C.24 Population Health Management (PHM) Program

REQUIREMENT: RFP Section 60.7.C.24

24. Population Health Management (PHM) Program (Section 34.0 Population Health Management Program)

a. Provide a comprehensive description of the Contractor's proposed Population Health Management (PHM) Program, including the following at a minimum:

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

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

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

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

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

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

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

d. Services and information available within each risk level.

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

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

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

h. Frequency of provision of services.

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

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

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

l. Methods for evaluating success of services provided.

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

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

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

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

Molina's Population Health Management program will improve health outcomes by proactively engaging Enrollees, addressing social determinants of health, and enrolling higher-risk individuals in care management.

This RFP and Attachment C, Draft Medicaid Managed Care Contract and Appendices, clearly demonstrate the intent of the Commonwealth to improve Enrollee health outcomes and quality of life. Kentucky currently experiences among the highest rates in the United States of heart disease, cancer, obesity, diabetes, chronic obstructive pulmonary disease (COPD), and substance use disorders (SUDs). Other conditions such as asthma continue to take a toll, particularly among children.

Molina's Population Health Management (PHM) program provides innovative evidenced-based strategies and a proven record of improving population health. ***Our PHM strategy is primarily one of early intervention and prevention.*** We will quickly identify Enrollees who have risk factors and/or are experiencing early symptoms of a condition and engage them in self-management and preventive care. Using analytics and predictive modeling tools, we will risk-stratify Enrollees at the time they join Molina and

- **Molina brings more than 25 years of Medicaid managed care experience** to address all population health issues of significance to the Commonwealth
- **Interventions are evidence-based** with clearly defined goals and metrics
- **CBO partnership network** addresses Kentucky's most pressing social determinants of health

continually thereafter. Our integrated systems will capture data through sources like enrollment, claims, and authorizations; results from Enrollee Needs Assessments and Health Risk Assessments (HRAs); and other care management data. We will continually mine data and perform risk stratification to alert our Care Management team when an Enrollee's risk level is rising, so our care managers and Molina Community Health Workers can engage them and offer person-centered interventions. Molina's risk-stratification algorithms will consider social determinants of health, which will be part of assessments and used by our care managers and Molina Community Health Workers to inform and guide interventions.

In preparing to offer services in Kentucky, we researched community health needs and examined lifestyles in all eight regions by reviewing Community Health Needs Assessment reports, conducting statistical research, and holding provider and consumer focus groups. We have traversed the Commonwealth to learn about the needs of Enrollees and the most significant healthcare issues facing Kentuckians in the eyes of the Department, providers, Enrollees and their family members, community-based organizations (CBOs), advocacy groups, and government agencies and officials. As one example, during conversations with staff at Audubon Area Community Care Clinic, a Federally Qualified Health Center (FQHC) in the western part of the Commonwealth with which we have formed a partnership, we gained a greater understanding of the impact of diabetes and obesity among their population. We also learned more about how a lack of affordable and reliable transportation impacts Enrollee access to care in the area that Audubon serves and throughout the Commonwealth.

Based on findings from our extensive research and initial population health assessment, as well as shared best practices from our affiliated Medicaid health plans, we will create a PHM program that improves the health and well-being of Enrollees and creates more equitable communities in Kentucky. ***We propose to include COPD and chronic kidney disease in addition to the Commonwealth's defined list of priority conditions—a result of our research into the most significant health issues facing Kentucky.***

In this section, we offer a comprehensive description of our PHM program; the innovations and program elements we will bring to Kentucky; our alignment with the NCQA PHM Model; our plan to ensure high levels of Enrollee participation; our approach to care management at each defined risk level; coordination with authorized providers; and ongoing review of the PHM program. We have designed our PHM program to comply with all requirements in Draft Contract, Section 34, Population Health Management Program.

a. COMPREHENSIVE DESCRIPTION OF PHM PROGRAM

Molina's fully integrated PHM strategy supports the *Triple Aim* goals from the Institute for Healthcare Improvement. We aim to improve the health of our populations, enhance the experience of care for our Enrollees, and reduce the cost of healthcare. Most importantly, we will help our Enrollees achieve their person-centered social, physical health, and behavioral health goals. We will submit our PHM program plan for Department review and approval within 30 days of Contract execution.

The strategy that informs our PHM Program focuses on four critical areas, as shown in Exhibit C.24-1.

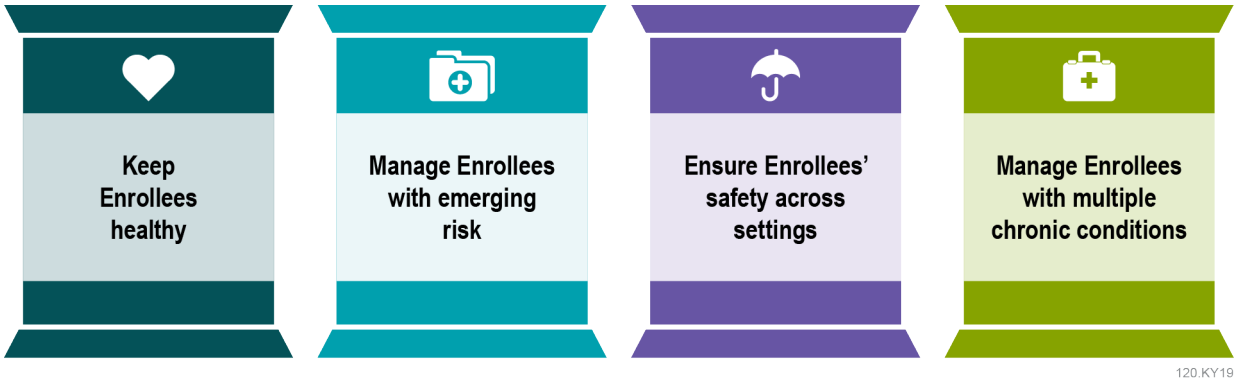

Exhibit C.24-1. PHM Strategy Components

Data analytics is the cornerstone of our PHM Program. In addition to identifying and stratifying Enrollees, we will use data to identify quality improvement (QI) opportunities and drive provider performance through value-based payment (VBP) arrangements. We will collaborate with the Commonwealth and other MCOs in an information exchange that benefits all Enrollees.

Predictive modeling will identify Enrollees who are appropriate for the PHM Program and initially stratify them into Levels I through IV. At the time of enrollment, Molina will use eligibility data, including clinical condition information (e.g., pregnancy), with Enrollee demographics and historical medical and pharmacy claims data supplied by the Commonwealth, to appropriately risk-stratify Enrollees. As new information is entered into our model, risk stratification will be updated, and appropriate actions taken. ***The algorithm will be customized to focus on Kentucky's priority conditions and populations to ensure Enrollees at higher risk are identified first and their needs addressed.***

In addition to the initial risk stratification, Molina will enhance our understanding of Enrollee needs with HRAs. Once the HRA is completed, our clinical staff will use this information to adjust the risk stratification, if necessary, to ensure Enrollees receive appropriate interventions. Risk stratification levels serve as a guide to allow us to conduct a wide range of activities that focus on appropriate healthcare and services for Enrollees across the care continuum.

Keep Enrollees healthy. This goal, which matches the Commonwealth's defined risk Level I, Health Promotion and Wellness, focuses on prevention and education. Our Enrollee Services team will use phone, mail, our website, Molina Mobile application, and community engagement activities to promote health and wellness activities such as annual flu immunizations at the appropriate time each year; wellness exams for Enrollees of all ages; age-appropriate wellness activities at the recommended intervals; and disease-specific follow-up recommendations per appropriate medical specialty society recommendations. ***Our expansive suite of value-added services is squarely focused on incentivizing Enrollees to engage in healthy behaviors.*** For a complete list of value-added services, see Proposal Section C.20, Covered Services.

Manage Enrollees with emerging risk. Molina's industry-leading risk identification tool will identify Enrollees with emerging risk. In addition to our comprehensive modeling tools, we will identify Enrollees with emerging risk either through self-reporting or provider referral. Our approach aligns with the Commonwealth's defined risk Level II, Management of Chronic Conditions. Molina will offer several programs supporting the emerging needs of higher-risk individuals, including asthma management, diabetes management, and the Building Brighter Days depression management program. Through these programs, care managers will work with Enrollees to help them manage their conditions.

Ensure Enrollees' safety across settings. Our Transition of Care (ToC) program, which will include both co-located nurses within high-volume provider facilities and strategically located members of the care team, will address Enrollee safety across care delivery settings. This activity corresponds to the

Commonwealth's Level III, Complex Care Management. The goal of this team will be to improve the lives of Enrollees by ensuring medication compliance and appropriate follow-up visits to reduce readmission rates. This team will begin planning activities while the Enrollee is hospitalized and will be engaged for at least 30 days following an Enrollee's discharge.

Manage Enrollees with multiple chronic conditions. This goal is reserved for Enrollees in Level IV, Intensive Needs, which we propose to add to the Commonwealth's defined three risk levels based on the frequency and unique nature of these Enrollees' high-intensity needs. This level will include Enrollees who have experienced a critical event or diagnosis that requires extensive use of resources, additional support in navigating the healthcare system, and multiple providers to coordinate.

Molina will develop specific PHM Program goals as we prepare for implementation. After we identify baseline rates for specific measures of performance, we will set targets to improve by a certain percentage for the next reporting period. If available, we will use national benchmarks for comparison. After implementation, we will monitor activities and make revisions based on our experience and strategy in Kentucky. This PHM intervention strategy will become a working document to allow us to make modifications that address the needs of the Commonwealth's Medicaid population.

Exhibit C.24-2 demonstrates the PHM Program development cycle, which we will repeat every year to ensure our target areas align with the Commonwealth's needs.

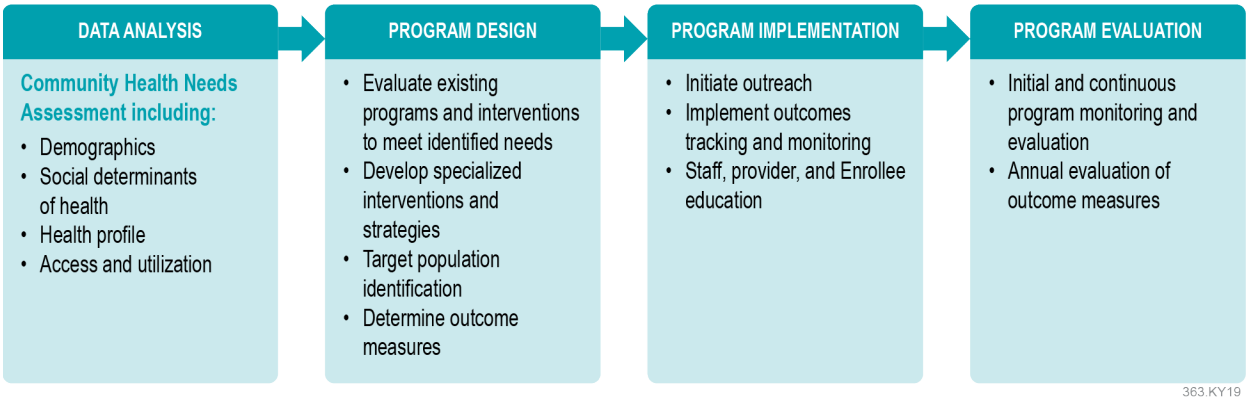

Exhibit C.24-2. PHM Program Development Cycle

Across all levels of our Care Management program, we will set goals to address key utilization measures. These measures will focus on inpatient medical/surgical admissions, inpatient behavioral health admissions, Emergency Department (ED) visits, and readmissions. Our care managers also will focus on reducing the effects of social determinants of health. For example, they will counsel Enrollees on how to apply for food assistance and connect them with a Molina housing specialist, a Molina Community Health Worker, or other community resources to help address factors that may be inhibiting their lifestyle and health.

We will engage providers in this effort using education, outreach, and a VBP strategy customized to primary care providers (PCPs) and emphasizing preventive care. To support providers, we will offer our innovative online Provider Scorecard tool, which will allow providers to self-monitor for improvement and performance against incentive benchmarks. In addition, our Provider Engagement Team will be dedicated to helping providers achieve their incentives.

a.i. INNOVATIONS AND PROGRAM ELEMENTS

Our PHM strategy will proactively address risk factors. We will use tools such as predictive modeling of Enrollees and an annual Community and Population Needs Assessment to identify priority conditions and possible causes that create or exacerbate those conditions. In researching the health status and needs of Medicaid beneficiaries and engaging with stakeholders, we identified many social determinants of health that can influence Enrollee physical health and behavioral health outcomes, including:

- Quality of education and literacy
- Access to educational, economic, and job opportunities
- Resources to meet daily needs, such as safe housing and food
- Transportation options
- Exposure to crime and violence
- Access to healthcare services

We have designed our PHM Program to address those social determinants of health, improve health outcomes, and help Enrollees better engage in their physical, mental, and emotional well-being.

Innovations

Our innovative solutions to address social determinants of health and improve Enrollee health will provide Enrollees with the support they need to live healthy, productive lives, including personalized care for those Enrollees who need more support. Highlights of our innovative Model of Care include:

Molina Healthcare National Social Determinants of Health Innovation Center

Because our parent company focuses solely on providing government-sponsored healthcare, a significant portion of our enterprise's 3.4 million members are vulnerable to one or more social determinants of health. To leverage all individual activities across our affiliated health plans and formulate evidence-based best practices, our parent company established the Molina Healthcare National Social Determinants of Health Innovation Center. Headquartered in Columbus, Ohio, this center will be a valuable resource for Molina's health plan leadership and Care Management teams.

The Innovation Center will work with plan leaders at Molina and subject matter experts throughout the organization. Tasks of the Innovation Center include:

- Managing social determinants of health program design and measurement
- Leading implementation at the market level with the support of the health plan
- Collecting and analyzing data on social needs among members to inform partnerships and program development, as well documenting interventions from sponsored programs
- Developing national programs/pilots aimed at advancing health outcomes through various supports
- Creating a database of pilots and outcomes that can guide design of best practices for implementation throughout the enterprise
- Collaborating and managing national relationships and contracts focused on addressing social determinants of health
- Developing local programs in partnership with health plan and Government Affairs leadership teams designed to meet the unique needs of the market and priorities of regulators, lawmakers, and community stakeholders
- Working with Marketing to develop a public relations plan that includes branding programs, third-party studies of results to be published within industry publications, and a communication plan to promote work in each market to regulators, lawmakers, and community stakeholders

This new effort is an extension of our organization's decades-long commitment to partner with local CBOs, providers, and other stakeholders to offer fully integrated programs and social supports throughout the Molina enterprise.

Amazon Prime Home Delivery Value-added Service

Transportation and lack of access to fresh and healthy food options are barriers in many areas of Kentucky. To help address these social determinants of health, ***Molina has partnered with Amazon to offer Amazon Prime home delivery at a reduced rate to all Enrollees who are at least 18 years old. The service is free for 90 days and available at a discounted rate of $5.99 per month after that.*** Amazon Prime's free home delivery on all shipments will help reduce transportation as a barrier to Enrollees' access to healthy foods. As an added feature exclusive for Molina Enrollees, food selections will include a curated and filtered list of healthy food items (low fat, low sodium, low sugar, and so forth).

For Enrollees who sign up for the service, all future rewards (for wellness checks, maternity care, and so forth) will be in the form of Amazon Prime credit, which will be distributed and tracked digitally and show up automatically in the Enrollee's account. Enrollees can access this financial benefit through the MyMolina portal or the Molina Mobile app, both of which have an Amazon Prime interface.

