C.18 Provider Network

REQUIREMENT: RFP Section 60.7.C.18

18. Provider Network (Section 28 Provider Network)

a. Provide the Vendor's proposed Provider Network development strategy to ensure a comprehensive statewide network across all provider types. The Vendor's strategy must describe the following:
   i. Innovative approaches to recruit providers and to develop and maintain the Vendor's provider network to ensure network adequacy standards and highest quality care, including:
      1. Strategies to recruit providers in traditionally underserved as well as non-urban areas, by health need, and to overcome expected accessibility challenges.
      2. Strategies and methods to address workforce shortages and network gaps, included proposed initiatives to collaborate with the Department and other contracted MCOs to develop innovative solutions to meet the healthcare needs of Enrollees.
      3. Strategies for contracting with providers in bordering states to help address network adequacy challenges, including lessons learned and successes or challenges with this approach.
   ii. Approach to providing out-of-network care when timely access to a Network Provider is not possible, including the Vendor's approach to supporting Enrollees in accessing such care.
   iii. Approach to ensure Network Providers are physically accessible and have accommodations for Enrollees with physical or mental disabilities.
   iv. Approach to ensure a comprehensive network to address the needs of all Enrollees, including the provision of services in a culturally sensitive and linguistically appropriate manner.
   v. Strategies the Vendor will implement to ensure the network adequacy and access standards are met if actual Enrollment exceeds projected Enrollment.

b. If Subcontractors will provide Covered Services, describe how network development efforts will be coordinated with the Vendor's provider network development strategy and how the Vendor will monitor the Subcontractor's activities and ensure transparency of these activities to the Department.

c. Describe the Vendor's approach to use telehealth services to improve access. Include the following at a minimum:
   i. Criteria for recognized sites.
   ii. Education efforts to inform providers and Enrollees.
   iii. Whether reimbursement will be available to the presenting site as well as the consulting site or only the consulting site. Include any requirements or limitations on reimbursement.
   iv. Lessons learned and successes or challenges with implementation of telehealth services for other programs the Vendor has served and that the Vendor will consider for provision of telehealth services in Kentucky.

d. Describe the Vendor's provider contracting strategies, including processes for determining if a provider meets all contracting requirements (at the time of enrollment and on an ongoing basis), as well as processes for corrective action and termination. Include copies of the Vendor's proposed contract templates for individual practitioners and for facilities as attachments.

e. Demonstrate progress toward developing network capabilities for statewide access by providing evidence of existing contracts or signed Letters of Intent with providers by provider type (for the Vendor and Subcontractor). Include the following information at a minimum:
   i. A Microsoft Excel workbook by provider type listing every provider that has signed a contract or Letter of Intent, including the provider's name, specialty(ies), address and county(ies), Medicaid Region(s) served, whether the provider is accepting new patients, accessibility status for individuals with disabilities, language spoken, and the provider's Medicaid Identification Number(s).
   ii. A summary Microsoft Excel worksheet with total provider counts by provider type by Medicaid region and county.
   iii. A statewide Geographic Access report of all providers with LOIs and/or existing contract color coded by provider type by Service Region.

f. Describe proposed Enrollee to provider ratios by provider type, as well as the Vendor's methodology for considering a provider's FTE when calculating network adequacy standards.

g. Describe the Vendor's proposed methods for ongoing monitoring and assessment to ensure compliance with network adequacy and access to care standards, including tools used, the frequency of reviews, and how the Vendor will use findings to address deficiencies in the Provider Network. The response should also address how the Vendor monitors appointment availability and wait times.
   Provide samples of tools and/or reports.

h. Describe how the Vendor would respond to the network termination or loss of a large provider group or health system. Include information about the following at a minimum:
   i. Notification to the Department and Enrollees.
   ii. Transition activities and methods to ensure continuity of care.
   iii. Analyses the Vendor will conduct to assess impact to network adequacy and access, and how the Vendor will address identified deficiencies.

Molina's provider network development strategy will meet the diverse physical health and behavioral health needs of Enrollees, ensuring access to all covered services and quality care when and where they need it, regardless of geographic location in the Commonwealth.

The Molina enterprise offers more than 25 years of experience developing and managing comprehensive high-quality provider networks, currently serving 3.4 million members across 15 states. We recruit experienced providers who have traditionally delivered a significant level of care to Medicaid beneficiaries, are committed to providing high-quality care, and willing to partner with us to improve health outcomes, minimize administrative costs, and collaborate to identify and implement access / care management solutions. ***For more than 25 years, we have passed every Readiness Review and have met network adequacy requirements before go-live for every one of our implementations.***

a. NETWORK DEVELOPMENT STRATEGY

The objective of Molina's provider network development strategy is to develop a comprehensive, broad, direct network that meets Enrollees' healthcare needs and aligns with the Commonwealth's goals of improving health outcomes, focusing on quality, and operating in a cost-efficient and effective manner. Exhibit C.18-1 illustrates our vision, goals, and the tactics we are employing in Kentucky to build our provider network.

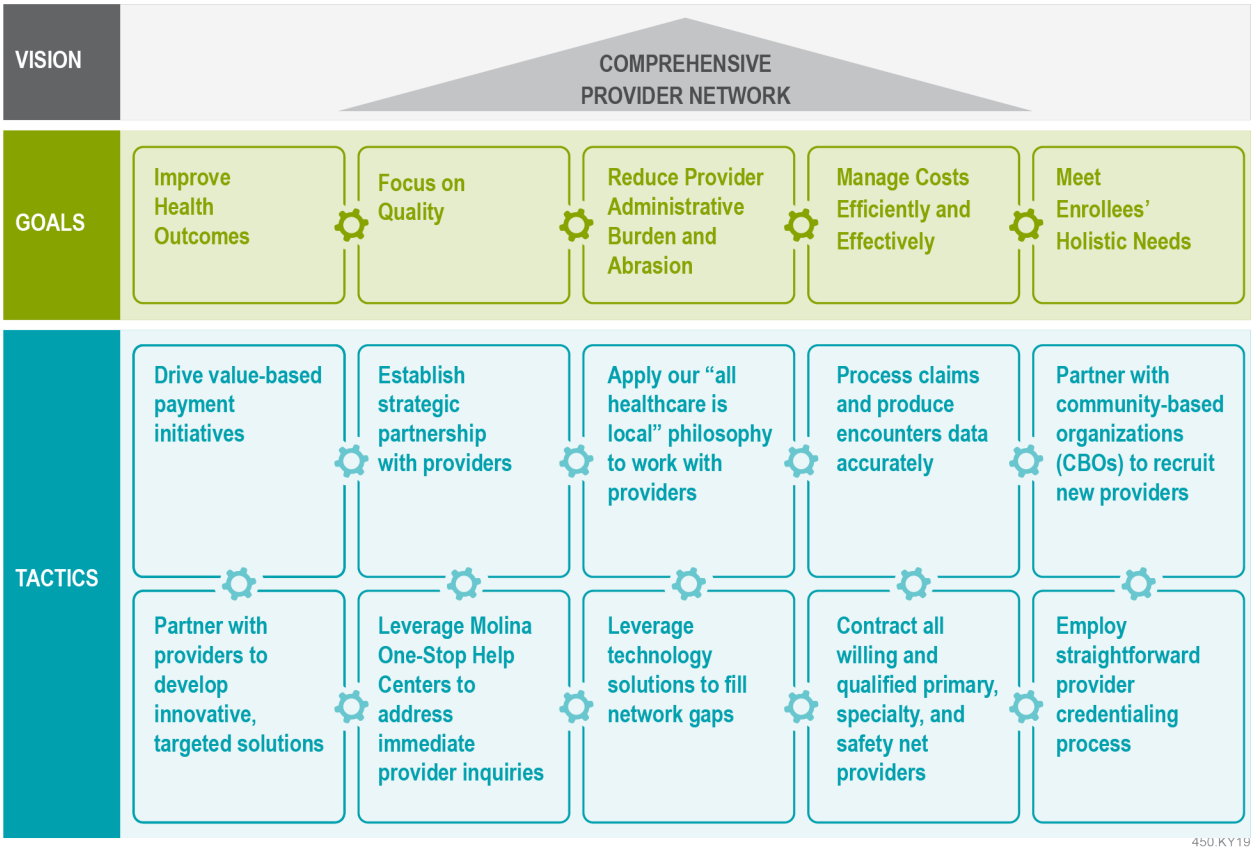

Exhibit C.18-1. Molina's Provider Network Development Strategy

By fostering relationships with all provider types in all Kentucky regions, we will enhance together the Commonwealth's current Medicaid managed care program, positively influence health outcomes, develop and implement innovative and targeted reimbursement solutions, and improve the overall provider experience.

Our network development approach considers providers' geographic location, distance, and travel time relative to Enrollees, office accessibility, cultural competency, ethnicity, language, if they are accepting new Medicaid patients, availability of telehealth services and/or technology, and other special needs of the Kentucky Medicaid population, including expected utilization of services.

Under the direction of Provider Network Director Kim Sweers, Molina's Provider Network team ***has recruited providers throughout the Commonwealth and in bordering states.***

Table C.18-1 provides a snapshot of regions and provider types for which we have already achieved network adequacy.

Table C.18-1. Network Adequacy Heat Map by Provider Category

Provider Type/Categories	Number of Counties at Adequacy							
	Reg 1	Reg 2	Reg 3	Reg 4	Reg 5	Reg 6	Reg 7	Reg 8
Acute IP Hospitals, ASC, IP Substance Abuse, IP Psych Facilities	4/12	6/12	9/16	14/20	19/21	5/6	8/14	9/19
All Other Specialties and Provider Types	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19
Behavioral Health, Substance Abuse, Psychiatry	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19
Community Mental Health Center	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19
Dental	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19
Diagnostics, Imaging, Laboratory, Mammography	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19
FQHC, Birthing Center, Health Dept, Home Health, RHC, Duty Nurse	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19
Pharmacy, DME	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19
Podiatry*	6/12	12/12	16/16	20/20	20/21	6/6	13/14	19/19
Primary Care, Family Planning, APRN, PA	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19
Renal Dialysis Clinic	12/12	10/12	16/16	20/20	21/21	6/6	14/14	19/19
Specialist Network	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19
Speech, Occupational, Physical Therapy, Chiropractor	10/12	11/12	16/16	20/20	21/21	6/6	14/14	19/19
Vision, Audiology	12/12	12/12	16/16	20/20	21/21	6/6	14/14	19/19

Legend										
100%	95.2%	92.8%	91.6%	90.5%	83.3%	70%	57.1%	50%	47.3%	33.3%

Acronyms: IP = inpatient; ASC = ambulatory surgical center; FQHC = Federally Qualified Health Center; RHC = rural health clinic; DME = durable medical equipment; APRN = advanced practice registered nurse; PA = physician's assistant

*Molina has identified adequacy gaps related to Podiatry. Appalachian Regional Hospital has podiatrists within its provider network and would address the shortfall in Region 5. We have identified 4 independent providers in Region 7. We will continue to pursue contracts with these organizations in advance of the event we are awarded a Medicaid Contract with the Commonwealth. If an Enrollee requires access to these providers, Molina would either enter into a single case agreement or provide transportation to another provider in an adjacent county.

Additionally, we have developed and continue to develop relationships with community-based organizations (CBOs), such as ***Kentucky Heartland Food Bank, Home of the Innocents, Boys and Girls Club of Bowling Green, and United Way of Northeast KY, that are critical for addressing Enrollees' social determinants of health and supporting our population health strategies*** that aim to improve health outcomes across the Commonwealth. With the support of these organizations, we encourage Enrollees to be empowered in their healthcare while reducing the administrative burden on providers.

Through face-to-face meetings with providers, we listen to their needs, their ideas, and their frustrations to understand where opportunities exist to improve the provider experience, reduce administrative burden, and create targeted solutions to address local healthcare issues and disparities in an effort to secure more providers to serve our Enrollees. Throughout Kentucky, providers expressed similar challenges: onerous, lengthy credentialing processes; difficultly getting timely assistance from MCOs; and burdensome administrative requirements required by MCOs. In preparing our network strategy for Kentucky, we considered the challenges providers are facing, and are proposing an innovative approach to recruit providers in traditionally underserved as well as non-urban areas, address workforce shortages and network gaps, and contract with providers in bordering states. Our three-pronged approach, described below, includes credentialing and onboarding providers using a swift, provider-friendly process; establishing regional Molina One-Step Help Centers to engage providers and their staff in person; and assessing referral and practice patterns to engage and contract the providers Enrollees use in bordering states.

a.i. INNOVATIVE APPROACHES TO RECRUIT PROVIDERS AND DEVELOP AND MAINTAIN A COMPREHENSIVE NETWORK

Understanding Kentucky's challenges related to Medicaid network access and adequacy—especially in rural and Health Provider Shortage Areas regarding provider concerns and other administrative frustrations—allows us to bring a tailored, dedicated approach to ensuring the implementation of a strong, robust provider network vital to the success of the Kentucky Medicaid program. For example, ***the U.S. Health Resources Services Administration has designated all but 10 of the 120 Kentucky counties as Health Provider Shortage Areas.*** Given the concerns that MCO networks are insufficient in rural areas, which limits access to care, Molina will continually recruit additional providers to strengthen our network in these shortage areas and encourage providers to open their panels to more Medicaid Enrollees.

