## C.29 Use Cases

**REQUIREMENT: RFP Section 60.7.C.29**
29. Use Cases
Submit the Vendor's response to the following use cases. The Department encourages the Vendor to provide a thorough response and suggest innovative ways to fulfill the requirements of this Contract.
The use cases represent hypothetical Kentucky Enrollees, families, Providers, or entities. Responses must include, at a minimum, the program and services listed within each use case, but the Vendor is not limited to responding only to those areas. The Vendor should include any limitations or exceptions to providing the programs and services listed.
The Vendor's response may include a detailed narratives, diagrams, exhibits, or detailed information specifically tailored for the Kentucky Medicaid managed care program to demonstrate its ability to meet or exceed requirements.

**Molina's evidence-based practices and more than 25 years of experience serving Medicaid members across the country guide our dedicated Care Management and Provider Services teams.**

Our comprehensive and agile care management approach and highly responsive Provider Services team set Molina apart among Medicaid MCOs. Government-sponsored healthcare is our only business; thus, ***our programs and operations are specifically designed to address the challenges facing the Medicaid population and our providers.***

In the following responses, each containing a maximum of six pages, we describe our approach to the following Use Cases:

**The Commonwealth's Use Cases highlight Molina's**

- Identification and response to urgent cases
- Enrollee-centric care management program
- Commitment to building strong relationships with providers

- A 30-year-old woman who recently discovered she is pregnant and faces challenges with depression, a substance use disorder (SUD), domestic violence, and housing insecurity. Early identification and active support from a care manager help address her living situation and her physical health and behavioral health needs.
- A 20-year-old woman whose blood sugar and blood pressure indicate she may be diabetic and hypertensive, and who wants to change her lifestyle but doesn't know how to take the right steps. Our Population Health Management program helps to educate her and build motivation to improve her nutrition and physical activity.
- A provider group that is experiencing difficulty achieving improvements under our two-year program to improve health outcomes by addressing social determinants. We commit to working with the provider group immediately on the most pressing issues and propose a collaboration with MCOs and practitioners throughout the Commonwealth for a long-term solution.

## C.29 Use Case 1

**REQUIREMENT: RFP Section**
USE CASE 1
Rhonda is a 30-year-old Enrollee who recently learned that she was pregnant after visiting the Emergency Room, by ambulance, with severe nausea and dehydration. She has a history of highrisk pregnancies. Of 5 pregnancies she has experienced one (1) live birth, three (3) miscarriages occurring early in the second trimester, and one (1) abortion in her teens. In addition to her history of complicated pregnancies she smokes a half pack of cigarettes per day and drinks approximately 2 -3 beers /week. During her pregnancies, Rhonda sporadically kept prenatal visits and had a history of noncompliance with routine care instructions.

Rhonda was shocked to learn that she was pregnant since she delivered a baby girl ten (10) months earlier. Her daughter, Amanda, was born at 32 weeks and was in the NICU for three (3) weeks. Amanda is feeding well and is steadily gaining weight. With that pregnancy, Rhonda experienced post-partum depression and was concerned whether she could care for Amanda. Rhonda's closet family is in Texas but visits are infrequent. She recently separated from an abusive partner who provides minimal financial and emotional support. Rhonda and Amanda sought safety in a family shelter on three (3) different occasions after her partner threatened to harm Amanda.

Rhonda became upset upon learning she was pregnant again and kept telling the ER nurse that it could not be true. She explained that she just moved out her apartment after splitting with her partner and was staying temporarily with friends. Rhonda does not have reliable transportation and often relies on friends to provide rides to the pediatrician and grocery shopping.

The ER nurse recommended that Rhonda talk with her OB/GYN and her MCO about her options. Rhonda's electronic medical record was updated and a referral was made to her OB/GYN.

Describe how the Vendor would address Rhonda's situation including a detailed description of prenatal programs and Quality Improvement Initiatives. At a minimum, address the following programs and services:
a. Applicable evidence-based Care Management practices;
b. High risk pregnancy initiatives;
c. Health Risk Assessment and Care Planning;
d. Environmental assessment;
e. Behavioral Health Services;
f. Family planning;

**Rhonda, 30 years old, Jefferson County, Kentucky**

| Care Management | Challenges |
|---|---|
| Level III (Complex Care Management) | **Physical:** Difficult pregnancy and history of miscarriages<br>**Behavioral:** History of postpartum depression, abusive relationship, smoking, alcohol use<br>**Social Determinants:** Unstable housing, no transportation, limited finances |

Rhonda faces crises for herself and the baby she recently learned she is carrying. Michelle, a Molina High-Risk OB program care manager, is alerted of Rhonda's recent emergency department (ED) visit via a daily update alert from Lucina Analytics, our Kentucky-based contracted pregnancy identification and risk-stratification analytics specialist. Michelle prepares for outreach by reviewing Rhonda's historical data, during which she identifies Rhonda's inconsistent prenatal care during her previous pregnancy and a prior NICU stay for her baby, Amanda.