Behavioral Health Provider Toolkit

The U.S. Health Resources and Services Administration has designated ***23 geographic areas (including high-needs geographic areas) as Health Provider Shortage Areas for behavioral health in Kentucky.*** The lack of providers in those areas, accompanied by access issues throughout the healthcare system as well as Enrollee unfamiliarity with certain behavioral health specialties, have left PCPs to navigate a health discipline with which they may not be familiar. Molina's Behavioral Health Toolkit addresses several mental health and SUD categories, including social determinants of health, and can be used to assess and treat behavioral health conditions in the primary care setting. The web-based toolkit includes 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.

Substance Use Disorder (SUD) Model of Care with Opioid Use Disorder Focus

While the opioid epidemic has been national in scope, certain states have been particularly hard hit, including the Commonwealth. ***Kentucky had the nation's fifth-highest rate of drug overdose deaths in 2017.*** Although the rate showed considerable improvement in 2018 (a reduction of approximately 15% per data from the Kentucky Office of Drug Control Policy), the opioid crisis and related SUDs continue to affect a significant number of Kentuckians, creating a heightened need for access to high-quality SUD prevention and treatment services within the healthcare and social services ecosystems. To address this public health crisis throughout the nation, our parent company created a new SUD Model of Care with Opioid Use Disorder Focus in 2019. This program synthesizes our national organization's best practices with guidelines from the American Society of Addiction Medicine and the National Institute on Drug Abuse.

Among the many facets of the program that will allow Molina to help the Commonwealth combat this emergency are Molina's SUD navigators and peer support specialists. Licensed clinicians in Kentucky, our SUD navigators will be care managers with extensive and ongoing specialized training in the rapidly developing field of addiction treatment and recovery, and will be assigned to partner with Enrollees based on the care manager's specialty and Enrollee needs, preferences, and cultural considerations. When appropriate, the SUD navigator will direct and connect Enrollees to available services in their community to address their needs, including syringe exchange programs, with an eye toward prevention, mutual support, harm reduction, medication-assisted treatment, and in support of societal public health efforts to reduce the transmission of communicable diseases.

Our peer support specialists will assist Enrollees with setting and pursing their recovery goals. With lived experience in addiction and recovery, peer support specialists can share their experiences in recovery, which has proven at our affiliated health plans to be a powerful influence on those in the beginning stages of treatment. Peer support specialists will be trained and certified to serve as counselors and motivators. ***Molina Healthcare of Ohio achieved a 66% reduction in inpatient visits in 2019 among members who***

were referred to a peer support specialist. We will partner with CHFS and the Department to synthesize our SUD Model of Care with ongoing initiatives such as the Kentucky Opioid Response Effort.

Care Connections

Molina is committed to supporting Enrollees where they are, including through initiatives such as the Molina Care Connections program. For example, ***Kentucky's diabetes rate of 12.7% is the seventh-highest in the nation. Maternal and infant mortality rates are higher than the national average as well.*** To provide targeted in-home care to populations with known difficulties related to access, Molina will deploy our Care Connections team comprising a staff of nurse practitioners who make home visits. ***We are one of only a few MCOs to keep this function in-house rather than go through a subcontractor or vendor.***

These community-based nurse practitioners will provide wellness and preventive care services and "boots on the ground" to determine whether social determinants of health play a role in Enrollees' health challenges. Services will include annual physical exams; a review of medical history, medications, and social determinants of health; assessments of pain and functional status; psychosocial well-being assessments; and identification and closing of preventive care gaps.

Success Story: Care Connections for New Mothers

In 2016, Molina Healthcare of California began to send nurse practitioners to the homes of new mothers, who often were unable to travel to a doctor's office for postpartum visits. In one year, the rate of African-American mothers receiving postpartum care increased by 37%. **Molina received California's first Health Equity Award in 2018 for this innovative program.**

In California, our affiliate's Care Connections team made a significant impact through the Mothers of Molina program, reducing the health disparity among African-American women receiving postpartum care because of transportation and childcare issues and perceived bias from doctors. As part of this successful program, the Care Connections team made an in-home postpartum visit and conducted physical health and behavioral health screenings.

Our organization has since expanded this program to offer in-home diabetic screening and care to combat access barriers and promote the health and wellness of members. The Care Connections team provides Annual Comprehensive Exams and Comprehensive Diabetic Care, offering point-of-care HbA1c and nephrology screening and diabetic retinal exam in the home. Nurse practitioners also monitor blood pressure and weight, perform abdominal exams, and record the results of members' self-performed breast exams. Visit notes and diagnostic results are shared with providers. ***In 2018, the Care Connections team's efforts in California led to meaningful improvements in HEDIS rates for HbA1c testing; HbA1c control below 7% and 8%; HbA1c poor control above 9%; blood pressure control <140/90 mm Hg; retinal eye exams; and medical attention for nephropathy.***

Based on the needs of local communities in Kentucky, Care Connections also will be equipped to provide in-home service for annual physical exams, pain and functional status assessments, PHQ-9 depression screening and Alcohol Use Disorders Identification Test, and well-child checks. In addition, the team can be deployed as needed to address unique concerns in the Commonwealth, such as providing pop-up clinics in underserved communities.

All information will be recorded electronically and shared with our Enrollees' PCPs and specialists. Care Connections has shared HIPAA-compliant electronic health records (EHRs) with 1,170 different organizations nationwide, sending out more than 1.1 million total records.

Housing Assistance Program

Molina understands that secure and stable housing is foundational to an Enrollees' ability to address their health concerns and ultimately, to lead healthy, productive lives. For that reason, our organization has tested strategies and found success with our Housing Assistance program in other states. Recognizing the

critical importance of housing to Enrollee health and well-being, ***we will hire four housing specialists who will work with Enrollees who are homeless or at risk of losing shelter.*** Our housing specialists will assess Enrollees for factors such as their current living situation, safety concerns, income, and barriers to housing. For the most urgent cases, the specialists will connect the Enrollee with CBOs; help them with completing applications for housing and funding assistance; and help intervene with landlords regarding rent disputes. Our Kentucky housing specialists will have expertise in working with individuals with behavioral health diagnoses to find specialized housing and financial assistance.

Pop-up Clinics

Molina will use geo-targeting software to identify hot spots or areas of need where healthcare access barriers are significant. Working with CBO partners, we will then identify locations to expand health services outside traditional settings, and we will work with network providers to offer well-care checkups and screenings (including for behavioral health) at our pop-up clinics. We also will partner with educational institutions to target back-to-school and other events to host these clinics. At pop-up clinics, we will screen for food insecure individuals and families and provide food assistance through community organizations such as Dare To Care, Kentucky's Heartland, and God's Pantry Food Bank.

Program Elements

Molina will carry out a comprehensive PHM program that encompasses the goals of NCQA and the Commonwealth. Our PHM program will address key NCQA program elements as illustrated in Exhibit C.24-3.

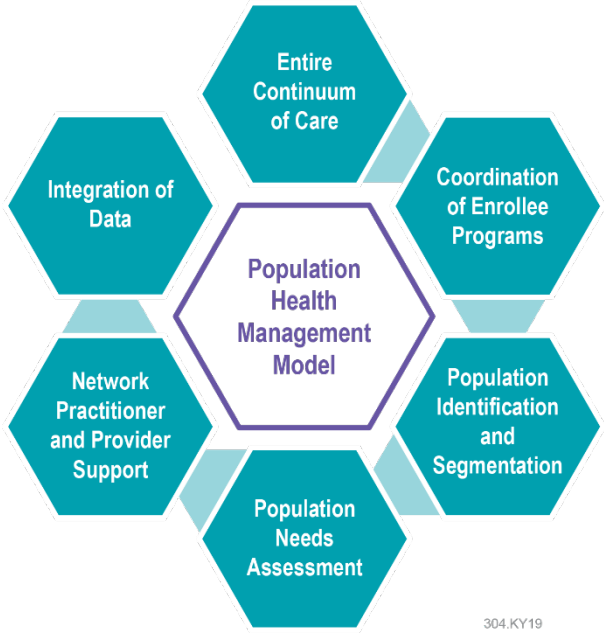

Exhibit C.24-3. Population Health Management Model

Table C.24-1 explains how each element will play a role in our PHM Program:

Table C.24-1. Key Components

NCQA Guideline	Molina Best Practices
Entire Continuum of Care	We will meet Enrollee needs in all stages of the healthcare continuum. Our focus will be on: • Keeping Enrollees healthy • Managing Enrollees with emerging risk • Ensuring Enrollees' safety across settings • Managing Enrollees with multiple chronic illnesses
Coordination of Enrollee Programs	We will have systems and processes in place to minimize duplication of services and contacts with Enrollees, including: • Using an electronic care management system, accessible to all program staff, to track all levels of care management contacts with Enrollees, including provider and external agency contacts, case notes, clinical reviews, and care plans • Ensuring program staff reviews the care management system before making outreach attempts to the Enrollee, and informing network providers of Enrollee participation in clinical programs • Creating Call Center logs of all call attempts to Enrollees, whether incoming or outgoing, and viewing previous contacts for context • Making focused outreach calls to parents and Enrollees who are due for key tests and/or visits; these calls, made by customer service representatives, will be tracked in the Enrollee contact system and reviewed by the QI team
Population Identification and Segmentation	We will segment (or stratify) our population, so we can focus our interventions: • We will analyze the impact of our PHM program annually • Our analysis will factor in cost, utilization, and clinical measures • Our method of stratification will incorporate continual learning and multiple data points such as historical data, Health Risk Assessment data, medical/pharmacy claims, and social determinants of health factors to triage the population for the most appropriate and timely interventions
Population Needs Assessment	We will assess our population each year to meet the needs of our Enrollees, including: • Assessing the characteristics and needs of our population, including social determinants of health • Identifying and assessing the needs of our Enrollee subpopulations • Assessing the needs of children and adolescents, Enrollees with disabilities, and Enrollees with serious and persistent mental illness • Using the population assessment to review and update our PHM activities and identify additional available community resources that can be used within our programs
Network Practitioner and Provider Support	We will work with network providers/practitioners to support our PHM program by: • Sharing data through distributing missing services lists to our practitioners, so they can work to bring their patients in for needed exams • Offering PCPs incentives to achieve patient-centered medical home certification • Providing comparative quality and/or cost data to our practitioners • Offering the opportunity to participate in VBP contracts • Embedding care managers in high-volume hospitals to provide ToC program services • Engaging in routine in-office Provider Engagement Team meetings to ensure appropriate and timely discussion and resolution of issues

NCQA Guideline	Molina Best Practices
Data Integration	We will integrate and use data from multiple sources, including: • Physical health and behavioral health claims and encounters • Pharmacy claims and encounters • Laboratory claims and encounters • Health Risk Assessment and Enrollee Needs Assessment results • EHRs, as available • Health Services programs, such as health management, care management, transitions of care, and medication management initiatives within Molina • Advanced data sources, such as health information exchanges, as available

a.ii. INCORPORATING THE NCQA MODEL

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

Many of the current NCQA PHM standards have been in place for the Health Plan accreditation program for many years. We meet NCQA PHM requirements that focus on Health Risk Assessments, self-management tools, population identification, segmentation, and complex care management. We have a good understanding of these long-standing requirements and are actively meeting the newly expanded NCQA PHM standards that focus on strategy, practitioner and provider support, and VBP contracts.

Our PHM program will leverage related models from throughout our national enterprise. Through regular reviews by the QI committees in each of our affiliated health plans and at the corporate level, we will share lessons learned and discuss challenges and successes.

Table C.24-2 highlights the Commonwealth's priority conditions and populations as stated in the Draft Contract. We additionally offer examples of relevant Molina successes in each category. ***In addition, after careful review of Kentucky Medicaid Enrollees' overall health status and areas of concern, we propose adding COPD and chronic kidney disease as conditions managed under the PHM program.*** We further describe our programs and services for these conditions and populations in our discussion under *Priority Areas*.

Table C.24-2. Implementation of Related Models

Population Condition	Kentucky Status	Molina Success
Diabetes	7th highest rate in U.S., with the largest increase in U.S. from 2012–2017	**Wisconsin:** Increased by 15 percentage points in Comprehensive Diabetic Care A1c control <8% HEDIS® measure, improving from the 25th to 90th percentile. ***The rate is above Wisconsin's and Kentucky's average for Medicaid.*** **Intervention:** Care managers completed outreach to members with care gaps to assist with appointment scheduling, transportation, and barriers to compliance. Care Connections staff contacted members due for A1c tests, retinal eye exams, and nephropathy testing, and scheduled in-home visits to complete the exams.

Population Condition	Kentucky Status	Molina Success
Heart disease	6th highest rate of cardiovascular deaths (299/100K vs. national average of 257/100K), and 8th highest rate of people with hypertension	**Illinois:** Increased 6 percentage points for the HEDIS measure "Statin Therapy for Patients with Cardiovascular Disease Received Statin Therapy—Total," improving from the 25th percentile to the 90th percentile. ***The rate is above Illinois' and Kentucky's average for Medicaid.*** **Intervention:** All providers were given a toolkit with clinical guidelines, best practices, tips to increase compliance, and education on hypertension and related measures.
Asthma	Rates of adults and children with asthma are well above the national averages	**Michigan:** Improved from below the 25th percentile to the 50th percentile in both Medication Management for People with Asthma: Medication Compliance 75% (age 19–50) and Asthma Medication Ratio (age 19–50) HEDIS measures. They increased 8 percentage points in the first measure and 6 points in the second. **Intervention:** Partnership with ClearCorps Detroit and Wayne Children's Healthcare Access Program (WCHAP). ClearCorps and Molina Community Health Workers completed in-home assessments to identify any asthma triggers. WCHAP offered up to six home visits with an asthma educator to instruct members and their families on proper inhaler/medication use, triggers, symptoms, and prevention.
Obesity	6th highest rate in U.S., with 34% of adults and children considered obese	**Ohio:** Weight Assessment and Counseling for Nutrition increased 11 percentage points, and Counseling for Physical Activity total increased 13 percentage points. ***The rates for both HEDIS measures are above Ohio's and Kentucky's average for Medicaid.*** **Intervention:** Provider Engagement Teams completed visits to primary care provider (PCP) offices to review the HEDIS Provider Scorecard and Weight Assessment and Counseling clinical guidelines, best practices, and tips to improve compliance.
Tobacco use	3rd highest smoking rate in U.S.	**Michigan:** The Medicaid CAHPS® rate for Medical Assistance with Smoking and Tobacco Use Cessation increased 6 percentage points, improving from the 25th to the 75th percentile. ***The rate is above Michigan's and Kentucky's average for Medicaid.*** **Intervention:** Provider Engagement Teams completed visits to PCP offices to review pay-for-performance initiative to improve Tobacco Cessation program participation.
Cancer	Highest rate of cancer deaths with 234.9/100K; U.S. average is 163.5/100K	**Florida:** Increased 6 percentage points for Breast Cancer Screening, improving from the HEDIS 25th percentile to the 75th percentile. Increased 19 percentage points for Cervical Cancer Screening, improving from below the HEDIS 25th percentile to the 50th percentile. ***The rates for both HEDIS measures are above Florida's and Kentucky's averages for Medicaid.*** **Intervention:** Members who had not received a mammogram scan in two years were added to the Breast Cancer Screening Call Campaign to assist with scheduling appointments. The health plan sent a fax blast to all network providers during National Breast Cancer Awareness Month to emphasize the importance of screening.

