

C.4 Financial Security Obligations

REQUIREMENT: RFP Section 60.7.C.4

4. Financial Security Obligations (Section 13.0 Contractor's Financial Security Obligations)
- Describe how the Vendor will comply with net worth, solvency, and surplus requirements.
 - Provide documentation of lines of credit that are available, including maximum credit amounts and available credit amount.
 - Describe any risk arrangements the Vendor proposes to have with providers for contracted services and describe oversight of such arrangements.

Molina's financial strength and condition are backed by our parent company, which is fully committed to and capable of providing the financial resources necessary for ongoing operations.

A core value of our organization is to be a good financial steward of taxpayer funds that are entrusted to us to manage as a government programs MCO. As a steward of public resources, we make wise choices about how our money is spent, and our conscientious fiscal management over the decades has resulted in long-standing financial strength and stability.

Molina, the Contractor, is a wholly owned subsidiary of our publicly traded, Fortune 500 parent corporation Molina Healthcare, Inc. Our financial strength and condition are backed by our parent company, which is fully committed to providing the financial resources necessary for start-up and ongoing operations.

a. NET WORTH, SOLVENCY, AND SURPLUS

Molina understands, agrees, and will comply with all requirements set forth in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 13, Contractor's Financial Security Obligations. Below, we describe how we meet net worth, solvency, and surplus requirements. Additionally, we provide information about our reinsurance policies to further demonstrate our financial strength. ***Our parent company will bring stability, financial strength, and access to the public capital markets to ensure our Kentucky health plan remains sufficiently capitalized throughout the term of the Contract.***

NET WORTH

Molina Healthcare, Inc.'s overall capital position is very strong, as evidenced by its consolidated stockholders' equity of approximately \$1.8 billion as of September 30, 2019.

Molina Healthcare, Inc. is committed to using its capital strength to fully capitalize and fund Molina Healthcare of Kentucky, Inc. (and its other subsidiary health plans) at all times, thereby ensuring Molina Healthcare of Kentucky, Inc. will not be subject to any meaningful risk of contractual non-performance or inability to honor all of its financial commitments. In fact, Molina Healthcare, Inc.'s policy is to maintain capital that is well above the state-mandated minimum for its health plans, which is usually based on an NAIC risk-based capital ratio of 200%. Molina Healthcare, Inc.'s aggregate risk-based capital ratio was 336% as of September 30, 2019.

Table C.4-1 demonstrates that Molina Healthcare, Inc.'s capital position has been consistently strong, which has increased due to improved earnings and also shows the strong, aggregate risk-based capital ratio for its health plans.

Our Financial Strength

As of September 30, 2019:

- Molina Healthcare, Inc.'s consolidated stockholders' equity amounted to \$1.8 billion
- Molina Healthcare, Inc.'s aggregate NAIC Risk-Based Capital (RBC) ratio amounted to 336%, which significantly exceeded the 200% RBC minimum

Table C.4-1. Capital Position

\$ in millions	2019 ³	2018	2017
Molina Healthcare, Inc. Stockholders' Equity	\$1,831	\$1,647	\$1,337
NAIC Risk-Based Capital ratio	336%	397%	286%

³ As of September 30, 2019

As a new entrant in the Commonwealth, Molina was initially capitalized through a \$3.5 million capital contribution from our parent in April 2019. Our parent will provide further capital to support start-up and ongoing operations as discussed in the “Surplus” section.

SOLVENCY

In accordance with the Kentucky Revised Statutes, Molina maintains a statutory deposit of \$500,000, which is held in U.S. Treasury notes. Additionally, Molina currently has checking and statutory custody accounts, including one for cash deposits, other operational use, and to serve for Minimum Capital and Surplus Requirements, and another account for deposits required by the Department of Insurance.

REINSURANCE

Our parent maintains a reinsurance policy for each of its health plans. For most of the subsidiary health plans, the current policies applicable to Medicaid business provide \$2 million in reinsurance protection per member per year with a \$1 million deductible. Policies are renewed annually. Upon Contract award, Molina will coordinate with the Department to ensure the coverage provided by our policy is structured to support all covered services of the Medicaid program.

