

B.1 Corporate Experience

REQUIREMENT: RFP Section 60.7.B.1

- a. Describe the Vendor's experience in the provision of managed care services to the populations specified in this Contract. Include the following information in the response:
- Experience in implementation of population health management programs and initiatives. Include information about how the Vendor has addressed social determinants of health.
 - Three (3) examples of initiatives the Vendor has implemented for Medicaid managed care programs that have supported improved outcomes. Describe whether such initiatives were cost effective and resulted in sustained change.
 - A summary of lessons learned from the Vendor's experience providing similar services to similar populations.
 - How the Vendor will apply such lessons learned to the Kentucky Medicaid managed care program.

Molina brings to the Commonwealth more than 25 years of enterprise-wide Medicaid managed care experience and a singular dedication to government-sponsored healthcare that make us the partner of choice to deliver high-quality, whole-person, and cost-effective integrated care and population health solutions.

Kentucky Enrollees will have access to a comprehensive, integrated health plan that will make a difference by providing *person-centered care that focuses on the specific needs of each individual Enrollee*. We will provide this customized person-centered care through our local Kentucky health plan and work with the Department and other Commonwealth agencies, providers, and community-based organizations (CBOs) to customize solutions that incorporate each stakeholder's local knowledge, experience, and expertise about the populations served by the Kentucky Medicaid program.

Throughout this section, we describe our experience in the provision of managed care services to the populations specified in this Contract. Drawing from the vast experience of our parent company and nationwide affiliated Medicaid health plans, we will deliver best practices to Kentucky for programs, initiatives, and services that promote person-centered care and apply them to improve outcomes and effect sustained change to benefit the Commonwealth's Medicaid Enrollees.

Molina's Value Proposition to Kentucky

- Be the Partner of Choice for the Commonwealth and the Plan of Choice for providers and Enrollees
- Deliver reliable service and seamless experience
- Provide effective, high-quality, and appropriate access to care
- Be the most affordable and cost effective plan

A. EXPERIENCE: OUR FOCUS ON GOVERNMENT-SPONSORED PROGRAMS

Our parent company, Molina Healthcare, Inc.,¹ and our affiliated Medicaid health plans have extensive experience managing member-centered, community-focused, and cost-effective plans, which have shown meaningful gains in population health outcomes, making Molina the ideal partner for the Commonwealth and all its stakeholders. What began in 1980 as a single clinic has blossomed into a *national managed healthcare leader with 15 health plans serving approximately 3.4 million members, including 14 health plans serving individuals in Medicaid programs*.

We have devoted ourselves to caring for the most vulnerable individuals and will bring more than 25 years of Medicaid managed care experience to Kentucky Medicaid program operations. While other companies support commercial programs, the Commonwealth, Enrollees, providers, and Kentucky stakeholders can be certain that our support is, and has been from day one, focused exclusively on individuals who rely on government assistance. This includes our Marketplace plans, where our goal is to

¹ The use of "we" and "our" throughout our response to I.B Corporate Experience refers to the collective experience of Molina Healthcare, Inc., including that of Molina Healthcare, Inc.'s operating subsidiary health plans and the bidding entity Molina Healthcare of Kentucky, Inc.

provide our Medicaid members with continuity of care in instances when they lose and may later regain Medicaid eligibility.

CURRENT PRODUCTS AND SERVICES

Our organization has a long, successful track record of serving populations like those enrolled in the Kentucky Medicaid program. As Exhibit B.1-1 shows, we manage health care for millions of people across the nation, which includes administering services for all categories of government-sponsored programs. Through our diverse portfolio of products, we cover all services required in Attachment C, Draft Medicaid Managed Care Contract and Appendices, and we specialize in many population health management programs, including those for high-risk pregnant women, members with a behavioral health (comprising mental health and/or substance use disorder [SUD]) diagnosis, and other special populations, as well as programs that address housing, food insecurity, education, socioeconomic status, and other social determinants of health.

Our approach for the Kentucky Medicaid program is based on decades of providing hands-on, continuous care for our members across the healthcare continuum to better manage existing conditions and, most importantly, provide them with the tools, information, and means to be proactive, self-manage, and focus on preventive measures that deliver results.

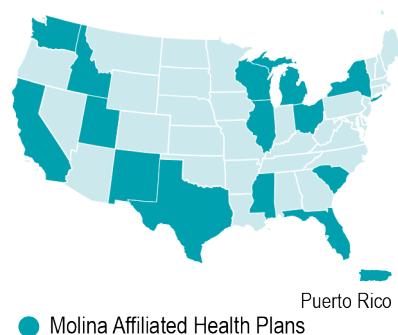
Medicaid. *Medicaid is our core business, and state governments and federal agencies trust us to provide a wide range of quality healthcare services to families and individuals.* Our parent company, through its subsidiaries, administers Medicaid plans in 14 states. Products in our Medicaid plans include Temporary Assistance for Needy Families (TANF); Aged, Blind and Disabled (ABD); Children’s Health Insurance Program (CHIP); Medicaid Expansion; Intellectually and Developmentally Disabled (IDD); Serious and Persistent Mental Illness (SPMI); Long-Term Services and Supports (LTSS); and Medicaid-Medicare Plan (MMP) programs.

Medicare. Our parent company serves about 100,000 Medicare members through Medicare Advantage plans, as well as Dual-Eligible Special Needs Plans (D-SNP), Medicare-Medicaid Plans (MMPs), and a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP). In the MMP and FIDE-SNP programs, our affiliated health plans administer all Medicare and Medicaid covered services, including state programs such as home- and community-based services (HCBS), and a care model that integrates members’ physical health, behavioral health, and social determinants of health needs.

Special Needs Population. The Molina family of companies is also an industry leader in serving special needs populations receiving government assistance. We administer plans that include more than 240,000 individuals eligible for LTSS, HCBS, and long-term institutional care provided through Medicaid programs in nine states, six MMPs, and a FIDE-SNP.

