the PHQ-2/Edinburgh Postnatal Depression Scale (EPDS) Assessment tools. If she screens positive for depression, she is referred to a social worker or behavioral health specialist, who assists the member in managing her depressive symptoms, provides education about depression and facilitates community-based connections.

Passport provides substance use disorder programs for pregnant mothers to overcome their addictions through extensive case management programs. The program offers tailored treatment options, education, and support for expected and new mothers to live a drug-free life for the health and well-being of them and their newborn.

Physical Health Behaviors: We have found that poor health behaviors impede many members' ability to manage their conditions during pregnancy. As a result, members' inability for self-management directly impacts adherence to their treatment plans. Passport identifies targeted behaviors identified through a screening/assessment or during ongoing member contact, which includes:

- **Nutrition:** Members identified with unhealthy diets are educated on the impact of diet during their pregnancy and encouraged to adopt healthy eating habits. These members may be referred to a dietitian, as appropriate.
- **Smoking:** For members who smoke, they are highly encouraged to participate in our smoking cessation program and are referred to the 1-800-QUIT-NOW line.
- **Exercise:** A regular exercise regimen promotes healthy living, and Passport encourages members to speak with their physician before starting an exercise routine.

Psychosocial Issues: The maternity Care Advisor screens members for psychosocial issues that may impact their ability to effectively manage complications during pregnancy. The screening process enables our Maternity Care Advisors to determine the member's needs related to caregiver support and resources, financial and transportation barriers, language preferences, and hearing or communication needs. Based on the screening results, the maternity Care Advisor develops a personalized care plan and interventions are implemented to fit the member's needs (i.e., TTY services for the hearing impaired and language services for non-English speaking members).

Caregiver Support: Having the appropriate social support system is important for members to be successful in their treatment plan. If the Maternity Care Advisors identify that a member needs a caregiver or additional caregiver resources, the Care Advisor engages a social worker for assistance. The social worker ensures the appropriate level of support is being provided; the caregiver is high-performing and helps in addressing any care gaps.

Self-Management Support: Passport's goal is for members to be able to eventually self-manage their care to gain personal freedom. Our Maternity Care Advisors work with members to develop and execute personal health care goals and use effective member coaching techniques in the process. The coaching methods include assessing the member's understanding of their treatment plan, educating on the importance of medication adherence, and managing their symptoms and complications.

NICU Support: Our Mommy Steps Maternity and Newborn Care Program incorporates specifically designed components to support babies in the neonatal intensive care unit (NICU) and their families. Our Care Advisors provide caring and compassionate coordination of care to stabilize the newborn's health, especially during the most critical time—the first 10 weeks of their life. The program extends beyond providing neonatal services while the newborn is in the hospital and offers transition of care services for the newborn to move safely from the inpatient setting to his or her new home.

Other programs for special populations include our Foster Care Program, Guardianship Care, Homelessness Services and Refugee Services. These programs serve Passport members at all risk levels and described above in **C.24.iv**.

C.24.iv.e. Description of the care planning process, including methods to ensure individualized and person-centered care plans, and summary of how the Contractor will include Enrollees, their caregivers, and multi-disciplinary teams.

Developing Member-Centric Care Plans in Collaboration with Providers

A summary of our care planning process is shown in **Exhibit C.24-18** and explained in more detail in the paragraphs that follow.

Exhibit C.24-18: Summary of Care Planning Process by PHM Risk Level

PHM Risk Level	Methods to ensure person-centered and individualized care plans in collaboration with members, caregivers and team for better health outcomes
Health promotion and Wellness	<ul style="list-style-type: none"> • HRAs • Action plans
Management of chronic conditions	<ul style="list-style-type: none"> • Comprehensive screening in addition to the HRA to identify individualized needs • Motivation interviewing with member and/or caregiver to understand their priorities, values, beliefs and preferences • Identify and address barriers • Assist member and/or caregiver with setting specific, measurable, attainable, realistic and timely (SMART) goals • Prioritize goals based on member and/or caregiver preference, including quality of life outcomes • Support member and/or caregiver with developing a self-management plan • Case conferences/rounds with interdisciplinary care team • Collaboration with provider through Identifi Practice, face-to-face, electronic or phone communication
Complex care management	<ul style="list-style-type: none"> • Comprehensive assessment in addition to the HRA to identify individualized needs • Conduct medication reconciliation • Motivation interviewing with member and/or caregiver to understand their priorities, values, beliefs and preferences • Identify and address barriers • Assist member and/or caregiver with setting SMART goals • Prioritize goals based on member and/or caregiver preference including quality of life outcomes • Support member and/or caregiver with developing a self-management and symptom response plan • Case conferences/rounds with interdisciplinary care team • Collaboration with provider through Identifi Practice, face-to-face, electronic or phone communication • When appropriate, joint conference with member, caregiver, provider and member of the care team

Passport’s care planning process begins with an HRA. The HRA is a standardized tool designed to collect certain health information from all of Passport’s membership. Passport attempts to collect an HRA from every member within 30 days of plan enrollment and then again annually. A member’s responses to the HRA are incorporated into risk stratification to help PHM staff understand the member’s risk level. Members determined to be lower risk (**Health Promotion and Wellness program level**) will receive **targeted campaign information to support activity completion**. The member’s PCP can view care gaps in Identifi

Practice and may reach out to the Passport PHM for assistance activating the member to schedule appointments to close the gaps.

Members identified to have potentially higher risk (management of chronic conditions or complex care management level) are referred to a CM program for engagement and completion of a comprehensive program-specific assessment/screening. The program-specific assessment is completed with input from the member, caregiver (with permission), providers and the interdisciplinary care team. We examine multiple aspects of the member's situation, including physical and BH, and psychosocial needs including any housing or financial assistance needs. The assessment is completed within thirty (30) days (or less) of identifying a member for a CM program and reassessments occur when a member's situation changes. Using our evidence-based algorithm, the member's assessment responses are utilized by the Identifi platform to detect potential areas of need and recommend clinical actions for our Care Management team to review.

Passport trains our PHM staff to “meet each member where they are,” which means listening to the member and their caregiver, learning about their beliefs and preferences, involving them in their care, and ensuring that their values guide all decision making. For example, a **member's desired wellness, health, functional, and quality of life outcomes** should dictate the care plan and determine how services are intended to help achieve these goals. This is foundational to the care planning process.

The process continues with the collaborative development of person-centered goals. Using the SMART framework, the care team work closely with the member/caregiver to identify the goals, break them down into manageable pieces, develop an Action Plan and follow up. The Action Plan includes tailored interventions that will support achieving the goal over time. For example, **social, educational and other services** to address barriers, such housing insecurity and financial strain. The Action Plan also highlights member risk factors and measures in place to minimize them (i.e., safe housing) as well as determining the motivation level of the member specifically for the individual goal. Those barriers are addressed through a multidisciplinary care team, including community health workers and social workers to connect the member (and ensure follow up) with necessary social services to ensure the member can live safely within the community.

Each care plan may include the following details:

- Care team contacts
- Member “concerns” (e.g., problems, conditions, etc.)
- SMART goals
- Planned interventions
- Identified barriers, including housing and financial barriers
- A schedule for follow-up and communication with the member
- Member self-management plans
- Social, educational and other services needed by the member
- Facilitation of member referrals to resources and a follow-up plan, considering appropriate level of care
- Education on Passport's benefits and available community resources

- Education on the member's specific condition(s)
- Symptom response plan
- Assess and establish appropriate timeframe for re-evaluation
- Monitoring and assessment of progress toward the goals of the care plan

Passport recognizes that members and circumstances change over time and our iterative model and platform capabilities enables our Care Advisors to easily update the CM plans to reflect the member's current interventions, goals and path to success. The **completed member needs assessment and care plan and updates are shared with the member, caregiver and provider** based on their preference. The care team also confirms that the appropriate medical and behavioral services are consistent with the PCP's medical diagnosis and clinical treatment plan

Evaluation of Care Planning Effectiveness

The ultimate goals of care planning are to provide direction for the care team, promote the use of evidence-based care, and track the member's progress toward goal attainment. We evaluate care planning effectiveness using quantitative and qualitative measures.

As part of the care planning process, care team members are responsible for documenting progress toward goal attainment, barrier(s) preventing goal attainment, and level of member importance in the Identifi platform. Progress toward goal attainment includes goals met, goals partially met and goals unmet. The specific barriers and pertinent dimensions are documented and categorized as well. Documenting and tracking the member's level of importance regarding the goals is a key part of self-management skill building and captured during encounters. Frontline team members are responsible for their documentation and measuring their member's progress to goal attainment. This information is shared and discussed during care team rounds, interdisciplinary meetings and with their people manager. Data across teams are aggregated and evaluated through the program evaluation process. To gain deeper understanding of the care plan effectiveness, Passport has put in place a formal audit program. This ensures that the person-centered care planning process is adhered to and contains all key quality components. Each month, five charts and two phone calls per PHM staff member are randomly selected to be audited. Chart audits are completed by an interdisciplinary team of trainers, auditors, managers and/or directors. Components of the chart audit include (among other items) timely assessment and care plan completion, member input into the care plan, and member prioritization of care plan goals. Likewise, when calls are audited, managers are listening for inclusive and person-centered language and interactions. PHM staff are given feedback monthly on their audit outcomes, with coaching where necessary to improve practices, which do not meet Passport's standards for work with our members.

C.24.iv.f. Stakeholder engagement strategies, including involvement of community resources to meet social needs.

Stakeholder Engagement Strategies

A summary of our stakeholder engagement strategies is shown in **Exhibit C.24-19** and explained in more detail in the paragraphs that follow.

Exhibit C.24-19: Summary of Stakeholder Engagement Strategies by PHM Risk Level

PHM Risk Level	Stakeholder Engagement Strategies
Health Promotion & Wellness	<ul style="list-style-type: none"> Serving on community committees Participating in coalitions Community service Advocate outreach and education Lifestyle Improvements for Everyone (LIFE)—health literacy program Collaboration with providers, including panel review with practice
Management of Chronic Conditions	<ul style="list-style-type: none"> LIFE—health literacy program Participating in coalitions Collaboration with providers, including panel review with practice
Complex Care Management	<ul style="list-style-type: none"> LIFE—health literacy program Participating in coalitions Collaboration with providers, including panel review with practice

As a local Kentucky-based plan with a history of serving the community, Passport is highly invested in the community and draws upon our strong relationships with community organizations to help meet the social needs of our members. We believe we can best improve the health and quality of life of our members when we work within communities to engage stakeholders. We can have a greater impact working together.

In 2019 we used the following strategies for stakeholder engagement:

- Serving on community committees
- Participating in coalitions
- Community service
- Advocate outreach and education
- LIFE—health literacy program
- Collaborating with providers

Passport staff serve on community committees and participate in coalition meetings to address many of the core issues our members face. Many of the coalitions our staff work with are focused on populations with complex care needs, such as individuals experiencing homelessness and newborns with neonatal abstinence

Serving our Communities in 2019

200 appointed boards, advisory committees, interagency councils, local chamber events, coalition meetings, re-entry coalitions, CHW associations, and more

1,912 one-on-one meetings with assisters, advocates, providers, and their staff, brokers, businesses, and pharmacies

214 formal presentations

syndrome (NAS). We also actively serve the communities we serve. Passport employees regularly volunteer at local nonprofit agencies and with community resources across the Commonwealth.

Passport's advocate outreach and education are focused on helping community stakeholders better understand our membership and benefits and services available to our members. **Our team works with more than 649 agencies**, including school and faith-based advocates, Family Resource and Youth Services Centers (FRYSC), community action agencies, interagency groups, advocates for people experiencing homelessness, extension offices, chambers of commerce, food banks, shelters, and Head Start.

"Passport's mission is to improve the health and quality of life for their members, and your NAS work continues to further that mission. Our Big Sandy NAS Prevention Coalition is a shining example of how collaboration among community partners can address a catastrophic issue like NAS in our region. With Passport's help, we have educated hundreds of people about NAS, hosted provider education events, and assisted in developing new programs that target the at-risk population. As NAS rates begin declining, it will be because of partnerships like ours."

—Danielle Franklin Harmon, Manager of Community Development, Appalachian Regional Hospital

Passport has redesigned our advocate web page to provide information to our community partners. This new page makes available information and resources these stakeholders may need to assist a Passport member. The web page contains an interactive map, so advocates may easily access contact information for the Community Engagement Representative in their area.

Passport has documented a sample of the thousands of interactions that have taken place in local communities to address the full spectrum of health and wellness, community engagement, and social/environmental issues across Kentucky's highly diverse communities at the regional, county and city/town levels. This sample of interactions is included in **Attachment A.1_Passport Community Engagement Examples** and is intended to serve as a description of the deeply embedded relationships Passport has across the Commonwealth not only with the geography but also within each *community*.

Passport's LIFE program provides health educators to lead health-related programs and events within Kentucky's communities. The LIFE program provides coaching and education about how to make changes to lead a healthier lifestyle. LIFE helps Passport engage stakeholders to make an impact at all PHM risk levels, especially at the health promotion and wellness and management of chronic condition levels. Health educators work with members at the individual level, but they also work with schools, churches, clubs, health departments, etc., to conduct classes and workshops on a variety of topics. These topics include proper hygiene, nutrition and exercise, violence prevention, disease management, decision-making and problem solving, stress and coping, and alcohol, tobacco and other drugs.

Perhaps Passport's most important stakeholders are our providers. Passport works collaboratively with our providers to understand their member population and the barriers they as providers face in meeting

members' needs. Passport connects provider staff with community resources and makes connections with agency social workers and leaders so that practices feel comfortable referring members for needed social services. Providers also refer members to Passport for assistance in meeting social needs. Because of Passport's strong connections in the community, our providers know we are likely to identify which resources can best help our members.

When Passport talks about community, we are talking about our community, including individuals experiencing homelessness, refugees, immigrants, internationals, people who are deaf or hard of hearing, grandparents/families raising children, foster families, people who learn differently, individuals with SUDs, people in domestic violence situations, former inmates, those with disabilities or special health care needs, or individuals experiencing barriers to accessing care—no matter their race, ethnicity, language, gender identity or age.

In these interactions in our communities, with our neighbors, we help members address their barriers to care, which could include:

- **SDoHs** such as housing, clothing, food security, transportation, education, record expungement, accessibility, and domestic violence/safety;
- **Health-Related Issues** such as dental, wellness and behavioral health/SUD, prevention/health education, vision, nutrition, substance use, heart health, respiratory care, cancer care; and
- **Community-Wide Issues That Create Barriers to Well-Being**, such as early childhood education, kindergarten readiness, school supplies, workforce-ready skills and after-school care.

We have served these communities since 1998 with passion and enthusiasm because these are our neighbors, in our community. We are extremely proud of the impact we have had on our fellow Kentuckians and look forward to the opportunity to continue to serve them well into the future.

C.24.iv.g. Technology and other methods for information exchange, as applicable.

Ensuring Connection with Members Through Technology

A summary of our technology and other methods for information exchange is shown in **Exhibit C.24-20** and explained in more detail in the paragraphs that follow.