Molina knows an effective MCO relies on a strong provider network to ensure Enrollees receive quality care when and where they need it. As a result, the Department and Molina share a common interest in recruiting and supporting providers to ensure they are empowered to offer effective and efficient care to Enrollees. This is especially true within a population health environment, which places critical importance on the delivery of high-quality preventive and ongoing care to improve health outcomes across the Commonwealth. ***Our approach is wholly focused on finding a cross section of dedicated providers that will meet the physical health, behavioral health, and social needs of our Enrollees.***

We employ various approaches to recruit providers and develop and maintain our network that all begin with our **It Matters to Molina** provider outreach program. Our It Matters to Molina program, which we have already deployed in Kentucky during our initial provider focus groups, was developed as a result of provider feedback in affilated health plans across the country. It Matters to Molina centers on our philosophy that providers are partners in improving Enrollees' healthcare and the Enrollee experience. ***During our meetings with providers in the Commonwealth, we heard providers' frustrations, like lengthy credentialing processes, and are deploying a unique approach in Kentucky to work with providers through face-to-face walk-in service at our six Molina One-Stop Help Centers, which will be in Bowling Green, Covington, Hazard, Lexington, Louisville, and Owensboro.***

Staffed with Molina Provider Services team members and members of our specialized community-based staff, our Molina One-Stop Help Centers will serve as locations to assist providers and their staff with a variety of needs, including:

- Resolving issues promptly
- Holding meetings to recruit new providers
- Conducting provider feedback forums
- Collaborating on the development of new Enrollee-focused initiatives
- Delivering training and education on topics like our value-based payment (VBP) program and the benefits of electronic health records (EHRs) and the Kentucky Health Information Exchange (KHIE)
- Hosting regional Provider Advisory Committee meetings to broaden in-person participation of rural providers

Supporting EHR Use

Molina will incentivize providers not currently on an EHR system to connect to the Epic Community Connect EHR platform by paying 80% of their ongoing maintenance fees, if they agree to meet quality performance metrics.

We also will use unique payment structures to incentivize and reward providers to improve the health of the Enrollees they serve.

VBP Incentives. We have designed our Kentucky VBP program to:

- Improve Enrollee and provider satisfaction
- Improve population health
- Reduce healthcare costs
- Improve provider performance
- Support key Department quality and healthcare outcomes priorities
- Deliver meaningful VBP incentive approaches
- Align with our Quality Assurance and Performance Improvement program initiatives and quality measures

a.i.1. Recruiting Providers in Traditionally Underserved and Non-urban Areas

Based on the experience of our affiliated health plans, we know providers in rural areas are sometimes reluctant to see Medicaid beneficiaries because the administrative burden placed on them by some MCOs can be too high. Recognizing the challenges and strain on quality care delivery in Kentucky's traditionally underserved and non-urban communities, we have developed an approach to meet the diverse health needs of Enrollees in these communities.

Reducing Claims Denials

Our Illinois affiliate recently identified a spike in claims from a large hospital foundation. Before the hospital realized there was an issue, our Illinois affiliate analyzed the data and determined the hospital had switched the National Provider Identification (NPI) number they were billing on claims, a change implemented at their clearinghouse. **Our Illinois affiliate provided the hospital with a list of the more than 12,000 claims impacted, so they could quickly bill correctly and be paid more than $1.2 million for services performed.**

In addition to our overarching approach to recruit providers in traditionally underserved and non-urban areas, Molina's Network Development staff visits providers in these areas to tell them the Molina story, reconfirm the issues they may be experiencing with other MCO, understand their capacity and desire to facilitate telehealth services, and

understand their desire to serve Medicaid Enrollees. During our time in each traditionally underserved and non-urban area, we also research existing CBOs to understand the services they provide and discuss how we can partner with them to complement the host of services traditional providers in the area already deliver.

Overarching Recruitment Approach. Our approach centers on four concepts to strengthen our ability to recruit providers who deliver care locally in the most appropriate and cost-effective setting, and includes:

1. **Reduce providers' administrative burden.** Understanding that providers delivering care in traditionally underserved and non-urban communities face challenges with sufficient resources to serve local Enrollees adequately, Molina will focus on reducing providers' administrative burden to maximize the amount of time providers spend in direct services delivery. Programs like our Preferred Provider PA Program, which relaxes or eliminates prior authorization requirements for providers demonstrating quality outcomes and proactively analyzes claims submission to reduce or eliminate claims denials, will help providers stay focused on delivering care.
2. **Reimburse providers promptly.** Because many providers in traditionally underserved and non-urban communities often struggle with adequate funding, Molina will employ advanced technologies like our Prospective Claims Accuracy Solution that uses an algorithm aligned to our payment policies to prospectively check claims for accuracy, electronic funds transfer, and remittance advice for faster and safer payment and explanation of payment. In fact, across all our affiliated health plans, we averaged ***10.6 days from receipt of a clean claim to payment in 2019***, including claims that required secondary quality review.
3. **Support providers with addressing Enrollees' unique healthcare issues and disparities.** Kentucky has been impacted by the opioid epidemic. We will support providers in traditionally underserved and non-urban communities with tools and resources like our:
   - Substance Use Disorder (SUD) Model of Care with Opioid Use Disorder Focus that includes proprietary tools providers can use to screen Enrollees for opioid use, an enhanced care opioid use care coordination model, and comprehensive data dashboard and report
   - Behavioral Health Provider Toolkit that will help primary care providers (PCPs) and specialists navigate an area of health with which they may not be familiar by providing them with 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
   - Community-based SUD navigator staff—trained in SUD treatment and dedicated solely to Enrollees with SUDs—who will engage with Enrollees with SUDs to encourage treatment, coordinate care for them, and work with them on treatment adherence.
4. **Partner with FQHCs, RHCs, and CMHCs on efforts to recruit graduating doctors and advanced practice nurses.** In every market our organization works, we focus on creating strong partnerships with FQHCs, RHCs, and CMHCs with the understanding that these resources serve the majority of members. In Kentucky, in addition to KPCA's safety net providers, we have begun discussions with several FQHCs to determine ways to recruit additional providers through targeted initiatives like providing grants and scholarships for medical students and advanced practice nurses; providing funding to acquire new or improve existing telehealth technology capabilities; and recruiting providers (e.g., pediatric psychiatrists) from outside the Commonwealth where needed. Additionally, as a member of the Kentucky Rural Health

Care Connections Team

The Care Connections program includes a team of Molina-employed nurse practitioners who provide wellness and preventive care services. Team members serve as an additional access point in the healthcare system.

Association (KRHA), we will explore ways of working with the KRHA in support of efforts to broaden the rural healthcare delivery system. We will also continue to work with CBOs, such as Family Scholars House and Audubon Area Community Services, to support healthcare workers across the continuum of care to increase access to care.

We understand that in traditionally underserved and non-urban areas, it often requires a "village" to ensure Enrollees have access to needed healthcare services. We will continually look for opportunities to work with non-traditional providers like paramedics and pharmacists to improve Enrollees' access to care.

Through our focused efforts and targeted solutions, our goal is to ensure all Enrollees in traditionally underserved and non-urban communities have access to all required covered services in a sufficient number, mix, and geographic distribution of providers to overcome expected accessibility challenges.

a.i.2. Addressing Network Gaps and Workforce Shortages

In focus groups with Kentucky providers and Enrollees across the Commonwealth, we have repeatedly heard about the challenges that workforce shortages and network gaps place on both the provider community and Enrollees seeking care. For example, we heard from Enrollees in Ashland who seek care from out-of-state hospitals because the closest in-state provider is more than a two-hour drive. We heard from providers who struggle with delivering care to Enrollees who either do not speak the same language as the Enrollee or do not understand Enrollees' cultural needs. We heard from behavioral health providers about the workforce shortages affecting access to behavioral health care close to where they live. To address these concerns and others common in areas with workforce shortages and network gaps, Molina will deploy the following methods in the Commonwealth:

Our Puerto Rico affiliate noticed that member utilization and compliance with the HEDIS measure for Diabetic Retinal Exams had been particularly challenging. Their quality committee identified that in rural regions, the lack of eye professionals certified to perform the exam was a contributing factor. To address this, they contracted with a mobile unit that could access all points on the island, and the mobile unit provider coordinated members' PCPs to identify members in need of the exam.

In the first month of operation, 156 members with diabetes visited the mobile unit and received eye exams.

Telehealth. Molina will use telehealth as a tool for facilitating access to needed services in a clinically appropriate manner that are not available within our network following KRS 205.559 and KRS 205.5591. Our telehealth offering will include access to physical health, behavioral health, and select specialty services. Molina affiliated health plans have effectively used telehealth to facilitate access to needed services, reducing costs by providing an alternative option to expensive urgent care and emergency department (ED) visits. Our telehealth strategy is described below in our response to Section C. Telehealth. Using targeted provider communications, we will alert providers willing to engage in telehealth services but lacking the technology for it that they can leverage the Molina One-Stop Help Centers in their area to provide telehealth services.

Pop-up Clinics and Mobile Health. We will augment and increase Enrollee access to our network by supporting traditionally underserved and non-urban communities with pop-up clinics and mobile health delivery via Molina's Care Connections program. Care Connections contributes to the Molina mission by expanding access to quality care by "meeting Enrollees where they are" including home visits, mobile clinics, pop-up clinics, and virtual visits. The Care Connections program will be proud to provide Enrollees with the right care, at the right time, in the right setting. Care Connections is established in all our affiliated health plans, ***offering services such as Medicaid annual comprehensive exams, comprehensive diabetic care, well-child visits, and "Mothers of Molina" postpartum visits.***

Care Connections team members will be responsible for comprehensive documentation of Enrollee conditions, diagnoses, and needs. The team will deliver advanced point-of-care testing that will create the space to educate Enrollees on their conditions. They will coordinate care and facilitate communication

between Care Management, PCPs, and Enrollees. They also will provide a "boots-on-the-ground" view into our Enrollees' social determinants of health.

We look to partner with our dental and vision services subcontractors to actively participate in "pop-up clinics" throughout the Commonwealth driven by our Care Connections team. For example, our dental vendor Avesis has a strong network of mobile and portable providers, along with operational policies to ensure consistent access to care, that can be leveraged to support our pop-up clinics.

Mobile/portable oral health providers (M/PPs) are best positioned to serve their patients when they work in collaboration with brick- and-mortar dental offices. The M/PP can make varying levels of dental services available in locations such as schools, nursing homes, senior citizens centers, and Head Start centers where children or adults often are available for screening and/or care. The M/PP provides diagnostic information for the local dental provider and triages patients to ensure those with emergency or urgent needs are treated quickly. On the other side of the partnership, the local dental office accepts referrals from the M/PPs, providing required follow-up care and creating the conditions for the patient to develop a stable dental home.

Project ECHO. We have leveraged the experience and best practices of our affiliated health plans in successfully contracting with rural providers, hospitals, and health systems. For example, one of our affiliated health plans partners with the CMMI Project ECHO (Extension for Community Healthcare Outcomes), an innovative model that leverages consultative telehealth case review with medical providers with specialized focus, expanding access to evidence-based care for patients in rural settings and corrections facilities. This partnership successfully focuses on educating rural providers on best-practice protocols, increasing access to case-based learning resources and lectures, and multiplying capacity to treat a wider spectrum of health conditions in that state's rural, frontier, and tribal areas. Additional information about Project ECHO is provided in our Telehealth response below.

Molina Community Health Workers. Molina Community Health Workers will support Enrollees' access to services. They act as extensions of our Care Management team, assisting Enrollees in navigating their healthcare needs and connecting 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. They address Enrollees' social determinants of health by establishing relationships with community shelters, churches, adult day programs, soup kitchens, and food banks, and working with these CBOs and local agencies to connect Enrollees with housing and employment support resources, food, clothing, utilities, transportation to appointments, scheduling appointments, medication refills, obtaining durable medical equipment, and maintaining eligibility.

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. Peer support specialists will travel hundreds of miles each month to meet with Enrollees, many of whom are in remote areas. They will communicate with Enrollees who are not currently in treatment for behavioral health needs but might benefit from it. Because of a shared experience in SUD recovery, peer support specialists will relate to and develop trust with Enrollees and overcome communication barriers.

Behavioral Health Professionals. To help address and mitigate the significant workforce shortage challenge of behavioral health professionals, we are pursuing several strategies with key partners, including using interns, licensed associates, bachelors-level trained behavioral health staff, peers, and community health workers. Our agency-level credentialing will allow providers to use a range of behavioral health-trained staff beyond licensed professionals, including community-based staff who are local and able to outreach to Enrollees who are not able to travel to clinics.

Because low reimbursement rates for behavioral health professionals continues to be a major driver of workforce shortages for professionals working in community-based settings, we will partner with our safety-net providers to optimize revenue to support paying competitive wages. This will include use of VBP models to improve cost-effective care delivery, reduce provider administrative burden, and ensure full encounter capture to account for the total cost of care that supports actuarially sound rates.

Mitigating Workforce Shortages in Mississippi

In Mississippi, workforce shortages have proven to be a challenge—especially in rural areas like the Delta region, which, like rural parts of the Commonwealth, is challenged by significant provider shortages across multiple provider types. One of our Mississippi affiliate's strategies has been to engage nurse practitioners. Their network development team is constantly contacting new nurse practitioners entering the state.

Other innovative solutions include contracting with Fast Pace Urgent Care. Fast Pace operates a network of urgent care clinics. **One goal of this partnership is to reduce the number of preventable ED visits for behavioral health-related issues.**

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Advanced Practice Nurses. We will encourage providers to employ advanced practice nurses and physician assistants in primary care and some specialty offices to expand network capacity. As such, we will strengthen our network and fulfill our commitment to work with strategically located community providers that serve low-income populations.

FQHCs, RHCs, and School-based Services. We value our partnerships with FQHCs, RHCs, and school-based health clinics and the critical role they play in serving the needs of low-income populations in the Commonwealth's most rural service areas. We believe in the coordination of care model leveraged by FQHC and RHC providers and school-based health clinics to support advanced quality care. School-based services, including behavioral healthcare, prevention, and wellness, are very important in Kentucky, and we will ensure their robust participation in our network. In our experience, offering well-care visits at schools where children and youth spend a large portion of their day improves health outcomes by enhancing access to important preventive care services. Through our partnership with KPCA, we will support telehealth services in schools in rural and underserved areas with provider shortages. Using telehealth will enable Enrollees to also access specialty services from a single location.