SURPLUS

As noted in “Net Worth,” Molina was initially capitalized through a \$3.5 million capital contribution from our parent. On an ongoing basis, Molina and our parent will monitor Molina’s capital and surplus levels for compliance with the Kentucky Revised Statutes and the Kentucky Administrative Regulations, including risk-based capital and hazardous financial condition requirements. Molina’s total capital and surplus will be maintained at Company Action Level Risk-based Capital or higher. It is our parent’s practice to monitor capital and surplus levels for all its subsidiary health plans at least quarterly. Our parent will provide further capital contributions or surplus notes to Molina to ensure its compliance with all surplus requirements.

Molina Healthcare, Inc.’s cash resources and borrowing capacity, as further described in “Lines of Credit,” below, are sufficient to support Molina for start-up and ongoing operations. Molina Healthcare, Inc.’s cash, cash equivalents, and investments amounted to \$796 million as of September 30, 2019.

Fidelity Bond

Our parent company, on behalf of Molina, currently maintains a Fidelity Bond amounting to \$10,000,000 for coverage of all affiliates and subsidiary health plans for theft, fraud, forgery, or any dishonest acts committed by any Molina employee. This fidelity bond covers at least \$1,000,000 per occurrence.

b. LINES OF CREDIT

Molina Healthcare, Inc. is a Fortune 500 corporation whose common stock is publicly traded on the New York Stock Exchange under the symbol MOH. As a publicly traded company, our parent has access to a wide range of financing sources, including publicly traded equity securities, publicly traded debt securities, revolving bank lines of credit, bank loans, and lease financing. We are prepared to meet any requests by the Department for additional information about our financial status. Our financial statements are also available for public view at our Investor Information site, which is linked from our home page: www.molinahealthcare.com.

Available Lines of Credit

Molina has full access to the financial resources of Molina Healthcare, Inc., including lines of credit. These lines of credit include a \$500 million Credit Facility and a \$600 million Term Loan Facility with a combined available borrowing capacity as of October 30, 2019, of \$878 million, available in the amounts and at the terms described below.

Credit Facility Borrowing Capacity

Our parent has a \$500 million Credit Facility with available borrowing capacity of \$498 million as of October 30, 2019. The Credit Facility expires on January 31, 2022. For evidentiary documentation, see Attachments to C.4, Molina Healthcare, Inc., Form 10-Q for the Period Ended September 30, 2019, filed on October 30, 2019, Notes to Consolidated Financial Statements, Note 7, “Debt.”

Term Loan Facility Borrowing Capacity

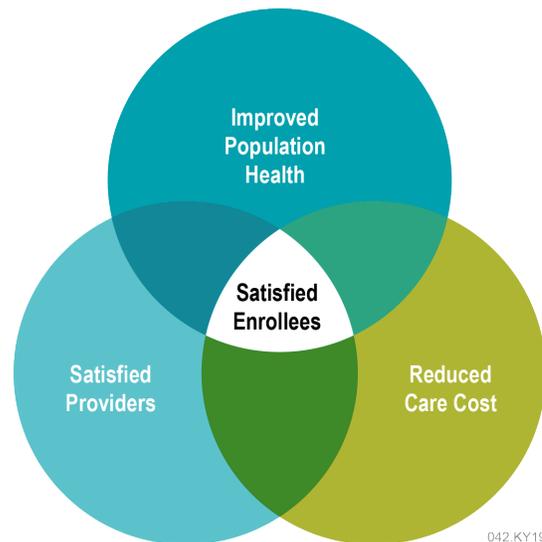
Additionally, our parent has a \$600 million Term Loan Facility. As of October 30, 2019, our parent has drawn \$220 million against the Term Loan Facility, resulting in remaining available borrowing capacity of \$380 million. Under the Facility, our parent may request up to 10 advances, each in a minimum principal amount of \$50 million, until July 31, 2020. For evidentiary documentation, see Attachments to C.4, Molina Healthcare, Inc., Form 10-Q for the Period Ended September 30, 2019, filed on October 30, 2019, Notes to Consolidated Financial Statements, Note 7, “Debt.”