## 1.a. EVIDENCED-BASED PRACTICES FOR CARE MANAGEMENT

Rhonda is confused about her life's direction. Her pregnancy with Amanda was difficult and led to postpartum depression. Later, she and Amanda fled from home because of an abusive partner. She has been drinking alcohol and smoking. When Michelle reaches out to her, Rhonda is not prepared to make informed and confident decisions.

Care managers, such as Michelle, are connections for Enrollees like Rhonda, linking them to medical care and community resources. These efforts contribute to better care, reduced costs, and healthier Enrollees. It is imperative to identify Enrollees such as Rhonda quickly to allow for early coordination and intervention and to empower Rhonda to take charge of her health.

Our care model will include processes to identify Enrollees who may need assistance with managing their care, through either data analysis or referrals. The care manager will use a holistic, person-centered assessment to identify each Enrollee's unique needs and preferences; support Enrollees in building an individual, goal-oriented care plan; guide Enrollees in understanding essential and available services and supports; coordinate provider collaboration with the Enrollee as the focus of the multidisciplinary care team's conversations; and follow up with the Enrollee and others within the multidisciplinary care team.

**Maternity Guideposts**

(Bold indicates those that apply to Rhonda)

- Behavioral health conditions in pregnancy
- Cervical insufficiency in pregnancy
- Diabetes in pregnancy
- **Domestic violence in pregnancy**
- ED overutilization in pregnancy
- **Healthy pregnancy**
- **History of preterm delivery**
- **Hyperemesis in pregnancy**
- Hypertension disorder in pregnancy
- Multiples (twins +)
- Pre-eclampsia and gestational hypertension
- **SUD in pregnancy**
- Teen pregnancy

Our care managers across the enterprise use industry-standard tools, including assessments nationally recognized as evidence-based practices, which have contributed to proven methods for increasing member attendance at medical appointments and compliance with maternity care instructions. We use multiple applications of evidence-based guidelines to promote collaborative care coordination and navigating transitions of care:

- Our ***clinical and maternity guideposts*** are fundamental components of our integrated care management approach, providing a roadmap for how our care managers will manage our Enrollees. These guideposts were created by Molina physicians to identify best practices for the management of chronic conditions most commonly addressed by care managers. The delivery and provision of coordinated member-centered services leverage our clinical guideposts and motivational

interviewing, are built off evidence-based practices, and align our care model with NCQA standards for population health. ***Michelle will use maternity guideposts as a tool to manage Rhonda's symptoms.*** We create our evidence-based materials using American College of Obstetricians and Gynecologists guidelines and standards.

- PHQ-2 and PHQ-9 initial and comprehensive depression screenings.
- CAGE-AID SUD screening.
- Edinburgh Postnatal Depression Scale screening.
- Motivational interviewing to identify Rhonda's priority goals and concerns, identify and address ambivalence, and strengthen personal motivation.
- Our care management process includes assessments, collaboration and communication, targeted interventions, and evaluation toward goals.

## 1.b. HIGH-RISK PREGNANCY INITIATIVES

Our High-Risk OB program focuses on the most medically challenging pregnancies, and care managers will be central to initiating referrals and identifying resources aligned with Rhonda's values and preferences. The primary goal will be to ensure both Rhonda and her unborn child are safe and healthy.

The 17P program provides progesterone therapy to those with a history of preterm delivery. We discuss possible use of 17P with pregnant women with a history of preterm delivery and work with their obstetrician to coordinate administration of the medication. Additionally, Michelle will partner with Rhonda's obstetrician to ensure that prental milestones are met in preparation for a healthy delivery.

The Mothers of Molina—MOM—program addresses difficulties some mothers like Rhonda face after giving birth. Through this program, a Molina nurse practitioner will meet Rhonda in her home within 3–8 weeks post-delivery. The visit will include a physical exam, depression screening, and information about community resources available to Rhonda, Amanda, and the new baby.