We have formed a partnership with the KPCA that includes delegated credentialing, data-sharing, and other terms of care coordination. Our relationship with KPCA is critical to meeting the needs of Enrollees and 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
- Patient 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 health information platform, which supports timely exchange of patient information to inform and develop more effective interventions

KPCA's network will provide Kentucky Medicaid Enrollees with access to more than 1,000 sites across the Commonwealth, comprising 434 total clinic sites, 350 FQHCs, 172 school-based health sites, and 84 RHCs as shown in Exhibit C.18-2.

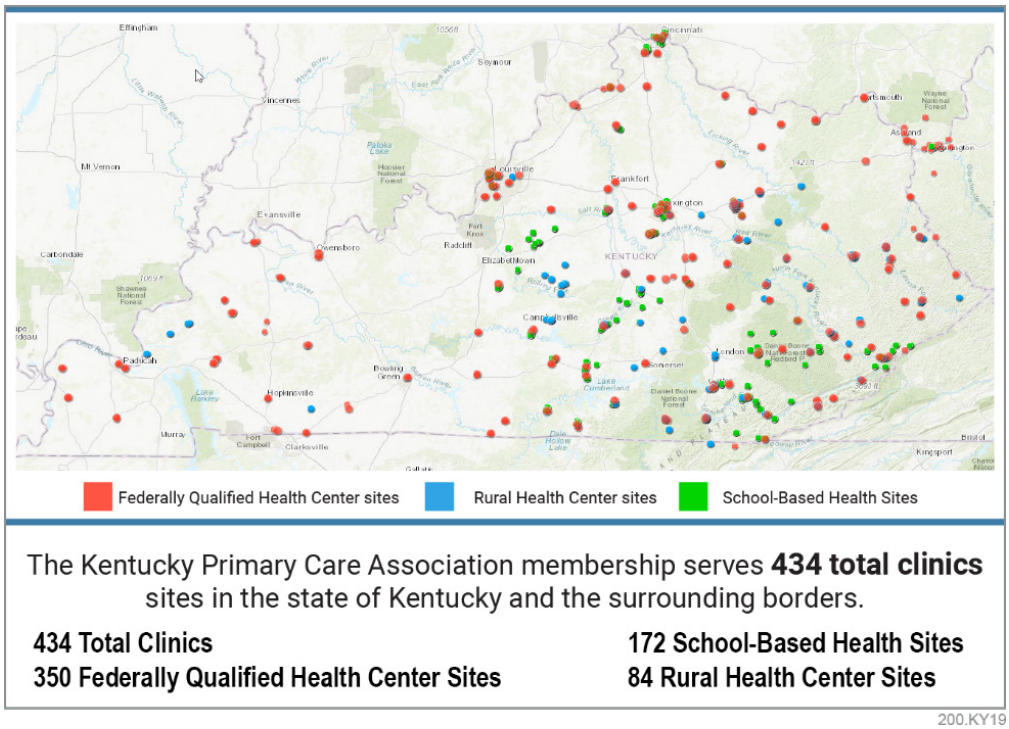

Exhibit C.18-2. KPCA's Kentucky Footprint

CMHCs. To address shortages of behavioral health providers in rural areas, we are developing innovative partnerships with the Commonwealth's CMHCs. We also will leverage the success of our affiliated health plans in developing these innovative partnerships.

One example is the partnership between our Illinois affiliated health plan and the Illinois Behavioral Healthcare Coalition (IBHHC). The Illinois plan works with IBHHC to better identify and help coordinate the intensive care of their patients. The relationship has grown from a successful pilot program to one that now includes several large provider groups, which the health plan anticipates will eventually work with more than 700 members. This partnership is based on effective communication with each provider partner, well-defined quality initiatives, and a robust care coordination program. The partnership works to increase ED diversion and the initiation of follow-up provider visits within a defined period.

This program has shown that unique MCO/provider partnerships can improve clinical outcomes, raise the quality of life of Enrollees, and reduce costs.

Collaborating with the Department and Other MCOs

As an MCO focused solely on providing services to government-insured individuals, we are experienced and fully prepared to collaborate with the Department, other Commonwealth agencies, and other MCOs. Collectively, our goal is to deliver the highest quality healthcare services to Kentucky Medicaid Enrollees.

In Kentucky we will collaborate with the Department and other MCOs to improve outcomes, reduce provider abrasion, and increase provider satisfaction. For example, Molina has the required experience and expertise and is prepared to be a valued partner with the Department and other MCOs to support the level of collaboration needed to create, implement, and manage the Kentucky Medicaid VBP program. Our affiliated health plan in Ohio provides an example of such collaboration.

Working closely with the Ohio Department of Medicaid, Molina Healthcare of Ohio and other Medicaid MCOs collaborated to develop and implement a patient-centered medical home (PCMH) VBP model, Ohio Comprehensive Primary Care. Ohio Comprehensive Primary Care is a fully aligned, uniform Ohio

Department of Medicaid-approved VBP program developed to adhere with CMS's State Innovation Model Initiative. This cooperative effort resulted in true practice transformation of VBP programs offered by the state's Medicaid MCOs.

To maintain communication and aligned goals, our Ohio affiliate meets monthly with representatives from the Ohio Department of Medicaid and other Medicaid MCOs to discuss Comprehensive Primary Care program successes, challenges, and best practices. Additionally, all participating MCOs meet monthly among themselves to remain aligned in their program efforts.

This collaborative effort has incentivized MCOs to "go the extra mile" in alignment with Ohio Department of Medicaid's request, developing and implementing consistent provider messaging, minimizing provider touch-points with multiple MCOs, and partnering with the state on continual program improvements.

The Ohio Comprehensive Primary Care program currently ***includes 280 Ohio PCPs serving 54% of our Ohio affiliate's total Medicaid membership. The broad, standardized program has been adopted by multiple MCOs and covers a sizeable percentage of membership statewide.*** It has further funded and incentivized primary care practices to a degree that true practice transformation can occur. Since launching the Ohio Comprehensive Primary Care program in 2017, the state has achieved an overall 18% improvement on behavioral health measures, a 4% improvement on adult health measures, and a 3% improvement on women's health measures.

We can use the best practices learned from our Ohio affiliate's experience to bring together the Department, MCOs, and the Kentucky Medicaid provider community to develop an effective VBP model that drives improved Department–MCO communication and Enrollee outcomes, while reducing provider abrasion.

During VBP model development, we recommend scheduling regular face-to-face meetings with key stakeholder groups, including the Department, MCOs, and providers. These meetings should be geared toward developing initiatives that support adoption, contribution to, and understanding of the model design.

Preparing for and following implementation, scheduling frequent key operational stakeholder meetings will be valuable to raise and address any operational questions or concerns that may arise. Moreover, close coordination of approach and messaging by the Department and Medicaid MCOs will be critical to effectively supporting practices throughout implementation of the VBP program.

Following implementation, the Department and MCOs will need to support participating providers through integrated, standardized, and actionable MCO data-sharing and reporting to drive practice transformation and performance improvement, opportunities, and positive evolution of the VBP program. Accurate, standardized data exchange and reporting also will drive understanding.

In addition, we believe monthly or quarterly stakeholder meetings will be useful forums for sharing best practices and lessons learned; reviewing population health data/trends and priorities around which to develop potential new VBP programs; and identifying funding mechanisms to address potential shortfalls—all to help further increase VBP progress.

We further believe MCO attendance of and participation in (as needed) Department-sponsored forums and Technical Advisory Committee meetings will provide additional valuable opportunities in which to report program performance, exchange information, and introduce/develop innovations and/or pilots germane to the VBP program.

a.i.3. Strategies for Contracting with Providers in Bordering States

We will specifically address provider shortages in rural and traditionally underserved areas using the following strategies to recruit additional targeted providers in adjacent states to strengthen our network as enrollment grows and/or medical service needs indicate:

- Evaluating patterns of care and referral patterns to reduce Enrollee disruption and ensure continuity of care
- Paying providers equitably in bordering states
- Talking with Enrollees and providers to understand where Enrollees seek care out-of-state

Molina currently has fully contracted Medicaid networks in our Ohio and Illinois affiliates available to serve Kentucky Medicaid Enrollees who live in communities that border these states. Additionally, we will assess patterns of care to recruit providers located within 50 miles of the Kentucky border in Indiana, West Virginia, Virginia, Tennessee, and Missouri. These providers may be helpful in meeting the needs of Enrollees in border communities especially for specialty care, emergency care, children's hospital care, and potentially rural PCP care.

Convenience and Better Accessibility

Molina understands that in cities such as Ashland, residents are inclined to go to facilities and practitioners in border states—for example, Cabell Huntington Hospital and Marshall Health in Huntington, West Virginia—when those providers are approximately half the time and distance of the closest in-state provider and, being a teaching facility, can deliver a wide range of specialty care services not readily accessible or convenient in Kentucky.

By expanding our network into these neighboring states, we will increase access to care and reduce drive times for Enrollees in nearby Kentucky cities and towns. This is particularly important for Enrollees with complex needs served by multiple providers and specialists. Molina will continue to sign agreements with and enroll providers in bordering states into our Kentucky Medicaid provider network. We will follow all Kentucky Medicaid enrollment rules when contracting with these providers.

As an example of our efforts to ensure access to all Enrollees, our Kentucky Medicaid network includes the following providers in bordering states:

- **Ohio.** Southern Ohio Medical Center and SOMC Medical Care Foundation (Clinicians)
- **Virginia.** Stone Mountain Health Services (FQHCs; 12 locations)
- **Indiana.** St. Vincent Evansville, St. Vincent Hospital for Women and Children, St. Vincent Warrick, and St. Vincent Medical Group
- **West Virginia.** Williams Health and Wellness Center (FQHC)
- **Tennessee.** Scott County Community Hospital (dba Big South Fork Medical Center) and Jellico Medical Center

We have reviewed Kentucky's network adequacy requirements and conducted a comprehensive analysis of our related GeoAccess mapping results to help us determine and prioritize out-of-state provider partners to pursue. Other sources of information for bordering state network expansion will include potential service gaps identified by our Care Management team or even by our Enrollees via the Call Center. A contracting need may also arise based on non-par claims data analysis (e.g., out-of-state volume) or review of non-par authorization requests from out-of-state providers.

We are currently in discussions with Cincinnati Children's Hospital in Ohio (which has expressed willingness to contract with Molina upon award). We have identified providers in other bordering states using the 50-miles-from-the-border guideline and have included outreach to them in our network development plan.

Lessons Learned

Our affiliated health plans offer valuable lessons learned based on their experience contracting in bordering states. For example, for our Mississippi affiliate, contracting with out-of-state providers has required a deep understanding of members' needs and their preferred providers, as well as accurately identifying key out-of-state partners that provide the most impact to areas of needed network adequacy.

Molina Healthcare of Mississippi experienced a challenge identifying the preferred out-of-state locations that members typically sought. After analyzing utilization trends and patterns of care and meeting with members to understand their preferences, our Mississippi affiliate contracted with providers in bordering states such as Tennessee (Baptist Memorial Health Care, Methodist Le Bonheur Healthcare), Louisiana (Ochsner Health System), and Alabama (University of South Alabama [USA Health])—all key out-of-state providers to meet their members' needs.

a.ii. PROVIDING ACCESS TO OUT-OF-NETWORK CARE

In rare cases in which an Enrollee requires the services of an out-of-network provider, our Utilization Management team will first work with and support the Enrollee and work with any of the Enrollee's current in-network providers to verify medical necessity for out-of-network services. Our Utilization Management team then will work with our Provider Services team to identify a licensed, out-of-state provider and confirm the provider is not on the Department of Health and Human Services or Office of Inspector General's excluded providers list. We then will negotiate a single case agreement to deliver the needed services to ensure the Enrollee has timely access, making sure we reach a mutually agreed-upon reimbursement rate and the provider understands they cannot bill the Enrollee for medically necessary covered services. Our process will ensure timely continuity of care for Enrollees and allow our Utilization Management team time to identify in-network providers offering similar specialty services. Our single case agreement also will ensure the out-of-network provider follows the same requirements as contracted providers for communication and coordination with the PCP and our care managers.

To maintain the Enrollee/provider relationship, we will use that opportunity to recruit the provider into our network, so the Enrollee may continue to receive services from the provider if desired. Our Network Development team will track and review monthly reports, indicating utilization of services from a non-participating provider, including providers of emergency services, and identify non-participating providers for contracting as an in-network provider.

Connecting Members to Needed Care

A Molina Healthcare of Ohio member needed a hearing aid for the first time. After talking with a friend, the member contacted the provider her friend recommended only to be told by the provider that they did not accept insurance of any kind. The member contacted our Ohio affiliate, and they worked with the provider to negotiate a single-case agreement on the member's behalf. The Ohio provider services team assisted the provider in submitting the claim for timely reimbursement.

After receiving her new hearing aids, the member called Molina Healthcare of Ohio to thank them for "going the extra mile" and making the experience less stressful.

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Out-of-network Emergency Care. Molina will not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms. If an Enrollee requires emergency care and contacts us before seeking care, we will direct the Enrollee to the nearest in-network provider of emergency services if within 15 minutes of the Enrollee's location or arrange for and direct the Enrollee to out-of-network emergency care in compliance with 42 C.F.R. 438.114.

We will reimburse out-of-network emergency services at the lower of the billed rate or the Medicaid fee-for-service rate as required by Section 6085 of the Deficit Reduction Act of 2005.