Exhibit C.24-20: Summary of Technology and Other Methods for Information Exchange by PHM Risk Level

PHM Risk Level	Technology and Other Methods to Exchange Information
Health Promotion and Wellness	<ul style="list-style-type: none"> • KHIE • Member portal • Passport Go (phone, text, email) • Identifi Care (care team) • Identifi Practice (provider) • EHR integration—Bidirectional Care Gap Closure • Unite Us (Louisville)/Healthify (Statewide) • Phone, text message, email
Management of Chronic Conditions	<ul style="list-style-type: none"> • KHIE • Member portal • Identifi Care (care team) • Identifi Practice (provider) • Identifi Engage (member) • Unite Us (Louisville)/Healthify (Statewide) • EHR integration—stratification risk, program and care plan • Remote care monitoring • Phone, email
Complex Care Management	<ul style="list-style-type: none"> • KHIE • Member portal • Identifi Care (care team) • Identifi Practice (provider) • Identifi Engage (member) • Unite Us (Louisville)/Healthify (Statewide) • EHR Integration—stratification risk, program and care plan • Remote care monitoring • Phone, email

Passport is investing in the power of technology to better connect with members, providers and the community resources members need. Passport understands members and providers are increasingly connected via technology, and in many cases, they prefer technology for connecting and exchanging information. For that reason, Passport has implemented multiple mechanisms for technology interchange.

One main mechanism for information exchange is **KHIE**. To date, more than eighty percent (80%) of our population is sharing data on KHIE through seventy-three percent (73%) of our contracted providers. To further increase participation, Passport will communicate the benefits of participation, including:

- **Quality Measures:** Limitations of the claims data is well known, and the added availability of KHIE information will significantly improve Passport’s quality improvement efforts.
- **Risk Stratification:** Passport has access to artificial intelligence and machine learning CM but is limited by availability of comprehensive patient data.

- **Real-Time Alerts:** Availability of admission, discharge, transfer (ADT) data and other real-time information can drive creation of alerts for both providers and internal population health teams. This is especially beneficial for improving outcomes such as readmissions where the opportunity to intervene is very small.

Beyond highlighting benefits of participation, Passport will directly support provider adoption through the technical and financial incentives described below in **Sections C.24.iv.n.** and in more detail in **Section C.08.**

Ensuring Communication Among the Care Team

- **Member Portal:** The Passport Member Portal allows members to play an active role in managing their benefits. The Member Portal provides access to relevant information for members day or night, reduces customer service inquiries and promotes member satisfaction. With a few clicks, a member can choose from two or more health plan benefits and see the results displayed side by side. Members can ask to see coverage plans that require only a specific copay amount. In a matter of minutes, members can print their own temporary ID card.
- **Passport Go:** A new multiuse platform to communicate health-related information to our members through text, IVR, email and other forms of communication. Outreach is done in collaboration with provider offices to reach members for visits and reinforce the importance of the provider-patient relationship.
- **Identifi Engage:** A mobile chat application supported on both Android and iOS platforms is fully integrated with Identifi Care and Practice and fosters member engagement to effectively manage care and improve outcomes. Designed for members and their designated caregivers to easily interact with their care team, the secure mobile application provides chat capability between the care team and the member. It also helps influence member behavior by pushing the right interventions to the member.

Ensuring Communication Among the Care Team

Identifi Care, Passport's PHM technology application, offers a suite of fully integrated and clinical applications with access to data in real time, from any location. All system capabilities work together to ensure that all member interactions are fully informed with a complete, holistic picture of the member. Care Management team members can view all activities documented or captured in the Identifi platform across all applications. For example, notes entered by UM specialists can be viewed by Care Managers, and UM specialists can see if members are engaged in a clinical program to inform others on the care team of changing events. For non-Passport care team members, such as the member's PCP, Passport conducts outreach by telephone—or in person if appropriate—to ensure Passport remains apprised of the member's care needs.

Unite Us/Healthify: While many other health care organizations make referrals to community-based organizations, very few track those referrals to ensure a successful outcome, let alone attempt to understand the downstream impact on the member's health or social wellbeing. Through Passport's partnership with the Metro United Way, we supported the launch of United Community – a community-wide initiative to deploy an innovative, shared technology platform to initiate and close referrals across many organizations,



**Closing the Loop
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agencies, and services. Passport represents the health plan perspective on the United Community Governing Team, along with the Louisville Metro Health Department for the health provider perspective, Evolve502 for the educational perspective, and Metro United Way for the social services perspective. The United Community's goal to be the first shared community social services record in the country to include the local school system is on its way to reality. The platform was launched in April 2019 and Passport has taken the data from our work with connecting members to social service providers and helped to ensure that the providers our members work with most are included in the United Community.

To address the needs of those members outside of Louisville metro area, Passport uses an online directory of curated social resources called Healthify. It provides an online questionnaire for members to gain insights into their personal situation and allows for bi-directional communication between Passport's care team and the referring agencies to ensure members are following up and to understand the outcome of the referral.

Ensuring Coordination of Care with Providers

Identifi Practice is Passport's provider-facing portal that supports utilization, quality improvement and coordination of care. Practice is designed to inform providers about actionable opportunities within their member panels by surfacing information about gaps in care, active CM programs, and cost and utilization metrics. Identifi Practice integrates with provider EHR systems to promote data exchange, improving care efficiency and the accuracy of our risk stratification models.

Practice includes several prebuilt member rosters that can be further customized by providers and their staff. The Total Members roster includes a snapshot of all members attributed to a provider or practice, detailing the risk of impactable ED visits and inpatient admissions, status of CM programs, the number of open care gaps for each member, and chronic conditions identified for that member. A more focused Members with Care Gaps roster identifies all the open care gaps within a provider's panel.

Providers can obtain additional detail about a specific member from one of the rosters or by searching for members individually. From the member profile page, providers can view problems, goals and interventions for members enrolled in CM or view the complete care plan provided by the Care Advisor to the member. Providers can also access detail about open care gaps for that member and close care gaps based on education provided to the member or EHR chart review.

Practice also includes detailed interactive dashboards highlighting compliance with quality measures relative to targets or additional details about their panels including recent medical and pharmacy service history. Quality measure compliance is calculated by a customizable rules engine that includes both NCQA-certified HEDIS measures and "HEDIS-like" 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 dataset. This allows Passport staff to define quality improvement initiatives targeting specific measures and/or providers/practices based on current and historical performance.

Practice also allows providers and their staff to submit prior authorization requests (inpatient, outpatient, DME) directly to the Passport UM team. Providers and practice staff can edit requests after initial submission and upload supporting information electronically. The status of authorization requests is available in real time to Identifi Practice users (based on their security profile).

EHR Integration

To date, Identifi has integrated with the following EHR systems that may already be familiar names to Passport providers: Allscripts, Amazing Charts, athenahealth, Cerner, Centricity, eClinicalWorks, eMDs, Epic EHR, GE Centricity, Greenway Prime Suite, NextGen, Practice Fusion, ReLiMed and Quest Care360. The following EHR Integration solutions support our providers in the sharing and use of information to best care for Passport's members:

- **Single Sign-on (Unidirectional into Identifi Practice from EHR):** Allows providers to easily navigate to Identifi Practice directly from their EHR to access member data critical to value-based care. The single sign-on passes user login and Passport member Identification information so that the EHR user can transition into Identifi Practice workflows.
- **Identification of Risk Lives (Unidirectional into EHR):** Identifies members who are attributed risk lives, lists the types of PHM program(s) he/she is enrolled in and provides contact information for members' Care Advisors.
- **Care Gap Identification and Closure (Bidirectional):** Provides a proactive approach to flagging and closing care gaps before and at the point of care, increasing efficiency, reducing duplicative tests/procedures and ensuring appropriateness of care.
- **Care Manager Notes and Physician Messaging (Unidirectional into EHR):** Shares clinically relevant Care Advisor-member interactions in the EHR in the form of a Care Advisor encounter and Care Note, with the option of sending a tailored message to the member's PCP.
- **Intelligent, guided hierarchical condition category (HCC)/Risk Adjustment (RA) Documentation and Coding (Bidirectional):** Provides a logic-driven form within the usual member visit workflow to enable providers to easily capture the most accurate RA score for value-based members and help physicians document the supporting notes and visit-level diagnoses.
- **Care Plan: (Unidirectional into EHR):** Enables users to share and update care plans with the provider.

We also exchange information through phone and email. Members who do not have access to a phone or computer can complete HRAs on paper and mail them to Passport. The data will be entered into our Identifi information platform and used for identification and stratification. The care team will follow up with the member by phone to address any needs.

C.24.iv.h. Frequency of provision of services.

Frequency of Provision of Services

A summary of our frequency of provision of services by risk level is shown in **Exhibit C.24-21** and explained in more detail in the paragraphs that follow. EPSDT, gaps in care, tobacco cessation and healthy weight resources are available to all risk levels.

Exhibit C.24-21: Summary of Frequency of Provision of Services by PHM Risk Level

PHM Risk Level	Passport Program	Minimum Frequency of Services	Program Duration
Health Promotion and Wellness	Care Compass	Every two weeks	90 days
	EPSDT	At least annually, and in line with HEDIS recommendations for age	Until age 21
	Care Gaps	At least once per care gap identified and again if the care gap is not closed within a specified time frame	As gaps are identified
Management of Chronic Conditions	Condition Care	Every three weeks	90 days
	Behavioral Health Care	Every two weeks	120 days, unless degradation in condition management is noted
	Remote Care Monitoring	Every three weeks or when sent a telemonitoring alert	90 days, unless degradation in condition management is noted
Complex Care Management	Catastrophic	Every two weeks	90 days, unless degradation in condition management is noted
	Complex Care (with integrated BH and SMI)	Every two weeks	120 days, unless degradation in condition management is noted
	Mommy Steps Maternity and Newborn Care	Every two weeks	Through 10 weeks postpartum
	Transition Care	Every week	30 days, unless degradation in condition management is noted

Frequency of outreach and provision of services varies based on each member's risk level, complexity of their condition and in which program they are engaged. Newly enrolled members may require much more frequent interactions than members who have strong self-management skills and whose conditions have shown improvement. Our outreach process includes contact attempts by telephone, email or in person. We make at least three attempts to contact members we are trying to engage in a CM program, making phone calls or face-to-face attempts on different days of the week and times of day with each new outreach attempt. If we are still unable to contact the member, we contact the member's PCP or other health care provider to try to obtain a usable number. We also send the member a letter welcoming them to the CM program with relevant information about the program and a number to call to learn more or enroll.

All programs at each PHM risk level are supported by a registered dietitian, a clinician and a clinical pharmacist who are available for consultation or additional outreach and intervention as needed. Members are reassessed if their condition, circumstances or needs change (e.g., a new diagnosis, inpatient admission or ED visit) or if they become homeless. In addition, a new assessment is completed annually, when the member requests, and upon referral from a provider or social service agency.

Health Promotion and Wellness

Health promotion and wellness programs are focused on educating lower-risk members about appropriate well care, how to access needed services and addressing social needs. Members at this level receive less frequent phone or face-to-face contact from Passport.

Management of Chronic Conditions

Members in our Condition Care and Behavioral Health Care programs receive more frequent contact either by phone or face to face. Health Educators contact members engaged in Condition Care at least once every three weeks. Members in Behavioral Health Care receive contact from a Care Advisor at least once every three weeks. These programs are for moderate-risk members.

Complex Care Management

Members engaged in Catastrophic Care, Complex Care, and Mommy Steps and Newborn Care receive contact from their Care Advisor and/or CHW at least once every two weeks. These high-risk members need more intensive intervention to help them achieve better health outcomes. Members in Transition Care are engaged immediately following an inpatient hospitalization. Contact with them is weekly to help avoid a readmission.

Regardless of program and risk level, Passport members receive regular mailings such as the *MyHealthMyLife* newsletter, and a portion of our members opt in receive text messages alerting them to needed well visits. Members may also receive and send chat messages with their care team via Identifi Engage. These contacts are as frequent as needed for the member and do not take the place of phone or face-to-face clinical sessions.

C.24.iv.i. Priority areas (e.g., specific health risks, conditions, social determinants of health, etc.).

PHM Programs Are Focused on Priority Areas

A summary of our priority areas is shown in Exhibit C.24-22 and explained in more detail in the paragraphs that follow.

Exhibit C.24-22: Summary of Priority Areas by PHM Risk Level

PHM Risk Level	Priority Areas—Specific Health Risks, Conditions, SDoH
Health Promotion and Wellness	<ul style="list-style-type: none"> • Screening and immunizations • Care gaps (e.g., HEDIS) • SDoH support • Tobacco use • Healthy weight
Management of Chronic Conditions	<ul style="list-style-type: none"> • Chronic conditions • BH • SUD • SDoH support
Complex Care Management	<ul style="list-style-type: none"> • Severe or debilitating conditions • Complex chronic conditions (often with co-occurring BH) • High-risk pregnancy • Low birthweight • SDoH support

Each PHM program focuses on a specific priority area, such as adults and children with special health care needs, high-risk pregnant women, and members identified by specific criteria and/or predictive analytics. Across all programs, Passport also uses external data to detect any SDoH risk factors affecting our members to provide better comprehensive CM services. Our system integrates dispersed SDoH data sources at different levels (e.g., individual, census block, census tract) across five (5) main domains (housing instability, transportation barriers, food insecurity, financial stress and health literacy). While these factors are already included in our risk stratification algorithm, late in 2020 the platform will create a distinct Social Needs Index (with five levels) that indicates SDoH-related risks that could affect members' health outcomes. The advantage of having one single index indicating how an individual's social needs place health outcomes at risk will not only be the ability to prioritize members for outreach and engagement, but also the simplification of the workflow for Care Advisors to integrate social support into clinical CM. We will use the index to direct efforts and resources to the most at-risk members and pinpoint their individual needs.

Care Compass. The Care Compass team, including Care Coordinators, CHWs and clinicians, help members navigate the complexity of the health care system while empowering them through self-management skill building. Specific services include:

- Identifying needs and available resources

- Resolving barriers
- Facilitating referrals
- Scheduling and coordinating appointments
- Supporting gap closure
- Coordinating transportation

While a member may be referred to address a specific need, such as transportation, the Care Coordinator will screen the member for uncovered SDoH needs or gaps and develop an Action Plan in collaboration with the member. Outreach occurs at a minimum of 20 days and more frequently if needed. A Care Advisor (nurse), registered dietitian, and/or pharmacist will be consulted and/or referred to as appropriate throughout the duration of the program. Passport goes beyond merely identifying and referring members for services. Team members conduct follow-up to ensure that the referral was completed and met the member's needs—we call this a closed-loop referral. Additional goals for each member in the Care Compass program include:

- Member has established PCP relationship
- Member is connected to necessary resources, equipment and supplies
- Member takes an active role in his/her own care

Passport intends to use the Care Compass program to support member needs comprehensively through care coordination, support and customer service. This program is fully developed, with launch implementation planned for Q3 2020. Members who are not identified for one of our other PHM programs but have identified care coordination needs due to barriers or SDoH will receive support and assistance through our Care Compass program. This program is designed to focus on health promotion and wellness. Many of Passport's HEDIS campaign efforts, EPSDT outreach and other care coordination initiatives end with members engaging in Care Compass for other SDoH needs.