Population Condition	Kentucky Status	Molina Success
Chronic Obstructive Pulmonary Disease (COPD)	In COPD-related deaths, Appalachian Kentucky (78.8/100K) and non-Appalachian Kentucky (57/100K) far outpace national average (42/100K)	**Florida:** Increased by 15 percentage points and rated highest among plans in use of spirometry testing and reached the HEDIS 75th percentile in use of bronchodilators. ***The HEDIS rates are above Florida's and Kentucky's averages for Medicaid.*** **Interventions:** The health plan's Molina Community Health Workers collaborated with its quality improvement specialist team and analytics to contact specific members diagnosed with asthma and considered at risk for COPD. Also, health educators called members who were either missing a controller medication or were discharged from the emergency department (ED) with an asthma diagnosis.
Infant mortality	6.5 deaths per 1,000 live births; above the national average of 5.8	**California:** Increased 4 percentage points in the timeliness of prenatal care HEDIS measure, improving from the 25th percentile to the 50th. ***The rate is above California's and Kentucky's average for Medicaid.*** **Intervention:** Members who completed their prenatal visit within the first trimester or new members who completed their visit within six weeks of joining Molina received a reward.
Low birth weight	9th highest rate in U.S.	**Wisconsin:** Increased 7 percentage points in the timeliness of prenatal care HEDIS measure. ***The rate is above Kentucky's average for Medicaid.*** Timeliness of prenatal care led to a reduction in low-weight births. **Interventions:** The health plan's BadgerCare Plus members received postpartum care incentives. Molina Community Health Workers were trained on the care measure and assigned to hospitalized members. All members from the prenatal detection report were assessed, and a small percentage were referred to the High-Risk OB care management team.
High-Risk OB / NICU	22nd highest maternal mortality rate in the U.S. with 19.4 per 100,000 live births	**California:** Increased 7 percentage points in the postpartum care HEDIS measure, improving from the 25th percentile to 75th percentile. ***The rate is above California's and Kentucky's average for Medicaid.*** **Interventions:** Health plan members who completed their postpartum visit within 21–56 days after delivery received a free package of diapers. Members who recently delivered received an outreach call to assist with scheduling an in-home postpartum visit. Nurse practitioners completed the visits.
Behavioral health, including SUDs	5th highest drug death rate in U.S., with 1,565 overdose deaths in 2017	**Ohio:** Reached the HEDIS 75th percentile and rated highest among plans in follow-up after hospitalization for mental illness for both 7-day and 30-day follow-up. ***Both HEDIS measure rates are above Ohio's and Kentucky's averages for Medicaid.*** **Interventions:** Eligible providers in Ohio received $50 for each visit within 7 days of discharge. The health plan also enlisted the Community Shelter CBO to locate and track homeless individuals.
Adults and Children with Special Health Care Needs	In 2017, the rate of disability among Kentucky children and adults was 17.5%, higher than the U.S. overall (12.7%)	**Ohio:** Increased 2 percentage points for Coordination of Care for Children with Chronic Conditions Composite on the CAHPS Item Set for Children with Chronic Conditions survey, improving from the 50th to the 75th percentile. **Interventions:** To improve the number of members receiving needed care and the care coordination CAHPS Measure, the health plan offered provider education about appointment availability.

Population Condition	Kentucky Status	Molina Success
Chronic kidney disease	Fifth-highest rate in U.S.	**Interventions:** Nationwide Molina program, beginning in 2020, focuses on education for Stages 1-3 (e.g., avoiding toxic medications) and accessing kidney specialist, dialysis and/or transplant for Stages 4-5

Lessons Learned, Challenges, and Successes

As a new Medicaid MCO in Kentucky, we will work toward NCQA PHM Accreditation. Molina affiliated health plans have used current programs and initiatives to successfully meet overlapping standards for NCQA Health Plan Accreditation, Multicultural Healthcare Distinction, and LTSS Distinction. The challenges have been in organizing and coordinating existing initiatives and reports to meet requirements specific to PHM Accreditation. Going forward, lessons learned will be addressed as follows:

- Coordination of programs and initiatives will be addressed through multifunctional collaborative meetings to ensure all key stakeholders are involved and are actively participating. Multifunctional participation will include, at a minimum, Healthcare Services, Medical Affairs, Quality, and Provider Services.
- PHM reports and measurement of effectiveness will be developed collaboratively and produced or evaluated at least every six months to jointly identify and address barriers, opportunities, and challenges.
- VBP programs for Kentucky will address PHM requirements up front, preventing rework of programs after implementation.

a.iii. ENSURING HIGH LEVELS OF ENROLLEE PARTICIPATION

When Enrollees do not respond to our attempts to contact them to complete the HRA and/or Enrollee Needs Assessment, the lack of assessment completion will be noted in our system. If an Enrollee calls later for any reason, our customer service representative will see this notation, explain the benefits of the HRA, and offer to transfer them to a staff member who can complete the assessment with them immediately. This tactic can be useful in attempts to engage the Commonwealth's defined priority populations. Because of their underlying health status, these individuals will be more likely to contact Molina for another reason, giving us an opportunity to reinforce the need for and benefits of an HRA and capture the information at that time.

If our predictive modeling risk-stratification tools indicate the Enrollee has a priority condition or is in a priority population, we will use several methods to find them and attempt to bring them into the healthcare system:

- Mosaic, a software tool developed by Molina, will provide our customer service representatives with phone numbers from multiple sources (claims, pharmacy, PCP change, subcontractor data) on one screen for primary and secondary contacts. The tool will aggregate contact information from multiple data sources and systems and present it in a single view along with other Enrollee demographics. Molina staff, with appropriate credentials, will be able to view secondary Enrollee contact information from other sources, such as pharmacies, PCP visits, or subcontractor data.

In Mississippi, Molina Community Health Workers have been vital in our efforts to engage Enrollees.

Our affiliate contacted 1,790 individuals in the first four months of 2019 who were candidates for care management and successfully enrolled 53% into the program.

- The Enrollee Locator Team will mine data and contact shelters, CBOs, and other locations to find high-risk/high-needs Enrollees.
- Molina Community Health Workers, our field-based team, will focus on locating Enrollees who are difficult to reach and linking them with their care team and community resources. In some cases, the Molina Community Health Worker will go to the Enrollee's last known address and knock on the door or find the Enrollee at a homeless shelter, for instance.
- We will contact Enrollees when they seek treatment in the ED or other setting to connect them with preventive and follow-up care.
- We will embed care managers on a part- or full-time basis as necessary in primary care practices, specialty offices, and other care sites such as EDs where utilization is high. Our embedded care managers can provide meaningful personal interactions with the Enrollee, identify needs, educate the Enrollee on the benefits of care management, and encourage completion of the HRA.
- If the Enrollee is admitted to the hospital, our ToC coaches, including those embedded in high-volume facilities, will outreach to the Enrollee to complete an assessment for needs identification while the Enrollee is in the hospital. The coach will offer an introduction and complete an assessment to identify needs upon discharge to ensure patient safety, including medications and durable medical equipment as well as social determinants of health such as secure housing and nutrition. The ToC coach begins discharge planning and follow-up care when the Enrollee is admitted.
- Care managers will engage the Enrollee's caregivers and other service coordinators if the Enrollee declines our efforts to complete assessments.

We will continue to employ active listening and motivational interviewing techniques at each contact to increase Enrollee engagement and participation.

a.iv. DEFINED RISK LEVELS

Care management encompasses much more than physical health and behavioral health interventions. Considering social determinants of health and health disparities is as important to ensuring the most vulnerable individuals in our communities have access to healthcare services and supports. Today, an individualized, self-directed, and whole-person care management approach is the benchmark for successful health plans. In response to the RFP requirement to include information about subparts a–n for each risk level, the responses below apply to all risk levels unless otherwise noted.

a.iv.a. Tools to Identify Enrollees and Support Services

Identifying Enrollees and Their Risk Levels

Data analytics will drive our process to identify Enrollees in need of care management services. Molina will use Optum Impact Pro predictive modeling software, which will assign a risk score and corresponding care management level to Enrollees based on data analysis of clinical risk, impactable opportunities, and social determinants of health. Exhibits C.24-4 and C.24-5 show the scoring methods and the factors included in each category.

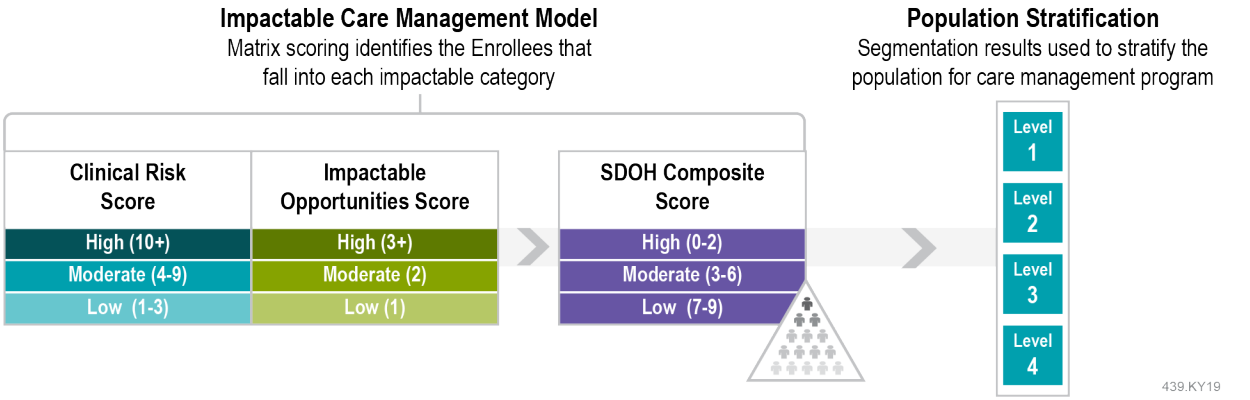

Exhibit C.24-4. Impact Pro Risk Scoring

Clinical Risk Factors	Impactable Opportunities	SDOH Indices
Historical and Predicted Utilization: • Inpatient • Readmission • ED Admission **Clinical and Behavioral:** • Multiple chronic conditions • Substance use / opioid use • Mental health condition **Other:** • Historical and Predicted • High Cost • Poly Rx (10+)	**Medical** • High ambulatory utilization • 4+ ED visits in last 6 months • No special consult when indicated • Frailty • New diabetes diagnosis **Pharmacy:** • Care opportunities: medication adherence (1+) • Not on appropriate medications • Treatment non-compliance concerns **Behavioral:** • OUD/OD/4+ pharmacies / providers and not Medication-Assisted Treatment (MAT) • Non-adherent to anti-depressants or anti-psychotics **Social:** • Economic or housing concerns • Literacy concerns	**Health Ownership Index:** • Level of Enrollee engagement with their own health regardless of health status (healthy or chronic) **Propensity to Engage – CM:** • Likelihood an Enrollee would participate in a care management program (Low, Med, High) **Propensity to Engage – Inbound Call:** • Likelihood an Enrollee would engage with the plan by telephone (Low, Med, High)

SDOH: Social Determinants of Health **OUD:** Opioid Use Disorder **CM:** Care Manager

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Exhibit C.24-5. Criteria for Scoring

Enrollees who are identified as high-risk, high-need, or are identified as pregnant upon enrollment based on historical data will be assigned directly to a care manager and prioritized for assessment within 30 days of enrollment. After pre-enrollment stratification, Enrollees may be re-stratified based on initial HRA outcomes, functional assessments, and other known factors affecting an Enrollee's ability to self-manage their care needs.

A Molina-standardized HRA tool, approved by the Commonwealth, will be used to assess all new Enrollees within 90 days of enrollment—unless the Enrollee is initially stratified to a higher level of care—and at least annually thereafter, or sooner based on changes in the Enrollee's health status. We will make at least three proactive attempts to contact each Enrollee and flag ongoing opportunities based upon Enrollee-initiated contacts. The HRA will obtain demographic information as well as the Enrollee's

current physical health and behavioral health status and potential social determinants of health. During the HRA, if the Enrollee needs services offered under the PHM program, we will outline the additional services available to the Enrollee.

Additional Assessments

Based on the results of the initial or annual HRA, additional information may be secured through an Enrollee Needs Assessment or a secondary condition-specific assessment, identification of barriers and social determinants of health, claims, Enrollee self-report, provider and CBO input, or clinical judgment. Information collected will include:

- Enrollee's immediate, current, and past healthcare, mental health and SUD needs, and main health concern
- Behavioral health screenings (CAGE-AID, NIDA, and ASAM for substance use; PHQ-9 for depression)
- Psychosocial, functional, and cognitive needs
  - Elder care
  - Traumatic brain injury
- Social determinants of health, including employment and housing status
  - Home safety evaluation
  - Learning and health literacy
- Ongoing conditions or needs that require treatment or care monitoring
  - Wound care, asthma, coronary artery disease, congestive heart failure, COPD, diabetes, chronic kidney disease, pain management, and so forth
  - Maternity care management (low/moderate risk or high risk)
- Current care and services being received from either formal or informal supports, including healthcare services or other care management
  - Service plans
  - Post-discharge
  - Transitions of care
- Current medications prescribed and taken
  - Medication adherence
- Support network, including caregivers and other social supports
  - Caregiver Activation Measure
  - Caregiver support
  - Caregiver self-assessment questionnaire

Support Services

Molina will leverage communication technology to communicate with Enrollees and track all care management activities for future reference:

Clinical CareAdvance is an integrated web-based care and disease management platform that promotes information sharing across care teams. Our care managers will use this tool to manage assessments, care plans, and other clinical information. Copies of the care plan will be provided to the Enrollee and caregivers as approved by the Enrollee.

mCare, our mobile assessment application, will enable Care Management team members to perform assessments and care planning during face-to-face and field-based site visits with our Enrollees in the community. Care managers can enter information and access data, including claims, pharmacy, lab results, past assessments, visit logs, and current care or care plan information.

The **Molina Mobile app** and **MyMolina portal** will give Enrollees access to their personal health information and other readily available resources. Enrollees can also use the messaging function to

communicate with their assigned care managers or a customer service representative. Enrollees also will have access to educational materials and Virtual Urgent Care.

The **Care Evolution—Member360 portal** will provide a consolidated view of historical Enrollee data within a single, web-based solution. Member360 will be used by our Enrollee Services, Utilization Management, Disease Management, Care Management, and Quality departments.

a.iv.b. Risk Stratification Methodology

Our highly structured and well-defined care management processes will enable us to stratify Enrollees into four levels. The first three levels will conform to the Commonwealth definitions in the Draft Contract. In addition, we have included Level IV, Intensive Needs, as is standard in Molina affiliated health plans nationwide. Level IV stratification will allow us to provide a more tailored approach to addressing member care needs. Exhibit C.24-6 describes each level:

LEVEL I HEALTH PROMOTION AND WELLNESS	For Enrollees whose physical or behavioral health conditions are low acuity, but whose unmet needs put them at risk for future health problems and compromise independent living • Focuses on disease prevention, health promotion, and Enrollee self-management • Goal is to achieve Enrollee wellness and self-management through improved access to timely care, advocacy, education, identification of support resources, and facilitation throughout the continuum of care
LEVEL II MANAGEMENT OF CHRONIC CONDITIONS	For Enrollees at risk for re-hospitalization, post-Transition of Care intervention, or with care management needs that warrant triage • Goal is to reduce the burden of disease through education and coordination of care • Care management team collaboratively assesses Enrollee's needs, creates care plan with prioritized goals, and facilitates appropriate and timely access to primary and specialty care as needed
LEVEL III COMPLEX CARE MANAGEMENT	For Enrollees who have experienced a critical event or diagnosis that requires extensive use of resources • Goal is to improve functional capacity and regain optimal health • Care manager leads creation of care plan with prioritized goals and a multidisciplinary team including caregivers, PCP/medical home, specialists, and others
LEVEL IV INTENSIVE NEEDS	For Enrollees with need for stabilization and/or end-stage diagnoses • Goal is to stabilize Enrollee's health status, improve ability to cope with the severity of the condition, and improve quality of life as defined by Enrollee's preferences and goals • Care manager facilitates and updates (as needed) care plan with prioritized goals and engages multidisciplinary team to provide services in the least restrictive setting

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Exhibit C.24-6. Molina's Four Risk Levels

Enrollees will be risk stratified using various data-driven methodologies before and at any point during enrollment. The primary method will be based on risk stratification and predictive modeling software. In addition, Commonwealth eligibility data, our HRA, condition-specific or Enrollee Needs Assessment, social determinants of health, consumer data, and referrals will be incorporated with clinical judgment to appropriately stratify and re-stratify Enrollees. Our risk stratification and predictive modeling tool will give us flexibility to specify risk levels. As we identify Enrollees' risks and needs, we will determine stratification levels for the various cohorts identified. We will put a focus on priority conditions and populations to ensure that those Enrollees who are higher risk are identified first, and their needs are appropriately addressed.