Supporting Continuity of Care. We will follow our established continuity of care protocols for coordinating care for an Enrollee moving into Molina's program who is receiving care from an out-of-network provider. Our processes will include:

- Obtaining existing authorizations before go-live and loading them into our QNXT system
- Authorizing care to out-of-network providers for time to promote continuity of care and ensure a safe transition to new providers
- Offering contracts to non-participating providers if appropriate to promote continuity
- Exchanging data with prior care manager to promote continuity and avoid repeat assessments
- Supporting the Enrollee through the transition process

a.iii. Ensuring Accessibility for Enrollees

According to the 2017 CMS report titled, "Increasing the Physical Accessibility of Health Care Facilities," 22.2% of U.S. adults report having a disability and are twice as likely as other adults to report unmet healthcare needs because of issues with the accessibility of a provider's location. ***To ensure network providers are physically accessible and have accommodations for Enrollees with physical or mental disabilities, we will:***

- Query providers during credentialing to determine their ability and accommodations to serve Enrollees with physical accessibility needs and/or physical or mental disabilities
- Conduct in-person site visits during the contracting phase and new provider orientation for high-volume providers and specialists to evaluate physical accessibility and accommodations available at providers' locations; our provider services representatives will note any limits to accessibility during provider site visits and share them with the provider during the visit
- Conduct provider training to increase awareness about serving Enrollees with physical accessibility needs and/or physical or mental disabilities

As part of our training, we will help increase provider awareness about specific needs of Enrollees with disabilities, answer frequently asked questions about treating Enrollees with disabilities (e.g., Is it okay to treat an Enrollee in a wheelchair while the Enrollee is in the wheelchair?), provide training on Americans with Disabilities Act (ADA) access standards, and make resources available, so providers can take advantage of federal rebate programs for accessibility modifications should they qualify.

Providers also will receive training about access services for Enrollees with hearing impairments or other cognitive disabilities. We will provide resources from our community partnership organizations and assess sites for use of auxiliary aids and services such as audio/visual assistive technologies, so we can direct Enrollees to provider location that best meet their needs. Additionally, we will educate providers on available communication access services to ensures Enrollees who are blind or who have low vision receive material in alternate formats such as Braille, large font, audio, or another electronic format.

a.iv. Ensuring a Comprehensive Network

Our provider network will comply with KRS 304.17A-515, 42 C.F.R. 438.206, and other Commonwealth and federal regulations as applicable. Molina will comply with the "any willing provider" statute as described in 907 KAR 1:672 or as amended and KRS 304.17A-270. We will continue to offer participation agreements to currently enrolled Medicaid providers who have received EHR incentive funds and who are willing to meet the terms and conditions for participation established by Molina.

We completed a comprehensive review of the Kentucky Medicaid program's covered services, demographics of eligible Enrollees, and current Medicaid network and network adequacy requirements to identify a high-quality, efficient network of providers that will meet our Enrollees' physical health and behavioral health needs and support diverse cultural, linguistic, and disability

needs. We have designed our network to support our population health objectives and interventions, meet unique Enrollee needs, and address the Department's stated Medicaid program priorities. We have an ongoing process to identify providers who are willing to meet our terms and conditions for participation, including all provider types identified in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 28.2, Network Providers to Be Contracted.

Kentucky Medicaid Network Development Plan. We began our Kentucky Medicaid network development activities in early 2019. Our comprehensive project work plan to contract with Kentucky Medicaid providers and establish a comprehensive, high-quality statewide network identifies the steps and associated timelines necessary for us to complete each task and related deliverables following the Draft Contract; milestones to be achieved; critical path tasks that must be followed to avoid project delays; contingencies to adjust to any unforeseen events; and health plan personnel resources to be assigned to each task. Our network development work plan will enable us to achieve network adequacy through completion of the following milestones:

- Contracting by the end of September 2020
- Credentialing by the end of October 2020
- Provider training and orientation beginning 60 days before go-live
- End-to-end configuration/testing by the end of November 2020

We will continue to leverage our proven processes to ensure we meet the identified implementation milestones above. We have already fostered collaborative relationships with numerous health systems and provider groups in Kentucky critical to the success of our network, building our network to meet Department-specific contractual requirements and discussing with providers VBP incentives that align provider financial incentives to the delivery of high-quality, cost-efficient Kentucky Medicaid Enrollee care, access, and satisfaction.

When establishing and maintaining a provider network, Molina considers:

- Anticipated Medicaid enrollment
- Numbers and types (their training, experience, and specialization) of providers required to provide the necessary Medicaid services
- Geographic location, distance, and travel time relative to Enrollees, including regional transportation disparities
- Physical accessibility for Enrollees with disabilities
- Languages the provider speaks, provider ethnicity, and provider cultural competency
- Expected utilization of services given the characteristics and healthcare needs of the specific Medicaid populations
- Numbers of network providers who are accepting new Medicaid patients
- Availability of telehealth services and/or technology

We employ GeoAccess and Quest Analytics (Quest ACC) report mapping solutions, customized to reflect Kentucky Medicaid requirements, to monitor network accessibility, identify gaps and deficiencies, and verify compliance with time and distance standards in each of the eight geographical regions. As additional information becomes available, such as utilization data, we augment our work plan to ensure we meet network standards.

Additionally, our health plan and Network Development leadership have met directly with numerous key Kentucky Medicaid providers spanning the Commonwealth over the past year to identify and begin to develop Kentucky-specific strategies (including timely and accurate credentialing and efficient claims payment) to mitigate provider abrasion.

We will continue to contract with any willing and qualified provider that delivers the entire spectrum of covered services to maximize access and ease Enrollee transition. As such, Enrollees will remain with

existing providers whenever possible. Objective requirements will be applied to consider participation in our networks, including quality (meeting credentialing, access/availability standards); location; Enrollee satisfaction; commitment to administrative efficiency; and commitment to controlling healthcare costs. We welcome providers that share our commitment to better care, healthier Kentuckians, and affordable care.

Culturally Sensitive and Linguistically Appropriate Service Delivery

Molina understands the importance of providing covered services in a culturally competent manner. From experience, we know culture influences:

- Concepts of health and healing
- Potential stigma on how illness, disease, and their causes are perceived by different cultures and genders
- The behaviors of patients who are seeking healthcare
- Attitudes toward healthcare providers

Molina will implement NCQA Standards for Culturally and Linguistically Appropriate Services in Healthcare (CLAS standards). ***Molina will offer comprehensive compliance training webinars to assist providers in meeting CLAS standards because we understand that when providers deliver culturally and linguistically appropriate services, it increases access to quality healthcare for Enrollees who are minorities with language or cultural barriers.***

MHI's **11 health plans with Multicultural Health Care Distinction** represent one of the largest percentage of all Medicaid health plans in the country awarded this distinction.

To achieve culturally competent care, providers must be able to communicate clearly and effectively with people from different cultures. We will collect languages-spoken information at the point of contracting with a provider, so information is available to be included in a directory. Cultural competency will be included as part of provider orientation as well as refresher trainings, and all Molina staff, including Contracting, Provider Services, and Provider Engagement staff, will receive regular cultural competency training.

Translation Services. For callers whose primary language is not English, we will offer over-the-phone and face-to-face translation services in more than 250 languages through GLOBO, our language translation vendor. In 2018, our latest available full-year results, GLOBO provided more than 840 face-to-face sign language interpretations; more than 750 face-to-face foreign language interpretations; and more than 41,000 telephonic interpretations for our California affiliated health plan. GLOBO also will conduct language proficiency assessments for Molina's customer service representatives and clinical staff.

In Kentucky, many different languages are spoken, and GLOBO will enable us to address Enrollees in their language. For example, during our recent provider focus groups, we heard from one of our CBO partners, Home of the Innocents, that the foreign languages spoken by the refugee population they serve include Arabic, Somali, Swahili, Kinyarwanda, Dari, Nepali, Burmese, Karen, Spanish, Pashto, Urdu, Chin, and Farsi. Our over-the-phone interpretation service will help providers meet the language needs of all Enrollees.

TTY/TDD services will be available for callers who are deaf or hard of hearing. These services will be critical to helping providers meet Enrollee needs.

Providers may request interpreter services for any Molina Enrollee, at no cost to the provider or the Enrollee, by calling customer service at (855) 322-4076. The hearing impaired may use our TTY line at (800) 955-8771. Molina will make available interpreter services to Enrollees at no cost 24 hours a day. To ensure accuracy of health information communicated between the provider and the Enrollee, Molina will

not permit minors, family members, or friends to translate for the Enrollee. Interpreter services will include:

- Telephonic interpreter services
- American Sign Language face-to-face interpreter services
- Relay service (711)
- 24-hour nurse advice line
- Bilingual/bicultural staff

Molina will provide the following language translation services to Enrollees as needed:

- Written material in other formats such as large print, audio, accessible electronic formats, and Braille
- Written material translated into languages other than English
- Oral translation for Enrollees with low English proficiency

a.v. Ensuring Adequacy and Access if Actual Enrollment Exceeds Projected Enrollment

Our strategy is to build a robust provider network that far exceeds minimum access standards in anticipation of larger-than-expected enrollment. We will employ detailed analytics to monitor the network continually, including GeoAccess and Quest Analytics report mapping solutions customized to reflect Kentucky Medicaid requirements; regularly reporting on network gaps and deficiencies; reporting on providers' compliance with time and distance standards; evaluation of referral and practice patterns; and discussions with our providers and Enrollees about colleagues and preferred providers, respectively.

We also will consider the Department-required 1,500:1 Enrollee-to-PCP ratio and identify and contract with all hospital-based provider groups to ensure participation of all providers of service an Enrollee may encounter during an episode of care. As of the date of our proposal submission, ***our Enrollee-to-PCP ratio is 115:1—far exceeding the Department's requirement.***

Key to our long-term network development strategy is continual recruitment of additional providers to strengthen our network as enrollment grows and/or as medical service needs indicate. As Enrollees begin to seek services, we will analyze claims and utilization data to augment our network development work plan to ensure continued network standards compliance.

Throughout our continual network development activities, our leadership team, including Network Development and Provider Services teams, will meet weekly to:

- Review data analytics, access, and adequacy metrics; quality and utilization metrics; and grievances
- Measure our network against documented access standards
- Review and discuss network development activities and progress, credentialing and provider data configuration status, provider materials, provider education, and claims testing

This team will meet weekly until program go-live to ensure a smooth implementation and transition for our providers.

Following go-live, Network Development staff will submit quarterly reports to our Quality Improvement Committee that measure our network against documented access standards, identify areas for improvement, and note progress made to remedy any deficiencies noted during the previous quarter.

b. SUBCONTRACTORS

For Kentucky Medicaid, we are working with existing subcontractor partners with which we have extensive experience in developing Medicaid networks in affiliated health plans. As such, oversight and auditing of subcontractors' network development activities is already an extensive and integral part of our overall Kentucky Medicaid network development work plan.

After comprehensive vetting and evaluation, we are partnering with the following subcontractors who have demonstrated strong capabilities and overall responsiveness to improve service value and complete all deliverables in a timely and efficient manner, and will deliver covered services to Enrollees:

- **Molina Healthcare, Inc.** Our parent company works seamlessly with its subsidiary health plans enterprise wide to provide a wide range of administrative resources and support.
- **Avesis.** Dental network and provider services
- **CVS Health.** PBM network and related provider services
- **March Vision.** Vision network and related provider services

Please refer to Proposal Section C.1, Subcontracts, for more details about Molina's subcontractors.

Subcontractor Oversight Program for Kentucky

Our established subcontractor oversight processes will support effective monitoring and continual evaluation of subcontractor performance to ensure compliance with all requirements while delivering high-quality products and services.

Molina will be responsible for subcontractor performance and has selected long-time partners with proven records of delivering high-quality service to Medicaid populations in Kentucky and other states. This partnership means we will hold ourselves and our delegates accountable for Enrollee outcomes, overall performance, and every dollar spent.

We will conduct pre-assessment audits to review a vendor's readiness, applicable licensure, and contract compliance. Our Delegation Oversight staff and Network Development leadership will closely monitor each subcontractor's network development and adequacy. During initial network development, each subcontractor must submit weekly status reports of network development activities and network adequacy for our review and assessment during our weekly network development project management calls. Once network adequacy is achieved, the subcontractor must submit monthly network reports that include identification of any new providers, terminated providers, and provider demographic changes, and attest to continued network adequacy or provide gap remediation.

We also will perform ongoing review and assessments as well as annual audits of the subcontractor's performance of each delegated function within 12 months of the previous assessment date. By conducting consistent report monitoring, including compliance with report content and reporting frequency; assessment activities, including timely response to a corrective action plan (CAP); or Enrollee complaint information, we can determine if a subcontractor is not carrying out any delegated activity following terms of the Delegated Service Agreement. If such a determination is validated, we may implement a CAP, up to and including revocation of the subcontractor's right to perform any delegated function or activity.

Information gathered through monthly reporting and monitoring activities will be reported to our Delegation Oversight Committee at least quarterly. These summary reports will include not only how the subcontractor is complying with performance expectations but will also identify any areas of potential concern or non-compliance. Based on these reports, the Delegation Oversight Committee can approve the CAP that includes changes to reporting frequency or content, or compliance audits of a specific function. Delegation Oversight staff then will be responsible for working with subcontractor staff on remediation efforts, until the Delegation Oversight Committee considers the deficiency to be closed.

In addition to Delegation Oversight Committee activities, information on performance of subcontracts also will be shared with the Department. Subcontractor performance data will be incorporated into Molina reports for functions like Call Center, Claims Processing, or Credentialing, and reported to the Department using agreed-upon templates.