Condition Care. The Condition Care program is designed for members with primary diagnoses of asthma, diabetes, COPD, CHF or CAD. This level of risk program is to support management of chronic conditions.

Adult members identified for this program have prior medical history available to Passport that indicates the presence of one of these conditions and meet at least one of the following criteria:

- Inpatient admission for the specific condition within the past six months
- Condition-related ED visit within the past three months
- Members without a PCP or condition-related specialist visit within the past twelve months
- Care gap specific to the member's condition, with the exception of CHF

Members under 21 years of age with asthma or diabetes and at least one of the following:

- Inpatient admission for the specific condition within the past six months
- Condition-related ED visit within the past three months
- Without a PCP or condition-related specialist visit within the past 12 months
- Care gap(s) specific to their condition

Complex Care. The Complex Care program is designed to address the impactable top three to five percent (3%-5%) of our membership and to reduce avoidable admissions. This program supports members identified through predictive modeling most likely to incur an acute and ambulatory treatable adverse event. Some of the covariates include coexisting chronic conditions, prior utilization, change in utilization rates, drugs that indicate disease progression or severity, medical equipment, and gaps in care.

Catastrophic Care. Multiple data sources, identified below, are used to identify members appropriate for the Catastrophic Care program. This program is also designed to support members with complex care risk level. Adults identified for this program have two or more inpatient stays in the last year and a primary diagnosis of one of the following:

- Amyotrophic lateral sclerosis
- Hemophilia/coagulation disorders
- Gaucher's disease
- Guillain-Barré syndrome
- Liver failure
- Cystic fibrosis
- Respiratory failure
- Ventilator dependency
- Severe cognitive functional impairment
- Burns >20% total body surface or second- or third-degree burns
- Spinal cord injuries
- Paraplegia with complications
- Sickle cell disease
- Malignant neoplasm disease
- Cerebrovascular accident
- Cerebrovascular hemorrhage
- Pediatric members can also be identified for Catastrophic Care.

Members under the age of 18 with two or more inpatient stays in the last year, or nine or more medications prescribed within six months or with any of the following conditions are stratified for Catastrophic Care:

- Malignant lymphoma
- Pediatric sickle cell anemia
- Hemiplegia
- Metastatic solid tumors
- Pediatric epilepsy
- Leukemia
- Hemophilia and coagulation disorders
- Pediatric juvenile rheumatoid arthritis

Transition Care. Members at risk of having a 30-day readmission after discharge from an inpatient setting are identified for Transition Care program. Members are identified through predictive modeling with risk factors such as prior admissions and increasing or decreasing rate of health care utilization in last three months; recent lab results testing albumin, bilirubin, glucose and estimated glomerular filtration rate levels;

history of being discharged to a setting other than home; and many SDoH factors such as level of housing, transportation cost burden, and the percentage below poverty in a member's census tract/block.

BH. Passport's integrated BH program identifies members at risk of an inpatient admission resulting from a behavioral or physical health-related concern. However, we support BH across all risk levels depending on need. Members are identified through predictive modeling with risk factors such as:

Adult:

Serious mental illness—any mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities:

- Anxiety disorders
- Bipolar disorder
- Depressive disorders
- Dissociative disorders
- Eating disorders
- Obsessive-compulsive disorders
- Personality disorders
- Schizophrenia spectrum and psychotic disorders
- SUDs

Pediatric/Adolescent:

- Serious emotional disturbance—any mental, behavioral or emotional disorder that results in functional impairment that substantially interferes with or limits functioning in family, school, or community activities
- Adjustment disorders
- Anxiety disorders
- Attention deficit hyperactivity disorder
- Bipolar and related disorders
- Depressive disorders
- Disruptive, impulse control and conduct disorders
- Dissociative disorders
- Elimination disorders
- Feeding and eating disorders
- Learning disorders or intellectual disabilities
- Neurodevelopmental disorders (autism spectrum disorder, tic and Tourette's syndrome, stereotypic movement disorder)
- Obsessive-compulsive related disorders
- Schizophrenia spectrum and psychotic disorders
- Sexual and gender identity disorders
- SUDs
- Trauma and stressor-related disorders

Mommy Steps and Newborn Care. Passport's Mommy Steps program is for all pregnant women. Women with lower risk pregnancies receive member education and an invitation to work with a Care Advisor as

needed. **High-risk** members receive contact at least every two weeks from an RN Care Advisor for support for mom and baby through 10 weeks postpartum or longer as needed, for instance in the case of a NICU baby. Members are identified as high risk when they have risk factors such as:

- Young maternal age (≤ 18 years of age)
- Underweight (BMI less than 18.5)
- Tobacco/Electronic Nicotine Delivery System Use, Alcohol or Substance Use
- Currently in a substance use treatment program
- Prescription opioid use
- Homelessness or unstable housing
- Domestic violence/intimate partner violence
- Unwanted pregnancy
- SMI/SED (including eating disorders)
- PHQ-9 score ≥ 15 , GAD-7 score ≥ 15 , CAGE AID score ≥ 2
- Chronic medical conditions (diabetes, hypertension, asthma, systemic lupus erythematosus, chronic renal disease, cardiac disease, thyroid disease, seizure disorders, sickle cell disease, HIV)
- Gestational diabetes in current pregnancy
- Hypertensive disorders of pregnancy in current pregnancy
- Placental abnormalities
- Fetal complications
- Preterm labor
- Short interpregnancy intervals (less than six months)
- History of preterm spontaneous delivery less than 37 weeks' gestation
- Preterm Premature Rupture of Membranes (PPROM)
- History of cervical insufficiency/incompetent cervix in previous pregnancy
- Antepartum inpatient admission in current pregnancy
- Two or more inpatient admissions in previous 6 months
- Maternal postpartum inpatient admission
- Edinburgh postnatal depression scale score ≥ 10 and/or member reports thoughts of self-harm or harm to baby
- Fetal death (stillbirth) ≥ 20 weeks' gestation or neonatal death
- Newborn discharged not in mother's custody
- Newborn admitted to NICU

C.24.iv.j. Description of staffing for each risk level, including staff to Enrollee ratios, modes of interface with Enrollees, and use of care managers.

Integrated Team Centrally Focused on the Member

A summary of our staffing by risk level is shown in **Exhibit C.24-23** and explained in more detail in the paragraphs that follow.

Exhibit C.24-23: Summary of Staffing by PHM Risk Level

PHM Risk Level	Passport Program	Staff Type(s)	
Health Promotion and Wellness	Care Compass	<ul style="list-style-type: none"> Community Engagements Representatives Population Health Managers Community Engagement Health Educators Quality Outreach Specialists Care Connectors 	10,000:1
	EPSDT		
	Care Gaps		
Management of Chronic Conditions	Condition Care	<ul style="list-style-type: none"> Health Educator 	70:1
	BH Care	<ul style="list-style-type: none"> Complex care (adult and peds) staffed by an RN/licensed clinical social worker (LCSW) 	50:1
		<ul style="list-style-type: none"> Management of chronic conditions (adult) and moderate risk (peds) staffed by an RN/LCSW 	60:1
		<ul style="list-style-type: none"> Health promotion and wellness (adult and peds) staffed by a CHW 	75:1
	Remote Care Monitoring	<ul style="list-style-type: none"> Health educator 	70:1
Complex Care Management	Catastrophic	<ul style="list-style-type: none"> RN Care Advisor 	50:1
	Complex Care (with integrated BH and SMI)	<ul style="list-style-type: none"> Community Health Worker 	34:1
		<ul style="list-style-type: none"> RN Care Advisor 	65:1
	Mommy Steps Maternity and Newborn Care (high risk)	<ul style="list-style-type: none"> RN Care Advisor (for high-risk members) 	60:1
	Transition Care	<ul style="list-style-type: none"> Health educator/RN Care Advisor Team The RN reviews all medication reconciliation and conducts via weekly huddles with health educators to provide guidance. 	30:1

Our CM program fully supports the member and provider relationship. We understand this connection is vital in the development of the care plan, prevention of medical complications and incidents, and creating a

positive member experience. We also encourage any specialist involved with a member to be a part of the CM process.

Care Team Approach and Use of Care Advisors

The multidisciplinary team uses the broad clinical skills and expertise of a Care Advisor, registered dietitian, clinician, licensed pharmacist, health educator, CHW, Program Coordinator, providers, family and/or caregiver—who are all centrally focused on the member. Care Advisors help the team identify barriers to care and services as the care plan is developed. They empower the member, support behavior modification, close care gaps, address medication adherence and coordinate care. The Care Advisor or Health Educator assesses the member’s health fluency (the degree of their understanding of their condition and needs), physical functioning and emotional well-being, and determines whether referrals to local or external resources are needed. Together, the team provides the needed CM services for members to be successful in achieving their health care goals. Passport’s care team roles and responsibilities are outlined in **Exhibit C.24-24**.

Exhibit C.24-24: Passport’s Care Team’s Roles and Responsibilities

Staff Role	Role Type	Licensure Required	Ratio	Primary Responsibilities
Medical Director	Clinical	Yes	Not applicable	<ul style="list-style-type: none"> Oversees all major health programs including PHM Provides clinical leadership Establishes treatment policies, protocols, quality improvement activities, PHM activities and UM decisions Participates in integrated care rounds
Care Advisor Team Manager	Clinical	Yes	Applicable only for groups with fifteen (15) or fewer direct reports. In that instance will need to outline partial caseload requirement	<ul style="list-style-type: none"> Manages/supervises the day-to-day activities of the Care Advisor team Facilitates and leads integrated care round and case review conferences Provides performance coaching and feedback to team members Evaluates reports and performance regularly with the team Conducts audits

Staff Role	Role Type	Licensure Required	Ratio	Primary Responsibilities
Registered Nurse or Licensed BH Care Advisor	Clinical	Yes	Please refer to Exhibit C.24-22 for caseloads by program	<ul style="list-style-type: none"> Facilitates the primary relationship with members and their PCPs Conducts comprehensive assessments, screenings and medication reconciliation for members Provides self-management coaching and care coordination services and refers member to other care team members as appropriate Develops, implements and evaluates the care plan
Registered Dietitian	Clinical	Yes	Approximately 35:1 (shared case load with Condition Care)	<ul style="list-style-type: none"> Supports the Care Advisor by providing food and nutrition advice and counsel to members Assesses dietary and health needs of members; develops meal plans Identifies barriers and problem-solves with members to promote or maintain adherence Links members with local network dietitians to develop a comprehensive nutritional/dietary plan
Clinician	Clinical	Yes	Approximately 200:1	<ul style="list-style-type: none"> Helps Care Advisor identify and remove behavioral, social, economic and safety-related barriers to care and care plan adherence, including referrals to psychiatrists and network social workers Identifies and provides access to network, community and governmental support services to meet members' key needs Maintains database of local resources for members and their caregivers
Licensed Pharmacist	Clinical	Yes	Approximately 65,000:1	<ul style="list-style-type: none"> Supports Care Advisor in conducting comprehensive medication review, identifying drug/drug interactions and reconciling medication Works with providers to modify medication regimens, when appropriate, to better meet members' needs

Staff Role	Role Type	Licensure Required	Ratio	Primary Responsibilities
Health Educator	Non-Clinical	Passport requires our health educator to be licensed, though it is not required by the Commonwealth	Please refer to Exhibit C.24-22 for caseloads by program	<ul style="list-style-type: none"> • Supports the Care Advisor by providing self-management coaching and care coordination services • Makes necessary linkages to meet member/caregiver needs • Engages/motivates members to make vital changes in their lives • Recognizes member/caregiver feelings and perspectives and takes interest in their concerns • Communicates member/caregiver needs and coordinates interventions with RN, as needed
CHW	Non-Clinical	No licensure requirements	Please refer to Exhibit C.24-22 for caseloads by program	<ul style="list-style-type: none"> • Conducts interviews with members to determine health literacy and the need for interpreter services • Conducts outreach calls to encourage members/caregivers to participate in CM programs • Helps providing information/referrals to governmental and community agencies • Schedules provider visits on behalf of the member • Maintains library on current available community resources
Program Coordinator	Non-Clinical	No licensure requirements	Not applicable; provides staff support	<ul style="list-style-type: none"> • Works under the direction of the Care Management team by generating reports and assigning cases to teamwork list/action item list • Sends out letters and helps the team manage to service-level and timeliness metrics • Takes inbound calls from members and connects them to the appropriate Care Management team member

Modes of Interface

Passport's PHM team across all programs uses multiple modes of interface to engage our members. Culturally and linguistically appropriate outreach occurs through numerous methods including **face-to-face, phone** (Passport will make at least three attempts to contact members by phone, with the three attempts on different days at different times. If we do not have an active telephone number for the member, we will contact the member's PCP or other health care providers to try to obtain a usable number or other methods they have used to successfully contact the member. **Passport Go** also is accessed for member phone numbers), **mail, email and through our Identifi Engage app**. The combination of these approaches enables Care Advisors, health educators, CHWs, and others to find and use the method of contact that is most appropriate to meet the member's unique needs.

Passport members take the lead and let us know the best place to meet with them face to face. It could be their home, the provider's office, homeless shelter or most any place they feel comfortable meeting with us.

Through our program evaluations, we have found that **face-to-face visits** are crucial to keeping our members engaged. Face-to-face visits provide our care team with the opportunity to provide high-touch support and coordination. Physical and Behavioral Health Care Advisors often meet with the member at the provider's office to discuss the member's care plan face to face.

Health educators and RN Care Advisors who are part of our Transition of Care program strive to **meet with members in the hospital prior to discharge** and then again at **their home in the days immediately following the discharge** to ensure coordination of services following discharge from an inpatient hospitalization. Meeting with our member while in the hospital is beneficial to ensuring discharge instructions are understood and carried out at home, as well as their overall understanding of their individualized plan of care. **Home visits** enable our care team to assess the home environment, reconcile medications and inform members of their benefits, available health plan programs and local community services. Passport's maternity and newborn RN Care Advisors request to **meet families face to face at the hospital when infants are being cared for in the NICU** to ensure they have everything in place to care for their newborn at home after discharge.

C.24.iv.k. If applicable, value-based payment (VBP) or incentive models the Contractor will include in Provider agreements to support involvement in the PHM Program.

Using Value-based Payment (VBP) for PHM Improvement

Passport is committed to helping providers achieve better performance results and improved health and wellness for members through better management of chronic and complex conditions. Our expectations and mutual obligations regarding participation in clinically based PHM activities that support these goals appear in our Provider Handbook, where we describe the use of clinical guidelines and the quality measures

that reflect good care. We support providers in achieving these goals by delivering specific, actionable data and guidance via our Population Health Manager communications and relationships. This support simultaneously helps providers feel heard, while assisting in moving providers along the glidepath to risk.

In addition, providers who are further along in the move to VBP and who participate in Passport's HealthPlus program enter into a formal contract amendment specifying expectations and potential rewards. Passport's obligations to them include, among others, on-site support for clinical and administrative issues, access to CM services and extensive analytic support. The path providers take to risk and the supports supplied to them by Passport are discussed in detail below.