Marketplace. Our parent company offers Marketplace plans in 11 states where it has Medicaid health plans. When members enroll in a Molina affiliate Marketplace plan upon loss of Medicaid eligibility, it enables them to stay with existing providers and keep out-of-pocket expenses to a minimum. *Continuity of care without changing providers is possible for Marketplace members who regain their Medicaid eligibility and re-enroll in a Molina-affiliated Medicaid health plan.* Our organization serves approximately 350,000 members through Marketplace plans, remaining fully committed to these

We serve 3.4 million¹ members across government-sponsored programs



1. Total enrollment relates to estimated membership as of November 2019

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Exhibit B.1-1. Corporate Experience

strategically important programs to serve its members and extend its mission. ***In keeping with the model in other states, Molina intends to file for entry into Kentucky Marketplace if we are awarded a Medicaid Contract.***

Enterprise-wide Commitment to Quality

Demonstrating our parent company’s commitment to quality, all Molina affiliated Medicaid health plans have either achieved or are working to achieve NCQA Health Plan Accreditation. In addition, our parent is an early adopter of other NCQA quality distinctions. For instance, ***11 Molina affiliated health plans have earned NCQA’s Multicultural Health Care Distinction*** for their focus on improving culturally and linguistically appropriate services and reducing healthcare disparities. These 11 health plans alone represent nearly a quarter (22%) of the 50 total Medicaid plans that have earned this honor nationwide. ***Moreover, four of our affiliated Medicaid health plans have also attained NCQA’s LTSS Distinction.***

Molina’s healthcare strategy is simple: address population health needs by always focusing on the individual characteristics of each state. We leverage our data-mining capabilities and our highly qualified and committed staff to quickly identify and act on areas of improvement—and it shows in our results. Exhibit B.1-2 shows that ***our affiliate plan in Ohio, which is similar in geography and population to Kentucky, scored on par or higher than current Kentucky Medicaid MCOs in many categories that are crucial to the Department’s goals*** for the Kentucky Medicaid program.

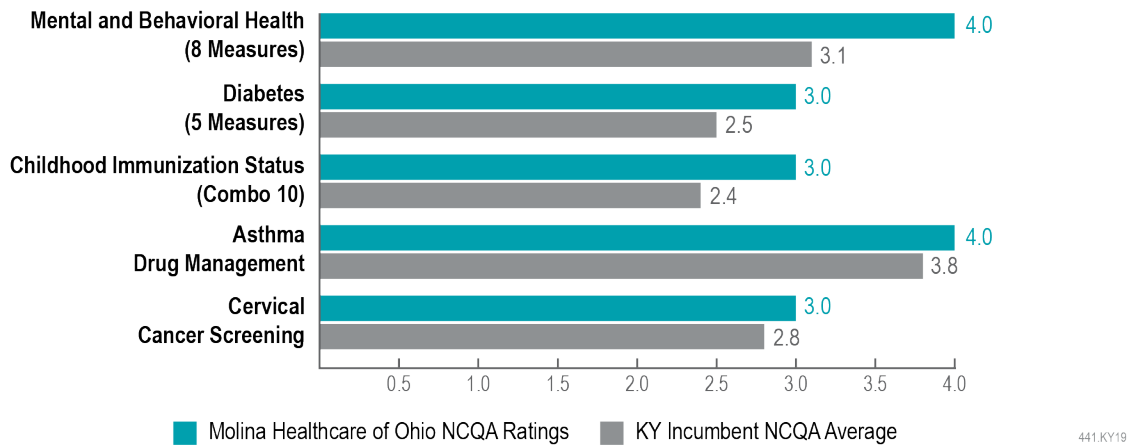


Exhibit B.1-2. 2019 NCQA Health Plan Rating Average: A Comparison Between Molina Healthcare of Ohio and Kentucky Medicaid Incumbent MCOs

a.i. EXPERIENCE WITH POPULATION HEALTH MANAGEMENT PROGRAMS AND INITIATIVES

As an enterprise, we have actively sought ways to successfully address population health management by providing holistic care management using a person-centered approach that is different than the traditional approach to managing individual disease states. By identifying social determinants of health affecting the members we serve—such as socioeconomic status, employment supports, housing needs, food insecurity, transportation access, and educational opportunities—we design effective, tailored solutions for identified needs. Our 14 affiliated Medicaid health plans continually develop population health-focused programs that specifically address social determinants of health, as demonstrated in the following sections, and we will bring these best practices to serve Kentucky Enrollees.

Integrating Social Determinants of Health

Every care plan we develop for a Kentucky Enrollee will incorporate and integrate Enrollees’ social determinants of health needs along with needed physical health and behavioral health interventions.

Our Extensive and Successful Population Health Management Experience

Each of our affiliated health plans develop and implement population health management programs and customized initiatives to address social determinants of health prevalent in their specific Medicaid markets. Table B.1-1 summarizes some of the successes our affiliates have had with population health programs and initiatives that are similar to targeted initiatives we will implement in Kentucky to address key health challenges faced by Enrollees.

Table B.1-1. Population Health Management Achievements

Population Condition	Kentucky Status	Molina Success
Diabetes	7th highest rate in U.S., with the largest increase in U.S. from 2012–2017	Wisconsin: Increased by 15 percentage points in Comprehensive Diabetic Care A1c control <8% HEDIS® measure, improving from the 25th to 90th percentile. The rate is above Wisconsin's and Kentucky's average for Medicaid. Intervention: Care managers completed outreach to members with care gaps to assist with appointment scheduling, transportation, and barriers to compliance. Care Connections staff contacted members due for A1c tests, retinal eye exams, and nephropathy testing, and scheduled in-home visits to complete the exams.
Heart disease	6th highest rate of cardiovascular deaths (299/100K vs. national average of 257/100K), and 8th highest rate of people with hypertension	Illinois: Increased 6 percentage points for the HEDIS measure “Statin Therapy for Patients with Cardiovascular Disease Received Statin Therapy—Total,” improving from the 25th percentile to the 90th percentile. The rate is above Illinois' and Kentucky's average for Medicaid. Intervention: All providers were given a toolkit with clinical guidelines, best practices, tips to increase compliance, and education on hypertension and related measures.
Asthma	Rates of adults and children with asthma are well above the national averages	Michigan: Improved from below the 25th percentile to the 50th percentile in both Medication Management for People with Asthma: Medication Compliance 75% (age 19–50) and Asthma Medication Ratio (age 19–50) HEDIS measures. They increased 8 percentage points in the first measure and 6 points in the second. Intervention: Partnership with ClearCorps Detroit and Wayne Children's Healthcare Access Program (WCHAP). ClearCorps and Molina Community Health Workers completed in-home assessments to identify any asthma triggers. WCHAP offered up to six home visits with an asthma educator to instruct members and their families on proper inhaler/medication use, triggers, symptoms, and prevention.
Obesity	6th highest rate in U.S., with 34% of adults and children considered obese	Ohio: Weight Assessment and Counseling for Nutrition increased 11 percentage points, and Counseling for Physical Activity total increased 13 percentage points. The rates for both HEDIS measures are above Ohio's and Kentucky's average for Medicaid. Intervention: Provider Engagement Teams completed visits to primary care provider (PCP) offices to review the HEDIS Provider Scorecard and Weight Assessment and Counseling clinical guidelines, best practices, and tips to improve compliance.
Tobacco use	3rd highest smoking rate in U.S.	Michigan: The Medicaid CAHPS® rate for Medical Assistance with Smoking and Tobacco Use Cessation increased 6 percentage points, improving from the 25th to the 75th percentile. The rate is above Michigan's and Kentucky's average for Medicaid. Intervention: Provider Engagement Teams completed visits to PCP offices to review pay-for-performance initiative to improve Tobacco Cessation program participation.