Oversight of Subcontractor Credentialing and Recredentialing

Molina will delegate credentialing and recredentialing activities to subcontractors and provider groups meeting our requirements for delegation and when delegation will improve efficiency and Enrollee access to quality care. While the Department does not consider contracted providers to be subcontractors, we believe it is important to include an additional level of oversight by requiring provider groups to adhere to the same processes and oversight as our subcontractors. Our Delegation Oversight Committee must approve all delegation arrangements and retains the right to limit or revoke all delegated credentialing activities when a delegate fails to meet NCQA, Department, or Molina requirements. To be delegated for credentialing, subcontractors must:

- Agree to our contract terms and conditions for credentialing subcontractors and be compliant with the Draft Contract
- Submit timely and complete reports to Molina as described in policies and procedures
- Correct deficiencies within mutually agreed-upon time fames when issues of non-compliance are identified by Molina
- Comply with all applicable federal and Commonwealth laws

We will conduct delegation pre-assessments before approving delegation to determine compliance with regulatory and accrediting requirements. The pre-assessment will include a compliance review of all applicable delegation requirements and performance standards, a review of the potential subcontractor's credentialing evidence for all activities to be delegated, and a review of the potential delegate's ability to comply with delegated credentialing reporting requirements.

We will require reports from our subcontractor that contain all information required to ensure accuracy in their respective management information systems for claims payment and network composition. ***We further will require subcontractors to notify us within two business days of any practitioner is terminated for cause, suspended, or when disciplinary action has been taken against a practitioner by any Commonwealth or federal agency. Upon receipt of this notification, Molina then will be able to share details with the Department on the adverse activity within the contractually required three business days.*** Monthly, our subcontractors must provide us with a list of practitioners that have been credentialed or recredentialed by the delegate during that month, a list of practitioners terminated by the delegate, credentialing timeliness data, and copies of new or revised credentialing policies and procedures approved during the month.

We will monitor ongoing compliance with reviews of monthly required reports from the subcontractor, evaluation of the delegate's credentialing committee composition and minutes, and annual on-site assessments. Subcontractors that are not able to maintain the established standards will be given a CAP to address areas of deficiency. These CAPs will be monitored for timely implementation. Sanctions may be applied when deficiencies have not been resolved promptly, and revocation of delegation may occur.

c. TELEHEALTH

Molina has embraced using diverse technologies to increase and improve access to care for Enrollees. We will leverage the experience of our affiliated health plans that coordinate telehealth for their Medicaid members. Each program is designed to meet the unique needs of the specific state partner and their beneficiaries.

Across our enterprise, we continue to explore and implement successful telehealth programs to expand our virtual care portfolio to include services that fill critical access gaps and improve member outcomes

and satisfaction. ***In Puerto Rico, for example, our affiliated health plan's telehealth provider reports that 92% of member issues are resolved after the first visit and 95% of members are satisfied with the health plan's suite of telehealth services.***

As chair of the American Telemedicine Association's (ATA) Standards and Guidelines Committee, Dr. Frances Gough, chief medical officer at our Washington affiliate, co-authored the ATA national guidelines for Primary Urgent Care Telemedicine. Our Washington affiliate has been an active participant in the governor-appointed Washington State Telehealth Collaborative since 2016 and remains the only Medicaid MCO that is part of this dynamic team of thought leaders. The ongoing work of this collaborative resulted in the passage of two pieces of legislation for telehealth in Washington—Locus of Care and the Interstate Medical Licensure Compact.

Our telehealth solution is designed to provide whole-person care and includes options for both general physical health and behavioral health care, specialty care, and teledentistry. We are also exploring offering a tele-vision solution for Kentucky Medicaid in partnership with our subcontractor MARCH Vision Care. Through using simple technology, Enrollees with language, communication, physical, cultural, or emotional barriers or barriers to due to social determinants of health (e.g., transportation, childcare) may more comfortably and effectively connect with their providers. For Enrollees with behavioral health conditions, home-based care will provide access to specialists who may otherwise be unavailable in rural communities. It also will ensure anonymity and may reduce anxiety, fear of bias, or profiling possible in a traditional office setting.

Telehealth experience in Medicaid benefits everyone. Molina is wholly committed to telehealth because we see its benefit for all stakeholders including Enrollees, providers, and state Medicaid plans. Experience data specifically related to Medicaid populations from our parent company's telehealth vendor Teladoc shows Medicaid beneficiaries use telehealth "after hours and on weekends" 74% of the time, indicating the significant opportunity we may have to redirect Enrollees from the ED and urgent care. ***Medicaid beneficiaries also have a significantly lower "no show" rate for telehealth appointments than for office-based consults;*** this data supports the idea that deploying telehealth can "free up" brick-and-mortar appointments for those Enrollees who need an in-office setting.

Redirecting Enrollees from higher-cost settings will benefit all aspects of the healthcare ecosystem while providing a more convenient and often faster option for Enrollees. Telehealth services will be vital to delivering integrated, whole-person care and reducing health disparities for Medicaid Enrollees who live in rural, urban, or geographically isolated areas, those who face barriers to accessing care in a traditional primary care setting, or those who require specialty care that may not otherwise be readily available.

As we do in other programs, we will encourage using telemedicine by incentivizing providers to establish a telehealth platform and/or designate clinic space for Enrollee consultation. We will offer a quarterly bonus to providers serving four or more Enrollees via telehealth. We look forward to collaborating with the Department and other MCOs to develop meaningful VBP incentive approaches that could potentially include a telehealth adoption incentive, such as financial assistance with related costs, to improve access and health outcomes for Medicaid Enrollees residing in rural areas of the Commonwealth.

TELEHEALTH SERVICES

Through our parent company's national telehealth vendor, Teladoc, we will provide telehealth services to Kentucky Medicaid program Enrollees. Teladoc offers both general medicine and behavioral health telehealth services. Enrollees will have 24/7 access to services by web, phone, or Teladoc's award-winning mobile app.

The board-certified physicians in the Teladoc network have an average of 20 years of experience. By offering Enrollees access to U.S. Board Certified doctors on demand, Enrollees will have easy access to the care they need from wherever they are. Our partnership with Teladoc will be particularly beneficial to

Enrollees in regions where provider access is a challenge due to the rural nature of Kentucky or where there is a lack of provider specialties such as psychiatry.

General Medicine

Teladoc's General Medicine option will give Enrollees convenient access to quality healthcare when and where they need it. Teladoc provides 24/7 access to on-demand, high-quality medical care for adults and children experiencing common and uncomplicated medical conditions. Enrollees can choose the access method most convenient for them—via phone, secure online video, or Teladoc's award-winning mobile app. The Enrollee experience when accessing telehealth is shown in Exhibit C.18-4.

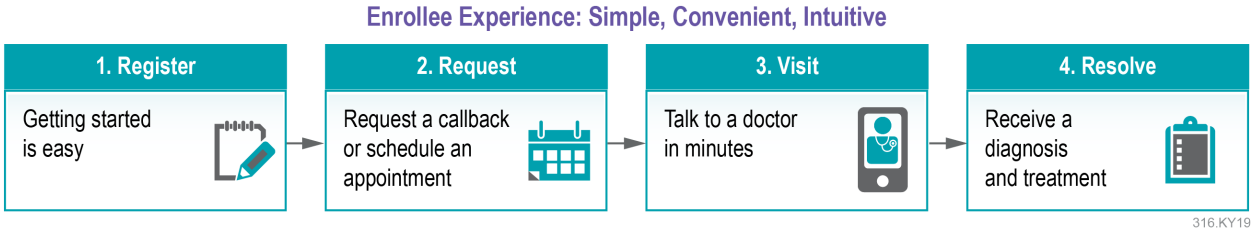


Exhibit C.18-4. Telehealth Enrollee Experience

After an Enrollee requests a visit, a U.S. Board Certified and Kentucky-licensed physician will contact the Enrollee in an average of about 10 minutes. Teladoc guarantees a physician response within 60 minutes. Enrollees can also schedule either phone or video visits for a specific date and time.

Physicians will use Teladoc's set of 104 proprietary, evidence-based, clinical guidelines to diagnose and treat Enrollees via phone or video. If the Enrollee's condition is outside the scope of telemedicine, Enrollees can be referred to in-person care, as appropriate.

After consulting with the Enrollee, the physician will recommend the appropriate treatment for the medical issue and if necessary, send a prescription to the Enrollee's pharmacy of choice using SureScripts. Teladoc physicians can prescribe non-DEA controlled medications, such as short-term antibiotics, antihistamines, cough suppressants, and anti-bacterial agents when medically necessary.

Teladoc also will ask Enrollees if they would like a summary of their visit or continuity of care record sent to their PCP at the end of their visit. Teladoc provides cross coverage for the PCP and does not usurp the patient/PCP relationship. Enrollees can also view their EHR at any time by logging in to the Teladoc Enrollee portal online or via mobile app. Enrollees can request a copy of their EHR at any time by calling 1-800-Teladoc. Sample patient outcomes for Teladoc are shown in Exhibit C.18-5.

Exhibit C.18-5. Telehealth Experience Outcomes

Behavioral Health

Enrollees will have access to care from their choice of Kentucky-licensed, Board Certified psychiatrists, licensed psychologists, therapists, or counselors. Behavioral health services will be available seven days a week by phone or video.

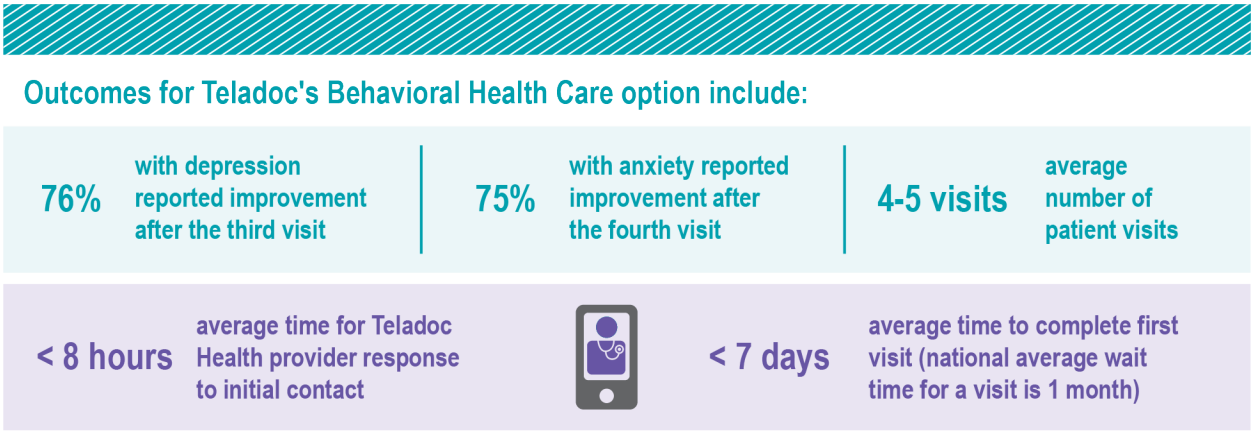
Enrollees can receive ongoing support with the same psychiatrist, psychologist, therapist, or counselor. This option will provide a secure, discreet, and confidential support resource, which can be helpful in reducing the stigma that may otherwise deter an Enrollee from seeking behavioral healthcare.

Teladoc uses tailored processes and guidelines to support the delivery of behavioral health services. They maintain proprietary practice guidelines for telemedicine, continually monitor patient and provider feedback, and adhere to clinical guidelines.

Teladoc has implemented the American Psychiatric Association Symptom Measurement Assessment. This tool offers:

- Validated longitudinal clinical assessment fully deployed in a telebehavioral health setting
- Patient evaluation over 13 mental health domains, including depression, anger, anxiety, and more
- Results available to the provider immediately
- Ability to track patient improvement over time

Teladoc's analytics group uses this data to identify opportunities for clinical quality improvements. Aggregated client-specific reporting provides visibility into population performance.



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Additional Specialty Support

In addition to general medical and behavioral health solutions, Molina will offer additional specialty telehealth support to Enrollees including:

Dermatology. Teladoc will offer a simple, efficient, and cost-effective way for Enrollees to access high-quality dermatologic care. Their dermatology program is "asynchronous," meaning Enrollees can submit high-resolution images and a symptom description via website or mobile app, rather than during a live phone or video visit.

Sexual Health. Teladoc's Sexual Health program will include anonymous, at-home STD lab testing through their partner, Analyte Physicians Group.

Tobacco Cessation. Teladoc will offer Enrollees a Tobacco Cessation program. It will combine access to Teladoc physicians for consults and prescription of drugs (e.g., Chantix, Nicotine Replacement Therapy) to support an Enrollee quitting tobacco use, with ongoing coaching support (outbound and inbound) from Teladoc's trained nurse team. Teladoc will also deliver tobacco cessation content to Enrollees through their secure message center. The program also will enable Teladoc physicians to take advantage of "teachable moments," such as proactively offering to enroll the patient in the tobacco cessation program when a smoker has a consult about cough symptoms.

Caregiver. AARP CareConnection and Teladoc will work together to deliver a caregiver support program. Caregivers can use Teladoc on behalf of / with the Enrollee as part of the provider's existing Teladoc account. Teladoc's caregiver support program provides:

- Three-way consults (with physician, caregiver, and Enrollee)
- Opportunities for caregivers to share consult summaries with PCPs and other providers

Teledentistry

With years of experience serving populations throughout Kentucky, including Kentucky Medicaid program Enrollees, Avesis has long understood the importance of improving access to dental care for individuals living in remote areas of the Commonwealth. The challenge is particularly acute for those Enrollees living in the rural counties of Appalachia, more than half of which are designated as dental health professional shortage areas by the federal Health Resources and Services Administration (HRSA).

Avesis is poised to partner with Molina to use teledentistry as a strategy to maintain and expand access to dental providers in traditionally underserved regions of Kentucky. Following the release of the final telehealth regulations by the Commonwealth on June 14, 2019, Avesis, under the leadership of their in-state Dental Director Dr. Jerry Caudill, is laying the groundwork to pilot the regulations in collaboration with one FQHC and one RHC. This pilot may include collaborating with public health hygienists in individual County Health Departments to help facilitate Enrollees' access to dental appointments using synchronous teledental technologies.