Supporting Providers on Their Path to Risk

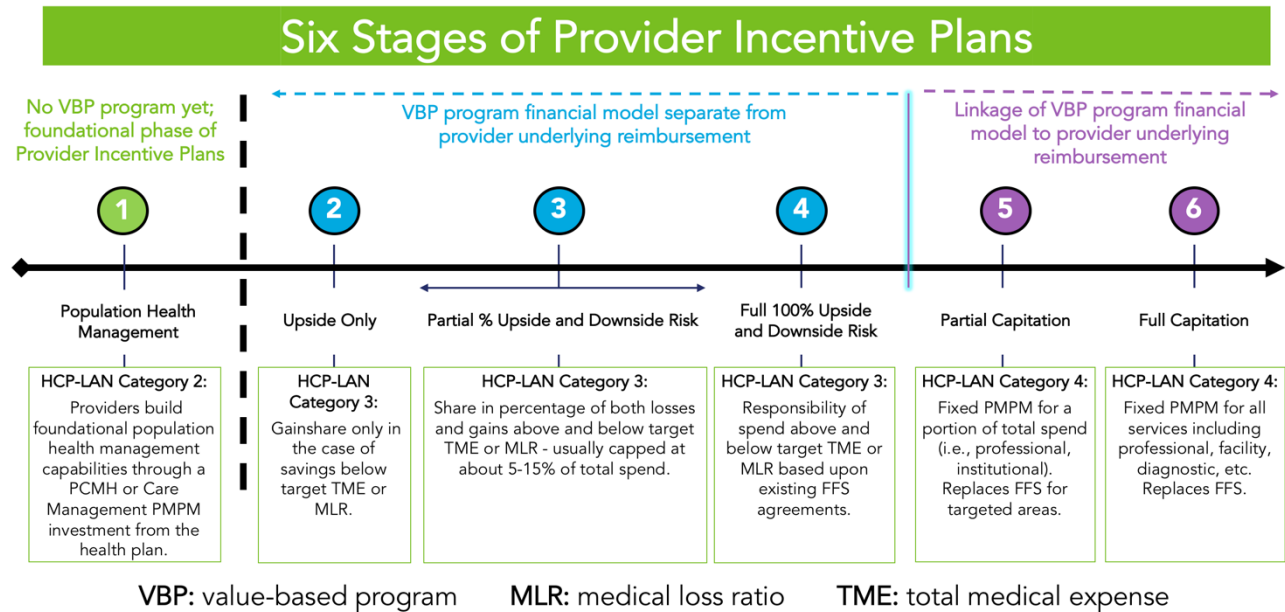
Passport knows taking on risk is often intimidating for providers, and they are therefore hesitant to engage in a shared savings program. Many providers across the country, including those in Kentucky, are in the early stages of risk readiness. We are unique in our commitment to understanding the challenges providers face in the shift to VBP and have taken meaningful steps to ensure the provider community has direct input into the evolution of VBP through forums such as the Partnership Council.

A majority of providers in our network still need to enhance their PHM capabilities before they will be ready for any shared savings risk that might potentially affect their fee-for-service compensation, let alone a capitated payment that would replace it. As such, Passport has developed a spectrum of Provider Incentive Plans, defined as any compensation program that rewards providers for improving the quality of patient care and outcomes. While a Provider Incentive Plan is most often implemented in the form of a VBP program, it can also take place through per member per month (PMPM) incentives that help the provider establish PHM infrastructure (see **Exhibit C.24-25**).

In response to feedback, Passport has partnered with providers to administer foundational Provider Incentive Plans to establish population health infrastructure such as a PMPM payment for CM services or Patient-Centered Medical Home (PCMH) certification. These programs help providers build core VBP capabilities by allowing for incentives to positively change behavior.

The below exhibit depicts the six (6) stages of Physician Incentive Plans. The first phase is a preparation phase, focused on building core population health capabilities through a PCMH or CM PMPM program. Stages Two through Six incorporate a VBP program with increasing levels of provider risk. In the case of more advanced risk, such as partial or full capitation, providers may or may not participate in a VBP program as defined by CMS' Health Care Payment LAN Framework (HCP LAN). Capitation alone does not necessarily improve quality of care, nor does it allow the arrangement to align with CMS' HCP LAN Framework. For this reason, when Passport's providers are ready for capitation arrangements, we intend to incorporate a VBP program.

Exhibit C.24-25. Glidepath of Physician Incentive Plans



Passport will advance its Physician Incentive Plans and VBP programs when providers are ready and willing. Passport will use CMS' HCP LAN Framework which outlines a four-category payment model classification system as our guide for defining Physician Incentive Plans, including VBP programs:

- 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 (APMs) built on fee-for-service architecture
 - Including: APMs (VBPs) with upside gainsharing or APMs (VBPs) with upside gainsharing & 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. However, Passport's primary care upside-only VBP program, HealthPlus, aligns with LAN Framework Category 3. Passport's goal is to graduate as much of its network into some form of risk sharing through Category 3 (financial model separates from underlying reimbursement) and Category 4 APMs (financial model linked to underlying reimbursement, such as bundled payments).



While Passport is evolving its VBP 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 done deliberately and incrementally, and as such has developed a tiered VBP program framework that allows for more mature models as providers continually master population health capabilities.

The VBP program strategy has 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 Joint Operations Committee (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 Emergency Department 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 medical expense ratio (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 further reduce.

Our VBP models have a sliding scale in 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 plans to continue to engage more groups in shared savings VBP programs. As providers establish foundational capabilities for upside gain share VBP programs and become comfortable in Population Health Management (PHM) 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.

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 few years. We have taken meaningful steps toward ensuring the provider community, such as through the Partnership Council and PCP Workgroup, has direct input to the evolution of our VBP programs and that they have the support they need to be successful. Passport refined the models we currently have in the market based on our learnings and input from the provider community.

Passport and its vendor, Evolent, have deployed VBP programs along the HCP LAN Framework and care continuums that: 1) demonstrate Passport's experience launching a provider-centric primary care VBP

program, 2) demonstrate our behavioral health shared savings model, 3) exemplify a VBP pilot for a specialty population, and 4) highlight a sample downside risk arrangement that incorporates capitation in another market supported by Passport’s vendor, Evolent. Below we detail our largest initiative, a VBP program for primary care. Refer to C.03 Capitation and C.09 Quality Management and Health Outcomes for additional information on Passport’s other Physician Incentive Plans, including the aforementioned VBP programs.

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

- Ensure the 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 PCPs—pediatric, family medicine and adult-only internal medicine practitioners. Continuously 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 gain-share program that rewards providers for improved cost and quality outcomes after a quality gate have 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 below, where “MER” is medical expense ratio, the percentage of premium spent on health care for assigned members, and “YoY” is short for year over year.

There are three separate earning mechanisms a provider group can yield savings incentive.

- **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* includes fifteen quality measures that can be customized to the needs of the specific practice, such as adjusting for adult primary care or pediatric care. Performance is measured on a

calendar year and rewards are paid out the following year once claims have matured, creating an accurate measurement of the provider's performance (see **Exhibit C.24-26**). These quality metrics were carefully selected with the PCP Workgroup focused on performance opportunities for the health plan and aligned with areas in which providers felt they could make a meaningful impact. The metrics were then refined based on participating group feedback through in-person meetings and a survey. Please see Section C.03 Capitation for additional details on how the program evolved from 2018 to 2020.

Exhibit C.24-26: 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 Joint Operations Meetings 2. Practices' key location(s) physician/clinical leadership and administrative leadership attendance at monthly Care Conference Meetings 	20% Weighted All
Potential Diagnosis Addressed Rate	<ol style="list-style-type: none"> 1. Medicaid Condition Addressed Rate – The percentage of suspect conditions addressed for patients identified as having an intervention opportunity 	20% Weighted All
Patient Experience	<ol style="list-style-type: none"> 1. The personal doctor explained things 2. Personal Doctor showed respect 	10% Weighted All

In 2018, **participating provider groups generated \$6.7M in shared savings**. Of the participating groups, a large practice serving the needs of adult and pediatric patients 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.24-27** reflects the final performance evaluation for participating groups in 2018.

Exhibit C.24-27: 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%
Prevention/ Quality 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%
Patient Experience	Personal Doctor Explained Things	86%	86%
	Personal Doctor Showed Respect	86%	86%

Supporting Population Health Management Through VBP

Provider payment models are not considered “value-based” unless payments have a strong link to improved outcomes and cost savings. **Exhibit C.24-28** offers a list of “measures that matter” for PCPs, hospitals and specialists that are considered in conjunction with the various domains and quality gates. This is a nonexhaustive list of metrics that support our VBP programs and quality gates.

Exhibit C.24-28: Quality Metrics that Support our VBP Programs and Quality Gates

Clinical and Efficiency	Population Health, Access and Satisfaction
<ul style="list-style-type: none"> Follow-up visit made within seven days following 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 post-partum depression 	<ul style="list-style-type: none"> Expanded office hours outside the hours of 8:00 AM-5:00 PM Member satisfaction (member experience score) Quarterly care plans Transition visit w/in five days of discharge Physician attendance at Physician Engagement programs Pre-visit planning Visit made following stratification of a member into a complex care program Practice adoption and use of our technology platform, Identifi Practice
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 percent of treatment period 	<ul style="list-style-type: none"> Medication management for people with asthma appropriate meds for at least 75 percent of treatment period Adolescent well-care visits Immunization status - Combo 2 Appropriate treatment of children with upper respiratory infection
Specialists VBP Measures That Matter	Behavioral Health VBP Measures
<ul style="list-style-type: none"> Many of the PCP metrics and specialist metrics can cross over to the other. Hospital readmission at 30, 60, 90, and 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, 6-weeks post-partum) 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 Patient Safety and National Quality Improvement goals • Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS) • Mortality rate for three conditions present on admission Indicators • Admission notifications within 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 target, with partial points for 50th and 75th. For Joint Commission measures, we use the Healthy People 2020 goal. Three 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 potentially preventable events. We have identified several clinical and efficiency measures that directly and indirectly reduce preventable events. To ease the burden of providers participating in multiple VBP programs, we may align our metrics with existing Commonwealth and MCO initiatives for potentially preventable events. The following are examples of VBP program metrics that target preventable events as outlined in **Exhibit C.24-29**.

Exhibit C.24-29: Potentially Preventable Event Measures

PCP Measures	Preventable Events
<ul style="list-style-type: none"> • Follow-up visit made within 7 days following 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 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 post-partum 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 Patient Safety and National Quality Improvement goals • Hospital Consumers Assessment of HCAHPS • Mortality rate for three conditions present on admission indicators • Admission notifications within 24 hours

Administering VBP for Population Health Management

We take a two-tiered approach to physician engagement and scorecard report distribution that offers a comprehensive bottom-up and top-down structure.

Care Conference (CC) Meetings: The purpose of the monthly CC meeting is to engage organizations' key practice managers and providers to ensure they understand the VBP program and have the information they need at the point-of-care to successfully participate as well as be able to test and learn from practice level adjustments discussed at the JOC meetings. Passport's Population Health Managers (PHMs) play a critical role in supporting practice-specific performance. Population Health Managers are different than Provider Network Representatives because they are specific subject matter experts around practice transformation, population health, and specifically clinical CM programs and VBP initiatives. Key activities led by PHM with practitioners include:

- 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 around the VBP program elements; and
- Educating providers on and supporting member engagement in appropriate Passport CM programs.

A major focus of Care Conferences goes beyond just the VBP metrics and elements. We use the opportunity to provide feedback and inform providers about broader HEDIS, EPSDT, quality, and clinical action items that we can work together on to impact member health more broadly as well as improvements in relationships between Passport and our practitioner network. It is this broader support effort that truly responds to provider asks for assistance in strengthening their PHM capabilities, which are needed for them to be successful in VBP programs and risk arrangements.

In-person Care Conference meetings with prioritized practice locations yield the greatest impact on the provider group's overall scorecard performance. Passport's network providers are also equipped with tools like the provider web portal and Passport's Identifi Practice to monitor quality and clinical measures.

JOC Meetings: The purpose of the quarterly in-person JOC meeting is to work collaboratively with provider organizations' executive leadership teams to discuss group-level MER and program performance data, best practices, and macro-level 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, and measure progress and jointly determine opportunities for improvement whether that is 1) further root cause drill down for actionable information at a practitioner level, or 2) an opportunity on the practice side including workflow efficiencies, administrative burden or practitioner engagement.

Passport is committed to providing encouragement and support to providers as they move to better understanding of PHM and the role of VBP. Our analytic support, our on-site Population Health Managers and Care Conferences, and our deep understanding of health care systems in Kentucky give us both the opportunity and obligation to join with providers and the Commonwealth to effect change.

C.24.iv.l. Methods for evaluating success of services provided.

Robust Methods for Evaluating the Success of our PHM Programs

A summary of our methods for evaluating success of services provided by risk level is shown in Exhibit **C.24-30** and explained in more detail in the paragraphs that follow.

Exhibit C.24-30: Summary of Methods for Evaluating Success of Services Provided by PHM Risk Level

PHM Risk Level	Methods for Evaluating Success of Services
Health Promotion & Wellness	<ul style="list-style-type: none"> • Quantitative Results – Clinical: care gap closure, immunization rates, screening rates, weight/BMI assessment, etc. • Quantitative Results – Cost/Utilization: child well-care visits, PCP utilization • Quantitative Results – Member Feedback: Satisfaction Survey • Comparison of Results with a Benchmark or Goal (e.g., Quality Compass®, Year-over-year trends) • Interpretation of Results with Identified Barriers and Opportunities
Management of Chronic Conditions	<ul style="list-style-type: none"> • Quantitative Results – Clinical: engagement rates, action/care planning rates, program graduation rates • Quantitative Results – Cost/Utilization: inpatient admission rate, readmission rate, ED visit rate, total cost of care per member per month • Quantitative Results – Member Feedback: Satisfaction Survey • Comparison of Results with a Benchmark or Goal • Interpretation of Results with Identified Barriers and Opportunities
Complex Care Management	<ul style="list-style-type: none"> • Quantitative Results – Clinical: engagement rates, action/care planning rates, program graduation rates • Quantitative Results – Cost/Utilization: inpatient admission rate, readmission rate, ED visit rate, total cost of care per member per month • Quantitative Results – Member Feedback: Satisfaction Survey • Comparison of Results with a Benchmark or Goal • Interpretation of Results with Identified Barriers and Opportunities

Passport has a systematic data-driven process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement. At least annually, we conduct a comprehensive analysis of the impact of our PHM strategy that includes the following components:

- Quantitative results for relevant clinical, cost/utilization and experience measures.
- Comparison of results with a benchmark or goal.
- Interpretation of results.