Population Condition	Kentucky Status	Molina Success
Cancer	Highest rate of cancer deaths with 234.9/100K; U.S. average is 163.5/100K	<p>Florida: Increased 6 percentage points for Breast Cancer Screening, improving from the HEDIS 25th percentile to the 75th percentile. Increased 19 percentage points for Cervical Cancer Screening, improving from below the HEDIS 25th percentile to the 50th percentile. The rates for both HEDIS measures are above Florida's and Kentucky's averages for Medicaid.</p> <p>Intervention: Members who had not received a mammogram scan in two years were added to the Breast Cancer Screening Call Campaign to assist with scheduling appointments. The health plan sent a fax blast to all network providers during National Breast Cancer Awareness Month to emphasize the importance of screening.</p>
Chronic Obstructive Pulmonary Disease (COPD)	In COPD-related deaths, Appalachian Kentucky (78.8/100K) and non-Appalachian Kentucky (57/100K) far outpace national average (42/100K)	<p>Florida: Increased by 15 percentage points and rated highest among plans in use of spirometry testing and reached the HEDIS 75th percentile in use of bronchodilators. The HEDIS rates are above Florida's and Kentucky's averages for Medicaid.</p> <p>Interventions: The health plan's Molina Community Health Workers collaborated with its quality improvement specialist team and analytics to contact specific members diagnosed with asthma and considered at risk for COPD. Also, health educators called members who were either missing a controller medication or were discharged from the emergency department (ED) with an asthma diagnosis.</p>
Infant mortality	6.5 deaths per 1,000 live births; above the national average of 5.8	<p>California: Increased 4 percentage points in the timeliness of prenatal care HEDIS measure, improving from the 25th percentile to the 50th. The rate is above California's and Kentucky's average for Medicaid.</p> <p>Intervention: Members who completed their prenatal visit within the first trimester or new members who completed their visit within six weeks of joining Molina received a reward.</p>
Low birth weight	9th highest rate in U.S.	<p>Wisconsin: Increased 7 percentage points in the timeliness of prenatal care HEDIS measure. The rate is above Kentucky's average for Medicaid. Timeliness of prenatal care led to a reduction in low-weight births.</p> <p>Interventions: The health plan's BadgerCare Plus members received postpartum care incentives. Molina Community Health Workers were trained on the care measure and assigned to hospitalized members. All members from the prenatal detection report were assessed, and a small percentage were referred to the High-Risk OB care management team.</p>
High-Risk OB / NICU	22nd highest maternal mortality rate in the U.S. with 19.4 per 100,000 live births	<p>California: Increased 7 percentage points in the postpartum care HEDIS measure, improving from the 25th percentile to 75th percentile. The rate is above California's and Kentucky's average for Medicaid.</p> <p>Interventions: Health plan members who completed their postpartum visit within 21–56 days after delivery received a free package of diapers. Members who recently delivered received an outreach call to assist with scheduling an in-home postpartum visit. Nurse practitioners completed the visits.</p>
Behavioral health, including SUDs	5th highest drug death rate in U.S., with 1,565 overdose deaths in 2017	<p>Ohio: Reached the HEDIS 75th percentile and rated highest among plans in follow-up after hospitalization for mental illness for both 7-day and 30-day follow-up. Both HEDIS measure rates are above Ohio's and Kentucky's averages for Medicaid.</p> <p>Interventions: Eligible providers in Ohio received \$50 for each visit within 7 days of discharge. The health plan also enlisted the Community Shelter CBO to locate and track homeless individuals.</p>

Population Condition	Kentucky Status	Molina Success
Adults and Children with Special Health Care Needs	In 2017, the rate of disability among Kentucky children and adults was 17.5%, higher than the U.S. overall (12.7%)	<p>Ohio: Increased 2 percentage points for Coordination of Care for Children with Chronic Conditions Composite on the CAHPS Item Set for Children with Chronic Conditions survey, improving from the 50th to the 75th percentile.</p> <p>Interventions: To improve the number of members receiving needed care and the care coordination CAHPS Measure, the health plan offered provider education about appointment availability.</p>

Molina will bring the same wide-ranging population health management expertise and dedication that resulted in our affiliated health plans’ successes to the Commonwealth and Kentucky Enrollees to effectively address and improve their health outcomes.

Current Population Health Initiatives Addressing Social Determinants of Health

When designing our population health initiatives, we consider social determinants of health to address whole-person needs. *We will introduce our most successful practices to Kentucky, including the following innovations:*

Care Connections



When members have difficulty accessing healthcare services due to geography, physical limitations, transportation barriers, and other factors, Molina brings services directly to the member through our Care Connections program, ensuring that access to healthcare is provided,

regardless of the remoteness of the setting.

We will have a Care Connections team of nurse practitioners in Kentucky who will visit homes and facilities throughout the Commonwealth, ensuring Enrollees can receive direct care. This type of proactive community-facing care also allows our Care Connections team to meet with our Enrollees who are experiencing homelessness.