## 1.c. HEALTH RISK ASSESSMENT AND CARE PLANNING

Michelle, the High-Risk OB registered nurse care manager, contacts Rhonda by phone to introduce herself and explain the benefits of the High-Risk OB program. Michelle conducts a Health Risk Assessment including the PHQ-2 depression screening, which yields negative findings. Michelle completes the Maternity Care Management Assessment, using motivational interviewing techniques to encourage Rhonda to tell her story. Rhonda says she is looking into scheduling her first OB visit and wishes to deliver a healthy baby, and she knows she must stop smoking and drinking to achieve that goal. She says she left an abusive partner because he repeatedly threatened to hurt Amanda and often did not allow them to leave the home. Rhonda says she and Amanda, also a Molina Enrollee, are temporarily sleeping on her friend Sarah's couch. Michelle identifies multiple factors linked to a high-risk pregnancy including:

- Unplanned pregnancy
- Recent ED visit for severe nausea and vomiting
- History of preterm deliveries
- History of multiple failed pregnancies
- History of postpartum depression
- Current substance use (alcohol and tobacco)

She also faces challenges because of social determinants of health, including housing and food insecurity, domestic violence, lack of informal support, transportation, and financial difficulties.

Michelle invites Rhonda to participate in the High-Risk OB program. Together, they review the assessments and develop a care plan, with Rhonda's priorities as the primary consideration.

## Care Plan

### Rhonda's Priority Concerns

- Homelessness / housing instability
- Limited access to food
- Safety from abusive partner
- No transportation; limited finances
- Deliver a healthy baby

### Additional Identified Needs

History of postpartum depression | History of preterm delivery | Lack of informal support

## Interventions

- **Molina housing specialist assists** in finding permanent housing and applying for financial assistance for rent and utilities
- **Michelle helps Rhonda identify transportation resources** for food and medical appointments
- Rhonda receives written material about **Molina's Population Health Management smoking cessation program**
- **Michelle and Rhonda develop a crisis plan** to keep her and Amanda safe, including use of crisis hotline numbers
- Michelle **reports suspected abuse of Amanda to Child Protective Services**
- Rhonda participates in **Molina-sponsored community baby showers**
- Michelle helps Rhonda understand the benefits of and apply for **WIC and SNAP benefits**
- Michelle ensures Rhonda and Amanda have **access to healthy foods,** and Amanda is receiving timely EPSDT services

## Multidisciplinary Team

- PCP, OB specialist, and/or "group care" facilitator
- Behavioral health provider with trauma-informed care emphasis
- SUD navigator
- Commonwealth social worker
- Rhonda
- Michelle, CM
- Domestic violence support group facilitator
- Molina Community Health Worker
- Kentucky's HANDS / Head Start community worker

## Monitoring and Follow-up

Weekly contact to address Rhonda's needs:

- Educate on importance of prenatal visits, proper nutrition, and healthy weight gain during pregnancy
- Ensure Rhonda understands all OB recommendations and all her questions are answered
- Educate on management of nausea and vomiting during pregnancy
- Educate on urgent vs. emergent symptoms
  - **Urgent:** mild bleeding (spotting), mild discomfort, nausea, and vomiting—call Nurse Advice Line, care manager, or on-call OB
  - **Emergent:** signs of preterm labor, uncontrolled blood pressure, severe pain—call 911 or go to ED
- Educate on effects of alcohol and tobacco on fetus (premature birth, low birth weight, increased risk of developmental delays and substance use)
- Encourage preventive care with primary care provider (PCP), dentist, and vision provider

***Michelle will remain the primary contact for Rhonda throughout her pregnancy.*** With each contact, they review the care plan and progress toward Rhonda's goals. A Molina Community Health Worker, our "boots on the ground" representatives, will increase our face-to-face contact with Rhonda.

## 1.d. ENVIRONMENTAL ASSESSMENT

Michelle meets with Rhonda and her friend Sarah to discuss Rhonda's living situation. Sarah is supportive and says she understands Rhonda is in a difficult situation, especially as she flees from an abusive relationship. Sarah welcomes Rhonda and Amanda staying with her until Rhonda finds permanent housing. An environmental assessment is completed to ensure safety for Rhonda, Amanda, and the unborn child. ***Michelle consults with Molina's regional housing specialist,*** who checks with resources such as the Department, the Louisville Metro Housing Authority, Center for Women and Families, New Directions Housing, and domestic violence shelters for mother/infant care. Once Rhonda and her children transition from Sarah's home to a permanent home, a Molina Community Health Worker will conduct a follow-up face-to-face environmental assessment in the new home.