Quantitative Results

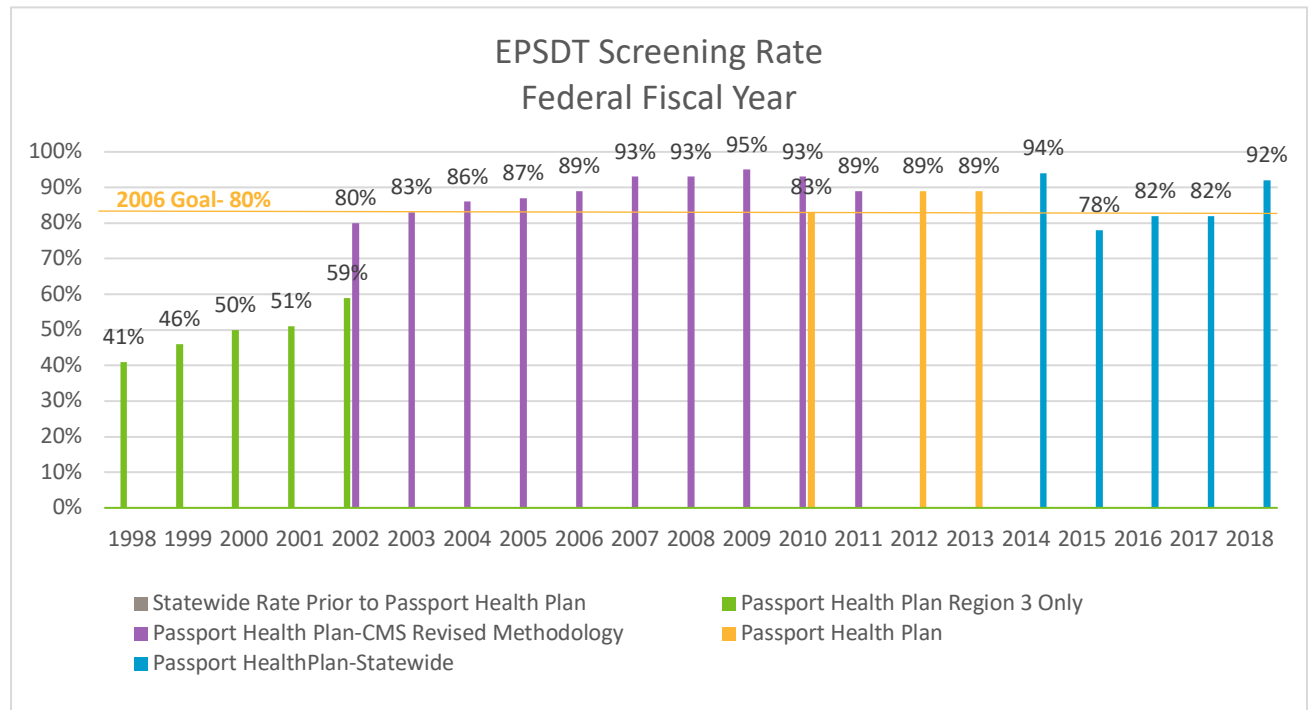
Passport's quantitative results include clinical measures, cost and utilization measures, and member feedback that are thoughtfully chosen to reflect the goals of our PHM program. A selection of measures and results are described below.

Clinical Measures: Passport's clinical measures can be categorized as activities, events, occurrences or outcomes that are statistically correlated with the goals of our program—to improve health outcomes for our population and empower members to improve their health and engage in their health care. Passport identifies these measures by first conducting a rigorous case-control study to quantify the impact of the program and then using advanced statistical methods (i.e., principal component analysis, factor analysis) to correlate the observed impact to specific operational activities (see end of this section for additional detail). These statistically significantly correlated measures include:

- **Engagement (absolute number and rate):** Members who have agreed to enroll in the program *and* have completed a comprehensive needs assessment submitted in Identifi. Rate denominator is those members identified for the program.
- **Timely Care Planning (absolute number and rate):** Completion of a member-centric care plan in Identifi within three days and two weeks of engagement (depending on the program). Rate denominator is those members engaged in the program.
- **Closed-Loop Referrals:** Percentage of referrals made that were addressed by the person or organization and information on the result of that referral was communicated back to the care team.
- **Graduation (absolute number and rate):** Member achieving identified goals of the program, as well as those identified by the provider and member. Rate denominator is those members engaged for the program's length/duration.
- **Care Gap Closure:** Percentage of open care gaps addressed during the measurement year.
- **Childhood Immunization Status (CIS):** Defined as the percentage of children two years of age who had the appropriate number of vaccinations for Combos two through 10 on or before their second birthday.
- **EPSDT Compliance Rate:** Defined as all eligible members receiving appropriate screenings according to the periodicity schedule.

Each measure is compared with a threshold, benchmark or prior performance (described below). **Exhibit C.24-31** shows Passport's EPSDT compliance rates for measurement year 2018.

Exhibit C.24-31: EPSDT Compliance Rates over the Last 20 Years, 1998-2018



Utilization and Cost Measures: Passport selects utilization and cost measures that are directly described as goals of our programs. For example, our Complex Care program is designed to prevent inpatient admissions and ED visits that can be avoided with proper ambulatory care. Our Transition Care program is specifically designed to prevent 30-day readmissions with proper discharging planning, coordination and self-management. Many of our Health Promotion and Wellness initiatives are designed to increase PCP utilization. **Exhibit C-24-32** shows a summary of select measures by program. Percentage reflects relative difference in the six months before and after program intervention in admissions per 1,000 ED visits and total costs PMPM.

Exhibit C.24-32: Summary of 2018 Cost and Utilization Impact of PHM Programs

PHM Program	Sample	Total Cost	Inpatient Utilization	ED Utilization
Condition Care (Asthma)	198	▼ 58%	▼ 74%	▼ 28%
Condition Care (COPD)	383	▼ 35%	▼ 24%	No Change
Condition Care (Diabetes)	277	▼ 17%	No Change	No Change
Condition Care (CAD)	244	▼ 24%	No Change	No Change
Condition Care (CHF)	37	▼ 65%	▼ 27%	No Change
BH Care	378	▼ 38%	▼ 37%	▼ 35%*
Catastrophic Care	426	▼ 16%	▼ 33%	▼ 16%
Complex Care	1,322	▼ 20%	▼ 32%	▼ 35%
Transition Care	1,016	▼ 8%	▼ 14%	▼ 8%

Experience Measures: Passport obtains and analyzes member feedback from all of our PHM programs using satisfaction surveys. We conduct an IVR survey for members who have participated in our programs to measure member-reported health outcomes and member experiences.

Members are called within one to two business days of their case closure if an appropriate closure status was selected. Feedback is **specific to the programs** being evaluated and covers how the program helped the members understand their health condition, if the Care Advisor was professional and polite, if the program materials were helpful, if the Care Advisor gave information that helped the members make decisions about their care, if the Care Advisor helped the members deal with their health condition, and if their overall health and quality of life had improved since working with the Care Advisor. **Exhibit C.24-33** is a snapshot of the results from our most recent member survey conducted in 2019.

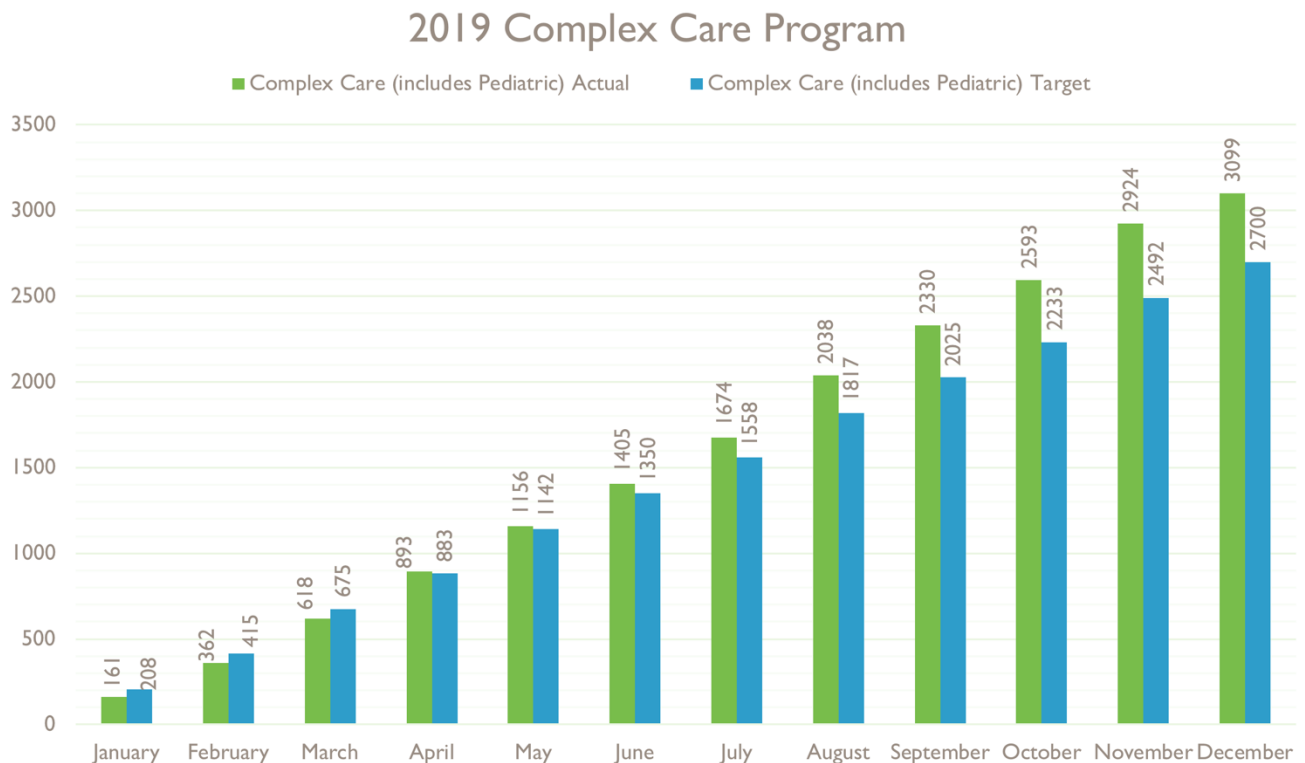
Exhibit C.24-33: Responses to Select Questions from Passport’s Member Satisfaction Survey of Complex Care Management for Cases Engaged in 2018



Comparison of Results with a Benchmark or Goal

Passport performs quantitative data analysis that compares the results described in the sections above with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed. For example, for quality measures, we often use ninetieth (90th) percentile from Quality Compass® as our goal. For engagement, we use both quantifiable goals and year-over-year comparisons to understand both relative and absolute progress. The target for member satisfaction surveys is great than an eighty-five (85%) favorable response rate. As an example, **Exhibit C.24-34** shows the number of members engaged in Complex Care relative to a target by month in 2019.

Exhibit C.24-34: Number of Members Engaged in Complex Care Relative to Target by Month in 2019



Interpretation of Results

Passport assesses the measures together, once defined, collected and analyzed, to provide a comprehensive analysis of the effectiveness of the PHM strategy. Interpretation of these metrics against target or within a trend is more than simply a presentation of results; it gives Passport insight into its PHM programs and strategy and helps us understand the programs' effectiveness and impact on our key areas of focus. If we do not meet our goals, we conduct a qualitative analysis to identify barriers and assess opportunities. For

example, below is an excerpt from our EPSDT program evaluation report highlighting an identified barrier to needed screenings and recommended opportunities.

Barrier:

Limited time by clinicians, in a busy office setting, to identify needed screenings as recommended by the Bright Futures/AAP Recommendations.

Opportunity:

- Supplement the physician office staff efforts by doing the following:
 - Leverage the auto-dialing technology and Care Connector team to engage members in need of assistance making appointments during auto-dialer campaigns to increase EPSDT screenings and immunizations.
 - Increase internal Community Engagement staff for outreach and education to noncompliant members in all age groups.
 - Provide additional member identification tools to clinicians to assist with identifying those members due for screenings (interval screening calculator available on the Passport's website).
- Continue clinician education through collaboration with:
 - Participating clinicians to improve compliance with Bright Futures/AAP Recommendations.
 - Passport Provider Network Management (PNM) account manager to assist with clinician education and updates related to EPSDT requirements and monthly EPSDT Screening and Immunizations Due Reports available online.
 - Passport's Quality department to conduct EPSDT Claims Audit to identify areas of opportunity.
- Clarify clinicians' confusion regarding EPSDT age-appropriate screening expectations through collaboration with DMS and the Island Peer Review Organization (IPRO) to combine the EPSDT Manual provided by the Commonwealth and the Bright Futures/AAP Recommendations.

Other Methodologies to Evaluate the Success—Advanced Key Performance Indicators

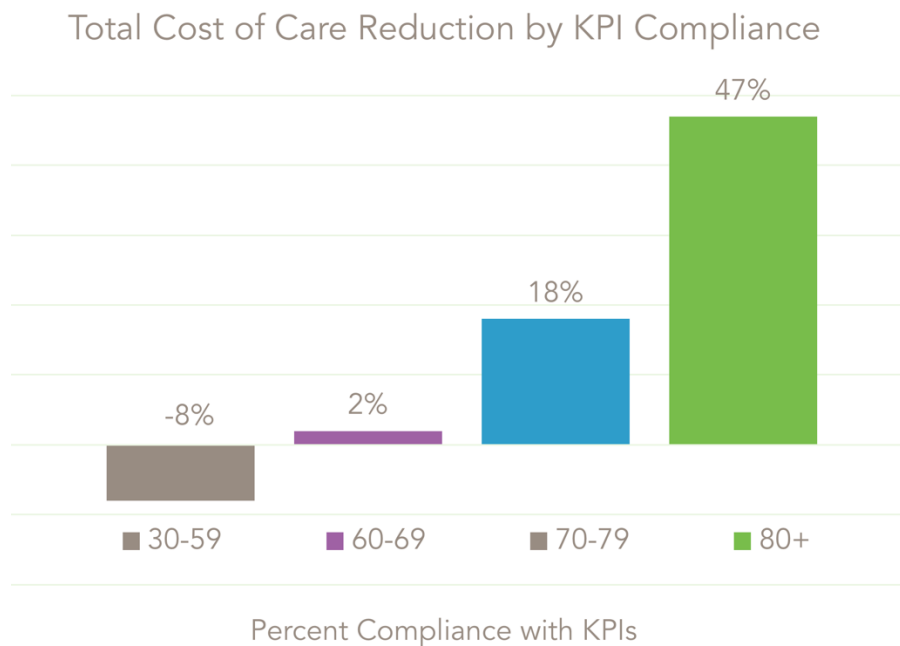
To support the identification and development of clinical measures described earlier, Passport engages in robust clinical analytics to develop advanced KPIs that are statistically correlated with positive clinical outcomes. Our internal research—using propensity matched case control studies and principal component analysis—shows that these KPI scores are directly proportional to enhanced clinical savings as well as member outcomes for management of chronic conditions and complex care management. This highly scientific and technical approach to developing KPIs ensures reliable measurement of activities that are leading indicators of impact. For example, through this analysis, we learned that the odds of having an inpatient admission for members with:

- Graduation goals met is thirty-four percent **(34%) less** than the odds of having an IP admission for members without graduation goals met
- Timely and dynamic care plans (i.e., the care plan is being updated as the member is making progress) is fifty-four percent **(54%) less** than the odds of having an IP admission for members without timely and dynamic care plans

- A minimum of two (2) clinical sessions per month is fifty-five percent (**55%**) less than the odds of having an IP admission for members with fewer than two (2) clinical sessions

Over time, we have identified nearly a dozen KPIs that are highly correlated ($p < 0.05$) with positive outcomes, including reduced cost, lower inpatient utilization, lower ED utilization and high PCP utilization. We have also observed statistically significant impact on total cost of care with higher KPI compliance—those **care teams that are more than eighty percent (80%) compliant with these KPIs show a forty-seven (47%) reduction in total cost** of care for their members as compared to a matched control group (see **Exhibit C.24-35**).