C. PROVIDER RISK ARRANGEMENTS FOR CONTRACTED SERVICES

Building on our national success, and supported by an experienced, local provider network management team, ***we are fully prepared to offer a range of carefully developed value-based payment (VBP) arrangements, including progressive risk-based contracting models***, with willing Kentucky Medicaid program providers who have been assessed as capable of meeting key fiscal, performance, and quality requirements.

Specifically, our proposed risk-based VBP arrangements for Kentucky Medicaid will follow Health Care Payment Learning & Action Network (HCPLAN) framework category guidelines and may include:

- **Shared Savings and Accountable Care.** Additional compensation from a share in savings or risk resulting from improved care quality and outcomes (e.g., providers paid a portion of any share in healthcare savings when financial targets are met) with potential to move to an accountable care arrangement that includes upside/downside risk based on benchmark data and quality measures.
- **Partial-/Full-risk Agreements.** Providers can progress into partial-/full-risk arrangements (e.g., provider is paid a surplus if costs are below set financial target or pays back a portion of losses higher than a set financial target) by demonstrating a track record or positive administrative experience and capability in successfully managing government-sponsored healthcare populations.



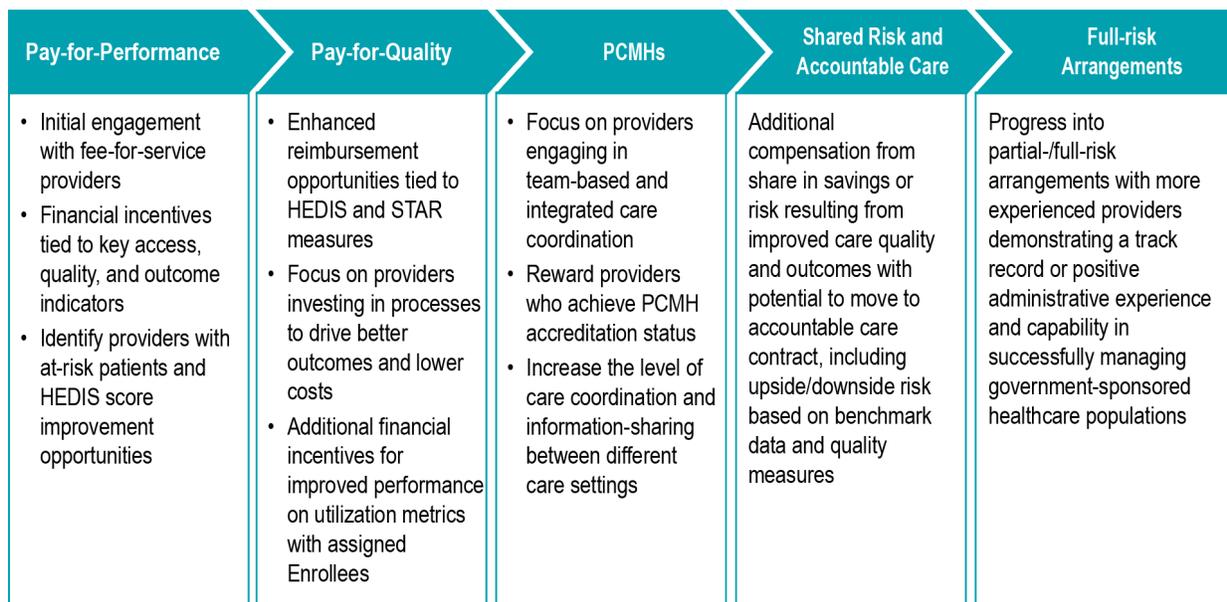
Per the Draft Contract, Section 6.5, Capitation Agreements, Molina understands and agrees to notify the Department for review and final approval of any capitation agreement, including agreement changes or updates, with our subcontractors or providers that include the assumption of risk by the subcontractor or provider.