Our Care Connections program addresses social determinants of health, such as access to healthcare due to transportation challenges and housing instability, by expanding access to quality care by meeting patients where they are—in their homes, at mobile or pop-up clinics, or on virtual visits. Care Connections is a team of 75 nurse practitioners working throughout the enterprise who concentrate on providing care in non-traditional settings to members who have difficulty accessing care in facilities. The nurse practitioners provide wellness and preventive care services and “boots on the ground” to determine if social determinants play a role in members’ health challenges. Services include annual physical exams; a review of medical history, medications, and social determinants of health; assessments of pain and functional status; psychosocial well-being assessments; and identification and closing of preventive care gaps.

In California, the Care Connections team administers the Mothers of Molina program to reduce health disparities due to lack of transportation and childcare issues and perceived bias from doctors. Under the Mothers of Molina program, Care Connections staff make an in-home postpartum visit and conduct appropriate physical health and behavioral health screenings for members identified as requiring such services via a standard Health Risk Assessment.

Since the program’s inception, Molina has since expanded Care Connections to cover additional in-home services, such as:

Success Story: Care Connections

In 2016, Molina Healthcare of California began sending nurse practitioners to the homes of new mothers, who often were not going to the doctor’s office for postpartum visits. In one year, the rate of African-American mothers receiving postpartum care increased by 37%. ***The health plan received California’s first Health Equity Award in 2018 for this program.***

- Annual comprehensive exams
- Comprehensive diabetic care
- Point-of-care A1c
- Nephrology screenings
- Diabetic retinal exams
- Blood pressure and weight monitoring
- Abdominal exams
- Recording the results of members' self-performed breast exams

As Care Connections nurse practitioners conduct assessments, they also assess for additional social determinants of health such as housing instability, food insecurity, economic/employment stability, literacy, and other conditions that may impact the member.

Care Connections nurse practitioners securely share visit notes and diagnostic results with members' providers, encouraging members to follow up with their PCP after the home visit and helping members make that appointment if needed.

Molina Community Health Workers



As far back as 2004, we understood that to successfully engage our members and treat the whole person, we needed to understand more than just their immediate healthcare needs. In response, our parent company implemented a **successful Molina Community Health Worker program, hiring from the local community to engage high-risk members in their homes and help coordinate and improve access to healthcare services through addressing social, environmental, and socioeconomic factors that might be contributing to healthcare access challenges.** Molina Community Health Workers act as care manager extenders who assist the member in navigating their healthcare needs and connect them to community-based resources, education, advocacy, and social supports. Because Molina Community Health Workers are members of the community in which they serve, they understand the community's culture, language, and norms.

Molina Community Health Workers address social determinants of health by establishing relationships with community shelters, churches, adult day programs, soup kitchens, and food banks. They also work with these CBOs and local agencies to connect members with housing and employment support resources, food, clothing, utilities, transportation to appointments, scheduling appointments, medication refills, obtaining durable medical equipment, and maintaining eligibility. Molina Community Health Workers also assist in finding difficult-to-locate members and in outreaching to members who may have an identified risk or need.

In our Michigan affiliate, **members who had a Molina Community Health Worker intervention were 25% less likely to have an ED or inpatient visit post-intervention.** Among these members, the health plan saw a significant decrease of \$218 PMPM total cost of care. There was a **cost avoidance of \$432,000 for the first year of the program and a total cost savings, net of program operation, of \$194,000—or an 80% return on investment.**

In our Mississippi affiliate, through the work of Molina Community Health Workers and care managers, the health plan contacted 1,790 individuals in the first 4 months of 2019 who were candidates for care management and successfully enrolled 943 (53%) into the program.

Using the Molina Community Health Workers intervention has resulted in better health outcomes for members, improved utilization patterns, and increased cost savings for states. As shown in Table B.1-2, a peer-reviewed study comparing the use of Molina Community Health Workers to a traditional care coordination model demonstrated that Molina Community Health Workers can help significantly reduce ED use, inpatient stays, and both narcotic and non-narcotic prescriptions in only 18 months.

Table B.1-2. Impact of Molina Community Health Worker Intervention

Category	Cost Reduction	Utilization Reduction
ED	65.4%	69.3%
Inpatient Stays	82.6%	83.0%
Non-narcotic Prescriptions	64.8%	62.7%
Narcotic Prescriptions	58.3%	64.8%

Due to the success of the program, it has been rolled out to all 14 Molina affiliated Medicaid health plans nationally, which combined, now employ 167 Molina Community Health Workers enterprise wide.

Housing Assistance Program



Our Ohio affiliate began its Housing Assistance Program in May 2018 in which housing specialists gather information regarding a member’s current living situation, urgency of the housing need, safety concerns, income, and any barriers to housing. For the most urgent cases, the specialists connect members with CBOs, help with applications for housing and funding assistance, help with utility payment disputes, and intervene with landlords regarding rent disputes.

Based on our success in Ohio and similar program success in Illinois, ***we will hire four full-time housing specialists in Kentucky who will work with Enrollees who are homeless or at risk of losing shelter.*** Our housing specialists in Kentucky will receive training on how to help Enrollees with behavioral health diagnoses find specialized housing and financial assistance.

Member Success Story: Housing Assistance

In our Ohio affiliate, a 46-year-old member with two children and a history of chronic homelessness was living in a shelter and could not find Section 8 housing in the community. She also struggled with depression and issues with past traumas. The Ohio plan housing specialist met with the member to discuss options for housing, contacted landlords in the community, and located one who would accept a housing choice voucher. The housing specialist also ensured the situation would meet the member’s needs, and the member and her children moved into their new home.

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Food Insecurity



Our affiliated health plan in Mississippi designed a program to address food insecurity and promote healthy eating by offering healthier food options to members.

The plan partnered with Alcorn State

Extension and Foot Print Farms to travel to various communities throughout the state to distribute fresh fruit and vegetables to members. Adult members receive one bag of fresh groceries per household.

Mississippi members have been receptive to these efforts and appreciate the fresh food provided at no cost to them.

On two occasions, the health plan even had excess produce

after distributing food to members, so staff donated the remaining items to the Salvation Army, a local church, and a local food bank, benefiting the community at large.