Exhibit C.24-35: Total Cost of Care Reduction by KPI Compliance Score for Complex Care



This body of research has been translated into a performance management dashboard that care teams and directors use to track the progress of PHM programs and care team staff on each KPI. The dashboard gives management the ability to aggregate by staff member to allow for identification of top performers and to facilitate discussion of best practices. For the care team, the dashboard gives them the ability to drill down to the member level to determine with which members they have been successful in meeting goals related to KPIs and where they have opportunities to take further action.

KPIs are part of the everyday language in Passport's PHM programs. Care team staff can access their performance dashboard in Identifi at any time and regularly receive coaching from their managers to identify opportunities to improve their scores. Star performers are recognized so that best practices can be identified and shared in team meetings and trainings.

C.24.iv.m. Methods for communicating and coordinating with an Enrollee’s primary care provider or other authorized providers about care plans and service needs.

Methods for Communicating with Member’s PCP or Other Providers About Care Plans and Service Needs

Passport uses a variety of methods when communicating with members’ PCP or their other providers regarding the members’ care plans and specific service needs. Passport uses Identifi Practice as its provider-facing portal that supports utilization, quality improvement and coordination of care. To date, Identifi has integrated with the following EHR systems that may already be familiar names to Passport providers: Allscripts, Amazing Charts, athenahealth, Cerner, Centricity, eClinicalWorks, eMDs, Epic EMR, GE Centricity, Greenway Prime Suite, NextGen, Practice Fusion, ReLi Med and Quest Care360.

More detail about Identifi Practice and EHR Integration solutions can be found in the response to question **a.iv.g.** above under the heading “**Ensuring Coordination of Care with Providers through Integrated Platform Technology.**”

A summary of our methods for communicating and coordinating with PCPs and other providers by risk level is shown in **Exhibit C.24-36** and explained in more detail in the paragraphs that follow.

Exhibit C.24-36: Summary of Methods for Communicating and Coordinating with a Member’s Providers by PHM Risk Level

PHM Risk Level	Methods for Communicating and Coordinating with Member’s PCP or Authorized Providers
Health Promotion and Wellness	<ul style="list-style-type: none"> • Identifi Practice • CHWs • Biannual review with population health manager
Management of Chronic Conditions	<ul style="list-style-type: none"> • Identifi Practice • Health Educators • CHWs • Care conferences with population health manager • Letters notifying of CM engagement • Collaborative Care Rounds • Phone calls to coordinate care
Complex Care Management	<ul style="list-style-type: none"> • Identifi Practice • EHR connectivity • Embedded CM staff • CHWs • Care conferences with population health manager • Letters notifying of CM engagement • Collaborative Care Rounds • Phone calls to coordinate care

As a provider-driven health plan, our providers are not just advisors, they have true governance responsibility over our PHM program through participation in the Board of Directors, the Partnership Council, and the Quality Medical Management Committee (QMMC) and its subcommittees. The guidance we receive from our physicians instructs how we communicate with our members' PCPs and other providers about members' care plans and service needs. We understand the best mechanisms to communicate, the level of detail to provide, and the frequency of updates most desired by our physicians.

When members first engage in a CM program, Passport sends a letter to their PCP, inviting them to participate in the member's care planning and discuss the member's needs. In addition, Passport leverages embedded Care Advisors in high-volume practices and CHWs also in high-volume practices and in the community, who are able to engage with providers to address member needs directly. Care Advisors will reach out to PCPs or specialists or their office staff to assist in making appointments and to coordinate care and service needs.

Additionally, when a member's risk level changes, we actively communicate that to the member's providers to support action. For example, if a member moves from moderate risk (chronic condition management) to high risk (complex care management) due to multiple missed pharmacy fills tracked through claims and processed through our ongoing stratification engine, Passport would notify the provider (via EHR, Identifi Practice or by phone) to update the care plan and work collaboratively to understand and address the member's barriers.

Ensure the Right Medication Regimen for John

John* (a member in our Transition Care program) was reviewing his discharge plan with his Care Advisor when he expressed confusion about his new medications following a surgery. The Care Advisor contacted John's PCP (prescriber of the member's regular medications), who offered to reach out to John's surgeon (prescriber of pain medication following surgery). The physicians were able to speak and realized that changes needed to be made to John's medication regimen. The PCP then followed up with John and the Care Advisor to clarify how the medications should be taken. The Care Advisor noted this interaction in the member record in Identifi, reinforced the changes with John, and checked in with him during subsequent contacts to ensure he fully understood his care instructions. Had his regimen not been changed, John likely would have been readmitted to the hospital due to side effects of his medication. *Member name changed for privacy

Providers are also welcomed to participate in person or via phone in Collaborative Care Rounds. Collaborative Care Rounds are multidisciplinary rounds held weekly to discuss higher risk members and members with more challenging social needs. Participants from Passport include a physician, a psychologist, RN Care Advisors, BH Care Advisors, Health Educators, CHWs, social workers, a pharmacist and a registered dietitian. Action plans are developed for each case discussed at Collaborative Care Rounds. If providers are

not in attendance, the primary Passport care team member will follow up as needed to update the established plan.

Our population health managers engage with providers and practice staff around members who may have been identified for participation in a program but we are unable to reach them or they have declined participation in the program. Providers are asked to reach out to their members to engage them and encourage their participation. Care conferences are the primary vehicle for the population health managers to communicate these needs. However, their service goes far beyond that. We use the opportunity to provide feedback and inform providers about broader HEDIS, EPSDT, quality, and clinical action items to affect member health more broadly as well as improvements in relationships between Passport and our practitioner network. This broader support effort truly responds to provider requests for assistance in strengthening their PHM capabilities. Population health managers are different from provider network representatives because they are specific subject matter experts around practice transformation, population health, clinical CM programs and VBP initiatives. Key activities led by PHM with practitioners include:

- Sharing broad to specific practice-level actionable information and reports on the member panel
- Helping providers track and improve quality, population health and performance metrics
- Educating providers on and supporting use for Identifi Practice

C.24.iv.n. Role, if any, the Kentucky Health Information Exchange (KHIE) will play in the Contractor's PHM Program as a resource.

The Role of Kentucky Health Information Exchange in Powering PHM

A summary of the role the KHIE will play by risk level is shown in **Exhibit C.24-37** and explained in more detail in the paragraphs that follow.

Exhibit C.24-37: Summary of Role the KHIE by PHM Risk Level

PHM Risk Level	Role KHIE Will Play in PHM Program
Health Promotion and Wellness	<ul style="list-style-type: none"> • Feed Continuity of Care Document (CCD) and ADT data to build member-level profiles to support real-time identification and stratification through rules engine. • Improve care coordination and gaps in care data for quality, HEDIS and EPSDT to direct resources in most cost-effective way.
Management of Chronic Conditions	<ul style="list-style-type: none"> • Feed CCD and ADT data to build member-level profiles. • Support real-time predictive risk stratification and identify risk level and polypharmacy.
Complex Care Management	<ul style="list-style-type: none"> • Feed CCD and ADT data to build member profiles. • Support real-time predictive risk stratification, reducing duplicative services and unnecessary medical procedures and polypharmacy through real-time information.

Interconnectivity Between KHIE and Identifi

Passport has been working collaboratively with DMS since 2011 to contribute detailed information on our members to the KHIE. We will be capable of immediately feeding Passport data to KHIE on the first day of the renewal contract term for a continuous feed.

Passport's Identifi platform can ingest CCD and ADT data to support building a comprehensive profile of each member. The collected information will be used for multiple initiatives to improve quality and reduce adverse events for the members, using better collaboration with the providers. A few examples include:

- **Quality Measures:** Limitations of the claims data is well known, and the added availability of KHIE information will significantly improve Passport's quality improvement efforts.
- **Risk Stratification:** Passport has access to artificial intelligence and machine learning CM but is limited by availability of comprehensive member data.
- **Real-Time Alerts:** Availability of ADT and other real-time information can drive creation of alerts for both providers and internal population health teams. This is especially beneficial for improving outcomes such as readmissions, where the opportunity to intervene is very small.

Passport will continue to collaborate with KHIE to leverage data in Identifi as KHIE develops mechanisms to make that available to MCOs and other entities.

The merits of interconnectivity and access to real-time, or near-real-time data, are self-evident and include more comprehensive physician-level reporting. The provider-facing solution we have available to providers, Identifi Practice, can be an enabler to facilitate information flow between the provider and the KHIE. This linkage will help bring information to the CM teams, population health managers, providers and the KHIE in a way that has not yet occurred. Passport care team staff will have portal access to KHIE, which will inform more comprehensive assessments and care planning for our members.

Passport Encourages Providers to Use KHIE

Presently, eighty percent (80%) of our members are being treated by providers that are connected to and using the KHIE. Passport has a long-standing, integrated care model for whole-person care predicated on care coordination and collaboration across providers of all disciplines. As such, we believe when every provider in the Commonwealth participates in KHIE, everyone will have greater opportunity to potentiate that model of care. Therefore, when working with providers to understand the benefits of KHIE, we focus on how external historical and current health care data can improve care coordination while reducing the likelihood of duplicative services and polypharmacy.

**80% of Passport's
membership is
represented in
the KHIE**

To further increase adoption, Passport will cover the use of Identifi Practice and educational onboarding for all interested providers in its network. For some providers not already participating in KHIE, those incentives will not be enough to prompt adoption. In targeted cases, Passport will offer technical support and help

providers fund the costs of KHIE adoption. The goal of this additional level of support is to maximize the number of providers connecting to the KHIE and providing care to large numbers of Passport members.

C.24.v. Provide the Contractor's proposed approach to coordination with other authorized providers such as the WIC program and others.

Passport's Approach to Coordination with Other Providers

As a member of the community for over two decades, Passport has built robust relationships and stays highly engaged with authorized providers and community resources. Our staff work with over 600 agencies in Kentucky, including school and faith-based advocates, individual FRYSCs, community action agencies, interagency groups, advocates for the homeless, extension offices, Chambers of Commerce, food banks, shelters, Head Start and many others. We look for opportunities to connect our members to community resources and to connect as an organization with the community organizations that provide our members with valuable services.



We know our members are best served when we not only connect them to the resources and services they need but also work hand-in-hand with those service providers. Passport achieves this by taking a multitiered approach to coordinating with these service providers. We work with authorized providers and community resources to implement initiatives that will help our members and other Kentuckians, and we coordinate with these agencies and providers at the member level to meet individualized needs. These efforts are part of the work Passport has done and will continue to do every day to improve the health and well-being of its members.

Our director of Community Engagement stays connected to our community partners and works to identify and implement new opportunities for programs and services. For individual members, our Care Advisors, social workers, population health managers, refugee specialist, and director of Community Engagement have extensive knowledge of available community resources and providers and make connections based on members' needs and locations.

Coordinating Care with Community Resources for Mothers and Their Children, Including WIC

Approximately fifty percent (50%) of our members are mothers and children who have complicated life situations and SDOHs. Passport's Care Advisors work individually with these members and with community organizations to make sure that members have what they need. Passport strives to understand the community resources available and makes it our mission to refer members needing services to a vast array of agencies to address their specific SDOH and other unmet needs.

Given the population-wide issues of obesity and food insecurity, WIC is a frequent referral, and we work to ensure that information about members' needs and issues flows back to WIC from our providers. Passport refers potentially eligible women, infants and children to the WIC program. We also ask that our contracted providers share information with the WIC program if requested by WIC agencies and if permitted by applicable law. This information is needed for the appropriate provision of care and services and may include nutrition-related metabolic disease, diabetes, low birth weight, failure to thrive, prematurity, infants

of mothers with a SUD or other drug addiction, developmental or intellectual disabilities, AIDS, allergy or intolerance that affects nutritional status, and anemia. WIC is an important resource to help ensure that mothers and their children have access to nutritious food and support for establishing healthy eating habits and connection to necessary BH services. **Exhibit 24-38** is a chart showing typical services used by our members, how we connect them and how we coordinate in an ongoing way

Exhibit C.24-38: Connections to Community Services for Mothers and Children

Provider	Services	Relationship/Referral Process
WIC	<ul style="list-style-type: none"> • Help with cost of healthy food options during pregnancy and breastfeeding • Help with cost of formula • Obtain prescription formulas to assist with cost for unique needs • Connect moms to lactation consultants for breast feeding issues/concerns • Nutritionists available to assist with appropriate diet during pregnancy and while breastfeeding 	<ol style="list-style-type: none"> 1. Referrals are sent through secure email to WIC by Care Advisors for members in need. 2. The referral becomes part of the member's care plan, which is updated and monitored on a biweekly basis when contact is made with the member. 3. Care Advisors follow up with the member to ensure WIC contacted her and the appropriate resources were received. 4. If a member reports that she has not been contacted, the Care Advisor will follow up with WIC, often using a three-way conference call to connect the member directly to WIC staff and helping to set up appropriate appointments or resources for the member. 5. The intervention is not closed in the member's care plan until contact has been confirmed by the member and appointments or resources have successfully been arranged.
Early Childhood Development Root Cause Team	<ul style="list-style-type: none"> • Provide Pack 'n Play or car seat options for little to no cost 	<ol style="list-style-type: none"> 1. Care Advisors work directly with the resource representative to refer a member to the program either by phone or email. 2. Pack 'n Play resource person can be contacted at 502.574.5963. 3. Continued contact is made with the member to ensure he/she received the resources.
HANDS	<ul style="list-style-type: none"> • Guidance for new mothers from skilled professionals that will make home visits to the member during pregnancy and the early years of a baby's life • Parenting skills development 	<ol style="list-style-type: none"> 1. Referrals are sent through secure email to HANDS by Care Advisors for members in need. 2. The referral becomes part of the member's care plan, which is updated and monitored on a biweekly basis when contact is made with the member. 3. Care Advisors follow up with member to ensure HANDS contacted him/her and the appropriate resources were received. 4. If a member reports that he/she has not been contacted, the Care Advisor will follow up with HANDS, often using a three-way conference call to

Provider	Services	Relationship/Referral Process
	<ul style="list-style-type: none"> Education on baby's needs, including what to expect as he/she grows Home environment safety assessment and education Assistance accessing community resources 	<p>connect the member directly to HANDS staff and helping to set up appropriate appointments or resources for the member.</p> <ol style="list-style-type: none"> The intervention is not closed in the member's care plan until contact has been confirmed by the member and appointments or resources have successfully been arranged. The Care Advisor adds the HANDS staff member assigned to work with the member to the care team for consultation and coordination moving forward, as needed.
Healthy Start	<ul style="list-style-type: none"> Assistance with making decisions for a healthy pregnancy Parenting classes Understanding infant development 	<ol style="list-style-type: none"> Care Advisors send referrals to Healthy Start. Members are also given the contact information for Healthy Start. The referral becomes an intervention in the member's personalized Care Plan, which is monitored and updated with each contact. If a member expresses difficulty in connecting with Healthy Start, the Care Advisors use three-way conference calling to connect the member and set up appointments. The intervention is not closed in the member's care plan until contact has been confirmed by the member and appointments or resources have successfully been arranged.
First Steps	<ul style="list-style-type: none"> Services for children with developmental delays or disabilities from birth to age three (3) years and their families Use routines-based approach to intervene within the family's natural setting and routine 	<ol style="list-style-type: none"> The care team sends first steps referrals as soon as a need is identified. The referral becomes an intervention in the member's personalized care plan, which is monitored and updated with each contact. If a member expresses difficulty in connecting with First Steps, the Care Advisors use three-way conference calling to connect the member and set up appointments. The intervention is not closed in the member's care plan until contact has been confirmed by the member and appointments or resources have successfully been arranged. The Care Advisor adds the First Steps primary staff member assigned to work with the member to the care team for consultation and coordination moving forward as needed.