We will work collaboratively with the Department and other MCOs to develop and implement a Medicaid VBP model in Kentucky that effectively aligns provider financial incentives to high-quality, cost-efficient Medicaid Enrollee care, access, and satisfaction. Moreover, our proposed VBP arrangements are designed to support and closely align with key Department population health and quality priorities while working synergistically with our quality assurance and performance improvement (QAPI) program initiatives, performance improvement projects (PIPs), and targeted quality measures.

Our affiliated health plans nationwide manage VBP contracts spanning multiple lines of business (Medicaid, Medicare, Medicare-Medicaid Demonstration Programs, Marketplace) and **supporting 3.4 million Enrollees and 29,000 providers, with more than 5,000 of those providers operating as certified patient-centered medical homes (PCMHs).**

These contracts cover the spectrum of provider incentive models, from basic pay-for-performance / pay-for-reporting / pay-for-quality to shared savings / gain share and progressive risk-based arrangements. These models encourage access to covered services and quality care improvement by incentivizing providers to focus on preventive care, reduce inappropriate emergency department (ED) use, improve quality and Enrollee outcomes, and streamline service coordination across all primary, specialty, hospital-based, and behavioral health (encompassing mental health and substance use disorder) providers and care settings.

Exhibit C.4-1 depicts the full continuum of Molina’s proposed VBP arrangements to support the Kentucky Medicaid program. These arrangements will be specifically tailored to support our providers’ varied states of readiness for VBP adoption, moving them along the continuum to improved Enrollee outcomes, accountability, and potential for increased rewards based on increased levels of risk.



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Exhibit C.4-1. Molina’s VBP Continuum

Our value-based programs will further encourage providers to be accountable to those they serve, which will result in appropriate service utilization and the right care at the right time in the right setting. In all, nearly **70% of Molina affiliated health plan members enterprise wide are covered under some form of VBP arrangement, including:**

- **Pay-for-performance and/or PCMH contracting arrangements**
- **Pay-for-performance/pay-for-quality agreements**

- ***Partial-, shared-, or full-risk VBP arrangements***
- ***Formal provider risk-based agreements***
- ***Diverse shared savings accountable care organization/accountable care entity and pay-for-performance agreements for nursing facilities***
- ***Tiered incentive and pay-for-performance agreements for hospitals***

We have met with hundreds of providers in Kentucky and recognize there is a high degree of variability in risk readiness and receptivity across the Kentucky provider community. As such, we will encourage providers at all levels of readiness to participate in value-based arrangements and to progress to more advanced arrangements through data-sharing, quality improvement measurement analytics, and medical cost review. Moreover, we will expertly tailor VBP arrangements to specific primary and/or specialty types, risk tolerance, and the amount of control providers have over referral patterns. Our VBP strategy will encompass the following elements:

Tiered Approach. We will initially engage providers where they are beginning within the VBP spectrum. For those not currently familiar with VBP, Molina can work with providers to implement basic VBP elements, such as pay-for-reporting, and advance toward more complex VBP partnerships. This will begin with a prioritization assessment of each provider to determine where they fall in our VBP spectrum.

Specific Goals. Our VBP program will prioritize improving health outcomes by:

- Reducing potentially preventable admissions
- Reducing readmissions
- Avoiding ED visits
- Promoting preventive care measures for Enrollees who have chronic healthcare issues
- Tailoring vital care and resources to an Enrollee's behavioral health needs, especially post-hospitalization follow-up and medication adherence. We further traditionally incentivize our VBP-contracted providers to meet and exceed the HEDIS 75th percentile and the CAHPS 75th percentile

Moreover, as applicable to specific provider types, ***our VBP program will strategically align HEDIS and other key quality and performance measures with:***

- The Department's stated quality and healthcare outcomes priorities for Kentucky Medicaid
- Key NCQA accreditation standards
- Our QAPI program and related PIPs, special initiatives, and quality measures
- Our proposed Enrollee incentives

Initial VBP Arrangements with Key Kentucky Providers

Kentucky Primary Care Association

As an example of our commitment to driving VBP in Kentucky, we are partnering with the Kentucky Primary Care Association (KPCA) to include a value-based reimbursement model incorporating clinical and provider gain share methodologies that support transparency and comparability, drive improved outcomes, and control costs.