In Kentucky, we are partnered with and have provided financial donations to vital community organizations that address food insecurity at the local level, including Dare to Care, Kentucky's Heartland, and God's Pantry Food Bank.

Peer Support Specialists



Discussed in more detail within our response to *Initiatives Supporting Improved*

Outcomes below, certified peer support specialists help members with behavioral health diagnoses. These specialists have a lived experience in addition recovery and formal training to deliver services that promote self-care, increased motivation, and improved overall health. Peer support specialists participate in the members' care teams and assist members with setting and pursuing recovery goals.

High-Risk OB Program



All Molina affiliated health plans across the country have successfully integrated our High-Risk OB and NICU Model of Care. The High-Risk OB program identifies pregnant women who may qualify for high-risk OB care management. Program components include pregnancy screening, risk-specific education, and care management interventions targeted towards improving pregnancy outcomes. Members remain in the program during

the duration of their pregnancy (or until resolution of identified risk factor) and for up to six weeks postpartum.

To identify Enrollees with high-risk pregnancies in Kentucky, ***we have partnered with Lucina Analytics, a Louisville, Kentucky-based maternity data analytics firm*** that will use data from sources such as claims and pharmacy to deliver a daily report with a prioritized list of Enrollees with the most urgent risk factors—for example, alcohol/drug use, history of NICU admissions, asthma, diabetes, maternal age, previous preterm deliveries, and cardiac-related conditions. The program will also address Enrollees' social determinants of health, including health literacy, food insecurity, transportation, and access to healthcare, and education needs specific to prenatal and postpartum care.

Our High-Risk OB care manager will refer eligible first-time mothers to Nurse-Family Partnership, where available, to receive additional care and services tailored to meet the Enrollee's needs.

Our **NICU Transitions of Care program** for babies with NICU stays will prepare mom and baby for safe and timely discharge and provide a transition of care coach for continual assessment and follow-up (30-to-45 days post-NICU discharge) to ensure a safe and successful transition back to the community.

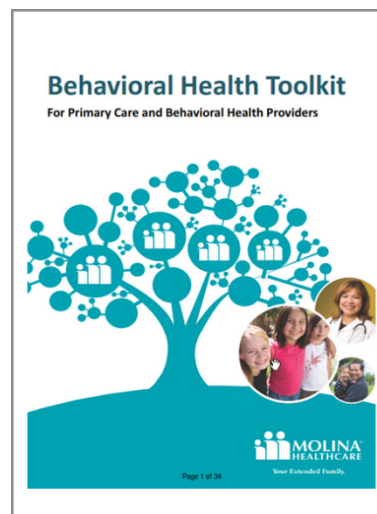
Behavioral Health Provider Toolkit



This corporate-wide training tool was created with the input of behavioral health specialists and is highly utilized by our 14 affiliated Medicaid health plans. The toolkit helps PCPs and specialists navigate an area of health with which they may not be familiar. The

Behavioral Health Toolkit addresses several mental health and SUD categories that are often related to social determinants of health and can be used to assess and treat behavioral health conditions in the primary care setting.

Our Kentucky Behavioral Health Toolkit will include screening tools, diagnostic criteria, clinical guidelines, interventions, links to additional clinical resources, and guidance on how and when to refer an Enrollee for treatment with a behavioral health provider. The Toolkit is yet another way we will ensure effective whole-person care in Kentucky.



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a.ii. EXAMPLES OF INITIATIVES TO SUPPORT IMPROVED OUTCOMES

We have implemented successful, cost-effective initiatives in our affiliated health plans that support demonstrable, meaningful, and sustained improved outcomes for our members. We present five examples of initiatives below that address health challenges similar to those faced by Kentucky Medicaid Enrollees.

Example 1: Comprehensive Diabetes Control Program

To increase member adherence with preventive diabetic exams, our South Carolina affiliate launched the Comprehensive Diabetes Control Program in 2017. The health plan targeted members between the ages of 18 and 64 with Type 1 or Type 2 diabetes to complete an HbA1c test, nephropathy screening, and a retinal eye exam. To engage members and encourage them to complete the exams, the health plan mailed postcard reminders that notified members of a \$25 CVS gift card incentive for each exam they completed. South Carolina's HEDIS Appointment team implemented a call campaign to inform members about the program and help them to schedule appointments with their providers while the Quality Engagement team engaged and educated providers about the program. The health plan also partnered with MedXm to schedule and provide in-home screenings for members to address any barriers to accessing their preventive tests.



Cost-effective, Sustained Change

Molina Healthcare of South Carolina's Comprehensive Diabetes Control Program

To increase member adherence with preventive diabetic exams, our South Carolina affiliate launched the Comprehensive Diabetes Control Program. Meeting members where they are through **targeted engagement, incentives, and support to ensure access to care** has yielded positive sustained results for the South Carolina health plan.

From 2017–2018, the health plan realized:



9.15%

Increase in adherence rate for eye exams



8.53%

Increase in adherence rate for nephropathy screening compliance



13.32%

Increase in adherence rate for completion of the HbA1c test

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Example 2: Peer Support Program

Our affiliated health plan in Ohio has led the way in employing certified peer support specialists to help their members with behavioral health diagnoses. Ohio’s specialized paraprofessionals provide support services for members across their respective states with mental health issues, drug and/or alcohol dependence, and physical illnesses, and deliver member education to promote self-care. Peer support specialists participate in the members’ care teams and assist members with setting and pursuing recovery goals. Because of a shared experience in SUD recovery, members relate with the peer support specialists, trusting them to provide help in a non-judgmental manner.



Cost-effective, Sustained Change

Molina Healthcare of Ohio’s Peer Support Program

Our Peer Support Program for members with mental illness and/or addiction offers critical emotional support as they navigate the healthcare system, knowing that type of help is more meaningful coming from others who have been through the same journey.

Initial positive program outcomes includes:



60

Members referred in 2019



\$328,900

Inpatient cost savings, due to a 66% reduction in inpatient visits



\$15,480

Increased pharmacy cost, indicating improvement in treatment / medication adherence

453.KY19

Example 3: “Homeless to Home” Housing Assistance Program

Homelessness and housing insecurity continue to grow and become more problematic in Ohio. In 2018, our affiliated health plan in Ohio created the “Homeless to Home” Housing Assistance program and began using housing specialists to help members address this most pressing need.