## 1.e. BEHAVIORAL HEALTH SERVICES

Michelle regularly consults with Molina's multidisciplinary team, including our staff psychiatrist, a behavioral health specialist, and a SUD navigator, ***all of whom provide behavioral health services in-house within our organization***. Improved behavioral health will enable Rhonda to better participate in healthcare decision-making, improving her compliance with ongoing healthcare needs and promoting self-management skills for long-term health.

Considering Rhonda's years of involvement with an abusive partner, Michelle collaborates with the behavioral health team to identify a behavioral health provider who specializes in trauma-informed care for further counseling.

To proactively confront Rhonda's history of postpartum depression, care plans include early education on recognizing the signs. Additionally, Michelle will complete the Edinburgh Postnatal Depression Scale within two weeks of delivery to screen for postpartum depression. Positive responses will be communicated with the OB provider immediately. ***Rhonda will also receive assistance from our Mothers of Molina program, where a nurse practitioner will provide a postpartum face-to-face visit with Rhonda*** within 3–8 weeks of delivery. This service has made a significant impact on reducing a health disparity at our affiliate plan in California, where the program accounted for an increase of 7 percentage points in women receiving postpartum care in 2018.

## 1.f. FAMILY PLANNING

Michelle encourages Rhonda to discuss birth control methods with her provider while pregnant, giving her time to consider long-term birth control and plan for a postpartum treatment decision. Michelle educates Rhonda on the concept of birth spacing and its benefits for the entire family.

The postpartum exam can be optimal timing for contraceptive counseling and intervention; the insertion of long-acting reversible contraceptive devices is something for Rhonda to consider. This can happen for patients while they are still hospitalized in the postpartum period (either in the delivery room or in the postpartum phase) and has been demonstrated to be markedly effective. Michelle and the doctor counsel Rhonda about this possibility.

## 1.g. ENROLLEE AND FAMILY ENGAGEMENT

Michelle initially encourages Rhonda to call her family in Texas and update them on the situation; however, Rhonda says she does not think her family would be helpful. Sensing Rhonda's anxiety discussing the matter, Michelle honors Rhonda's preference and does not discuss it further. Instead, Michelle focuses on Rhonda and Amanda, with attention given to Sarah's role as a friend who provides emotional and practical support. While coordinating Rhonda's care, Michelle contacts Molina's EPSDT coordinator to verify if Amanda has received her well-child checkups and immunizations. Together, Michelle and Rhonda choose a PCP for Amanda, and she begins her preventive care.

A Molina Community Health Worker helps Rhonda identify legal aid resources as she seeks a protective order against her abusive partner. Michelle contacts Child Protective Services to report Rhonda's accounts of her ex-partner threatening harm to Amanda.

## 1.h. LINKAGE TO COMMUNITY RESOURCES AND SUPPORT

To help Rhonda build a support system in the absence of a large network of friends and family, Michelle leverages Commonwealth resources and community-based organizations (CBOs), including Molina partners. These resources include

**Kentucky's Health Access Nurturing Development Services (HANDS).** Michelle contacts the Department-run program to refer Rhonda, who receives a home visit that begins a regular schedule of counseling and education that will last for up to two years of the baby's life.

**Dare to Care.** To supplement Rhonda's WIC and SNAP benefits, Michelle directs her to Dare to Care, a Molina CBO partner that serves healthy food boxes to families in need.

**Early Head Start.** Amanda is eligible for the federally funded program, which provides education and enrichment opportunities in a day-care setting. This program would allow Amanda to develop her social and cognitive skills.

**Kentuckianaworks.org.** A Molina Community Health Worker helps Rhonda navigate the website for employment and training resources in hopes of supplementing her current income. With Amanda beginning Early Head Start, Rhonda has more hours available to work.

**Urban League and Family Scholar House.** Both Molina CBO partners provide counseling and training for individuals on a path to family-sustaining employment.