Connecting Maggie to Infant and Postpartum Resources

Maggie* was a member in the Mommy Steps Maternity and Newborn Care program. During the assessment, our Care Advisor learned that Maggie did not have a safe sleep environment (e.g., crib, bassinet, or Pack 'n Play) for her baby. Maggie said the plan was for the baby to sleep in bed with her. Passport's Care Advisor educated Maggie on safe sleep habits for her newborn that would lower the risk of sudden infant death syndrome (SIDS) and offered alternatives to co-sleeping with the baby after discharge. The Care Advisor also learned that Maggie was worried about breastfeeding and having the right support at home. In response, the Care Advisor connected Maggie to HANDS, which offers a home visit with Maggie and baby, as well as to WIC for lactation consultation and support. The Care Advisor also called the local health department and spoke with the maternal and child health coordinator, who was able to locate a Pack 'n Play for the baby. The Care Advisor coordinated a pick-up time for the member to get the Pack 'n Play the next day after the initial assessment. Upon discharge, Maggie felt much more confident in providing her new baby a safe and nurturing environment with the support she needed to be successful.

*Member name changed for privacy

Coordinating Through Population Health Management Team Referrals

Other Passport members can also benefit from community resources, and our care staff regularly assess needs for such services. All direct care staff and supervisors at Passport have extensive knowledge of authorized providers and community resources throughout the Commonwealth. Our social workers and CHWs excel at providing our members with a warm handoff to these service providers, helping them understand the community resources available to them and removing barriers to access. Our care team members—social workers, Care Advisors, Health Educators and CHWs—are often the liaisons between members and community partners, working to ensure the member's needs are communicated and met.

Care team staff refer, educate and encourage members to use Kentucky Department for Public Health offerings that are available to them, well as other public programs such as Head Start and Supplemental Nutrition Assistance Program (SNAP). We discuss members' unique needs with them and work with the authorized providers to find appropriate resources/services for members. We remind new parents of pediatric well-child care visits and vaccinations, which are available at their local health department. We follow through to make sure referrals are followed up on and that any obstacles to receiving these services are removed.

While many health care organizations make referrals to community-based organizations, very few track those referrals to ensure a successful outcome, let alone attempt to understand the downstream impact on the member's health or social well-being. Through Passport's partnership with the Metro United Way, we supported the launch of United Community, a community-wide initiative to deploy an innovative, shared technology platform to initiate and close referrals across many organizations, agencies and services. Passport represents the health plan perspective on the United Community Governing team, along with the Louisville Metro Department of Public Health and Wellness for the health provider perspective, Evolve502 for the educational perspective, and Metro United Way for the social services perspective. The United Community's goal to be the first shared community social services record in the country to include the local school system is on its way to reality. The platform was launched in April 2019. Passport has taken the data from its work with connecting members to social service providers and helped to ensure that the providers our members work with most are included in the United Community. We are currently helping to design the analytics tools to evaluate the impact of the partnership and platform; this evaluation will not only assess whether it is improving health outcomes but also whether it helps to prevent other adverse social outcomes, such as unemployment and incarceration.

"Passport joined alongside Metro United Way as one of four founding partners of the United Community platform, which digitally links individual referrals between healthcare, community-based organizations and education across our community. The platform offers the ability to share referrals and track key measures in real time, including patient experience and effectiveness and timeliness of care. Thanks in part to the leadership and commitment of Passport, the platform is gaining national recognition and is set to be a game changer for our community."

~Theresa Reno-Weber, President and CEO, Metro United Way

Our care team members participate in weekly integrated care rounds to discuss cases that need extra attention. When a barrier arises for a member, these rounds provide the opportunity for the multidisciplinary team to bring its expertise together and use its shared knowledge of available resources. **Exhibit 24-39** shows a selection of community services with which we partner.

Exhibit C.24-39: Select Community Services with Which Passport Partners

Resource	Assistance Available
New Roots	Farm-fresh markets with hours at local churches and community centers in food insecure neighborhoods
Louisville Asset Building Coalition	Helps with taxes
Project CARAT (Coordinating and Assisting the Reuse of Assistive Technology)	Provides donated DME to the community (locations throughout Kentucky)

Resource	Assistance Available
Wayside Christian Mission Respite Care	Homeless respite services for members who need to heal after hospitalizations or severe injuries
Dare to Care and other food pantries/banks	Provides emergency food baskets to those in need
The Table Restaurant	Allows community members to pay what they can or work for food
City Schoolhouse	Private school that allows parents to pay what they can
Love City	Free after-school and entrepreneur programs for children and family-centered events and festivals
Habitat for Humanity	New housing with volunteer hours, repair programs, and low-cost furniture and home repair goods
Golden Arrow	Children's clothing, diapers, formula and other infant needs
New Directions	Low-income housing and home repair program
Portland Promise Center	Free childcare to children after school and during the summer, which includes Kids Café meals
Dental Lifeline	Dental assistance throughout Kentucky
Feed the City	Daily meals and food boxes in exchange for volunteer service
Norton Special Needs Car Seat program	Car seats for children with special needs
New Eyes for the Needy	Free eyeglasses for children or adults
Head Start	Promotes school readiness, early learning, health and family well-being for children ages birth to five (5) years from low-income families

Supporting Fred with His Reentry Through Our Closed-Loop SDoH Model

Fred* was a member with diabetes who was on home incarceration. A Passport Care Coordinator (and social worker) conducted a post-incarceration reentry call and learned that Fred had no means of transportation and was in desperate need of healthy foods to effectively manage his diabetes. The Care Coordinator referred Fred to community agencies outside of his service zone using the Unite Us application (the closed-loop referral technology through Passport's relationship with United Community). New Roots Inc. responded to the outreach for help and went above and beyond to deliver medically tailored meals to Fred. The Care Coordinator was alerted when the referral was addressed through our closed-loop SDoH model and called Fred to check in. He was grateful for having food again and was beginning to feel better. With his basic needs met, Fred was able to focus on other ways to manage his diabetes and was referred to Passport's Condition Care—Diabetes program to further engage in his health. *Member name changed for privacy

Initiatives and other Opportunities for Coordination

As mentioned earlier, Passport works with over 600 agencies. As Kentuckians serving Kentuckians, we are frequently active participants in the creation or adaptations of programs. This can include co-development of programs, providing funds or staff. Going forward, we will continue supporting our community partners and seeking additional ways to create communities of care.



Initiatives and Community Partners

Providing Cribs for Safe Sleep: A few years ago, Passport was alerted to seven infant deaths as a result of SIDS associated with unsafe sleeping environments in the Lincoln Trail Health District. The manager of Passport's Mommy Steps maternity and newborn CM program stepped into action. She partnered with Lincoln Trail District Health Department and the HANDS program to develop a plan to provide Pack 'n Play cribs to members who needed a safe place for their child to sleep. After ensuring all regulatory requirements were met, the project was established. Passport awarded a \$10,000 grant to the Lincoln Trail HANDS program. Once the crib program started in the Lincoln Trail region, zero (0) infant deaths due to unsafe sleep environments occurred in 2016 and 2017. In 2018 and 2019, the only infant deaths that occurred in the five (5) counties were families who were not HANDS program participants. This is an ongoing collaboration that Passport continues to fund.

HANDS: Passport partners with HANDS programs in public health districts in Eastern Kentucky to provide educational classes on nutrition, safe sleep, stress management and other topics. Our Health Educators lead these presentations for HANDS participants. This is an ongoing relationship that we value and will continue.

Big Sandy NAS Coalition: In collaboration with Johnson County Health Department and Highlands Regional Medical Center, Passport helped to found and implement the Big Sandy NAS Coalition. Up to seventy percent (70%) of all newborns in the Big Sandy Region were born with NAS. The Big Sandy NAS Prevention Coalition's mission is to lower the percentage of children born with NAS. Since its inception, the founding members have educated more than nine hundred (900) high school students, held focus groups with NAS mothers, hosted provider education events, and grown the coalition to more than thirty community members. These preventive efforts are in place to help reduce the number of babies born with NAS.

Family Scholar House: Passport and Family Scholar House have a long-standing history of working together to deliver programs and services that help families break the cycle of poverty through educational attainment and success. Passport's newest project, Passport to Connectivity, supports Family Scholar House's newest population, young adults who were formerly in foster care, to ensure a successful transition into adulthood. Passport sponsored the purchase of laptops for the foster youth who were previously using their phones to complete college papers. This collaboration with Family Scholar House will continue at the Passport Health & Well-Being Campus, where Family Scholar House intends to co-locate.

Smile Kentucky!: Smile Kentucky! provides free dental screenings and dental education to targeted schools in Shelby and Bullitt counties. The Smile Kentucky! Steering Committee is made up of representatives from nine companies. A Passport Health Educator participates on the committee and assists with providing dental education in the classroom. The committee meets throughout the year to select schools, recruit volunteers and secure supplies.

Empowerment Workshop: Freedom House provides a residential treatment program for alcohol or drug dependent pregnant women and women with young children. This holistic and comprehensive program is designed to treat the women's SUDs, break the cycle of addiction in families, reunite families broken apart by addiction, and promote the birth of healthy, drug-free babies. Passport's health education manager and two volunteers of America (VOA) board members are offering a once-a-month empowerment workshop to help the program participants to strengthen their self-esteem and resilience. Practical skills around self-care, family care, kindergarten readiness, job preparation and networking with women professionals are discussed in a safe, healthy, interactive setting.

Future Coordination and Collaboration

Looking to the future, Passport will continue the collaborations listed above for the benefit of our members and the health of the Commonwealth. We would also like to expand our existing relationships to have a greater impact. Some of our ideas are discussed below.

Passport has a close relationship with the Salvation Army, which provides over 400 meals per day to homeless individuals via their Louisville and Franklin County locations. They also offer a culinary arts program for their clients. Over the next three years, Passport will seek to increase the collaboration between Salvation Army case managers and Passport's CM team so that together we can better meet the needs of our homeless members.

Passport also works closely with Dare to Care. One of our Health Educators was recently trained as a nutrition volunteer for Dare to Care. In 2020, she will be co-facilitating classes with a chef volunteer. The classes are called Cooking Matters and teach participants how to cook nutritious meals. Upcoming groups that our Health Educator will train for Dare to Care include Maryhurst (youth in foster care) and Mercy Housing (seniors).

Passport's director of Community Engagement joined the recently convened Older Adult and Vulnerable Populations Homeless Committee. This group intends to affect the health outcomes for this population via collaborative efforts.

In 2020 and beyond, Passport hopes to partner with schools to sign more families up for women infants and children (WIC) and with senior-serving organizations to sign more seniors up for Senior Farmers' Market Nutrition Program (SFMNP). The vouchers available through these programs can be used in the Community Farmers Market Double Dollar program. This program doubles the vouchers (up to the first \$10) every day, helping the vouchers stretch further for members to be able to obtain healthy, fresh, locally sourced foods.

Additional examples of our collaboration with authorized providers and community resources can be found in C.22 Special Program Requirements.

Kentucky's community is Passport's community. Our Population Health program is designed to improve the health and well-being of all of our members, regardless of their situations. Community agencies and authorized providers are essential to our program because they provide services and programs our members need and benefit from. We look forward to extending our relationships with the community as we work together in service to all Kentuckians.

C.24.vi. Describe the Contractor's approach to ongoing review of its PHM Program, including potential real-time measurement, and how the Contractor will use results to address identified issues. the Contractor's approach to ongoing review of its PHM Program, including potential real-time measurement, and how the Contractor will use results to address identified issues.

Passport's Approach to Ongoing Review of Its PHM Program

Passport's PHM program is designed to ensure safe, effective, member-centric, timely, efficient, and equitable care and services are created and delivered to our members. Our programs pursue value and improvement in quality of life and outcomes. Our ongoing evaluation and review of the PHM program reflects our commitment to improve clinical quality and safety by using evidence-based clinical guidelines that have been developed to maximize safe clinical practices.

Our evaluation activities ensure all of our programs are designed to help members regain optimum health or improved functional capability, in the right place, at the right time and in a cost-effective manner. These program evaluations involve a comprehensive assessment of each program to determine if we have adequate resources in place, effective evidence-based interventions and approaches, and sophisticated analytics that drive decision-making when it comes to modifying or enhancing programs. Information gained

from all evaluations is used to make adaptations to PHM programming to improve clinical and quality outcomes for members.

Population Health Program Review and Evaluations

Each PHM program evaluation is conducted annually by the Quality and PHM teams. Program evaluations are completed based on the goals and objectives described in each program description, which are reviewed and updated no less than annually. Passport conducts multiple activities to evaluate the PHM program overall, including:

- Real-time analysis using Identifi Reports
- Monthly staff quality audits
- Monthly Operations Review (MOR)
- Annual program evaluations
- Annual population assessments
- Continuously through our NCQA accreditation cycle process

Each of these activities provides the necessary information for Passport to evaluate and adjust its programs to ensure it continues to deliver successful and appropriate services and interventions for its members. Passport has a history of working with DMS and other Commonwealth agency partners to plan and implement demonstration studies or other initiatives to affect the needs of Kentucky Medicaid members.

Real-Time Analysis Using Identifi Reports

Our care teams rely heavily on real-time and actionable information ensure they are taking the necessary actions to address opportunities and affect our members. Identifi supports this effort by providing our care teams with a suite of reports focused on program activities and outstanding opportunities. A selection of Identifi Reports are discussed below:

- The **My Care Dashboard** is one tool that our CM teams use to monitor real-time achievement of key steps in clinical program workflows.
- The **Care Program Details Report** details program-level elements and key operational metrics on program activities. This report can be run daily.
- The **Care Outbound Communications Report** provides information on communications such as letters and faxes sent to members and providers.
- The **Care Note Details Report** provides details of all care notes created during a specified period of time.