Before Enrollment

Data may be used for initial stratification (e.g., eligibility data with clinical condition information such as pregnancy). These conditions would indicate a Level II or III stratification. Similarly, when Enrollee demographic data and historical medical or pharmacy claims data are received from the Commonwealth, it will be fed into the risk stratification and predictive modeling software for risk scoring and stratification.

After Enrollment

Data captured—such as Enrollee authorization, medical and pharmacy claims, HRAs, and other care management data—will be fed into the predictive modeling software for scoring and risk stratification. Additional data may also be incorporated into the software process as available such as social determinants of health information including income, health literacy, transportation and social isolation, consumer data, and Nurse Advice Line data.

Predictive Modeling Risk Stratification

Optum Impact Pro, our comprehensive predictive modeling software, is an industry-wide accepted rules-based risk engine that will use Enrollee-centered analytics to classify Enrollees into risk categories. The solution will incorporate service-based risk markers in its analysis engine to produce an accurate risk score for each Enrollee. Optum Impact Pro is a transparent, predictive analytic engine that will enable clinicians to fully understand the risk drivers of an Enrollee or cohort and the risk weights attributed to each risk marker.

The model will use an Enrollee's clinical episodes of care, prior use of healthcare services including prescription drugs and lab results, and social, consumer, and other data when available as markers of their future healthcare use. These markers of use will be weighted and can be both predictive and provide clinical insights into why an Enrollee is high risk. The tool user can explore model results to better understand Enrollees of highest risk or rising risk and their most important diseases and conditions and psychosocial factors impacting health. Future utilization can be predicted with a calculated probability of one or more hospitalizations or ED visits, for example.

a.iv.c. Methods to Identify Enrollees for Priority Conditions or Populations

As detailed in our discussion under *Priority Areas*, our PHM program will include all priorities and populations defined by the Commonwealth in the Draft Contract; in addition, we have chosen to include COPD as a priority condition.

Table C.24-3 details the methods we will use in Kentucky to identify Enrollees for priority conditions or populations in the PHM program.

Table C.24-3. Methods to Identify Enrollees for Priority Conditions or Populations

Identification Method	Process
Risk Stratification	Based on claims, utilization, and software; model includes likelihood to engage
New Enrollee Welcome Calls	Call center can warm transfer Enrollees to care manager based on self-reported condition
HRAs	For all new Enrollees and annually thereafter
Referrals	From care managers, Molina Community Health Workers, medical directors, Nurse Advice Line staff, Utilization Management staff, providers, Commonwealth agencies, and CBOs
Self-referral	Includes caregiver referral
Community and Population Needs Assessment	Identifies characteristics by geography (e.g., obesity by county) and other factors

Using our risk stratification and predictive modeling software, we can set priority conditions as high, moderate, or low for stratification into any one of our PHM program levels before enrollment. Molina care management staff will outreach to these Enrollees more quickly and attempt to contact them for administration of our HRA. Through our predictive modeling software, Molina can also identify existing Enrollees with priority conditions of which we were unaware or for whom we did not receive historical data, or who had a change in healthcare condition.

Different pockets of risk in a population can be identified and targeted, including Enrollees:

- With specific disease/conditions such as asthma, obesity, or high-risk OB
- With previously high levels of costs and utilization and therefore likely to continue to be of higher risk
- Of low or moderate previous risk likely to experience increased risk going forward (rising risk)

The predictive modeling risk stratification tool will support both Enrollee-centric (entire health plan) applications, as well as disease-specific predictions. Enrollees with high-risk conditions (e.g., congestive heart failure, coronary artery disease, diabetes) are recognized as well as those with acute and chronic conditions that may predict an Enrollee's future level of risk.

The flexibility to adjust and specify different levels of risk to meet specific population health needs allows us to stratify and target priority conditions and populations and ensure that those Enrollees' needs are appropriately addressed.

a.iv.d. Services and Information Available at Each Risk Level

All services authorized under the Contract will be available to all Enrollees regardless of risk level. Higher levels of care management will entail an increase in the frequency of outbound calls, care plan updates, and multidisciplinary care team meetings as applicable. Table C.24-4 details the services and information Enrollees will receive based on their risk level:

Table C.24-4. Services and Information Available by Risk Level

Service/ Information	Level I Health Promotion and Wellness	Level II Management of Chronic Conditions	Level III Complex Care Management	Level IV Intensive Needs
Annual HRA	✓	✓	✓	✓
Predictive Analytics / Risk Stratification	✓	✓	✓	✓
Referrals		✓	✓	✓
Enrollee Needs Assessment		✓	✓	✓
Face-to-Face Assessment		✓	✓	✓
Care Plan		✓	✓	✓
Outreach	Enrollee will receive mailed educational materials on lifestyle factors that, if left unchecked, will increase the risk of disease onset or exacerbation. Enrollee may engage in telephone-based health coaching with Health Promotion and Wellness staff.	Care manager may have direct telephone or face-to-face interactions with Enrollee and/or caregiver. Care manager may enlist a Molina Community Health Worker to visit the Enrollee to provide education, access, or information exchange.	Interventions will include more face-to-face contacts for assessments and supportive services, as well as more frequent contacts to help Enrollees reach a level of stability and/or self-management.	Enrollee will require more services because of deterioration of mental or physical condition, fragile or insufficient informal/formal caregiver arrangements, and/or a terminal illness. Enrollee will receive more frequent follow-ups based on their needs and preferences. Molina staff will work closely with this population to ensure they are receiving home- and community-based services as needed.

The level of care can be adjusted in either direction based on changes in health status or increased risk, or by care manager clinical judgment.

a.iv.e. The Care Planning Process

Before contacting the Enrollee to begin formulating the care plan, the care manager will complete a pre-call review, which will include a 360-degree review of documentation in our system. The care manager will study the Enrollee's physical health and behavioral health conditions, utilization patterns, medications, psychosocial factors, potential gaps or barriers to care, demographic data, and changes in conditions. This review will allow the care manager to have an overall picture of the Enrollee's needs, provide meaningful and appropriate interventions, identify potential areas that may impact care, and appropriately implement and follow up on items in the care plan.

To create the care plan, our Care Management team will review and incorporate results from the HRA and Enrollee Needs Assessment; historical data, lab and pharmacy data, and current utilization data; and, if applicable, recommendations from the Enrollee's multidisciplinary care team. Goals will be prioritized and target dates established with the Enrollee/caregiver. Frequency of care plan review will be based on clinical acuity, Enrollee need, identified change in health status, care transition, and/or contractual requirement.

Our care managers will be the single point of contact for Enrollees and caregivers and will be accountable for ensuring that care plans are completed, and Enrollee needs are met.

Molina will strongly encourage the Enrollee and their family members and caregivers to participate in care plan development based on Enrollee needs and preferences. This involvement is especially important when family members or caregivers are helping to support the Enrollee to attain self-management goals. We will accommodate the availability of family members and caregivers to participate in the HRA and care planning process. Enrollees will be encouraged to take an active role in developing their care plans, and input from the multidisciplinary care team will be included when Enrollee needs, requests, or risk level warrants. The Enrollee will have the primary decision-making role in identifying his or her needs, preferences, and strengths, as well as a shared decision-making role in determining the interventions and supports that are most effective and helpful in building their care plan. The care plan development process will include the full integration of an Enrollee's treatment plan, unmet needs, and identified gaps in care for physical health, behavioral health, and functional needs.

Molina Care Management staff will review the care plan with the Enrollee and/or their designee. The Enrollee's agreement with their care plan will be documented in the electronic care management clinical platform. The established communication plan will include anticipated frequency and method of contacts with the Enrollee and the preferred caregivers, the PCP, and as appropriate, other multidisciplinary care team participants based on Enrollee needs and preferences.

Care plan (Exhibit C.24-7) creation and revisions may be communicated—by telephone, fax, mail, and/or secure web portal following HIPAA-compliant practices—to the Enrollee or Enrollee's representative and multidisciplinary care team participants based on Enrollee needs and preferences. Identified changes and elements to the care plan that are communicated to Enrollees and the participants of the multidisciplinary care team may include, but are not limited to:

- Significant changes to health/functional status
- Transitions of care such as hospital inpatient stay / skilled nursing facility services
- Changes in caregiver status
- Changes to living environment
- Outcome of the multidisciplinary care team meeting

Care managers will monitor and update the care plan as needed at each Enrollee contact at all programmatic levels to facilitate treatment compliance through coaching, education, and motivational interviewing techniques with the Enrollee/caregiver. Care managers will be carefully selected, continually

trained, offer direct experience with the populations we serve, and well-informed about the local community resources and providers who best understand the issues and needs of the Kentucky Medicaid population. Drawing upon their experience and motivational interviewing skills, care managers will engage Enrollees in the development of their care plans, giving them ownership of the process and providing expert clinical guidance and support along the way. They will lead multidisciplinary care teams as needed, and they will be specially trained to collaborate with a wide array of providers, specialists, and community partners to provide a well-rounded care plan that considers the physical health and behavioral health aspects of an Enrollee's life and accounts for disparities and social determinants of health that may create additional challenges.

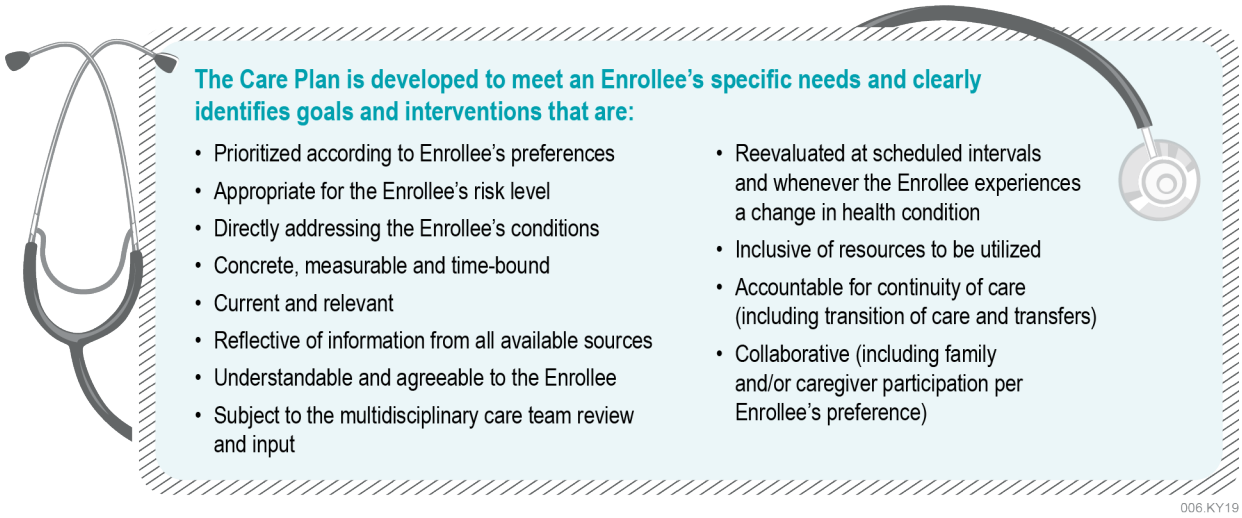

Exhibit C.24-7. Care Plan

During the assessment, the care manager will identify and begin to understand the Enrollee's situation, including the Enrollee's main health concern(s). Based on discussion with the Enrollee and/or caregiver and review of available data, the goals and interventions will be prioritized per Enrollee preference. Issues that might interfere with the Enrollee's ability to achieve goals or comply with the treatment plan also will be identified. Examples of barriers identified include lack of family/social support, lack of transportation resources, difficulty accessing providers, physical or financial limitations, cognitive issues, and language and/or cultural and religious practices.

The care manager will create the care plan with the input of the Enrollee and/or caregiver. The care plan will encourage and empower the Enrollee to achieve self-management while improving their health and well-being. The care plan will include concerns/care gaps identified during the HRA or other Enrollee contacts. It also will include goals, interventions, measurable outcomes, and barriers. It will outline and address all coordination of care activities, risks, and opportunities prioritized by the Enrollee or their representative.

The care manager may determine that a multidisciplinary care team is necessary to achieve the Enrollee's goals. The participants invited to join the multidisciplinary care team typically will include the Enrollee and/or caregiver, Molina care manager, Molina medical director, Enrollee's PCP, specialists in physical health and/or behavioral health, nurses, social workers, and other non-healthcare professionals as needed and approved by the Enrollee. Enrollees will be educated about the multidisciplinary care team process, at a minimum, during initial and annual assessments, including how to access, participate in, and designate core participants of a multidisciplinary care team meeting. A multidisciplinary care team meeting will be held to coordinate all aspects of the Enrollee's health along the continuum of care by bringing together multiple providers in various disciplines to cross-communicate and provide holistic care planning. If a

multidisciplinary care team has been created to support the Enrollee, the multidisciplinary care team will have input into the initial care plan and any subsequent updates.

The care manager will schedule appropriate follow-up with the Enrollee to assess progress and address barriers to meeting goals of the care plan. The care manager also will be responsible for collaborating with providers to ensure the Enrollee receives the right care promptly and consistent with the care plan.

The care manager, with the involvement of the multidisciplinary care team and based on Enrollee preferences and needs, may include the following services within the care plan:

- Facilitation of referrals to resources
- Follow-up to determine whether Enrollees and/or representatives acted on referrals
- Development of regular schedules for communication with Enrollees
- Development and support of Enrollee self-management plans, through oral or written communication
- Assessment of Enrollee progress as measured against care management goals established with the Enrollee
- Reassessment and adjustment of the care plan, as needed

All Enrollee education will be provided in alignment with nationally accepted guidelines for their specific health condition. In addition to ensuring the Enrollee learns and understands his or her condition and role in directing the care plan, the care manager will also ensure the Enrollee and their family have adequate resources to successfully implement the care plan.

For Level III and some Level II Enrollees, the care manager will communicate self-management goals of the care plan and confirm the Enrollee can manage or receive assistance in:

- Performing activities of daily living (dressing, bathing, transferring, toileting, eating/feeding)
- Performing instrumental activities of daily living (meal prep, housework, laundry, shopping, telephone, finances)
- Administering medications and/or medical procedures/treatments (change wound dressing)
- Managing equipment (oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment/supplies)
- Maintaining a prescribed diet, and/or charting daily weight or blood sugar

An Enrollee's care plan will be available on Molina's secure Web portal, and hard copies may be sent via fax, mail, or email following HIPAA-compliant practices to the Enrollee, PCP, relevant specialists, and other multidisciplinary care team participants upon request for inclusion in the Enrollee medical record based on individual needs and preferences. The care plan will be documented, reviewed, and revised in Molina's electronic care management platform.

The Enrollee's caregiver and PCP will be notified of any significant revisions to the care plan, and the method of communication will be based on Enrollee needs and preferences. Participants in the multidisciplinary care team will also be made aware verbally during multidisciplinary care team meetings that they can request copies of the care plan through a request to the assigned care manager. Enrollees will review care plan options and provide their care manager with input to ensure their decisions and choices are reflected in the care plan. The Enrollee will be engaged and participate in every step of the assessment and care planning process.

a.iv.f. Stakeholder Engagement Strategies

Our commitment to whole-person care means our model incorporates all stakeholders in a collaborative effort. This includes Enrollees, caregivers, providers, Commonwealth departments and agencies, and CBOs throughout Kentucky. We will seek relationships with organizations that provide services that can positively impact our Enrollees' well-being, such as nutrition, housing, and employment assistance.