Molina and KPCA's joint interdisciplinary partnership will drive a shared agenda focused on increasing care coordination and close collaboration to achieve a seamless Enrollee experience with an emphasis on:

- Joint Enrollee outreach and education
- Creating interventions for Enrollees with a recent avoidable ED visit
- Enrollee follow-up post-inpatient discharge
- Leveraging resources to remove barriers associated with social determinants of health
- Increasing data-sharing capabilities by leveraging KPCA's proprietary CHARLI platform, which supports timely exchange of patient information to inform and develop more effective interventions

Under this partnership, KPCA will be eligible to receive a percentage of shared savings if the actual Medicaid medical cost ratio is less than benchmark and one or all agreed-upon standardized quality incentive measures are achieved. Additional key features of this proposed VBP arrangement will include:

OVERSIGHT OF RISK ARRANGEMENT PERFORMANCE

We will track and monitor VBP program performance in several ways to ensure program efficiency and success, and to identify new opportunities for a provider's progression along our VBP continuum. Within our claims processing system, we will have Contract configuration flags that identify providers eligible for value-based payments through one of our VBP programs. This will allow us to identify those providers at any time and effectuate timely payments on a monthly, quarterly, or annual basis as applicable.

Upon entering into a VBP agreement, we will load the provider into our VBP database to ensure data can be compared to a quality performance matrix, which will include baseline, targeted, and actual performance as well as variance from target and projected financial status. Providers will be able to retrieve reports from the provider Web portal or receive HIPAA-compliant performance monthly reports, including variance metrics. Our dedicated Provider Engagement Team also will schedule regular Joint Operating Committee meetings between providers and our Quality and Analytics teams to discuss results and outcome improvements.

Our in-person Joint Operating Committee meetings with providers will allow us to collaboratively review operations, quality metrics, and education. The meetings will be monthly or quarterly depending on provider size (i.e., large hospitals/health systems versus smaller, rural primary practices), VBP complexity (based on HCPLAN alternative payment model framework category), and provider preference.

We will review utilization trends and top utilizers, which will help identify overall trends such as frequent ED and inpatient utilizers, gaps in service, pharmacy data (to help identify medications commonly used by Enrollees and Enrollee co-morbidities), claims processing, and denial trends.

Ongoing Monitoring and Analysis of Provider VBP Performance

A valuable lesson in our journey from volume to value enterprise wide has been recognizing the need to harness the power of data in our VBP contract arrangements. This is critical to evaluating VBP efficacy which, in turn, helps us successfully and effectively manage the care of members and advance population health across all of our affiliated health plans. Recent successes with improved data sharing include:

- Real-time ED and hospital (inpatient admission, observation, and discharge) data with providers via secure online access
- Secure online access for VBP-contracted providers to their performance reports, which are updated monthly via secure file transfer protocols

We enhanced our oversight of VBP arrangements by implementing 3M Transformation Suite technology and proprietary groupers to provide new analytics tools and levers that will positively impact our ability to evaluate VBP effectiveness, track costs, promote innovative population health and disease management, and report on quality metrics related to health outcomes.

Table C.4-2 depicts ways the 3M Transformation Suite will allow Molina to enhance provider and stakeholder engagement in Kentucky, and, in turn, improve cost and quality outcomes tied to VBP.