Our Ohio affiliate hires housing specialists with a background in housing assistance and who are experienced in helping members with mental health and/or SUDs or other special needs find specialized assistance funds and appropriate recovery housing resources. The health plan trains their housing specialists on the housing resources and funds available throughout the state.

When the health plan identifies a member as homeless or at risk of being homeless, a housing specialist completes a housing needs assessment. The assessment gathers information on the member’s current living situation, urgency of the housing need, housing level-of-care needs, safety concerns, barriers to housing, and the member’s income and other resources. In addition, they ask about any available family, friends, or community supports and if the member is linked to community resources for utility assistance.

Using this assessment, the housing specialist assists the member with applications for both housing options and financial assistance. They partner with the member through the process until housing is secured or issues with utility and/or rent payments have been resolved.



Cost-effective, Sustained Change

Molina Healthcare of Ohio’s “Homeless to Home” Housing Assistance Program

Molina Healthcare of Ohio’s “Homeless to Home” Housing Assistance program addresses member’s housing insecurity needs to greatly reduce avoidable inpatient admissions and ED visits and improve the member’s management of chronic conditions.

Since beginning the program in Ohio:



> 1,000

Member referrals



\$1.3 million

Medical cost savings after helping homeless members and those with housing insecurities



55%

Decrease in ED visits

35%

Decrease in inpatient hospital visits

454KY19

Example 4: Partnerships with Local Detention Centers

In Ohio, Medicaid health plans have an opportunity to partner with local detention centers and begin care coordination for members who are incarcerated before their release back into the community. In 2014, our Ohio affiliate was the only plan to launch a program in the state specifically designed for justice-involved members because we understand that connecting these individuals to proper physical health, behavioral health, and social services immediately upon release holds great potential for reducing recidivism, improving health and quality of life, and decreasing overall costs to both the healthcare and justice systems.

After the Ohio Department of Rehabilitation and Correction (ODRC) identifies offenders who will be released within 105 days, our Ohio affiliate works with ODRC to connect with members before release and engage them in care coordination. Ohio affiliate care managers went through special training, so they could move freely and safely throughout the detention centers with access similar to that of detention center guards. The care managers initiated contact with members while incarcerated, performed an assessment, and identified key factors needed to support the member upon release. They coordinated both physical health and behavioral health needs, identified and addressed social determinants of health, and promoted medication adherence.



Cost-effective, Sustained Change

Molina Healthcare of Ohio's Partnerships with Local Detention Centers

Molina Healthcare of Ohio partners with local detention centers and to begin care coordination for members who are incarcerated before their release back into the community with a goal of reducing recidivism, improving health and quality of life, and decreasing overall costs to both the healthcare and justice systems..

Molina Healthcare of Ohio's participation in this program has resulted in:



Reduction in recidivism rate

57%

before the
program



14%

after
interventions



Reduction in member ED use

64%

compared to non-participating
justice-involved members

455.KY19

Example 5: Emergency Department Support Unit (EDSU) Program

Hospitals in California face enormous pressure to contain costs while improving quality. In 2016, our California affiliate launched the EDSU program to assist California's highest-volume hospitals with transitioning members out of the ED to the most appropriate level of care.

Our California affiliate established a dedicated EDSU team, composed of both clinical and non-clinical health plan staff, to assist members and support ED providers in achieving optimal member outcomes, continuity of care for members, increased member satisfaction with the hospitals, and reduce claims denial because of admissions not meeting medical necessity criteria. The program works to:

- Increase real-time access to Molina medical staff for higher or lower level of care needs
- Improve timely identification and transition of members with complex needs to care management
- Increase telephone outreach to members after the ED visit to promote follow-up care and connection to their PCP
- Improve education on the use of observation as an alternative to admission and short stays



Cost-effective, Sustained Change

Molina Healthcare of California's Emergency Department Support Unit (EDSU) Program


Molina Healthcare of California launched the EDSU program to assist California's highest-volume hospitals with transitioning members out of the ED to the most appropriate level of care to assist members and support ED providers in achieving optimal member outcomes, continuity of care for members, increased member satisfaction, and reduced claims denials.

Because of the EDSU program, in 2019, the health plan realized:

 **1,835**
Members converted to ED observation

 **443**
Members admitted to skilled nursing facilities

 **280**
Members connected to PCP or specialists for a non-emergent appointment

 **8.3%**
Reduction in the rate of ED inpatient admissions between 2017 and 2019

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a.iii. LESSONS LEARNED

Through the experience and hard work of our affiliated health plans providing services to populations like those covered under Kentucky Medicaid, we have learned important lessons about using our greatest resources to best serve members: serve members where they are, create strong providers partnerships, engage with CBOs, and leverage the support of the entire Molina enterprise, all of which we detail below.

Serving Members in the Community

In 2015, 70% of our California affiliate's African-American members did not receive postpartum care, compared with 59% of women of other races. Overall, the health plan's postpartum compliance rates lagged below the NCQA's 25th percentile. In response, our California affiliate created the Mothers of Molina program to address this deficiency.

Through the program, a nurse practitioner visited mothers in their home to provide postpartum care that included a physical exam and a postpartum depression screening. Nurse practitioners also provided information on WIC and the importance of childhood immunizations. They served as a resource for the new mothers and provided contact information for any follow-up questions. In hiring their initial staff of eight nurse practitioners, our California affiliate prioritized finding personnel with an array of ethnic backgrounds and trained these professionals to accommodate cultural differences.

Based on the success of the Mothers of Molina program, the Molina enterprise recognized that the specialized staffing model and care delivery method of meeting members in the community, their homes, or a location where the member felt safe, helped engage members, reduce disparities, and improve their health outcomes. As a result, Molina looked for additional ways to incorporate specialized staffing positions to meet members in the community. ***What started as a single specialized position serving a single purpose has grown into eight specialized positions—including housing specialists, SUD navigators, and transition of care coaches—serving members in their own communities and homes.***

Creating Strong Provider Partnerships, Specifically in Rural Areas

No matter in which market we provide managed care services, providers are the key to our overall success, ensuring the administration of optimal care and services to our members. These strong provider relationships, particularly with Federally Qualified Health Centers (FQHCs) in rural areas, create trust between the MCO and the provider and help foster communication and information-sharing, preventing the silos that so often limit the ability to serve member needs in the most effective and efficient manner.