Molina has been active in Kentucky for more than two years in preparation for entering the Commonwealth as an MCO. We have convened focus group meetings with Enrollees and providers to learn about the current Kentucky Medicaid landscape. We have met with legislators and participated in community forums. ***Our national organization has awarded $525,000 in grants to CBOs in Kentucky through the Molina Community Innovation Fund. Upon Contract award, we commit to awarding further grants totaling $2.5 million over four years.***

Most recently, in January 2020, we sponsored a Legislator Meal-packing Day with the Feeding Kentucky network of food banks. Our donation paid for 2,100 bags of food for Kentucky schoolchildren who face food insecurity, and our executives teamed up with legislators to pack the bags at the State Capitol Building. Three of Feeding Kentucky's affiliates—Dare to Care, Kentucky's Heartland, and God's Pantry Food Bank—are among our established CBO partners.

Engagement of Community Resources to Meet Social Needs

Table C.24-5 describes the partnerships we have formalized through our Molina Community Innovation Fund. Beyond this financial commitment, we have talked to more than 110 CBOs and agencies about building partnerships to improve Kentuckians' health.

Table C.24-5. Molina's Community Innovation Fund Grants

Organization	Program Name	Purpose
Dare to Care	Mobile Market	Mobile grocery store delivers fresh fruit and vegetables to "food deserts" in Louisville (Region 3)
	Prescriptive Pantry	Enrollees receive nutritious take-home food package while at their doctor's office (Region 3)
Kentucky's Heartland	Diabetes-appropriate food and education	Pilot program features diabetes-appropriate food, educational classes, and cooking demonstrations. Partner agencies work with local healthcare providers to track data for outcomes in order to improve food security and dietary intake (Regions 1, 2, and 4)
Home of the Innocents	Multisystemic Therapy for families	Program is the Commonwealth's first to offer the new Multisystemic Therapy for Family and Community Preservation Program. Youths ages 12–17 and their families receive counseling on the effects of trauma, with the goal of helping youth heal from past trauma and preventing the trauma from becoming a disorder that leads to the child's removal from the family or incarceration (Region 3)
Family Scholar House	Healthcare Pathways	Healthcare Pathways program provides targeted academic coaching, apprenticeship coaching, job shadowing, mentoring, and other services to help single mothers pursue careers in healthcare-related fields (Region 3)
Louisville Urban League	"It Starts with Me!"	Community health workers engage families with identifying and addressing social determinants of health and barriers to achieving family-sustaining employment (Region 3)
	Expungements	Molina will fund 50 expungements in Louisville or other locations. Molina One-Stop Help Centers throughout the Commonwealth will host Urban League training and outreach (Region 3 plus others TBD)
Boys and Girls Club of Bowling Green	Triple Play	Molina revived this comprehensive health and wellness program—which had been discontinued due to insufficient funds—to teach young people about the benefits of exercise, nutrition, and developing healthy relationships (Region 4)

Organization	Program Name	Purpose
Audubon Area Community Services	Pop-up Clinics	Standalone healthcare site near school in rural Hancock County will offer well-child screening and immunizations. Molina has provided Audubon Area Community Services financial support to expand the health center in Hancock County to add more exam rooms, expand behavioral health services, and grow their capacity to provide telehealth services (Region 2)
God's Pantry Food Bank	Patient Pantry	Patient Pantry program where food bank is partnering with hospital systems in rural areas to identify food insecure patients through existing screening processes and providing those patients with a take-home food box at discharge, along with information about the pantry closest to their home (Regions 5 and 8)
United Way of Northeast Kentucky	2-1-1 service support	Organization will expand its Kentucky 2-1-1 service, which helps callers by searching database of more than 300 agencies and 1,000 programs to address healthcare, food insecurity, housing insecurity, rent and utility assistance, and other services (Regions 5, 6, 7, and 8)
Goodwill Industries of Kentucky	Reentry and Expungements	Molina has partnered with Goodwill to create RISE (Reintegrating Individuals Successfully Every Day) Lexington and fund 50 expungements in Lexington to support the community reentry of justice-involved individuals. Molina will participate in expungement, reentry, and reintegration classes (Region 5)
Kentucky Primary Care Association (KPCA)	Connecting Kids to Coverage	Molina will provide funding for KPCA to expand its program, in which assisters work with Federally Qualified Health Centers to enroll children in Medicaid. The program can be used to enroll any eligible child in Medicaid regardless of whether the child becomes a Molina Enrollee (Region 8 with possible statewide expansion)

Engagement with Other Stakeholders

Molina values input from all stakeholders in the Medicaid system. Our regional Quality and Member Access Committees will meet quarterly, and we will invite Enrollees and their families to participate with the goal of having at least 15 Enrollees attend each meeting. Our Quality and Member Access Committees will align with our local Molina One-Stop Help Centers in Louisville, Covington, Lexington, Hazard, Bowling Green, and Owensboro.

We will actively recruit providers of all types for our Provider Advisory Workgroup and our QI Committee, ensuring both physical health and behavioral health providers are represented. Finally, as outlined in Proposal Section 2, Collaboration, we believe states are served best when MCOs and government agencies work together to bring innovations to all Medicaid beneficiaries. We look forward to taking a leadership role within that workgroup.

We continually seek ways to reach our Enrollees in the manner most comfortable to them. For instance, in January 2020, the American Heart Association published an article about a University of Kentucky study of 355 people who had at least two risk factors for heart disease[1]. Participants took a 12-week self-care course on their chosen topic of interest: blood pressure, cholesterol levels, or body weight. When

[1] https://www.heart.org/en/news/2020/01/14/researchers-listen-to-rural-kentuckians-then-score-a-win-for-heart-health

researchers checked their progress a year later, participants had improved health in all three categories; the rate of smoking also went down even though cessation was not part of the program.

The study's author, UK nursing professor Debra K. Moser, noted that researchers intended to work with participants individually, but soon found that Kentuckians are particularly community-focused and preferred the group approach. This study confirms our approach is correct and gives us reason to expand our offerings to deliver services in group settings. Those offerings will include:

- WW (Weight Watchers) classes as a value-added benefit
- Group classes on managing diabetes and addressing obesity
- Network providers who offer Centering Pregnancy, a prenatal visit that brings a group of women together for approximately two hours, with each woman visiting individually with the obstetrician during a portion of the time

Finding solutions that work for our Enrollees is always our goal and delivering those solutions in a way that our Enrollees will embrace is a key part of achieving that goal.

a.iv.g. Technology and Other Methods for Information Exchange

Molina will leverage technology to communicate with Enrollees, providers, and the Commonwealth. For Enrollees, we will continually improve the user experience and their ability to self-manage their health and communicate with Molina. For providers and the Commonwealth, robust data-sharing will be a core value and an essential component of our interventions to improve population health.

Enrollees

Molina will encourage Enrollees to participate in their healthcare virtually. By leveraging the power of our connected enterprise, we can provide secure access for Enrollees either through our Molina Mobile app (Exhibit C.24-8) or through the Enrollee Web portal (Exhibit C.24-9). Enrollees can create a personalized user experience that enables them to easily access a variety of resources, including our regional offices and Call Centers.

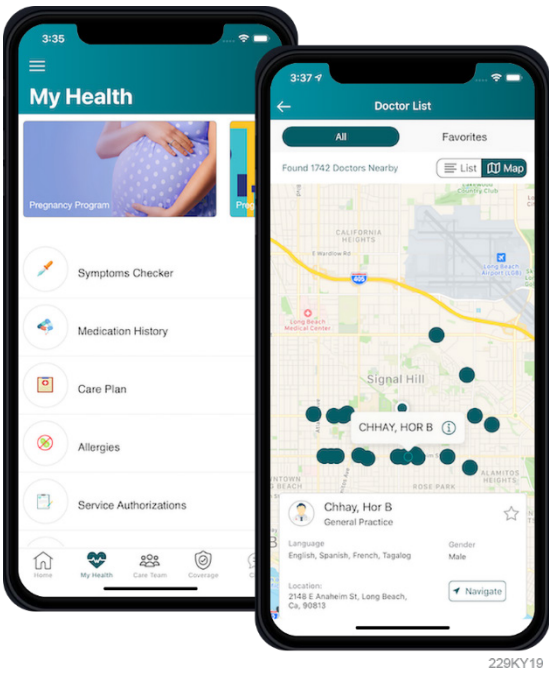

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Exhibit C.24-8. Molina Mobile Application

The latest version of our Molina Mobile app was released in January 2020. With this update, Enrollees can:

- Check symptoms
- View personal health information such as their care plan, medication history, assessments, allergies, inpatient admissions, and enrollment history
- View care management information, family/care team participant data, and a provider directory
- Find an urgent care clinic or a pharmacy
- Choose a "Favorite Doctor" option
- Manage their rewards account through Amazon if they have enrolled to receive free/discounted Amazon Prime home delivery from Molina
- View and use the benefits at a glance, evidence of coverage, and benefit summary documents; the Rx mail order form; the Enrollee Handbook; the procedure cost estimator; and more
- Access virtual ID card with sharing and printing options

- Use TouchID/FaceID integration
- Access My Doctor information, search providers, change doctors, get directions to the doctor, and view health education content

In addition, our website and app will carry news articles and other information that will keep Enrollees updated not only on their current health conditions but on tips to live healthier.

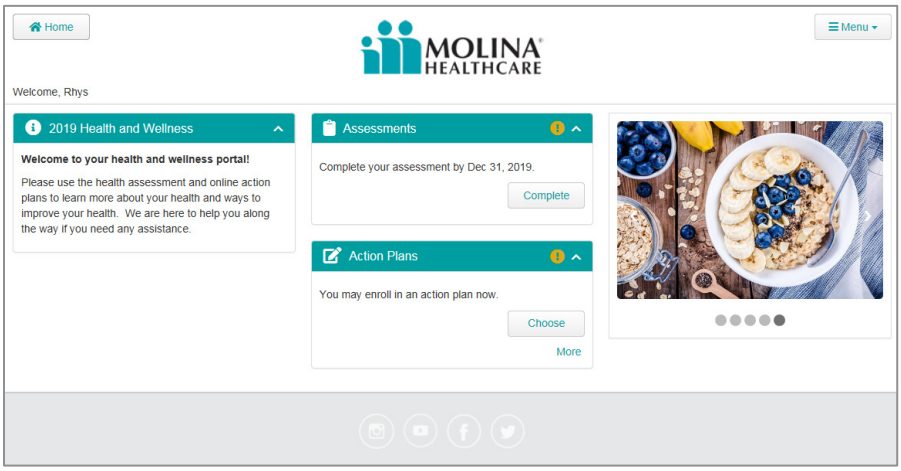


Exhibit C.24-9. Molina's Enrollee Web Portal: Health and Wellness

Providers will be essential to helping us improve Enrollee outcomes. ***Molina has partnered with the Kentucky Primary Care Association (KPCA), the Commonwealth's largest independent practice association, and can connect to their quality data-sharing platform, CHARLI.*** Working with the Kentucky Health Information Exchange (KHIE), CHARLI, the Commonwealth, and other MCOs will provide us with rich claims data and HEDIS measures to support gaps in care analysis, data acquisition and aggregation, and clinical reconciliation to have a meaningful impact on reducing costs and improving health outcomes.

Molina Staff

Care managers will use Clinical CareAdvance and mCare applications to update Enrollee status after each interaction. These applications will make information available in real time to all staff who need access. In addition, the Care Evolution–Member360 portal will provide a consolidated view of historical Enrollee data within a single, web-based solution. Member360 will be used by our Enrollee Services, Utilization Management, Disease Management, Care Management, and Quality departments.

Before every outreach, our care managers will conduct an internal pre-call review that involves a 360-view of an Enrollee's claims, utilization, pharmacy, and other pertinent information. The pre-call review will give the care manager insight into the Enrollee's physical health and behavioral health conditions, utilization patterns, medications, psychosocial stressors, potential gaps or barriers to care, and demographic data. With this context, the care manager can be aware of any triggers during the call that would indicate the need for more frequent provision of services.

Providers

Our intent is to bring every provider into data-sharing. To work toward this goal, we will offer incentives based on using EHR and the standardizing of data elements. In addition, ***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.***

To address behavioral health specialties, our parent company has begun to deliver a Facility Scorecard with the goal of improving health outcomes among members who suffer from mental illness and SUDs.

The initiative involves using data analytics to identify and reward high-performing facilities and collaborate with low-performing facilities to assist them in meeting or exceeding quality indicators. This initiative is based on the success of our organization's Provider Scorecard in helping PCPs achieve quality improvements and incentives through our VBP program.

a.iv.h. Frequency of Provision of Services

Molina will employ a host of methods to outreach to Enrollees, including by mail, the Molina Mobile app and Enrollee Web portal, telephone, and face-to-face engagement, based on identified Enrollee needs. The standard outreach time frames for Enrollees will be adjusted frequently based on clinical judgment, Enrollee needs, or the current situation. We will conduct standard outreach calls based on levels as follows:

- Level I, Health Promotion and Wellness: Monthly to quarterly
- Level II, Management of Chronic Conditions: Monthly
- Level III, Complex Care Management: Weekly to monthly
- Level IV, Intensive Needs: Frequency as needed

For Level I, most of the services will be provided through mail, although we will reach out annually for the Enrollee to complete an HRA. Our latest release of the Molina Mobile app includes a "My Health" page that will make it easier for Enrollees to self-manage their health and receive appointment reminders and educational materials.

This schedule will vary based not only on the risk level but on the particular condition or health event. For instance, after all hospitalizations, our ToC coach will contact the Enrollee three times in 14 days post-discharge, and services can continue for up to six weeks regardless of the Enrollee's level of care management.

a.iv.i. Priority Areas

Using data analysis and technology, our targeted programs will identify Enrollees at the highest risk for excess utilization of healthcare services. Programs will be based on fundamental disease management components comprising multidisciplinary provider engagement, evidence-based interventions that target specific conditions, and Enrollee education to support and empower self-management.

The Commonwealth defined its priority conditions and populations in the Draft Contract, Section 34.2, Conditions and Populations. As stated, ***we propose to add COPD and chronic kidney disease to that list.*** Below, we describe services offered by our 14 affiliated Medicaid health plans that we will bring to Kentucky to address these priority areas.

Asthma

Our asthma program will use a team approach and an asthma action plan that incorporates health education and clinical care management interventions. These interventions will include coaching and providing materials on self-management, with the goal of improving quality of care to help Enrollees maintain normal activity levels and near-normal pulmonary function rates, avoid chronic troublesome symptoms, and minimize ED visits or hospitalizations.

Heart Disease

We will offer materials to all Enrollees that emphasize the importance of diet, exercise, and other lifestyle factors in avoiding heart disease. Our "Clear and Easy" booklet series includes easy-to-read books on congestive heart failure, coronary artery disease, and hypertension. We will offer prevention tips and emphasize to our adult populations the importance of regular physical exams with a PCP.

For those who have been diagnosed with heart disease, we will take a more active role. For instance, in California, our affiliate sent targeted mailings to members identified as having heart disease to emphasize the importance of managing hypertension. Materials educated members on medication adherence, tips to control blood pressure, and a pill box to remind them to take medications consistently. Kentucky

Medicaid Enrollees may also be enrolled in a co-managed medication therapy management program to improve adherence to their treatment regimen.

We also will give providers a Provider Toolkit and service lists to identify Enrollees who have missed well-care and preventive visits. We will work collaboratively with our provider network to coordinate access to care and follow-up on both preventive visits and services as well as management of chronic conditions to help Enrollees achieve better control and a healthier life.