Project ECHO

We will partner with Project ECHO to increase telehealth capacity in Kentucky's rural areas. Project ECHO will allow PCPs to virtually connect with specialists for medical specialty areas and psychiatry consultation and case review. Project ECHO will link expert specialist teams at an academic "hub" with primary care clinicians in local communities—the "spokes" of the model. Together, they will participate in teleECHO clinics, which are like virtual grand rounds, combined with mentoring and Enrollee case presentations. PCPs will receive timely, Enrollee-specific clinical guidance and recommendations.

Specialists will serve as mentors and colleagues, sharing their medical knowledge and expertise with primary care clinicians. Essentially, ECHO will create ongoing learning communities where primary care clinicians receive support and develop the skills they need to treat a particular condition, such as hepatitis C or chronic pain. As a result, they can provide comprehensive, best-practice care to Enrollees with complex health conditions, right where they live.

Our organization has been a longtime supporter of and partner with Project ECHO, a world-renowned effort to increase—through virtual learning using medical rounds as the format—the medical specialty knowledge of providers serving populations who present at rural and frontier community-based clinics, EDs, and hospitals. As such, we will partner with Project ECHO to expand access to specialty care through community-based providers who are weekly participants of Project ECHO's virtual medical rounds.

c.i. CRITERIA FOR RECOGNIZED SITES

Molina fully supports SB112, effective July 1, 2019, which requires equivalent reimbursement for telehealth services; expands the definition of a "recognized site," allowing Enrollees to seek telehealth services even when they are not physically present with a provider; and allows for Enrollees to seek telehealth services without prior authorization. Through this bill, Enrollees across the Commonwealth now have greater access to care.

Technology developments and the evolving Commonwealth regulatory landscape driven by the changes included in SB112 provide opportunities to enhance Enrollees' access to care through telehealth. Enrollees can now connect with providers from clinics, nursing facilities, and even their homes. Enrollees will have the option to choose either a video or phone consultation and can access services by phone, smartphone, tablet, or computer. For example, through our contact with the University of Kentucky, Enrollees will have access to a variety of specialty care services delivered via telehealth.

To encourage providers to engage in the delivery of peer-to-peer telehealth services, Molina will pay both an originating site fee and a consulting site fee to support both sides of the visit.

We will meet requirements of Draft Contract, Section 28.2.10, Telehealth by requiring telehealth providers to be licensed in Kentucky to receive reimbursement for telehealth services under Medicaid.

We understand that we cannot require a Medicaid provider to be physically present with an Enrollee, unless the provider determines it is medically necessary to perform those services in person; require a Medicaid provider to be employed by another provider or agency to provide telehealth services that would not be required if that service were provided in person; or require a provider to be part of a telehealth network.

Molina's policies and procedures will follow all federal and Commonwealth security and procedure guidelines. The policies and procedures will incorporate the Department's policies and procedures for the proper use and security for telehealth, including but not limited to, confidentiality and data integrity, privacy and security, informed consent, privileging and credentialing, reimbursement, and technology.

Restricting the originating site of care was a barrier to accessing telemedicine services. Molina advocated strongly to redefine the originating site of healthcare as anywhere an Enrollee chooses to receive it, moving healthcare beyond traditional clinic settings to bring care directly to our Enrollees.

c.ii. EDUCATION EFFORTS TO INFORM PROVIDERS AND ENROLLEES

Molina will educate and encourage providers to engage in telehealth services and develop partnerships with new providers, leveraging lessons learned from our affiliated health plans, to support the development of their capabilities and guide them toward understanding and/or providing virtual care services. We will explain our virtual care options during provider orientation. Our Provider Services and Provider Engagement teams will discuss virtual care options as they meet with providers in their local communities. We also will make use of our provider website, provider bulletins, and blast emails as methods to keep providers informed. Our Provider Handbook also will offer information on and promote Molina's virtual care options.

Additionally, through our six Molina One-Stop Help Centers, we will deliver provider education on telehealth and offer providers who would like to participate in telehealth but do not yet have the technological capabilities a secure, HIPAA-compliant location to deliver telehealth services to Enrollees or participate in peer-to-peer consultations.

Telehealth Education that Drives Utilization

Molina Healthcare of Utah has been offering General Medicine services for Medicaid and CHIP products in partnership with Teladoc since October of 2017.

Per member satisfaction feedback in 2018, 100% of members responding to the survey rated their experience with available telehealth services as either Good or Excellent. **The health plan reports that telehealth services have generated strong utilization since inception along with a significant number of ED diversions.**

Enrollee engagement and communication will be a fundamental component of Molina's telehealth offering. Core communications will include proven and tested materials to drive awareness and use of telehealth. Teladoc will mail personalized Welcome Kits to eligible Enrollees' homes. Enrollees also will receive two seasonal mailers focused on reasons to use Teladoc—one in the spring promoting use for seasonal allergies and one in the fall promoting use for cold and flu. Teladoc will support these communications with ongoing email communication as well as digital messaging through social media, digital display, text messaging, and messaging via mobile app. Teladoc will also leverage Google Search, Facebook, and other local media to promote the benefit.

Molina will communicate the availability of telehealth services via the provider directory, Enrollee Handbook, Enrollee Web portal, Enrollee Welcome Kit, Molina customer service representatives, and staff located in our six Molina One-Stop Help Centers. We also will include instructions on how to access telehealth services on the Enrollee ID card.

c.iii. REIMBURSEMENT

We will reimburse telehealth providers at 100% of the Medicaid fee schedule. Molina will reimburse both the presenting and the consulting site, as well as continually monitor all telehealth services for appropriateness. We understand all telehealth providers must be licensed in Kentucky to receive reimbursement for telehealth services under Medicaid.

From experience, we know the importance of incentivizing providers to encourage participation in our telehealth program. We will provide VBP incentive approaches to telehealth adoption including providing financial assistance with related costs.

c.iv. LESSONS LEARNED

Across the country, Molina has advocated strongly to redefine the presenting site of healthcare as anywhere an Enrollee chooses to receive it. We are pleased that SB112 will increase Enrollee options for access to services. Restricting the originating site of care has been a barrier to accessing telehealth services nationally. Molina applauds Kentucky's redefining the originating site for healthcare as anywhere an Enrollee chooses to receive it.

Molina will continue to innovate in our telemedicine strategy to increase utilization and reduce costs. Telemedicine options will virtually bring otherwise inaccessible specialists to Enrollees in remote areas. It will be an invaluable tool providing new access points that bridge gaps in availability. For example, telehealth in methadone clinics expands access to addiction treatment. Our assessment of available services for members in tribal, rural, and frontier communities in one of our affiliated health plan states uncovered gaps for psychiatric services, addiction treatment, and some physical health specialties. In response, the health plan contracted with a telehealth vendor to provide behavioral health telemedicine.

Virtual Urgent Care

Our Washington affiliate was the first Medicaid MCO in the state to offer 24/7 virtual urgent care services. From June 2016–July 2019, the health plan delivered more than 6,260 visits. In 2018, network providers delivered more than 15,530 telepsychiatry visits.

The health plan is also working with the University of Washington Latino Center for Health to expand phone-based cognitive behavior therapy intervention in Spanish to depressed, low-income patients serviced by community health centers.

Since the program started, our Washington affiliate has learned the following lessons:

- Email campaigns are highly effective because members save emails for future access
- Messaging and education that focuses on *immediacy of care*, *free access to care*, *availability of care*, and *convenience of care* most significantly drive utilization
- Members return to the program for future concerns (particularly among frequent ED users), in part, because of high satisfaction with the virtual program

We will explore opportunities to leverage the University of Kentucky's telehealth services to expand our telehealth offering in Kentucky.

General Medicine Telehealth

Molina Healthcare of Ohio, in partnership with Teladoc, is also offering General Medicine telehealth services to their Medicaid Adult population. Enrollees using their Virtual Care benefits now have better access to the health plan's diverse network.

Since the program started, our Ohio affiliate has learned the following lessons that we will implement in Kentucky:

- Members prefer to use the Teladoc mobile app with more than 50% of their member utilization of telehealth service being delivered via the app, and education about the app's availability is key
- Offering a variety of services through telehealth has reduced ED utilization, with 65% of members using the service stating they would have sought help through an ED or urgent care visit if Teladoc were not offered

d. PROVIDER CONTRACTING

PROVIDER CONTRACTING STRATEGY

Under the direction and leadership of Dwayne Sansone, chief executive officer (CEO), and Kim Sweers, provider network director, our experienced Network Development team is building a high-quality, efficient Medicaid network for Kentucky. We have committed a team of contracting, credentialing, and data configuration specialists to ensure we meet our work plan deliverables and timeline for developing our comprehensive network of providers.

As of the submission date of our response, our network currently includes providers under contracts and LOIs in locations across the Commonwealth and in bordering states, creating a robust Kentucky Medicaid program provider network. The number of Molina-contracted providers will continue to grow as we continue our contracting efforts in preparation for award and implementation. Our network development timeline ensures we will be fully prepared to complete Readiness Review successfully. We will continue to contact providers; it has been our experience that most Medicaid providers in other state programs contract with Molina upon contract award.

Provider Contracting Team. Our Provider Contracting staff is responsible for the initial engagement, recruitment, and contracting of providers. Our Provider Contracting team began contacting Kentucky Medicaid providers in early 2019. Before executing a contract, Molina's Contracting staff is available to respond to any questions and further outline requirements via telephone and email. Once a provider has an executed contract, a Molina provider services representative will conduct a formal orientation within 30 days of the contract's effective date to explain key information.

Each member of the team is dedicated to Kentucky Medicaid providers, has a vast understanding of the Kentucky Medicaid providers' needs and expectations, and a commitment to ensure each provider has a successful experience working with Molina. Upon contract award, we will augment the Network Development team with local provider support staff located throughout Kentucky, living and working in the communities of providers they serve.

Contract Templates

Our Kentucky Medicaid provider and facility contract agreements are compliant with Commonwealth, federal, and Kentucky Medicaid program requirements. Our Network Development staff, along with our Legal team, has reviewed applicable federal and Kentucky laws and regulations as well as Draft Contract requirements to ensure all required provisions are included in our provider and facility agreements.

We will ensure continued contract compliance by including language in our agreements that reserves our right to unilaterally amend the agreement upon required regulatory changes. ***Copies of our proposed contract templates for both individual practitioners and facilities, along with select sample provider contract templates from our subcontractors, are included as Attachments to C.18.***

Value-based Performance Programs

Another key component supporting our provider recruitment strategy will be our proven VBP program that incorporates a broad array of alternative payment models designed to engage and meet Kentucky Medicaid providers across the entire spectrum of readiness for adoption and integration.

The following are proposed VBP arrangements to support the Department's Kentucky Medicaid program goals:

Primary Care and Specialty Care Providers

- **Pay-for-performance.** Initial engagement with fee-for-service providers; financial incentives are tied to key access, quality, and outcomes indicators; moreover, this model identifies providers with at-risk patients and HEDIS score improvement opportunities. We also will collaborate with the Department and other Vendors on pay-for-performance arrangements that may include incentivizing providers to establish KHIE connectivity and submission of standardized data sets and encourage provider adoption and use of EHRs
- **Pay-for-quality.** Enhanced reimbursement opportunities tied to relevant HEDIS measures; this model focuses on providers investing in processes to drive better outcomes and lower costs; additional financial incentives are available for improved performance on utilization metrics with assigned Enrollees
- **PCMH.** Focuses on providers engaging in team-based and integrated care coordination; this VBP rewards providers who achieve NCQA PCMH Recognition status, increase the level of care coordination and information-sharing between different healthcare settings, and help improve the Enrollee experience
- **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 of positive administrative experience and capability in successfully managing government-sponsored healthcare populations
- **Bundled / Episodes of Care Payments.** Tailored specifically for specialty providers, this model supports a single comprehensive payment across multiple providers in a patient's episode to encourage more seamless care coordination

Our Ohio affiliate's Episodes of Care program includes some **1,600 unique primary and specialty practices** serving adults, women, and pediatric members, and providing **30 distinct health care services.** The program **serves more than 71,900 Ohio affiliate members** (26% of the plan's total Medicaid enrollment), with **provider payments totaling $62.4 million in 2018.**

Hospital-based Care Providers

- **Pay-for-performance.** We offer enhanced reimbursement opportunities tied to relevant measures such as appropriate ED utilization, preventable readmission rates, Leapfrog Score, patient satisfaction, discharge planning, and transitions of care. Molina also will offer a pay-for-performance incentive for hospital partners to establish connectivity to the KHIE system
- **Pay-for-quality.** Enhanced reimbursement opportunities tied to relevant HEDIS measures; this model focuses on providers investing in processes to drive better outcomes and lower costs; additional financial incentives are available for improved performance on utilization metrics with assigned Enrollees
- **Shared Risk and Accountable Care.** Additional compensation from a share in savings or risk resulting from improved care quality and outcomes with potential to move to an accountable care arrangement that include upside/downside risk based on benchmark data and quality measures

Several of our affiliated health plans offer hospital-focused VBP arrangements, ranging from tailored pay-for-performance/pay-for-quality to shared savings / gain sharing models.