For our Illinois affiliate, understanding the needs of rural providers has paid great dividends in relationship-building and delivering excellent care and services to members. The Illinois plan has received feedback from rural providers in central and downstate Illinois that they often feel forgotten by MCOs because they have fewer claims and total spend in comparison to their urban counterparts. Although rural providers have less total spend, they are more heavily reliant on Medicaid claims and are an important voice for members.

To help address the concern, the health plan sent its vice president of network management and operations to meet with Southern Illinois Healthcare in Carbondale representatives at their facility and provide an overview of changes that had happened at the health plan. The plan also assigned a provider network representative to Southern Illinois Healthcare who lived in the neighboring county and understood the unique challenges faced in a rural community.

After three months of its contracted partnership with our Illinois affiliate, Southern Illinois Healthcare terminated their agreement with a competitor MCO and requested that all members be reassigned to our Illinois affiliated health plan, as Molina Healthcare of Illinois had become the “plan of choice” for Southern Illinois Healthcare.

From this experience, Molina learned how ***close partnerships and truly dedicated provider service results in open lines of communications with those who know their communities best and will work with us to serve Enrollees.***

Sustaining Provider Relationships

Before 2017, our Illinois affiliate held Joint Operating Committee meetings with key provider groups to discuss their concerns with health plan operations. It was soon determined these meetings were proving difficult in terms of maintaining focus on the appropriate topics, such as quality, as the discussions ranged too widely in scope often regarding claims payment and became unproductive.

In 2018, our Illinois affiliate revised the Joint Operating Committee model, splitting it into two separate meetings with the provider groups: the Joint Operating Committee and a new quality-focused meeting. The Joint Operating Committee began limiting the agenda to one operational topic per meeting, while the quality-focused meeting concentrated on topics about improving and delivering high-quality care.

Based on the success of this approach in building stronger provider relationships through focused discussion, the ***Molina enterprise now structures provider feedback meetings to capture meaningful, targeted discussion that allows us to engage with providers and, subsequently, act on the topics that are forefront on their mind.***

Engaging CBOs to Find and Engage Members

Sometimes the biggest challenge to providing healthcare to members is to locate and engage them. Members who are homeless or whose phone numbers or physical addresses constantly change may be nearly impossible to track down.

To address this issue in San Diego, our California affiliate partnered with a housing CBO in San Diego, which provides shelter for people working toward independent living. After the health plan shared its challenges with finding members, the agency was able to identify and locate 10 members by screening their residents. The health plan connected with the members; verified and updated their information; helped them request a new ID card, access transportation benefits, and learn about available programs and benefits; and connected the members with health plan care managers when needed. Based on this success, our California affiliate engaged with other CBOs to target member needs, such as offering free classes on diabetes, hypertension, weight management, and other health conditions and providing members incentives for attending a class and learning strategies to manage their health conditions.

Given the success realized in California, the Molina enterprise began looking for unique opportunities to partner with CBOs to connect with our members who may be reticent to engage with the health plan. Across the entire organization, ***our affiliated health plans have employed several strategies that have been effective in both finding members and working with CBOs in the communities they serve.***

Leveraging the Expertise and Support of Affiliated Health Plans

When Molina Healthcare of Mississippi formed, Mississippi health plan leadership contacted affiliated health plans with similar state-specific requirements to ensure they were leveraging the best processes and procedures from across the organization. For example, the Mississippi health plan is required to track and report all vendor relationships and dollars spent on small and minority businesses. Our Illinois affiliate had a similar requirement in their state and assisted the Mississippi plan with establishing policies and setting up processes based on their successful methods for vendor tracking.

Our Mississippi affiliate also enlisted the help of resources available through the South Carolina and Florida health plans to:

- Ensure deliverables for readiness were fulfilled in compliance and on time until the health plan could hire and train local Mississippi-based resources
- Create the first draft of the Mississippi Member Handbook by using our parent's standard template and customizing it to Mississippi-specific contract requirements
- Help train local employees by coming onsite or hosting Mississippi employees at their health plans for training sessions

Because of this collaboration across the enterprise, the Mississippi health plan met 100% of all deliverables. Molina Healthcare of Mississippi's approach has since helped ***establish an organization-wide best practice of early and open lines of communication and information-sharing to benefit all Molina affiliated health plans both during start-up and ongoing operations.***

a.iv. APPLYING LESSONS LEARNED TO THE KENTUCKY MEDICAID PROGRAM

We carefully analyze our operational experience to learn best practices and have started applying these lessons to our efforts in Kentucky in concrete ways. Below, we describe how we will apply the lessons learned above to our work in the Commonwealth.

Community-based Specialized Staff / Roles to Address Social Determinants of Health

Molina has structured our Kentucky Medicaid organization to foster close relationships with our Enrollees, providers, and other stakeholders such as CBOs because we have witnessed the benefits of high-touch member outreach by specialized individuals trained to target specific member needs in our

affiliated health plans. In support of this approach, our organizational structure features the following community-based positions demonstrated in Table B-1.3:

Table B-1.3. Specialized, Community-based Molina Staff

Role	Responsibilities
Care Connections Nurse Practitioners	Care Connections nurse practitioners will either be co-located at high-volume provider offices or CBOs or in the community providing in-home services. These nurse practitioners will link Enrollees with the array of care and services they need to take charge of their health and obtain services.
Molina Community Health Workers	Molina Community Health Workers will support Enrollee access to services appropriately and help them navigate the healthcare system. They will assist with housing, food, clothing, and transportation needs, scheduling appointments, and more.
Housing Specialists	Housing specialists will partner with local homeless shelters. Molina’s housing specialists will have expertise in working with individuals with mental health needs and SUDs.
SUD Navigators	SUD navigators will continually engage Enrollees with SUDs, including Enrollees struggling with opioid use disorder, and encourage treatment adherence. Our SUD navigators are care managers whose specialty is serving Enrollees with SUDs.
Peer Support Specialists	Peer support specialists will help our Enrollees with either mental health or SUD diagnoses. They have a lived experience in recovery and formal training to deliver services that promote self-care, increased motivation, and improved overall health.
Transition of Care Coaches	Molina will deploy transition of care coaches in targeted communities, including embedding them in high-volume facilities. Working closely with facility discharge staff, transition of care coaches will support Enrollees for 30 days after discharge.
Embedded Care Managers	We will embed Molina care managers in PCP sites and other key care sites to engage Enrollees and provide education and assistance. Molina care managers will engage with Enrollees, providers, and provider office staff to identify and address Enrollee needs and barriers, including understanding their health and ability to navigate the healthcare system.
Enrollee Locator Teams	Our Enrollee Locator Teams will deliver specialized support in locating difficult-to-reach Enrollees, like those experiencing homelessness. Our local team will know where homeless individuals tend to sleep and congregate, and will contact shelters, the Salvation Army, Community Mental Health Centers, and CBOs.