Diabetes

Our Diabetes program will work to mitigate risk factors associated with diabetes, slow its progression, and reduce complications by promoting compliance through education, counseling, and support. This care management program will include a weight management and nutrition intervention, and a registered dietitian conducting a comprehensive consultation and follow-up. Care management staff may also work with providers to determine if WW (Weight Watchers) or other interventions such as home health, physical therapy, or occupational therapy are appropriate to achieve increased compliance and mobility. To close gaps in care, our Care Connections team of nurse practitioners will complete annual and wellness assessments including Comprehensive Diabetic Care, where A1C, nephrology screening, and retinal eye screening all will be done in the community or Enrollee's home. Medication therapy management will be another component to improve the treatment regimen and provide additional counseling to both Enrollees and providers on treatment options tailored to the individual.

Chronic Kidney Disease

Kentucky has the fifth-highest rate of chronic kidney disease in the nation. Our new Chronic Kidney Disease program, which will be initiated throughout all affiliated health plans in 2020, will identify Enrollees with stages 1–5 chronic kidney disease and implement strategies at each stage to reduce progression of kidney disease. Stages 1–3 will focus on providing Enrollee materials, including how to avoid medicines that are toxic to the kidneys. Later stages will focus on getting the Enrollee the right care with a kidney specialist at the right time, supporting kidney transplantation, and ensuring best dialysis access well before initiating dialysis. Enrollees with chronic kidney disease are highly likely to have heart disease and strokes, so having the Enrollee evaluated early on by a cardiologist will be a priority. With this new program, we expect to reduce hospitalizations, death, and disability related to chronic kidney disease.

Obesity

Our weight management program will involve one-on-one telephone education and coaching by a care manager to support weight management by assessing the Enrollee's readiness to lose weight; educating the Enrollee on nutrition and the benefits of weight reduction; supporting the Enrollee throughout participation in the program; teaching behavior modification techniques; and collaborating with the Enrollee's provider to implement appropriate interventions. With prior authorization, Enrollees can receive 13 weeks of WW (Weight Watchers), a Molina value-added service. Enrollees can be referred by providers, internal departments, or self-referral.

Tobacco Use

Our smoking cessation program will support Enrollees by providing assessment and telephonic outreach through a care manager; developing an individualized smoking cessation plan of care; encouraging Enrollees to work with contracted providers to determine appropriate pharmacological aid if needed; educating Enrollees on stress management and coping techniques; informing them on dealing with addiction, habit, and psychological dependency; and preparing them for quit day and ongoing maintenance.

Cancer

We will promote preventive screenings to detect cancer early and allow for interventions. Our Analytics department will analyze our Enrollee population by risk factors such as age and previous conditions that

indicate a higher likelihood of cancer. Through telephonic and mail outreach and notification to providers, we will remind Enrollees of the need for cervical, breast, and/or colon cancer screenings. All our HRAs will seek information about whether an Enrollee has had or is being treated for cancer. Our assessments also will ask if Enrollees have completed age-appropriate preventive screenings such as a mammogram and colonoscopy.

Enrollees who are being treated for cancer will move to a higher level of care management. We will address their functional needs such as proper nutrition, transportation, and family/caregiver support during this difficult time. We will work collaboratively with the Enrollee's care team to ensure the Enrollee's care goals are achieved, and quality of life is improved.

High-Risk OB

The High-Risk OB program will aim to identify pregnant women who may qualify for High-Risk OB care management. Program components will include pregnancy screening, risk-specific education, and care management interventions targeted towards improving pregnancy outcomes. Enrollees will remain in the program during the duration of their pregnancy (or until resolution of identified risk factor) and up to six weeks postpartum.

To identify Enrollees with high-risk pregnancies, we have partnered with Lucina Analytics, a Kentucky-based analytics firm that will use data from throughout healthcare (claims, pharmacy, and so forth) and deliver a daily report to us with the most urgent cases at the top. A care manager will contact the Enrollee and create a care plan with the Enrollee and the Enrollee's prenatal care provider. Risk factors that will indicate eligibility for the High-Risk OB program will include, but will not be limited to alcohol/drug use, history of NICU admissions, asthma, diabetes, maternal age, previous preterm deliveries, and cardiac-related conditions.

Our High-Risk OB team will work with Molina Community Health Workers to assist pregnant Enrollees who have difficulty with maternal depression and/or substance use. Our High-Risk OB care manager will refer eligible first-time mothers to Nurse-Family Partnership, where available, to receive additional care and services tailored to meet the woman's needs. Our High-Risk OB team will educate pregnant Enrollees on:

- The importance of early and regular prenatal and postpartum care (care managers will offer assistance with scheduling if needed)
- Pregnancy nutrition (care managers will assist with referrals to food banks and community-based resources)
- Cesarean-section awareness to reduce unnecessary c-sections
- Long-acting reversible contraception and the importance of birth spacing

Low Birth Weight / Infant Mortality

When an Enrollee is identified as high risk through analytics and our partnership with Lucina Analytics, we will mobilize resources to ensure prenatal care is optimized to maximize the best outcome for mother and baby. These interventions will include access to obstetrical care, regular follow-up, and an assessment of nutrition, safety, and social determinants of health. In those unfortunate circumstances where a low birth weight baby is admitted to the NICU, we will monitor the baby's progress closely through our NICU program. Our NICU program will be led by clinical staff with comprehensive knowledge of NICU Enrollees. We will provide inpatient concurrent reviews to ensure appropriate levels of care. We will provide follow-up and family support before, during, and after discharge. We have also developed a NICU ToC program that will prepare the baby and mother for a safe discharge. Additionally, the ToC program will ensure appropriate postnatal care for the mother and appropriate follow-up care to track the baby's developmental milestones and administer preventive services. The ToC coach will provide continual assessment and follow-up for 30-to-45 days post-NICU discharge, or longer depending on the level of need.

Behavioral Health and SUDs

Our behavioral health programs will improve care and clinical outcomes for Enrollees with a primary diagnosis of depression or SUD. Building Blocks for Recovery will help Enrollees with SUD through a care manager's guidance. Building Brighter Days will address the needs of those diagnosed with depression or those undiagnosed who show symptoms. Through proactive identification and risk stratification, we will engage the Enrollee and combine education, clinical care management, and provider resources in our whole-person system of care.

Based on national guidelines and our work in other states, we have created a new SUD Model of Care with Opioid Use Disorder Focus. It focuses on specialized care management (through an SUD navigator), early identification, and improved screening procedures. For a complete description of this new model, see Proposal Section 23, Behavioral Health Services.

COPD

According to the Centers for Disease Control and Prevention, COPD is usually caused by smoking, and as many as 80% of COPD deaths are smoking-related. The COPD mortality rate in Appalachian Kentucky is nearly two times the national rate. For these reasons, we propose adding COPD to the Commonwealth's list of conditions to be addressed by the PHM program.

Our COPD program will take a collaborative approach including Enrollee education, care management, and provider support and education to generate an action plan for the Enrollee. We will use data analytics and work with contracted practitioners in the identification, assessment, and implementation of appropriate interventions for individuals with COPD. The goals of COPD management will include promoting routine follow-up care with the PCP and specialist (if appropriate), identifying barriers and modifying interventions to support adherence, and promoting self-management through education, empowerment, and the development and implementation of a COPD action plan.

The COPD action plan will include educating Enrollees on urgent and emergent symptoms and providing them with tools to quickly identify and address the early signs of exacerbation. During the development phase of the COPD action plan, the care manager will work with the Enrollee and provider to order and fill emergency medications, which may include bronchodilators, steroids, and antibiotics. The Enrollee will keep these filled medications in the home and have them readily available in the event symptoms worsen and signs of COPD exacerbation are present. Early symptom control will promote quality of life, empower Enrollees to take charge of their health, allow the Enrollee time to schedule an appointment with a provider and secure transportation, and prevent avoidable ED visits and hospitalizations. Additional components of our COPD program will include education on smoking cessation, promotion of flu and pneumococcal vaccines, assessment for the need for supplemental oxygen, promotion of lifestyle changes, education on urgent versus emergent symptoms, medication therapy management, and resources for transplant versus palliation during end stage.

Individuals with Special Health Care Needs

Our predictive modeling and HRAs, as well as referrals from Molina departments or external groups, will help us identify Individuals with Special Health Care Needs (ISHCN). The Draft Contract recognizes eight subcategories of this population. Our assessments will incorporate questions about social determinants of health as well as physical health and behavioral health; by emphasizing this whole-person view, we will be better able to identify individuals who could fall under the ISHCN classification and receive a higher level of service. Services targeted to this group will include transitions of care, caregiver support, and Molina resources such as Molina Community Health Workers to help homeless or housing-insecure Enrollees find safe and reliable housing.

a.iv.j. Staffing Levels

To build staff for implementation of the Kentucky Medicaid program, Molina estimates an initial enrollment of 300,000. To maintain the approximate ratios reflected below, we will adjust staffing based on initial and ongoing enrollment. We will have appropriate staff in place by the go-live date to manage

our initial caseload, which will include conducting HRAs for all Enrollees within 90 days, or within 30 days if the Enrollee has been stratified to a higher risk level.

Table C.24-6 describes the staffing model including staff-to-Enrollee ratios, modes of interface, and use of care managers.

Table C.24-6. Staffing

Risk Level	Staffing Description
Level I Health Promotion and Wellness	Our health educators, Enrollee Engagement and Community Engagement specialists, and customer service representatives will help Enrollees who are in good health and may simply have a question about access to care or similar needs or Enrollees with low acuity risk factors that should be managed. • **Staff-to-Enrollee Ratio:** [redacted] • **Modes of Interface with Enrollees:** Targeted educational mailings (e.g., books about asthma management), outbound calls (e.g., EPSDT services reminders), inbound calls, Molina Mobile app and website, community events • **Use of Care Managers:** Care managers will assist with annual HRAs. If Enrollees have needs beyond the capability of our Call Center, care managers will be available to assist via warm transfer, including elevating the Enrollee to a higher level of care management.
Level II Management of Chronic Conditions	Education will remain a priority, and Enrollees will talk with care managers who complete condition-specific assessments and determine the additional assistance needed. • **Staff-to-Enrollee Ratio:** [redacted] • **Modes of Interface with Enrollees:** Telephone or face-to-face interactions with care manager or Molina Community Health Worker, two-way texting through Molina Mobile app, multidisciplinary care teams, Molina-sponsored group classes (e.g., diabetes management), educational mailings, inbound and outbound calls • **Use of Care Managers:** The care manager will administer the Enrollee Needs Assessment and work with Enrollee/guardian to create the care plan. The care manager will serve as the nexus of the multidisciplinary care team defined in the care plan. Furthermore, HRAs and Enrollee Needs Assessments will be conducted at least annually, or sooner after a health event or a change in health status.
Level III Complex Care Management	Care managers, including specialist ToC coaches if a hospitalization for physical or behavioral health reasons occurs, will help Enrollees regain functional capacity. Molina's in-house Behavioral Health team will help provide solutions in an effective manner that respects the Enrollee's preferences. Housing support specialists will help Enrollees who are homeless or at risk, and peer support specialists will help those who are in SUD recovery. • **Staff-to-Enrollee Ratio:** [redacted] • **Modes of Interface with Enrollees:** Face-to-face and telephone interactions; for instance, ToC coaches will meet with Enrollees during a hospital stay and three times in the 14 days after discharge. Enrollees/guardians and providers will be strongly encouraged to attend multidisciplinary team meetings with Molina staff and identified community resources (e.g., social workers). Housing support specialists and peer support specialists will travel to meet Enrollees as needed. • **Use of Care Managers:** The care manager/ToC coach will ensure medication reconciliation, identification of behavioral health needs, and determination of available benefits and resources, whether covered by Molina or offered through another resource (e.g., LTSS carve-out). Care managers will facilitate post-discharge support such as scheduling follow-up appointments and securing delivery of durable medical equipment.

Risk Level	Staffing Description
Level IV Intensive Needs	At this level, Enrollees face deterioration of their mental health and/or physical health condition, and/or are at the end stage of a terminal illness. Care managers, Molina Community Health Workers, and other staff, including in-house Behavioral Health staff and palliative care experts, will also offer input. • **Staff-to-Enrollee Ratio:** [redacted] • **Modes of Interface with Enrollees:** Face-to-face and/or phone contact will occur at least weekly, but typically more frequently based on Enrollee need. A Molina Community Health Worker may make regularly scheduled in-home visits or accompany the Enrollee to a physician/provider office. • **Use of Care Managers:** Care managers will monitor the care plan and revise it as needed. They will contact providers to encourage participation in the multidisciplinary care team. They will pay particular attention to ensuring Enrollees receive home- and community-based services as needed.

a.iv.k. VBP and Other Incentives

We will actively recruit providers into our VBP program, with a particular emphasis on PCPs because of the importance of preventive health in our PHM program. Because providers are at varying levels of readiness to enter into such an agreement, we will offer a tiered structure that allows them to choose the appropriate arrangement based on their size, technology resources, and ability to use data to drive improvements. As they achieve gains in one arrangement, they will move forward in this continuum:

- **Pay-for-performance.** This arrangement will include initial engagement with fee-for-service providers. Financial incentives will be tied to key access, quality, and outcomes indicators. Moreover, this model will identify 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 as well as encourage provider adoption and use of EHRs.
- **Pay-for-quality.** This arrangement will include enhanced reimbursement opportunities tied to relevant HEDIS measures and will focus on providers investing in processes to drive better outcomes and lower costs. Additional financial incentives will be available for improved performance on utilization metrics with assigned Enrollees.
- **Patient-centered medical home (PCMH).** This arrangement will focus on providers who engage in team-based and integrated care coordination and will reward those who achieve NCQA, Joint Commission, or URAC PCMH accreditation 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.** This arrangement will include additional compensation for providers from a share in savings or risk resulting from improved care quality and outcomes (e.g., providers may be 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 will be able to progress into partial-/full-risk arrangements (e.g., the provider will be 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.

As a basic introduction to the VBP program, we will offer pay-for-performance incentives to providers who establish connectivity to the KHIE system, use EHRs, and participate in data exchange. We will also offer Enrollees a financial reward in the form of a $50 gift card each time they complete a follow-up visit with their PCP within 7 days of hospitalization for mental illness.

Our Physician Incentive Plan strategy will identify and address many of the Commonwealth's most immediate population health concerns by strategically aligning:

- HEDIS and other key quality and performance measures
- The Department's stated quality and healthcare outcomes priorities
- Key NCQA accreditation standards
- Molina's Quality Assurance and Performance Improvement program and related performance improvements projects (PIPs), special initiatives, and quality measures
- Proposed Enrollee incentives
- VBP model designs applicable to specific provider types

Table C.24-7 depicts the quality measures we will use to drive our VBP offerings; measures align with Department population health priorities:

Table C.24-7. VBP and Enrollee Incentive Quality Measures

DMS Priority Area	VBP Measure	Enrollee Incentive/Measure
Colorectal Cancer (Model Contract priority for PIPs)	Colorectal Cancer Screening (COL)	
Cervical Cancer Screening (Model Contract priority for PIPs)		Cervical Cancer Screening (CCS)
Obesity (Department for Public Health priority)	• Weight Assessment and Counseling for Nutrition and Physical Activity – BMI percentile documentation • Weight Assessment and Counseling for Nutrition and Physical Activity – counseling for nutrition • Weight Assessment and Counseling for Nutrition and Physical Activity – counseling for physical activity	• Well Child • WW Weight Watchers Program
Diabetes (Model Contract priority for PIPs)	• Comprehensive Diabetes Care – Eye Exam • Comprehensive Diabetes Care – HcA1c testing	• Comprehensive Diabetes Care – Eye exam (retinal) • Comprehensive Diabetes Care – HcA1c testing
Diabetes Medication Adherence (Department priority)	Statin Therapy for Patients with Diabetes (SPD) – statin adherence 80%	
Tobacco use cessation/prevention – adolescents (Department for Public Health priority)	Adolescent Well Care (AWC)	
Behavioral Health (Model Contract priority for PIPs)	• Follow-Up After Hospitalization for Mental Illness (FUH) – 7-day follow-up • Antidepressant Medication Management (AMM) – effective acute phase and effective continuation phase treatment	PCP Follow-Up within 7 days after inpatient hospitalization or behavioral health stay

We have reached an agreement with KPCA, the Commonwealth's largest independent practice association, to create an Accountable Care Entity partnership. This partnership aligns with our strategy nationwide to collaborate with the largest providers and provider groups to effect population health improvements. We will have VBP arrangements with KPCA, and we look forward to expanding the opportunity to all willing and qualified providers in the Commonwealth.