Table C.4-2. 3M Transformation Suite Features

3M Transformation Suite VBP Design and Analytics Competencies
<ul style="list-style-type: none">• Leverages proprietary groupers that include potentially preventable readmissions, population-focused preventables, and potentially preventable events• Features analytics tools that accurately capture relevant utilization datasets (e.g., complications, admissions, readmissions, ED visits, ambulatory services)• Provides detailed and expert analysis of risk-adjusted claims data, starting with analysis of Molina affiliated health plans' current VBP arrangements, to set a meaningful baseline and comparison among populations• Uses 3M proprietary methodology combined with Molina's more than 25 years of government healthcare program expertise to implement innovative evidence-based VBP models designed to reduce potentially preventable events by developing a comprehensive analysis of healthcare data across providers and populations• Reflects upon process of care and transitions between care settings to better understand the requirements for improving acute care outcomes, access to care, and avoidable services outside the inpatient setting• Allows stakeholders to identify performance gaps and generate appropriate plans of action to make improvements• Identifies members at high risk as well as members who exhibit early signs of being at a substantial risk of emerging as persistently high-need, projecting utilization and setting equitable (risk-adjusted) VBP goals and incentives

The 3M Suite's innovative dashboards and business intelligence-based VBP reporting tools further drive better informed VBP design and decision-making by:

- Improving patient care by identifying opportunities to lower resource utilization, track costs, coordinate care, and reward quality improvements
- Supporting bundled payment with sophisticated algorithms that include risk adjustment, outlier thresholds, and empirically derived relative payment weights based on actual historical expenditures
- Comparing provider costs by calculating expected resource use with consideration for the clinical risk of a patient's chronic illness and co-morbid conditions
- Expressing episodes and health risk in a clinically meaningful way, so clinicians and other health professionals can understand and act on information

With our successful onboarding of 3M's proprietary methodologies, we will be able to provide smarter VBP goals and incentives that align with Kentucky Medicaid program and Department population health goals, as well as provider needs and care objectives. We also will share robust data with our providers via our secure provider Web portal, allowing access to dashboards and actionable reports for greater transparency.

Assessment and Oversight of Provider VBP Readiness

We leverage a comprehensive assessment and oversight approach enterprise wide to determine provider readiness to successfully participate in our VBP programs. This allows us and our providers to evaluate core capabilities and systems that are critical for providers to succeed under VBP contracts. This proven approach includes consideration of a provider's organizational size and the number of empaneled Molina affiliated health plan members, as well as the provider's level of sophistication in managing clinical, financial, operational performance, data integration and data integrity, and levels of risk. Exhibit C.4-2 illustrates elements of our VBP readiness assessment.

Clinical Considerations	Organizational Support	Financial	Operational
<ul style="list-style-type: none"> Care Standardization Decision-support Tools Patient-centered Care / Chronic Care Management QI and Data Monitoring HIT/HIE PCMH Accreditation (as applicable) 	<ul style="list-style-type: none"> Commitment from Leadership Staffing Data Resources 	<ul style="list-style-type: none"> Understanding Patient Cost of Care Through Data Aggregation and Analysis Coding Accuracy Stable Revenue Cycle Management Provider Performance Incentive Distribution Capabilities 	<ul style="list-style-type: none"> Monitoring Provider Productivity Improving Cost Efficiencies Identifying Patients Covered Under VBP
Services and Partnerships: To Facilitate Care Coordination and Data-sharing Across Multiple Providers			
<ul style="list-style-type: none"> Formal/Informal Relationships Services Under Provider's Scope / Continuum of Care Data-sharing Capabilities 			

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Exhibit C.4-2. Readiness Assessment

Upon completion of the assessment, we begin collaboration and negotiation with each provider on VBP model design, performance targets, readiness, and implementation. In the Commonwealth, the VBP agreements we will develop will include a path to participation in programs in higher-level HCPLAN alternative payment model framework categories, timelines, quality metrics, performance expectations, and enrollment thresholds.

To develop provider readiness and evolution along the VBP continuum, we will provide ongoing provider education, readiness development, and technical support through data exchanges, Joint Operating Committee meetings, data collection, analysis and sharing, and even embed care managers when applicable (e.g., partner hospitals). Table C.4-3 outlines the support and assistance we will share with all providers in VBP programs to develop and support their capability to evolve along the continuum.