These reports at our fingertips allow PHM program managers and CM staff to adjust swiftly when a problem is identified. A Care Advisor, for example, may not have created an action item for the next outreach to a member, but they can identify from the My Care Dashboard that the outreach is due, thus allowing them to make the contact with the member to ensure they are on track with their care plan and stay in compliance with our program description and NCQA standards. A manager can use these same reports for overall compliance to key operational metrics and identify trends of their team as a whole or by individual. The

manager can then ensure all individual cases are brought into compliance and provide additional focus for the team on key factors that influence our members' success in programs.

Other reports outside of Identifi, such as cost and use reports, help clinical leadership to analyze trends in member utilization and make changes within our overall PHM program accordingly.

Monthly Staff Quality Audits

Quality audits of documentation and calls are completed on a monthly basis for each Care Management team member.

Each team member has a minimum of five (5) charts and two (2) phone calls audited monthly for:

- Timeliness of interaction
- Completeness of documentation
- Referral follow-up, as warranted
- Care plan completion
- Protected health information (PHI) verification
- Addressing open care gaps
- Other ad hoc areas of interest

Audits cover many scenarios—newly engaged to graduated cases—to ensure the full spectrum of care is being reviewed. The phone call audit can include clinical sessions, outreach attempts and voicemails.

For members receiving outreach to address social needs (via Care Compass), to remind about EPSDT well child visits, or to attempt to close care gaps, program coordinators, outreach specialists and other team members also have their documentation audited for quality purposes. Elements of these audits include:

- Timeliness of mailings or phone calls
- Accuracy of documentation
- Completeness of documentation

No matter which PHM program they are working in, staff are given immediate positive and constructive feedback about their quality audits. This ensures every member interaction is primed for engagement and success.

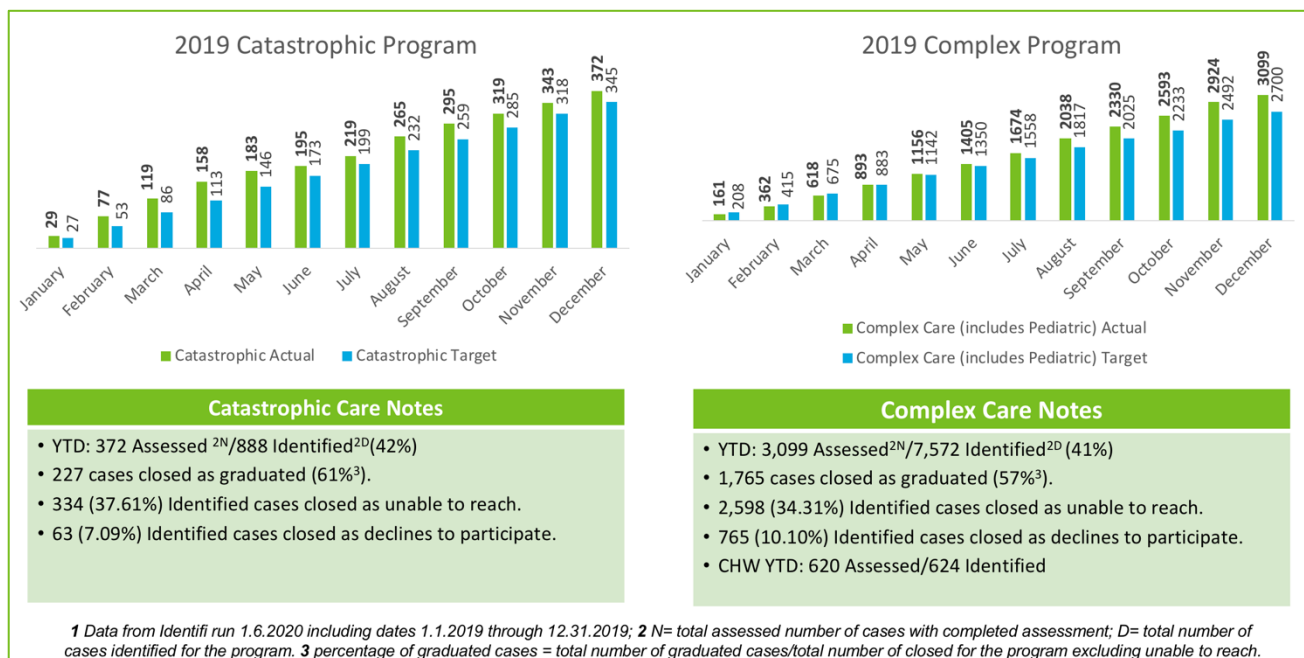
Condition Care Program Improvement

During the annual program evaluation in 2017, an opportunity for staff training/skill level enhancement was discovered. Variation was found in the disease management education delivered to members by the staff. Based on the variation, the current Health Educator training was replaced with a more rigorous format that included motivational interviewing skills and required Health Educators to obtain certification as a Health Educator. Based on the enhanced curriculum and the required certification of Health Educators, the graduation/program completion rate in 2017 of 40.61% improved to 64.73% in 2018 (a 67% increase).

Monthly Operations Review

Our MOR is an important governance forum for Passport leadership to provide oversight for key initiatives. In the MOR, Passport clinical leadership reviews monthly, year to date (YTD) and YoY metrics. Clinical program engagement is examined against established targets for four of our key programs (Catastrophic, Complex, Condition and Transition) and delves into details related to percentage of members engaged, graduated, unable to reach (UTR), and declined. Engagement is also examined on a YoY basis. These evaluations are used to identify engagement trends that need immediate correction and assist with development of strategies to achieve greater success. **Exhibit C.24-40** shows data from a recent MOR.

Exhibit C.24-40: Excerpt from Recent MOR Showing Engagement Results by Month Against Target for 2019



Transitions of Care Opportunity

An example of ongoing program modification occurred in April 2019. During an MOR meeting, the participants noted that the Transitions program, at only fifty percent (50%) of expected progress toward year-end goal, was not meeting expected engagement and enrollment targets. During a root cause analysis exercise, the participants discovered that this program was not part of the performance management monthly review because it sat under different governance structure, and the metrics were not part of the overall MOR metrics. In collaboration with the governance leadership for this program, the participants collectively decided to move the program under the governance structure for other programs. The issue was discovered in April. Following the discovery, immediate team reeducation was conducted regarding process, tools and other success factors. The team was notified of a reporting and governance structure change in May and moved to the new structure effective July 1, 2019. Steps taken upon discovery of the issue and during and after team transition included:

1. The Transitions program was moved from UM to CM.
2. Upon completion of the change in reporting structure, a monitoring and review of productivity was initiated using weekly performance reports and monthly MOR and performance management meetings.
3. Trends in KPIs were noted, including low engagement rate and low number of members being reached.
4. Discussion of possible barriers with the Transitions team were discussed during biweekly team meetings.
5. Potential solutions for low-performing areas were identified by management and the Transitions team members.
6. A step-by-step plan was created to increase engagement, including:
 - a. Staff reeducation on evidence-based CM techniques, such as motivational interviewing.
 - b. Implementation of a hospital rotation for each staff member to visit a local hospital with identified members to meet them face-to-face.
 - c. Staff retraining on documentation requirements.

By implementing hospital visits and reeducating the team on processes, expectations and expected outcomes, we saw a twenty percent (20%) increase in productivity in just two months (July-August). The Transitions team was meeting weekly engagement targets within just a few weeks and met its annual goal by early December. The team, which had been at fifty-one percent (51%) of its YTD goal in April, ended December at one hundred two percent (102%) of its YTD goal.

Annual Program Evaluations

Passport understands that regular evaluation of its clinically validated programs is imperative to ensuring their ongoing impact and relevance to its members. On an annual basis, Passport evaluates the success of

each of the clinical programs offered through the PHM program. We collect data on the CM programs, including outreach and engagement, care plan development and care plan progress. We also collect data on outcome measures, measures of cost/utilization and member experience, and participation rates. Quality improvement activities include measuring, trending, analyzing and interpreting results against performance goals or benchmarks for the program. For each program, the following metrics are tracked and reported:

- Participation rate (engaged versus identified members), annually and monthly
- Member engagement YoY, annually and monthly
- Top ten (10) comorbid diagnoses
- Referral sources
- ED and inpatient utilization pre/post-engagement
- Cost trends for ED and inpatient utilization and thirty (30)-day readmissions
- Total cost of care pre/post-engagement
- Program discharge status
- Achievement of care plan goals
- Satisfaction results for services received
- Satisfaction results for the improvement of health and quality of life

In addition, program-specific metrics are tracked and reported, including HEDIS and Healthy Kentuckian metrics relevant to specific conditions.

For each program, specific barriers are identified, with associated opportunities to correct or mitigate the barriers. A summary of key initiatives associated with each program is documented to ensure Passport achieves its overall goals for continual quality improvement and transformation. The data in the report informs planned activities for future years, which are also documented in the program evaluation.

At least annually, Passport evaluates member experience with programs through member feedback obtained via satisfaction surveys and complaints data. This allows for identification of opportunities to improve satisfaction with the program. Member active participation rates will be measured annually by collecting the number of members who have received at least one interactive contact. Interactions with members include activities such as educational mailings, IVR surveys and staff phone interactions.

Action is taken as needed for metrics that do not meet the goals or are deemed to be an opportunity for improvement. Interventions or actions to make improvements to identified areas of the programs are implemented to maximize health outcomes, experience and satisfaction, and effectiveness.

Complex Care Program Improvement

Another example of a program change that was based on program indicators and data analysis occurred in the Complex Care team. An analysis of staff committed to the program and the number of members that were successfully engaged per individual was conducted by the Research and Development department. The department recognized that some members were still in the “identified” bucket within Identifi. Because the engagement rate of Passport has consistently trended above that of other Medicaid engagement rates, an

exploration commenced to design an initiative to quantify the impact of increased staffing levels and gauge the resultant member engagement and program enrollment rates.

Through trending current staffing levels and resultant performance, the exploration discovered that the addition of nine staff—five RNs, three CHWs and a manager—was projected to increase enrollment rates by fifty percent (50%). The program rolled out in mid-2018. By mid-2019, with the addition of staff, all projections had not only been met but were slightly exceeded in successful engagement and enrollment of additional members into complex care management. Members in the Complex Care program increased one hundred seventy-one percent (171%) in 2019 compared to 2018.

Mommy Steps Program Improvement

During the annual program evaluation, an opportunity to develop a more integrated model to care for high-risk moms and newborns was discovered. The concept was to combine high-risk NICU admissions with high-risk pregnancy members to follow both mom and baby for up to ten (10) weeks after delivery.

Additionally, Mommy Steps previously was managed in a different medical management system, but, as of December 2019, Mommy Steps is now being managed in Identifi, the same medical management system as the rest of our clinical programs. This will allow us to better monitor clinical outcomes and performance enterprise-wide.

The hypothesis is that engaging both mom and baby in an integrated program will promote healthy pregnancies for members and healthy newborns. In this model, the same Care Advisor will be the primary contact for both mom and baby. We believe this model has the ability to increase engagement prior to delivery, which will help foster a strong relationship to carry into the first two months after delivery and NICU stay.

Working in this integrated program, we expect to see improved outcomes related to length of NICU stay, postpartum and newborn follow-up visits with providers, and improve our already good outcomes for low birth weight and very low birth weight newborns.

Remote Care Monitoring Program Improvement

During the annual program evaluation, we confirmed that remote care monitoring was successful for managing members with COPD and asthma. Based on these successes, we felt there was an opportunity to expand to other priority conditions. Diabetes was added to the Remote Care Monitoring program in the summer of 2019. CHF was then added into remote care monitoring in December 2019. Focus on these additional priority conditions increased the number of members served by fifty-one percent (51%). As stated, this also increased the number of priority conditions served by remote monitoring from two to four conditions. As we continue to monitor program outcomes, we may identify other conditions appropriate for remote care monitoring.

Population Assessment

Each year, Passport completes a full population assessment to understand and evaluate the needs of its members. The population assessment is the tool that gives the greatest insight into the utilization of health

care services, the effectiveness of existing programs, and opportunities for future initiatives. We evaluate the characteristics and needs of the member population, crosswalk those needs to existing programs, and identify improvement opportunities. An important outcome of the population assessment is the identification of performance trends for best practice and gaps in services offered to our members, including an analysis of the impact of relevant SDoH. Health status and risks are also examined by using utilization data broken out into age cohorts while also considering the needs of special populations, including members with disabilities and members with SMI.

Behavioral Health Care Program Improvement

During the population assessment, we confirmed opportunities to enhance the BH and SUD programs. Incidence and prevalence of SUD has been increasing in the Commonwealth. We increased of staffing BH Care Advisors effective January 1, 2020, and expanded outreach to members using predictive modeling to focus and touch members with rising risk. Based on the increased staffing available for outreach, coupled with the increase in identification of members, we expect an increase of up to three hundred percent (300%) in members engaged in BH programs and up to four hundred percent (400%) in members identified for outreach resulting from the employment of enhanced predictive modeling.

NCQA Accreditation Cycle

Passport is proud to have an 18-year track record of continuous NCQA accreditation, with its initial health plan accreditation received in 2002. The NCQA accreditation cycle helps us remain vigilant in reviewing our programs and results, and finding room for improvements. On a monthly basis, we complete rigorous quality chart and call reviews for each of our PHM CM programs. Real-time feedback to front-line staff helps us to ensure we continue to meet all NCQA standards.

Each year, we also review our program descriptions, making sure they meet the needs of our population as well as all NCQA standards. Our formal program evaluation process described earlier is an essential element of our NCQA accreditation cycle.

Passport also has a formal process for reviewing all clinical policies and procedures annually. This ensures we have the most up-to-date information in each of our policies and that they align completely with our clinical programs, contract requirements, industry best practices and NCQA. The accreditation cycle helps to drive these tasks on a monthly, quarterly and annual basis.

Sharing Results of PHM Program Monitoring and Review

To increase transparency and information sharing, Passport includes information and highlights of its PHM program through a variety of means. We include information and highlights of our PHM programs in our **member and provider newsletters and our website**. Our CHWs and health education specialists discuss relevant aspects of PHM program results directly with our members during **face-to-face visits and telephonic outreach**.

Passport's population health managers, who are dedicated to supporting our providers, share the results of its evaluation through both informal touch points and formal practice **Care Conferences and Joint Operating Conferences** with larger provider groups. Our Community Engagement specialists meet with various **community-based agencies, advocates, and other stakeholders** and share the results of our programs

Finally, our program results are also discussed during our **Quality Member Advisory Committees**, so that we can solicit feedback directly from the members. Finally, **QMMC** is another venue for sharing the ongoing review of our PHM programs with providers. We discuss lessons learned and identified best practices and seek input for our programs that will ultimately lead to better care, experience and outcomes for our members.

Conclusion

Passport has 22 years of experience applying population health principles and serving Kentucky's most vulnerable citizens. We partner with members, providers and community-based agencies across the Commonwealth to meet members' needs, with the overall goals of improving health outcomes, empowering members to improve their health and engage in their health care. This approach enables us to address both urban and rural disparities. Our programs offer state-of-the art predictive analytics to stratify risk and identify members for our Health Promotion and Wellness, Chronic Condition Management and Complex Care Management programs. We have and will continue to develop innovative strategies and interventions to improve the overall health and wellness of our membership.

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.