During VBP model development, we recommend scheduling regular meetings, preferably face-to-face and at least monthly, 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.

In 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.

a.iv.I. Methods to Evaluate Success

As we re-evaluate Kentucky Enrollees' health and areas for improvement every year based on our Population Needs Assessment, we will identify measures to evaluate the program's impact. Table C.24-8 details the interventions we will begin upon implementation, and the measures we will use to track performance and improvement, based on our knowledge of Kentucky's current health landscape:

Table C.24-8. Evaluating Success of PHM Program Services

PHM Program Component	Evaluation Measure
Flu Shot Educational Campaign	Flu shot rates using CAHPS survey data
Annual Health Education and/or Incentives	• HEDIS Adults' Access to Preventive/Ambulatory Health Services • HEDIS Children and Adolescents' Access to Primary Care Practitioners
Enrollee Education and Collaboration with Providers on Behavioral Health	Antidepressant Medication Management HEDIS measures
Behavioral Health ToC and Follow-up After Hospitalization	Follow-up after Hospitalization for Mental Illness HEDIS measures
ToC	Readmission rates using internal utilization data
Care Management	Admission, readmission, and ED rates using internal utilization data
Care management Level II (Management of Chronic Conditions) and Level III (Complex Care Management)	Survey of Enrollees on 1–10 scale rating care manager and care management program based on following categories: • Satisfaction with care manager • Helped Enrollee understand doctor's treatment plan • Helped Enrollee get needed care • Paid attention and helped with concerns • Treated Enrollee with respect • Enrollee's health improved as a result of work with care manager

Annually, we will conduct an analysis of Enrollee grievances and inquiries related to the program, and we will review HEDIS Effectiveness of Care measures and National Quality Forum measures for chronic illness to measure the clinical effectiveness of our care management programs.

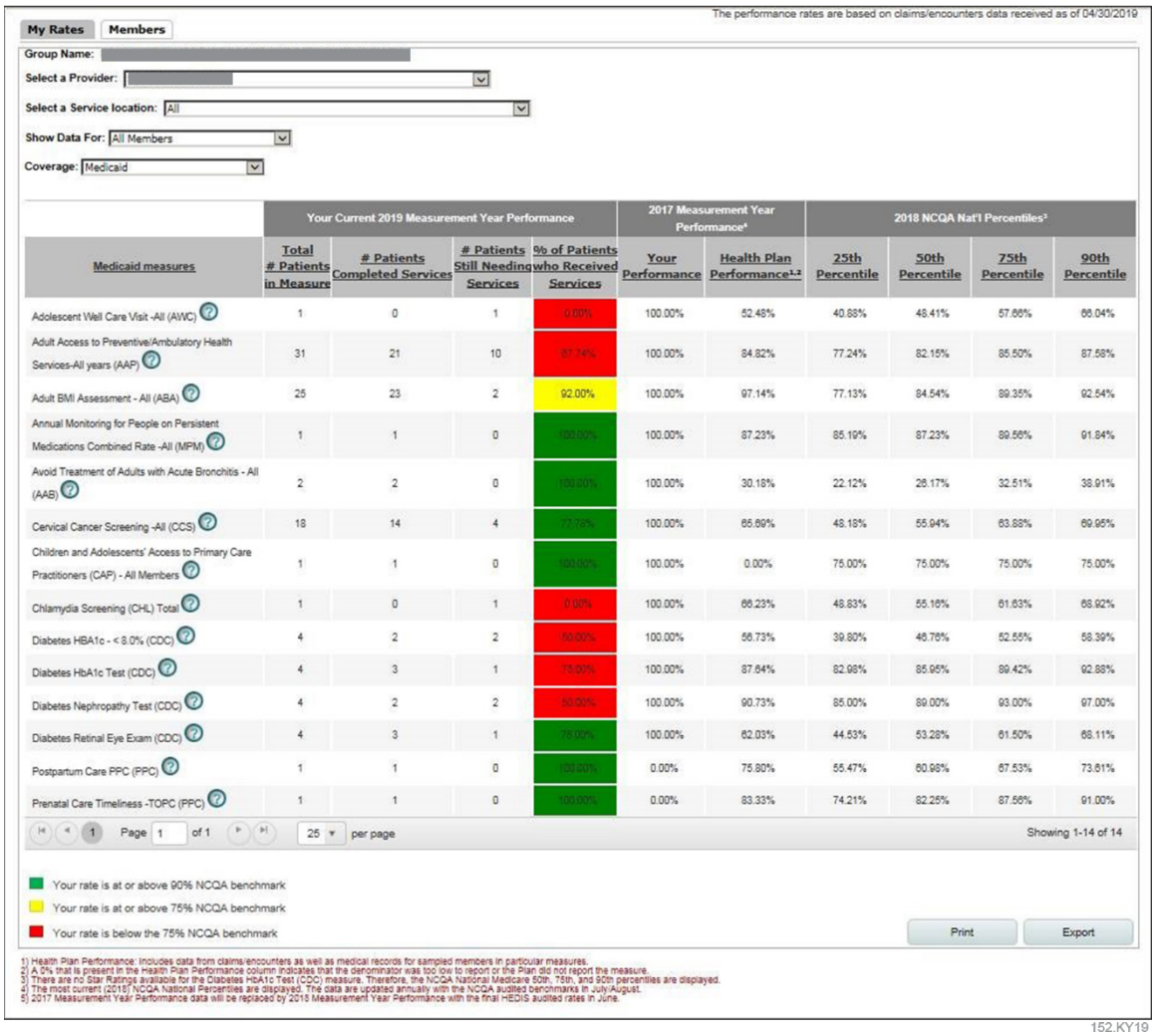
a.iv.m. Methods to Communicate and Coordinate with PCPs and Other Providers

Our care manager will take the lead in ensuring appropriate communication with providers, bringing together a support system to help our Enrollees achieve health goals and improve outcomes. With a deep understanding of the cultural impact on an Enrollee's care, we will work with our Enrollees and their providers (who are part of a multidisciplinary care team where applicable) to coordinate care and ensure they receive high-quality services from providers using evidence-based practices. We also will assist with scheduling timely appointments and educating Enrollees on healthy lifestyles.

The care manager will share care plan updates with providers based on individual needs and circumstances of the Enrollee and to address any interventions that require more formal or informal communication, such as holding a multidisciplinary care team meeting. Care managers also will monitor missed services and/or appointments and coordinate with PCPs, specialists, and other providers involved in the Enrollee's treatment plan, along with connecting Enrollees to additional providers or community-based resources as needed.

We will leverage our provider Web portal to facilitate information access and exchange. Through the Web portal, providers can view HEDIS scores to compare against national benchmarks and quickly identify Enrollees who have completed or are missing specific HEDIS measures. Reports will be generated to identify providers who are poor performers on preventive care or clusters of Enrollees who need the most preventive services. We will work with providers and Enrollees to coordinate interventions and follow-ups. Through analytic tools, we will measure HEDIS/EPSDT outcomes, gaps in care, and utilization trends to measure the efficacy of our preventive efforts.

Through the provider Web portal, we will offer a suite of data that enables providers to track their performance against their peers and in line with any incentive plans we offer. Exhibit C.24-10 shows our Provider Scorecard, a valuable tool in this effort.



The performance rates are based on claims/encounters data received as of 04/30/2019

My Rates | Members

Group Name:

Select a Provider:

Select a Service location: All

Show Data For: All Members

Coverage: Medicaid

Medicaid measures	Your Current 2019 Measurement Year Performance				2017 Measurement Year Performance[4]		2018 NCQA Nat'l Percentiles[3]			
	Total # Patients in Measure	# Patients Completed Services	# Patients Still Needing Services	% of Patients who Received Services	Your Performance	Health Plan Performance[1,2]	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Adolescent Well Care Visit -All (AWC)	1	0	1	0.00%	100.00%	52.48%	40.88%	48.41%	57.66%	66.04%
Adult Access to Preventive/Ambulatory Health Services-All years (AAP)	31	21	10	67.74%	100.00%	84.82%	77.24%	82.15%	85.50%	87.58%
Adult BMI Assessment - All (ABA)	25	23	2	92.00%	100.00%	97.14%	77.13%	84.54%	89.35%	92.54%
Annual Monitoring for People on Persistent Medications Combined Rate -All (MPM)	1	1	0	100.00%	100.00%	87.23%	85.19%	87.23%	89.56%	91.84%
Avoid Treatment of Adults with Acute Bronchitis - All (AAB)	2	2	0	100.00%	100.00%	30.18%	22.12%	26.17%	32.51%	38.91%
Cervical Cancer Screening -All (CCS)	18	14	4	77.78%	100.00%	66.69%	48.18%	55.94%	63.88%	69.95%
Children and Adolescents' Access to Primary Care Practitioners (CAP) - All Members	1	1	0	100.00%	100.00%	0.00%	75.00%	75.00%	75.00%	75.00%
Chlamydia Screening (CHL) Total	1	0	1	0.00%	100.00%	66.23%	48.83%	55.16%	61.63%	68.92%
Diabetes HBA1c - < 8.0% (CDC)	4	2	2	50.00%	100.00%	56.73%	39.80%	46.76%	52.55%	58.39%
Diabetes HbA1c Test (CDC)	4	3	1	75.00%	100.00%	87.64%	82.98%	85.95%	89.42%	92.88%
Diabetes Nephropathy Test (CDC)	4	2	2	50.00%	100.00%	90.73%	85.00%	89.00%	93.00%	97.00%
Diabetes Retinal Eye Exam (CDC)	4	3	1	75.00%	100.00%	62.03%	44.53%	53.28%	61.50%	68.11%
Postpartum Care PPC (PPC)	1	1	0	100.00%	0.00%	75.80%	55.47%	60.98%	67.53%	73.61%
Prenatal Care Timeliness -TOPC (PPC)	1	1	0	100.00%	0.00%	83.33%	74.21%	82.25%	87.56%	91.00%

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Your rate is at or above 90% NCQA benchmark
Your rate is at or above 75% NCQA benchmark
Your rate is below the 75% NCQA benchmark

Print | Export

1) Health Plan Performance: Includes data from claims/encounters as well as medical records for sampled members in particular measures.
2) A 0% that is present in the Health Plan Performance column indicates that the denominator was too low to report or the Plan did not report the measure.
3) There are no Star Ratings available for the Diabetes HbA1c Test (CDC) measure. Therefore, the NCQA National Medicare 50th, 75th, and 90th percentiles are displayed.
4) The most current (2018) NCQA National Percentiles are displayed. The data are updated annually with the NCQA audited benchmarks in July/August.
5) 2017 Measurement Year Performance data will be replaced by 2018 Measurement Year Performance with the final HEDIS audited rates in June.

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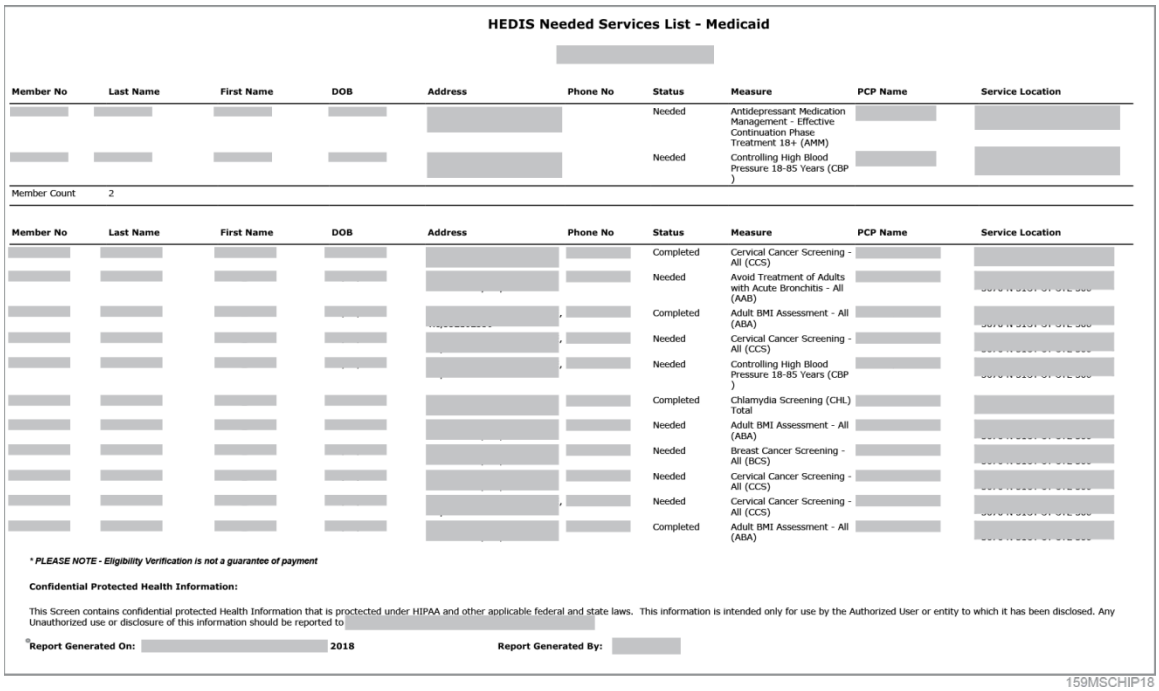
Exhibit C.24-10. Provider Scorecard

The monthly scorecard will measure performance on key clinical measures. Providers can easily see their performance in the current year versus last year and their current performance on HEDIS measures.

Other reports will highlight Enrollees who are likely to benefit from provider outreach and more active engagement.

Exhibit C.24-11 is an example of the HEDIS Gaps in Care report, which will show Enrollees who have missed needed services. Exhibit C.24-12 is an example of a report showing which Enrollees have been admitted to a hospital or visited an ED. Both reports will be updated monthly.