Mental Health / SUD Providers

We are ready to work with the Department and other MCOs to develop and implement innovative behavioral health (mental health and SUD) VBP models that address the Commonwealth's significant mental health and opioid use disorder crises. These models include, but are not limited to:

- **Pay-for-performance.** Initial engagement with fee-for-service providers; financial incentives are tied to key access, quality, and outcomes indicators; moreover, this model identifies providers with at-risk patients and HEDIS score improvement opportunities
- **Pay-for-quality.** Enhanced reimbursement opportunities tied to relevant HEDIS measures; this model focuses on providers investing in processes to drive better outcomes and lower costs; additional financial incentives are available for improved performance on utilization metrics with assigned Enrollees

Molina Healthcare of Ohio—Innovative Behavioral Health-focused VBP

With the state of Ohio facing many of the same behavioral health challenges as Kentucky, including alarming rates of opioid abuse, overdoses and related ED visits, and drug-related deaths, our affiliated health plan in Ohio has taken a lead role in developing behavioral health-focused VPB models that we will leverage for the Kentucky Medicaid program, including:

- **Pay-for-performance.** In partnership with its key community mental health providers, ***Molina Healthcare of Ohio offers a pay-for-performance program rewarding these providers for completing needed 7- and 30-day HEDIS follow-up visits following hospital discharge.*** This program has been successful in incentivizing mental health community providers to focus on connecting with members quickly after discharge to ensure needed visits are completed promptly.
- **Behavioral Health Home.** Collaborating with, and under the leadership of, the Ohio Department of Medicaid, our Ohio affiliate and other Medicaid MCOs are launching a Behavioral Healthcare Coordination program focused on members with significant mental health and/or substance abuse issues. Currently slated for go-live July 2020, ***the program creates a behavioral health-focused PCHM*** in which community behavioral health providers can voluntarily participate and receive funding to perform a variety of activities (including care coordination) to help members access resources and manage their behavioral health and medical needs in their community. The goal is to increase care coordination and provider collaboration to reduce behavioral health-related ED visits and inpatient stays and improve health outcomes.

Molina's Preferred Provider PA Program

During our focus groups, we heard frustrations from providers about prior authorization requirements. We understand and are sensitive to the administrative burden placed on hospital systems and provider groups. As a matter of practice, Molina systematically reviews its approach to prior authorization codes to discern the utilization, approval rates, and impact on both quality and cost. We regularly perform an extensive review of all codes that require prior authorization to identify those that we may be able to build into our VBP programs to relax or eliminate the requirements of prior authorization, removing barriers to Enrollee care and improving provider relationships.

Molina will incorporate a Preferred Provider PA Program in partnership with Kentucky's highest functioning health systems and provider groups that have demonstrated quality outcomes by identifying certain codes that create administrative burden for providers. After implementation with these selected preferred providers, we will hold quarterly Joint Operating Committee meetings with these providers to review utilization, quality, and cost metrics to determine if adjustments to the program are warranted.

CREDENTIALING AND RECREDENTIALING PROCESS

We conduct credentialing simultaneously with provider contracting to ensure timely processing of the application and that credentialing is completed before execution of the contract with the provider. We continually solicit provider feedback regarding the timeliness and effectiveness of our process.

Molina heard from Kentucky providers during focus groups that credentialing was often a frustrating experience with turnaround times often exceeding 90 days.

During our recent Mississippi implementation, all contracting and credentialing requirements were successfully met before go-live.

Using the same thoughtful strategy and focused effort we are using (and will continue to use) in Kentucky, ***our Mississippi affiliate has decreased its credentialing turnaround time to 14 days. The key to the health plan's success has been a high-touch approach, working with providers on the front end to ensure the submission of a complete and accurate credentialing application. The result of this approach is that providers are credentialed and enrolled in less than 30 days.***

At the time of initial credentialing and recredentialing, the practitioner or facility must complete an application that provides us with information necessary to perform a comprehensive review of their credentials. We apply the Council for Affordable Quality Healthcare's online credentialing application process that supports our administrative simplification and paper reduction efforts as well as the accuracy and integrity of our provider database. Once we receive a completed application, we log it into our credentialing system based on receipt date, allowing us to track the application, monitor turnaround times, adjust staffing to accommodate large influxes of applications, and meet our deadlines.

We create an electronic credentialing file for each provider applicant. This file contains all copies of documentation received as well as verifications and a signed attestation statement, following NCQA and Department requirements. We make at least three outreach attempts to resolve missing or expired information issues when we receive an incomplete credentialing application. Additionally, we encourage delegated credentialing to our large provider systems as it reduces overall credentialing time. All our delegated systems undergo annual delegation audits.

A Credentialing Committee's decision to accept or deny an applicant is based upon primary source verification, recommendation of peer practitioners, and additional information as required. Our medical director chairs the committee, which meets at least monthly (or as often as necessary) and includes a variety of participating providers. The committee applies NCQA-approved processes to review and render decisions regarding initial and continued participation in our network. The committee recommends approving, denying, terminating, approving on watch status, placing on corrective action, or deferring decisions pending additional information. In addition, the medical director will approve clean files weekly to expedite the process.

Corrective Action

We will monitor our entire contracted and all non-contracted/par/non-par network every 30 days against all Medicare and Medicaid sanction databases. In addition, we will continually monitor all Enrollee complaints/grievances and provider relations feedback and survey tools. When occurrences of poor quality are identified, or performance is not as expected, we will place the provider on a CAP. If the provider does not improve or the provider's behavior is egregious, we will take additional appropriate action against practitioners up to and including termination.

Molina will use the National Practitioner Data Bank (NPDB) continuous query to monitor our credentialed providers for any license actions, or Medicare or Medicaid sanctions reported to the NPDB. We will receive notification within 24 hours of a report being submitted to the NPDB.

Timeline for Credentialing and Provider Data Loading

Our average turnaround time across all Molina health plans for the completion of credentialing activities over the past year is 19.2 calendar days from receipt of a credentialing application. We send a letter to every provider with notification of our medical director's or Credentialing Committee's decision on their network participation.

We load all information for participating contracted and credentialed providers into QNXT within 14 calendar days of the provider being fully contracted and credentialed. Their participation becomes effective upon the date of medical director approval of a clean file or Credentialing Committee approval if needed.

We routinely monitor provider data loading activity to ensure quality, accuracy, and timeliness standards are met and maintained. The staff is audited 100% until they meet a 95% threshold for accuracy and timeliness. Once the 95% accuracy threshold is met, random audits with a 3% sample are completed to verify that the 95% accuracy and timeliness threshold is maintained.

e. DEVELOPING NETWORK CAPABILITIES

Molina is developing a Kentucky Medicaid provider network to meet the Department's availability and access requirements in Draft Contract, Section 28, Provider Network. Our goal will always be to ensure adequate and appropriate provision of services to Enrollees in urban and rural areas of the Commonwealth.

e.i. PROVIDER TYPE LISTING

As part of this submission, we include in Attachments to C.18, Molina Provider Network Detail File, a Microsoft Excel workbook that contains proprietary information and data, listing every provider by provider type (color coded by provider categories) who has signed a Contract or Letter of Intent. The list includes the provider's name, specialty(ies), address and county(ies), Medicaid Region(s) served, whether the provider is accepting new patients, accessibility status for individuals with disabilities, language spoken, and the provider's Medicaid Identification Number(s).

e.ii. PROVIDER COUNTS BY PROVIDER TYPE

A summary Microsoft Excel worksheet with total provider counts by provider type by Medicaid region and county is included in Attachments to C.18, Molina Network Summary Report.

e.iii. GEOGRAPHIC ACCESS

A statewide Geographic Access report of all providers color coded by provider type by Service Region is included in Attachments to C.18, Molina Statewide Geographic Access Report—Regions 1–8.

To produce the most accurate network adequacy report, a file with an Enrollee's address is necessary. In preparing our Geographic Access report, Molina did not have access to a detailed Enrollee file. As a result, Molina applied a conservative approach to Enrollee location with respect to time and distance based on county location. It is important to note that Geographic Access software does not allow for changes to time and distance requirements within a regional map that may have both urban and rural counties. Molina applied a stringent 30 minutes and 30 miles criteria for both urban and rural counties even though 50 minutes and 50 miles standards were allowed.

Our network meets access standards in more than 98% of the reportable provider categories. In applying the most stringent minutes/miles requirement mentioned above, a limited number of identified gaps exist. Molina continues to work with available providers to actively address these provider access concerns on behalf of potential Enrollees. Molina fully anticipates having the gaps outlined below addressed well in advance of the effective date of a managed Medicaid Contract with the Commonwealth.

Contracting Efforts to Date

Acute Inpatient Hospitals

Appalachian Regional Hospital. Molina has repeatedly attempted to engage Appalachian Regional Hospital in contract discussions. After numerous outbound phone calls and emails, Molina was informed that Appalachian Regional Hospital would engage Molina only in the event Molina was awarded a Medicaid Contract with the Commonwealth. Based off the direct feedback from Appalachian Regional Hospital, Molina is confident that upon award of a Medicaid Contract, we will successfully enter into a contract with Appalachian Regional Hospital.

Baptist Health. Molina has entered into contract discussions with Tom Butterbaugh, senior director, government payer / ancillary contracting from Baptist Health. Additionally, Molina, via a paid consultant, had direct discussions with Gerard Colman, chief executive officer. Subsequently, Molina received the following guidance directly from Baptist: "We will not seek a letter of intent with Molina, instead choosing to seek an agreement with the successful vendors upon the award of the bid." Based off the direct feedback from Baptist Health, Molina is confident that upon award of a Medicaid contract, we will successfully enter into a contract with Baptist Health.

Owensboro Health Regional. Molina has entered into contract discussions with Owensboro Health Regional. After several months of negotiations, Molina was informed the decision was made by executive leadership to discontinue any further contract conversations until the Commonwealth awarded Medicaid Contracts.

The absence of Appalachian Regional Hospital, Baptist Health, and Owensboro Health Regional created adequacy shortfalls in acute inpatient hospitals in 27 counties within Regions 1–5, 7, and 8. Molina will continually outreach to hospitals throughout these Regions to address Enrollee access concerns, and we are confident that we will successfully resolve these shortfalls well in advance of the effective date of a Medicaid Contract with the Commonwealth.

Community Mental Health Centers (CMHCs)

Kentucky River Community Care. Currently, Molina's network includes 12 of the Commonwealth's 14 CMHCs. Molina has outreached to Kentucky River Community Care in attempts to enter into either a contract or LOI. The provider has been non-responsive after multiple attempts. Molina will continue to outreach and is confident that upon award of a Medicaid Contract, we will successfully enter into a contract with Kentucky River Community Care. If an Enrollee requires access to this provider, Molina would either enter into a single case agreement or provide transportation to another provider in an adjacent county.

Renal Dialysis Clinic

Molina's network includes Fresenius Medical Care and all its locations throughout the Commonwealth. We are also in advanced contract negotiations with DaVita, Inc. The absence of DaVita created adequacy shortfalls in 2 counties within Regions 2. If an Enrollee requires access to this provider, Molina would either enter into a single case agreement or provide transportation to another provider in an adjacent county.

Occupational Therapy / Physical Therapy / Chiropractor

Molina has identified adequacy gaps related to Occupational Therapy, Physical Therapy, and Chiropractor providers in 2 counties in Region 1 and 1 county in Region 2. Molina has outreached to Fulton County Hospital, Baptist Sports Medicine & Rehabilitation, and Crittenden Hospital to fill gaps in Region 1. Also, we will continue to pursue contracts with Jennie Stuart and Baptist Health in the event we are awarded a Medicaid Contract with the Commonwealth to fill the remaining gaps in Region 2. In the event an Enrollee requires access to this provider, Molina would either enter into a single case agreement or provide transportation to another provider in an adjacent county.

Podiatry

Molina has identified adequacy gaps related to Podiatry in 1 county in Regions 5 and 7. Appalachian Regional Hospital has podiatrists within its provider network and would address the shortfall in Region 5. Also, Molina has identified 4 independent providers in Region 7. We will continue to pursue contracts with these organizations in advance of the event we are awarded a Medicaid Contract with the Commonwealth. In the event an Enrollee requires access to these providers, Molina would either enter into a single case agreement or provide transportation to another provider in an adjacent county.

f. ENROLLEE-TO-PROVIDER RATIOS

Molina will comply with the Commonwealth's ratio of 1,500 Enrollees per PCP. We will measure our network of contracted PCPs against the Kentucky Medicaid membership to calculate the actual ratio.

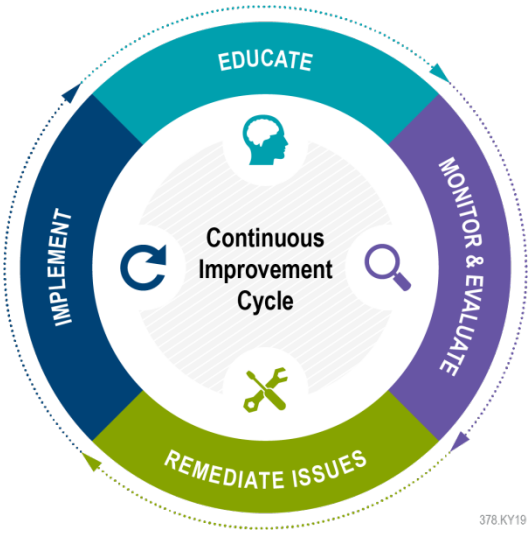
As of the submission of this RFP response, our ratio is 1 PCP:115 Enrollees (assuming a 300,000 Enrollee membership).

Molina typically considers a provider as being a full-time provider at their service location (assuming they do not specify something less). If the provider has two offices, then we will split the time equally between the two sites. We limit the number of sites a provider can be associated with to three.

g. ENSURING NETWORK ADEQUACY AND ACCESS TO CARE

PROCESS FOR CONTINUAL NETWORK MONITORING AND IMPROVEMENT

We will improve network and Enrollee access to quality services through ongoing monitoring and evaluation of provider availability, appointment access, performance standards, and total enrolled membership. Our approach to ongoing network improvement will include review of Enrollee complaints about accessibility, scheduling, wait times and delays; an annual access study that examines our network's appointment availability and after-hours access standards and related performance; and quarterly reviews of grievance and appeal summaries, updated GeoAccess and time/distance reports, nurse advice line reports, and Enrollee and provider satisfaction surveys. We have included sample network adequacy and accessibility reports from our Utah and South Carolina affiliated health plans within Attachments to C.18.



Throughout our initial network development, our leadership team has met weekly to review and measure our network against documented Kentucky Medicaid program access standards and discussed network development activities and progress. Our leadership team will continue to meet weekly until the program goes live to ensure a smooth implementation and transition for our network providers.