Provider and Provider Association Partnerships

One way we are taking lessons learned about the importance of provider partnerships to heart is through our agreement with the Kentucky Primary Care Association (KPCA). Our relationship with KPCA will be critical to meeting the needs of Enrollees in traditionally underserved and non-urban communities. The partnership between Molina and KPCA will provide for inclusion of key FQHCs, rural health clinics (RHCs), dental, school-based, and other providers from KPCA in Molina’s network. It will offer a value-based payment (VBP) model with gain share and risk share methodologies with the goal of improved outcomes and lower costs. Along with establishing the VBP, the partnership will also establish a quality program, fully integrated with Molina’s, to improve Enrollee experience, address population health to positively affect health outcomes, and control costs. Some of the additional mutual benefits of the partnership will include increased care coordination, addressing avoidable ED admissions, and increasing data-sharing through KPCA’s proprietary population health technology platform, Charli, which increases efficiency in patient information-sharing and promotes timelier and more tailored Enrollee care.

Targeted Solutions to Reduce Provider Administrative Burden

Administrative burden was one of the main challenges cited during our provider focus groups and in meetings with provider associations. As part of our partnership approach with Kentucky providers, we will continually seek opportunities to reduce administrative burden on providers while ensuring high-quality outcomes for Enrollees. Molina will incorporate a Preferred Provider PA Program in partnership

with Kentucky's highest functioning health systems and provider groups throughout the Commonwealth, such as KPCA, that have demonstrated quality outcomes. We will regularly and systematically perform an extensive review of all codes that require prior authorization, especially those that create administrative burden to providers, to relax, or sometimes eliminate, the need for prior authorization of those codes. This approach will help remove barriers to Enrollee care and improve provider relationships.

After implementation with these selected preferred providers, Molina and the providers will hold quarterly Joint Operating Committee meetings to review utilization, quality, and cost metrics to determine if adjustments to the program are warranted, which can be made at Molina's sole discretion if necessary.

CBO Partnerships

Based on experience in our affiliated health plans, we know the importance of partnering with CBOs to find and engage Enrollees and connect them with resources and support beyond what is covered in their Medicaid benefits. As an important component of our continuing efforts in Kentucky, we have met with more than 110 CBOs all over the Commonwealth to start building relationships and learning about what matters most to the communities we are looking forward to serving. Several of the challenges we heard were regarding food insecurity, lack of understanding how their Medicaid benefits worked, and lack of employment opportunities in their area.

Understanding Enrollees needs in these areas, we are partnering with CBOs to allow us to connect our Enrollees to committed organizations that will help ensure their needs are being met. We have chosen to engage with these CBO partners because of their diligent work in their communities to address social determinants of health, such as food insecurity, access to rural healthcare, and Enrollee self-empowerment. We have also contributed financially (\$525,000 to date) to some of these key organizations because we believe in their missions and support the work they do to improve the lives of Kentuckians. Our CBO partners include:

- ***Goodwill Industries of Kentucky***, which offers free expungement clinics and reintegration nights that help justice-involved Enrollees seeking a second chance to address a variety of unique barriers they may experience as they reenter the community
- ***Connecting Kids to Coverage Region 8 Assister Program***, which focuses on reaching the underserved and hard-to-reach populations, and partnering with reentry and rehabilitation agencies from the state correctional system
- ***Dare to Care, Kentucky's Heartland***, and ***God's Pantry Food Bank***, which work to address food insecurity
- ***Boys and Girls Club of Bowling Green***, which promotes health education
- ***Family Scholar House*** and the ***Louisville Urban League***, which help Kentucky residents explore economic opportunities and find a way out of poverty
- ***Audubon Area Community Services*** and ***United Way of Northeast Kentucky***, which work to expand access to healthcare in rural communities
- ***Home of the Innocents***, which provides multisystemic therapy to children who have been abused or neglected

We will continue building CBO relationships throughout Kentucky both before and after Contract award. Please see Attachments to Section B.1 for letters of support from Kentucky CBOs.

Enterprise-wide "Open Door" Approach

Our affiliated health plans have found great value in working closely with other affiliates to leverage their support for a variety of needs. Molina will do the same as we implement operations in the Commonwealth to serve Kentucky Medicaid Enrollees. Our affiliates have a depth of experience serving populations across the healthcare spectrum and have faced and successfully met challenges that we can learn from to make the health plan, Enrollee, and provider experience a good one from the beginning of operations. Across the enterprise, our affiliated health plans have implemented programs, initiatives, and

best practices that we will build into our Kentucky health plan. We will leverage our Ohio affiliate's successful High-Risk OB program and their expertise regarding its implementation, approach, and best practices.

Our Ohio affiliate is ready to help serve as an advisor and mentor on overall program and health plan operations from day one, sharing their best practices serving their Medicaid members. Additionally, we will leverage the support of other affiliated health plans that share geographic- and population-similar characteristics with the Commonwealth. The Mississippi plan recently completed a successful implementation in October 2018 and can share their experiences with us to help complete a smooth and successful health plan implementation. Our Illinois affiliate has deep experience forging strong provider relationships in the state and can mentor us on how to avoid provider abrasion. As we implement new business in Kentucky, Molina will have access to all 14 affiliated Medicaid health plans for advice, mentorship, and support during start-up and operations and will leverage those resources to ensure that Molina starts off on the right foot and continues to administer healthcare and services efficiently and effectively throughout operations.