HEDIS Needed Services List - Medicaid

Member No	Last Name	First Name	DOB	Address	Phone No	Status	Measure	PCP Name	Service Location
						Needed	Antidepressant Medication Management - Effective Continuation Phase Treatment 18+ (AMM)		
						Needed	Controlling High Blood Pressure 18-85 Years (CBP)		

Member Count 2

Member No	Last Name	First Name	DOB	Address	Phone No	Status	Measure	PCP Name	Service Location
						Completed	Cervical Cancer Screening - All (CCS)		
						Needed	Avoid Treatment of Adults with Acute Bronchitis - All (AAB)		
						Completed	Adult BMI Assessment - All (ABA)		
						Needed	Cervical Cancer Screening - All (CCS)		
						Needed	Controlling High Blood Pressure 18-85 Years (CBP)		
						Completed	Chlamydia Screening (CHL) Total		
						Needed	Adult BMI Assessment - All (ABA)		
						Needed	Breast Cancer Screening - All (BCS)		
						Needed	Cervical Cancer Screening - All (CCS)		
						Needed	Cervical Cancer Screening - All (CCS)		
						Completed	Adult BMI Assessment - All (ABA)		

** PLEASE NOTE - Eligibility Verification is not a guarantee of payment*

Confidential Protected Health Information:

This Screen contains confidential protected Health Information that is proctected under HIPAA and other applicable federal and state laws. This information is intended only for use by the Authorized User or entity to which it has been disclosed. Any Unauthorized use or disclosure of this information should be reported to

Report Generated On: 2018 **Report Generated By:**

159MSCHIP18

Exhibit C.24-11. HEDIS Gaps in Care Report

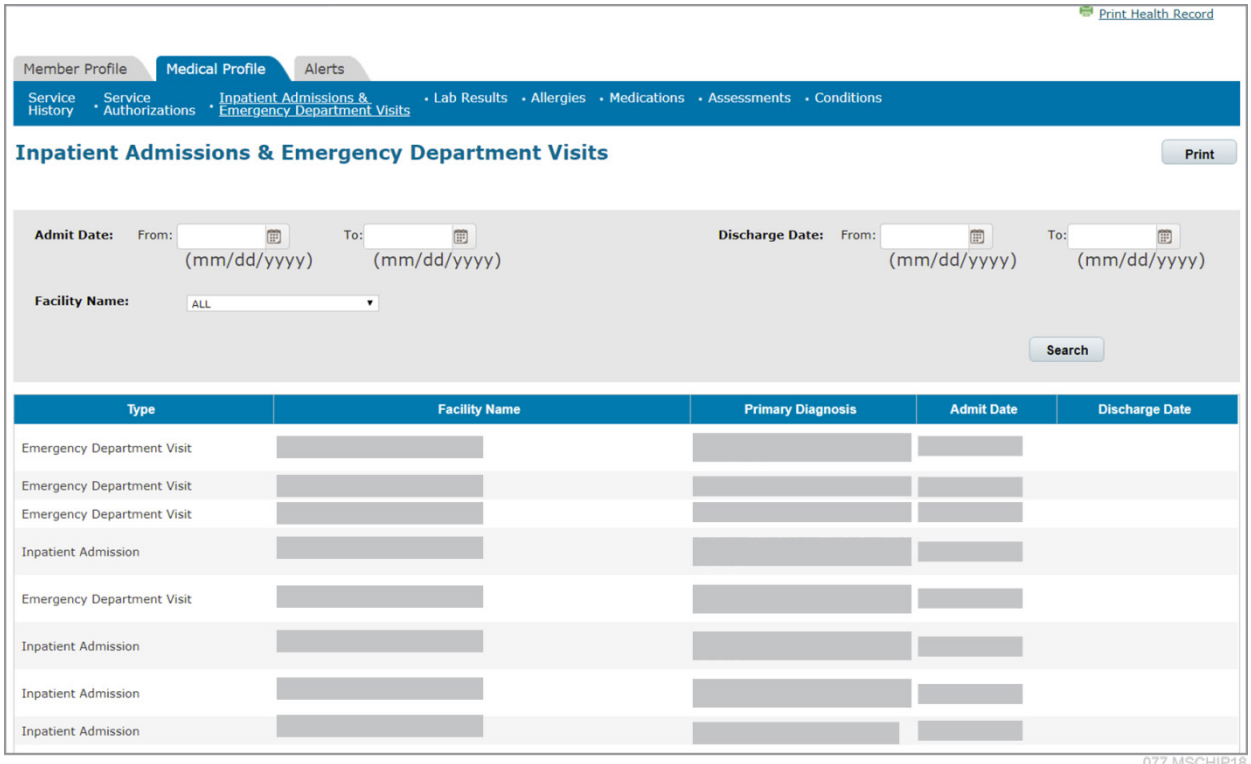


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Exhibit C.24-12. Inpatient Admissions and ED Visits

Care managers will maintain contact with the Enrollee/caregiver and providers on an ongoing basis by using the tasking function in our electronic care management platform. The care manager also will use this tasking function to maintain regular multidisciplinary care team meetings, with appropriate plan leadership and the medical director as needed, to evaluate the feasibility of the treatment plan and the Enrollee's progress toward his or her goals.

a.iv.n. Role of KHIE in Molina PHM Program

Population health management relies on data to drive improvements, and we understand that no single entity can deliver all the data required to make a positive impact. ***Molina fully embraces the opportunity to collaborate with the Commonwealth and to take a leadership role in developing the next phase of KHIE,*** the Commonwealth's effort to offer a comprehensive patient health record and share data to improve population health. For example, our affiliated health plan in Mississippi is a leading participant and key design contributor to the state's HIE, partnering with the state on a virtual, real-time exchange that helps the state gain insight into how therapies affect health outcomes and the cost of care.

We envision great growth potential in KHIE. For instance, because identification and risk stratification depend on claims data, we will face up to a six-month delay in stratifying new Enrollees. Some states can provide data on Enrollees when they move from another MCO. If KHIE develops this ability, it would benefit Enrollees who might need a higher level of care management but whose HRAs and utilization do not indicate that.

We intend to establish partnerships with KHIE and local and regional hospital systems to educate providers about adopting EHR. Part of our strategy is offering an incentive plan for providers who join us and KHIE. To increase participation, especially among rural providers, ***Molina will incentivize providers not currently on an EHR 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 have a history of collaboration with states and other MCOs to promote data exchanges:

- Our Washington affiliate was one of five MCOs that collaborated with the state to create Emergency Department Information Exchange software that helps to preempt unnecessary ED visits. ***The state saw a nearly 10% reduction in ED visits and $34 million in savings in the first year.***
- In 2018, our Illinois affiliate led the effort among nine MCOs to create a universal roster template that enabled providers to be credentialed with one form instead of having to submit nine different applications. ***This reduced the time needed to load providers into the system from 60 days to 30 days*** and also reduced billing errors.

v. COORDINATION WITH OTHER AUTHORIZED PROVIDERS

We will take a holistic approach to ensure effective coordination between our care managers, provider partners, CBOs, and authorized providers.

Using our HRA, which includes questions about social determinants of health, we will identify potential needs that can be addressed through partnerships with authorized providers and other partners that provide those services. As part of the care plan developed in response to these assessments, we will identify services and organizations to connect with our Enrollees, such as WIC; Kentucky's HANDS; Head Start; First Steps; school-based services; the Department of Community Based Services; the Department for Behavioral Health, Developmental and Intellectual Disabilities; the Department for Public Health; and the Kentucky Transportation Cabinet Office of Transportation Delivery.

In addition, we will coordinate with and refer Enrollees for additional supports through our partner CBOs such as Goodwill Industries, United Way, Home of the Innocents, the Louisville Urban League, Audubon Area Community Services, and affiliates of the Feeding Kentucky network of food banks (Dare to Care, Kentucky's Heartland, and God's Pantry Food Bank).

Creative Collaborations

Our Ohio affiliate is a Navigation Partner with CBOs in Cleveland and Cincinnati through CMS' Accountable Health Communities initiative. Molina care managers interview individuals who have screened positive for health-related social needs (e.g., housing, transportation), develop an action plan to address the need, and follow up to see the need is filled

In our California affiliate, a woman in the High-Risk OB program faced a domestic violence crisis. A Molina Community Health Worker helped her obtain a protective order against her abuser, assisting with the initial request and accompanying her to all court hearings.

We will hire care managers and Molina Community Health Workers from local Kentucky communities who have knowledge of relevant programs and community partnerships that may be of assistance to our Enrollees. Based upon identified needs, our staff will refer eligible Enrollees to available programs and help them fill out applications if needed. Our training for these positions will include Kentucky-specific information on state and local agencies that provide non-emergency medical transportation in the Commonwealth.

WIC, SNAP, HEAD START, FIRST STEPS, AND SCHOOL-BASED SERVICES

Molina understands that health begins even before birth, and we are committed to making sure all Kentucky children receive high-quality care and support. To further that effort, we will use our HRAs to screen for social determinants of health and possible need for other resources for care/services. Through these and other assessments, we will identify parents and children who might benefit from relevant programs. We will inform them of the programs and provide necessary support for applications. Throughout each child's life, we will make referrals and follow up to verify whether they are receiving services. Our education and monitoring will begin as early as pregnancy, when we will advise women of nutrition programs such as WIC and SNAP. During in-home postpartum visits by our Care Connections team of nurse practitioners, we also will instruct and support mothers in applying for WIC and other relevant programs. Throughout Enrollees' childhoods, we will connect them to the following age-appropriate resources as needed:

- **Birth:** Mom and baby/infant nutrition, referral to the Department for Public Health
- **0–3 years old:** Early Head Start (Department for Community Based Services) and First Steps (Department for Public Health) for early intervention for children with developmental delays
- **3–4 years old:** Head Start
- **3–21 years old:** School-based services (Department of Medicaid Services) through our network providers, or through school personnel for children who have an individualized education plan

In looking specifically at food needs, we will comply with Section 1902(a)(11)(C) of the Social Security Act requiring coordination between Medicaid MCOs and WIC. We will refer potentially eligible women, infants, and children to the WIC program, and if requested by WIC agencies and permitted by law, we will supply information including:

- Nutrition-related metabolic diseases
- Diabetes
- Low birth weight
- Failure to thrive
- Premature birth
- Infants of mothers with an SUD or other drug addiction
- Developmental disabilities or intellectual disabilities
- AIDS
- Allergy or intolerance that affects nutritional status and anemia

For all our affiliated health plans, it is standard procedure for our care managers to notify pregnant women of nutrition programs such as WIC and SNAP both during pregnancy and at the postpartum visit.

DEPARTMENT OF COMMUNITY BASED SERVICES

Our organization has a track record of collaboration with state partners in all our affiliated health plans, and we look forward to building a similar relationship with the Department for Community Based Services and other Commonwealth agencies. Molina One-Stop Help Centers throughout the Commonwealth will serve as a resource center for Enrollees, and these sites can be made available for events to promote the needs of Enrollees. Through HRAs and our care managers and Molina Community Health Workers, we will refer individuals to Department for Community Based Services who may be eligible for food assistance or other social services. Our Molina Community Health Workers will be strong advocates for Enrollees to access needed services from both Commonwealth social service agencies and community-based resource providers. Our staff will collaborate directly with these agencies and organizations.

DEPARTMENT FOR BEHAVIORAL HEALTH, DEVELOPMENTAL AND INTELLECTUAL DISABILITIES

Molina will build a strong partnership with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). Given the importance of the shared goal of DBHDID and the Department for Medicaid Services to promote a DBHDID/Medicaid service delivery system that promotes evidence-based best practices, Molina proposes monthly meetings in addition to the quarterly meetings required in the Draft Contract. Rather than meet individually, we recommend that all MCOs meet jointly with the departments, to better facilitate the Commonwealth's goals of minimizing provider abrasion and enhancing continuity among MCOs. This model follows our experience in other states. We place high importance on frequent meetings to ensure open and collaborative communication and facilitate local community engagement activities and clinical consultations with behavioral health provider groups.

During a 2019 meeting with DBHDID, Molina discussed topics such as expanding the continuum of care opportunities for people with serious mental illness; partnering more closely with plans around specific services such as crisis services; and using data to drive policy and VBP opportunities. In addition, as described above, we will fully synergize our SUD Model of Care with the Kentucky Opioid Response Effort. We look forward to continuing discussions on these and other topics and bringing all MCOs together.

OFFICE OF TRANSPORTATION DELIVERY

We will coordinate and communicate with the Office of Transportation Delivery to enable eligible Enrollees to access non-emergency transportation through the Human Services Transportation Delivery program. Our customer service representatives and care managers will be trained on the Commonwealth's eligibility requirements to access these services, and we will screen Enrollees to ensure they meet these requirements before we make a referral. The Enrollee Handbook will include phone numbers and websites for Enrollees to contact transportation brokers or the Kentucky Medicaid office.

DEPARTMENT OF WORKFORCE INVESTMENT

As part of our multi-pronged staffing approach, Molina has reached out to the Kentucky Education and Workforce Development Cabinet's Department of Workforce Investment and its Career Development Office for guidance and assistance in building our health plan staff. Our goal will be to fill these positions with people who reside in, understand, and reflect the communities they support across the Commonwealth. Working with Department of Workforce Investment staff specializing in the healthcare field and the Kentucky Career Centers located across the Commonwealth, we will take advantage of their specialized services, such as the job posting portal "Focus Talent" to post job announcements and descriptions and search resumes for qualified candidates. We also will participate in Kentucky Career Centers' career fairs to meet face-to-face with candidates, and we will promote these and other career fairs to Enrollees who have been identified as unemployed or underemployed.

DEPARTMENT FOR PUBLIC HEALTH

Our organization is an enthusiastic partner with the state in all our affiliated health plans, and we will be in Kentucky as well. We have studied the Department's programs and have relevant experience in key areas of focus. As one example, the Commonwealth is promoting breast and cervical cancer screening. In 2017, our South Carolina affiliate joined other MCOs, along with survivors and leaders from cancer advocacy groups, on the steps of the Statehouse for "SC United in Teal & White," a rally to promote early screening efforts for cervical cancer. As part of this effort, Molina helped providers schedule 111 screening appointments, and the Community Engagement team staged "Teal & White" celebrations at several practices.

We will offer similar experiences and share the Department's goals for its programs addressing diabetes, early childhood health (HANDS), and tobacco and smoking cessation. Notably, as the Commonwealth attempts to expand Syringe Services programs and encounters opposition in some areas, Molina's Community Engagement team can participate in education efforts with the shared goal of extending this important harm-reduction measure to all counties.

We understand that local health departments work independently, and we will seek opportunities to partner with those departments to address their top health priorities.

KENTUCKY HOUSING CORPORATION

Our housing assistance specialists will live in Kentucky, be knowledgeable on all current housing resources throughout the Commonwealth, and make a point of engaging the Commonwealth's housing agency to learn about new and ongoing programs and opportunities for our Enrollees. We have identified this as an important social determinant of health for our neediest Enrollees, and we are committed to finding unique solutions.

CBO PARTNERSHIPS

Our community partner strategy begins long before contract execution and is entirely focused on the populations we will serve. Care managers will work with Enrollees and their caregivers during the comprehensive assessment process to identify areas of need as well as life goals (e.g., employment, housing). Based on those needs and goals, and applying their knowledge of the Enrollee's community, the care manager can provide one or more options for CBOs that will become an integral part of that Enrollee's care plan and oftentimes, with the Enrollee's direction, can become a participant in the

multidisciplinary care team. We will continue to address our Enrollees' needs with creative CBO partnerships. Our current partnerships include:

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

- Additionally, coordinating care for special needs or vulnerable populations requires forging resilient community-based partnerships to meet their health needs. These relationships form a community support structure that enables sufficient access and delivery of health services and supports, promotes quality of care, and strengthens the entire community in which the population resides.

vi. ONGOING REVIEW OF PHM PROGRAM

We will measure service and program outcomes to identify progress toward person-centered and population health goals using a combination of innovative tools for tracking and trending. We will solicit feedback from various sources, including our regionally based Quality and Member Access Committees and Provider Advisory Workgroups, on our PHM program and how we can improve health outcomes.

We will report these results internally to our QI Committee. We will work with the Department to develop a comprehensive set of measures to collect, analyze, and report on program success.

Based on our experience, we propose reporting program measures at least monthly to ensure Molina and the Commonwealth recognize emerging trends and can create interventions proactively. In addition, we support the possibility of real-time measurement in the Commonwealth and have the technological capability to participate in such an effort. Our measures for the PHM program focus on a variety of domains for health and wellness including, at a minimum, the following measures:

- HEDIS data and Commonwealth-based or federally based performance measures for acute and behavioral health care
- CAHPS data
- ECHO behavioral health survey data
- Health Outcomes Survey data
- Qualified Health Plan Enrollee satisfaction survey data
- System performance indicators that address service coordination, family, and individual participation in provider-level decisions; the utilization of and outlays for various types of services and supports; cultural competency; and access to services
- Staff stability indicators that address the stability and competency of direct contact staff
- Family indicators that address how well the public system assists Enrollees and their families, and how satisfied those individuals and families are with the services

The data analytics from this exercise will drive our health education programs and interventions, give us insight into the social determinants of health that have the most significant impact, and keep us on track to help the Commonwealth achieve its population health outcome goals.