Our Network Development team will analyze a variety of data each quarter to ensure compliance with contractual requirements, access to care that meets our Enrollees' needs, and quality of services. They will continually monitor our network to ensure consistent compliance with program standards and report quarterly to our Quality Improvement Committee.

These quarterly reports will measure the network against access standards, identify any areas for improvement, and identify progress made to remedy any deficiencies identified in the previous quarter. This multidisciplinary approach will ensure inter-related issues are communicated effectively throughout

the organization and analyzed from multiple perspectives to support the development and execution of effective integrated solutions.

Our focus will ensure our Enrollees have access to the broadest range of providers in the most accessible locations possible. We will place a premium on continual network improvement and Enrollee access to quality services through education, ongoing monitoring and evaluation of provider availability, and appointment and performance standards.

Monitoring Network Accessibility

Our Network Development team will analyze a variety of data monthly to ensure compliance with contractual requirements, access to care that meets our Enrollees' needs, and quality of services. The team also will provide quarterly reports to our Quality Improvement Committee. These reports will measure our network against documented program access standards, identify areas for improvement, and note progress made to remedy any deficiencies noted during the previous quarter.

We will use GeoAccess and Quest Analytics report mapping solutions, customized to reflect Kentucky Medicaid requirements, to monitor network accessibility, identify gaps and deficiencies, and verify compliance with time and distance standards. We also will consider Enrollee-to-provider ratios and identify and attempt to contract with all hospital-based provider groups (such as ER groups, radiology, pathology, and anesthesia groups) to ensure participation of all providers of service an Enrollee may encounter during an episode of care.

We also will employ GeoAccess or similar analysis to ensure our Enrollees with physical, developmental, and other disabilities have access to provider sites sufficiently equipped to serve them. Additionally, we will analyze Enrollee complaint data related to network access. With this information, we will recruit additional targeted providers as indicated.

Contract managers will stratify their assigned regions using Quest Analytics data for the currently contracted providers, then use those providers to assist in obtaining new leads for any outstanding gaps, such as speaking with a PCP office to find their referral patterns and then reaching out to those providers to contract with them.

We will continuously assess provider distribution network wide to ensure adherence to appointment access standards, using appointment availability and after-hours access surveys to monitor access. We also will recruit additional providers in key ZIP Codes for services to augment the network as enrollment grows and/or medical service needs indicate.

In the rare event a service gap develops, we will arrange access to similar out-of-network providers (e.g., transportation) at no cost to Enrollees. We will obtain out-of-network single case agreements with providers as urgent network needs arise or when notified that no available network provider exists within specified time and distance standards. To maintain the Enrollee/provider relationship, we also will initiate discussions with these providers to establish a one-time agreement or a full contract to join our network, as appropriate.

Monitoring Compliance with Appointment Availability and Wait Time Standards

Annually, we will conduct an appointment and after-hour accessibility audit on a defined sample of PCPs, high-volume specialists, high-impact specialists, and behavioral health providers. Monitoring and evaluation will include a review of Enrollee complaints related to accessibility, scheduling process, wait times, and delays, which also will be conducted on an ongoing basis. Measuring performance against standards will be conducted routinely by reviewing:

- **Access.** We will compare access questions within the CAHPS Enrollee Satisfaction Survey to assess Enrollee perception with access to healthcare. The following CAHPS questions will be used:
  - In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
  - In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your healthcare at a doctor's office or clinic as soon as you thought you needed?
  - CAHPS Composite: Getting Care Quickly

  Scores for the questions above will be compared to national benchmarks. Our goal is to score at or above the 75th percentile of Medicaid plans.
- **After Hours.** A representative from Quality Improvement (QI) will call PCP offices after hours and assess the after-hours phone message. The sample will be random and statistically significant. Providers' after-hours phone messages will be scored to see if the message allows Enrollees to talk to a provider for an after-hours need. A referral to an after-hours nurse hotline for triage will meet the requirement. A report will be generated listing those providers that did not meet the after-hours requirements and will be sent to Provider Services.
- **Complaints.** A QI specialist will gather the complaint data from the call tracking module in QNXT for the Enrollee complaint category access/availability and present the report to the Enrollee and Provider Satisfaction Workgroup.

Our Provider Services staff will use town hall meetings, the Web portal, the Provider Manual, and periodic newsletters to educate providers about mandated appointment and access standards. Provider Services will monitor provider access standards and work with providers to improve identified deficiencies. If a provider does not meet basic access standards, we will address the matter immediately with education and corrective measures, ranging from a phone call or visit to a formal CAP. If the provider does not meet the access and availability requirements, the provider will face disciplinary action up to and including termination.

h. LOSS OF A LARGE PROVIDER GROUP OR HEALTH SYSTEM

Our extensive, multi-functional planning activities, advance notification process, vast network, and robust care coordination activities will ensure an Enrollee's seamless access to services despite any changes in the provider network. Upon notice of a termination or loss of a large provider group or decision to terminate a provider, a multidisciplinary team, which will include the leaders of our Healthcare Services, Enrollee Services, and Provider Services departments, will initiate a recovery approach that promotes the best quality of care for the Enrollee, supports seamless continuity of care, and minimizes disruption to the Enrollee. This team will immediately employ a set of policies and procedures, including a comprehensive work plan, as highlighted in Exhibit C.18-6.

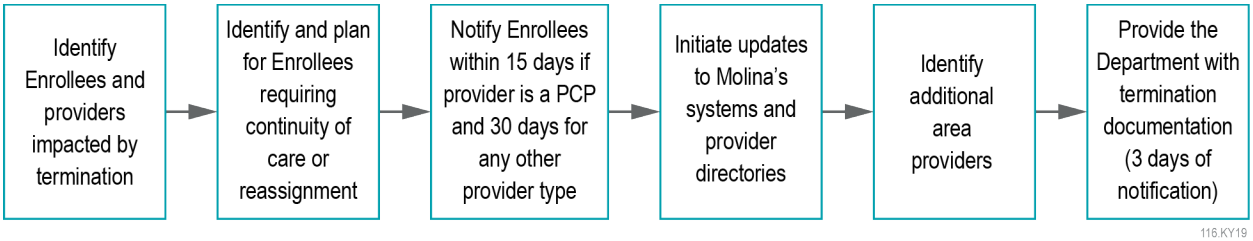


Exhibit C.18-6. Process to Address Loss of Group or Health System

h.i. NOTIFICATION TO THE DEPARTMENT AND ENROLLEES

Notification to the Department

Understanding collaboration with the Department is essential to minimizing Enrollee disruption. We will notify the Department via email of provider terminations within three business days. Notifications to the Department about a provider termination will include:

- The reason for termination
- A brief description of the provider's actions and/or applicable information leading to termination
- NPI
- Medicaid ID
- Entity name
- Two-digit provider type
- Complete mailing address

Molina will send the email notification to the Department Commissioner's Office, Division of Program Quality and Outcomes, and the Division of Program Integrity, and any applicable designee(s). The Contractor notification to the Department shall provide assurances of how we will maintain network adequacy and access to care despite the provider termination.

Molina will survey all providers who choose to exit the network and use exit survey results to improve provider retention and recruitment. We will provide the Department with the provider exit survey template for review and approval before use and for any subsequent changes. We will provide the Department with survey results upon request.

Notification to Enrollees

Using QNXT, our core system application that includes claims, membership, provider, authorization, and other encounter data, we can quickly identify which Enrollees are assigned to the provider (in the case of a terminating PCP) or have regularly used the services of the terminating provider.

We will notify Enrollees assigned to the PCP or who have received a service from the terminating provider within the previous six months or are affected by the loss of the provider for other reasons. We will mail the notice within 15 days of the action taken if the rendering provider is a PCP and within 30 days for any other provider type.

If the terminated provider was a contracted PCP, the notice will contain information about selecting or being auto-assigned to a new PCP and how Molina will assist the Enrollee to transition care to the newly assigned PCP, letting them know they will receive an additional communication confirming their newly assigned PCP. If the terminated provider was a specialist, information will be provided about how Molina will assist the Enrollee to transition care to another specialist.

The notice also will contain assurances that current treatments will be covered under our continuity of care commitment, a date after which Enrollees who receive an ongoing course of treatment cannot use the terminated provider, a list of available high-quality providers, contact information for our Enrollee Services team, and a reminder the Enrollee can speak with our Call Center and/or their care manager to select a new provider.

Each care manager and customer service representative will be available to speak with the Enrollee, answer any questions, and provide information about our network providers to help inform the selection of a new provider that meets Enrollee-specific needs including, but not limited to, medical needs, transportation, gender, language, and cultural preferences. Additionally, we will post notices about the termination and how to select a new provider on the Enrollee Web portal and update the provider directory.

Minimizing Disruption for Enrollees

Our processes will ensure Enrollee continuity of care, minimize disruption, and result in a quick return to network access and adequacy compliance in the event of a provider termination or loss. Staff will assist affected Enrollees in the selection of new PCPs, specialists, or facilities, as appropriate. Following termination or loss, leaders of our Healthcare Services, Enrollee Services, and Provider Services departments will meet to review, strategize, and implement the following actions, as appropriate:

- Identify Enrollees who require relocation or continuation of services, as well as any special needs of these Enrollees
- Conduct telephone outreach and care coordination at least 60 calendar days before the effective date of the suspension or termination, or immediately for immediate terminations, for Enrollees who require relocation or are in active care, as well as any special needs of these Enrollees
- Conduct care coordinator outreach to our Enrollees within the first week following the provider's termination to assist with the transition as well as selection of a new PCP in their area
- Prioritize Enrollees based upon their medical, safety, social, and behavioral health needs, scheduling care coordinator-led meetings with Enrollees, their families, and their caregivers to discuss transition of care and identify any preferences that may exist
- Develop a specific continuity of care plan of action to transition Enrollees to alternative sites or providers to ensure no disruption in care occurs, including transportation arrangements
- Document all actions of the recovery team, including when and where Enrollees are transferred, notifying the Department of specific actions taken
- Transfer all appropriate medications, medical equipment, and medical charts to the receiving facility or provider
- Establish on-site monitoring of the receiving facility or provider to ensure the appropriate quality of care is provided by the new facility or provider
- Track availability of other facilities that better reflect Enrollee wishes if an Enrollee must temporarily be placed in a residential facility that is not their first choice
- Analyze the network to identify new network gaps and limitations in Enrollee choice created by the provider loss

Once transition is complete, our Transition team will conduct an inter-departmental follow-up meeting to assess the effectiveness of their actions and identify areas for improvement. The team also will assess if any early indicators of provider loss were present and if they were properly identified. We will incorporate any lessons learned from this process into the recovery plan.

Success Story

After the loss of a large provider system in our Utah health plan, the mother of a member with Autism asked for help in finding new providers. Though she could have switched to the large provider system's insurance and providers, she instead remained with our health plan. She said the family felt well supported over the years and valued the ongoing check-ins by our care management and care connection teams. Despite the network changes, the member's Molina Community Health Worker found a new prescriber and new occupational therapist to meet the member's needs. The family says they now feel very prepared for the change.

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Automated Systems and Membership Supports

Enrollees can use our Web portal, mobile apps, and our Call Center to select a PCP or specialist. Our portal and mobile applications include an interactive search tool that will allow Enrollees to search for current providers based on location, services provided, languages spoken, and other data elements promoting a thoughtful provider selection. Customer service representatives also will be available to help Enrollees select new providers.

Additionally, our care managers will conduct in-person and telephone outreach for Enrollees who require relocation or are in active care, as well as address any specific Enrollee needs. Care managers will visit with Enrollees, their families, and their caregivers to discuss transitions of care and identify any existing preferences. A continuity of care plan of action will be implemented to transition Enrollees to alternative sites or providers to alleviate potential disruptions in care, including transportation arrangements and appropriate transfer of all medications, medical equipment, and medical charts to the receiving facility or provider.

h.ii. TRANSITION ACTIVITIES AND METHODS TO ENSURE CONTINUITY OF CARE

Unless a provider is terminated for cause, we will allow Enrollees to continue an ongoing course of treatment from the provider for up to 60 calendar days from the date they are notified of a provider's termination or pending termination for up to 60 calendar days from the date of the termination, whichever is greater. We will extend this continuity of care period when clinically appropriate. We also will employ single case agreements with out-of-network providers to ensure continuity and access to care while we attempt to contract with the provider.

Our care management software is configured to support continuity of care requirements, including alerts to notify care managers of outstanding PCP assignment needs and alerts if regular appointments or if lab tests are missed or maintenance prescriptions are not filled that may indicate a need for intervention. Our Care Management team will work with the new provider to make sure the provider has necessary patient-related information.

For at-risk Enrollees currently in inpatient care, we will employ our transition of care program to reduce avoidable readmission during the provider transition process. Interventions will include assessment of health status, including mental health and substance use issues and needs; medication management; follow-up care; coordination of post-discharge services; evaluation of housing/shelter to facilitate services if appropriate; and nutritional management.

h.iii. ASSESSING IMPACT AND ADDRESSING DEFICIENCIES

Following any notice of a provider termination, we will use Quest Analytics to gather and analyze information to determine network adequacy from both a quantity and quality perspective before the provider even leaves our network to ensure we have providers in place to fill resulting gaps, if any. We also will monitor our network capacity to accept new patients to ensure our Enrollees maintain access to high-quality providers. Quest Analytics will help us understand the impact to access and adequacy for Enrollees based on time and distance standards. Once we determine a deficiency exists, we will look at available recruitment targets and begin contracting efforts.

Our network also will include robust telehealth resources through key contracted partnerships to address gaps, ensure primary/specialty service delivery, and augment service delivery to Enrollees. We also will expand network capacity by encouraging providers to employ physician extenders in primary care and specialty offices.

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