Table C.4-3. Readiness Support

Method of Support	Description
Data Collection and Analysis	<ul style="list-style-type: none"> We will collect and process quality, claims, and other related provider performance data in our claims processing system. Data will be compared to a quality performance matrix, which will include baseline, targeted, and actual performance as well as variance from target and projected financial status.
Data Exchanges	<ul style="list-style-type: none"> Providers will have real-time access through the provider Web portal to retrieve eligibility, claims, and reports and obtain HIPAA-compliant performance monthly reports, including variance to target. They will also have access to data and analytics through the Web portal, enabling the provider to manage financial risk and understand their monthly risk position and provider performance. We will use customizable dashboards and functionality in our secure online care management platform to review areas such as Enrollee eligibility, claims status and creation, service requests and authorization, Enrollee rosters, HEDIS profiles and "Missed Services" alerts, reports, links, forms, and account tools. We will provide real-time access to providers' electronic medical records to ease the burden of referral/authorization/discharge planning as well as access to quality data and insight into potential care gaps.

Method of Support	Description
Joint Operating Committee Meetings	<p>We will conduct in-person meetings with providers to review operations, quality metrics, and education. These meetings will be monthly or quarterly depending on HCPLAN alternative payment model category and provider preference. Reviews will include but will not be limited to:</p> <ul style="list-style-type: none"> • Overall enrollment and current enrollment demographics • Quality, which will help identify gaps in Enrollee care and the potential to earn money through VBP agreements • Pharmacy data • Claims processing and denial trends • Utilization trends at the Enrollee level, including top ED and inpatient utilizers
Care Management	<p>We will embed care managers / care coordinators in provider offices with high volumes of our Enrollees to assist Enrollees and help providers with referrals, authorizations, and care management.</p>
Financial	<p>The following are a few examples of how Molina will provide financial support for providers to move beyond basic pay-for-performance arrangements and into pay-for-quality programs, as well as demonstrate readiness for additional compensation opportunities further along the continuum, up to accountable care arrangements that include upside/downside risk based on benchmark data and quality measures.</p> <p>Coordination of Services Quality Incentive Program. We will offer prepaid funding opportunities (i.e., PMPM payments) for participating providers to invest in dedicated team-based provider coordinators. These coordinators will assist care management teams with patient outreach and education and promote integrated care coordination across treating providers and vendors providing community benefits, along with treatment planning and compliance, which will drive better outcomes and lower costs.</p> <p>PCMH Quality Incentive Program. We strongly support the PCMH care model, which promotes team-based and integrated care coordination in a shared-information practice environment. Grant investments will be available for participating providers to cover PCMH accreditation consultant expenses, along with ongoing prepaid funding opportunities (i.e., PMPM payments) for achieving and maintaining recognized accreditation modules (i.e., NCQA).</p>

We will provide comprehensive support to our providers to encourage and enable progression through the VBP continuum. Our strategy will consider factors such as scope of practice, practice size, availability of cash reserves, and geography, which can all impact the amount of risk providers are willing and able to assume.

Integrated health systems in Kentucky with a large scope and diversity of care will have greater influence over the total cost of care for their population. This means they will be able to assume more financial risk and be early candidates for VBP programs in HCPLAN alternative payment model framework categories 3 and 4. We may provide additional development and support to smaller and more rural practices facing challenges with establishing coordinated networks of care over large geographical regions. This support may include development of virtual delivery systems to enable them to move into more progressive amounts of financial risk.

Our VBP program will be built on our sound understanding of Kentucky’s diverse Medicaid population and the health and social determinants challenges they face. Moreover, it will be a key driver of our overarching strategy to improve healthcare access and health outcomes across the Commonwealth, especially in rural and historically underserved areas.

For more detail about our proposed overall VBP approach for the Kentucky Medicaid program, please see Proposal Section C.3, Capitation Payments.

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