## 1.i. SOCIAL DETERMINANTS OF HEALTH

Although Rhonda's friend Sarah has provided a safe environment for the time being, Rhonda will need a more stable living situation for herself and her two children. The social determinants of health that are most affecting her are all linked. Table C.30-1 explains these social determinants and the solutions to each:

**Table C.30-1. Social Determinants of Health—Use Case 1**

| Rhonda's Challenge | Solution |
|---|---|
| Housing instability | Molina housing specialist helps Rhonda find permanent housing, reaching out to groups such as Volunteers of America and Louisville Metro Housing Authority |
| Limited finances | • Housing specialist helps Rhonda find financial assistance for rent and utilities<br>• CBO partnerships such as United Way and Family Scholar House provide job training and counseling toward self-sufficiency |
| Food insecurity | • Michelle and a Molina Community Health Worker work together to make sure Rhonda has applied for WIC and SNAP benefits<br>• They refer her to Dare to Care, a CBO that provides healthy food boxes to Enrollees who screen for poor food access / nutrition |
| Domestic violence | • Rhonda receives contact information for Center for Women and Families<br>• Michelle and Rhonda create domestic violence protocols to ensure Rhonda feels safe and has thought about how to contact someone if her ex-partner confronts her |
| Lack of social support | • Michelle links Rhonda to Kentucky's HANDS<br>• Michelle recommends a Centering Pregnancy provider, where Rhonda can receive support from other women in addition to medical care |

## 1.j. PROVIDER ENGAGEMENT

Michelle has listened as Rhonda discussed her lack of family and other support, and she suggests Rhonda consider an OB who offers Centering Pregnancy. In this form of care, the prenatal appointments are in a group setting that offers friendship and support from other women. The sessions include 15–30 minutes reserved for each woman to have a private appointment, including ultrasounds and lab tests as appropriate. Most of the session involves the provider leading the group discussion about a specific topic. Women take turns speaking and learn from each other's successes and challenges. Topics include pregnancy education, child care (such as the benefits of breastfeeding), stress-reduction techniques, and meditation/mindfulness. Rhonda is interested, so Michelle locates a network OB through University of Louisville Physicians who offers this service. Rhonda chooses this OB as her provider.

Michelle contacts the provider and figures out the Centering Pregnancy group schedule, which works for Rhonda. While on the phone, Michelle shares that Rhonda is in Molina's High-Risk OB program, and she had a preterm delivery less than a year ago. Michelle forwards a copy of Rhonda's care plan and her electronic medical records to the provider's office and invites the OB to join Rhonda's multidisciplinary care team. The OB agrees to be part of the team.

## 1.k. TRANSPORTATION

Though her friend Sarah is available to take Rhonda and Amanda to buy groceries and help with some additional tasks, her job leaves her unable to provide all needed transportation. Michelle, Rhonda, and Sarah work together to develop a schedule for Rhonda to buy groceries every other weekend. Michelle and Rhonda also identify two women who attend the same Centering Pregnancy program who have built strong relationships with Rhonda and have offered to give her a ride to and from the sessions.

For other medical transportation or as an alternative for the Centering Pregnancy sessions, Michelle refers Rhonda to Federated Transportation, the Commonwealth's contracted provider in Jefferson County. Although there are limitations to this service, such as that Rhonda cannot take Amanda with her, it could be a useful option in some circumstances.

## OUTCOMES

Rhonda is in her 37th week of gestation, continues to attend routine prenatal visits, and is on track to deliver a healthy baby boy. She has had no ED visits or hospitalizations in the past seven months. She and Amanda now live in an apartment, and the housing specialist has helped her apply for financial assistance with utilities. Our Molina Community Health Worker completed a follow-up environmental assessment to verify the home was safe for Rhonda and her children. Rhonda remains thankful to her friend Sarah for her ongoing support and has grown close to the other two women from the Centering Pregnancy program.

Rhonda has remained connected with Michelle throughout her pregnancy, and the two review Rhonda's progress at each contact. With the support of Rhonda's multidisciplinary care team and using the resources identified by the smoking cessation program—1-800-QUIT NOW and quitnowkentucky.org—Rhonda has not smoked or used alcohol for the past six months. To stay on track, Rhonda continues to participate in monthly counseling sessions.

If the baby needs to be admitted to the NICU, Rhonda will be assigned a NICU transition of care coach. The transition of care coach coordinates with the NICU facility's discharge planner to ensure Rhonda has received all applicable training(s); home health services have been ordered and authorized; and resources are in place. The transition of care coach completes a home safety assessment before discharge to identify any barriers and ensure readiness for discharge. After the baby goes home, the transition of care coach completes a series of follow-up assessments over the next 30 days, ensuring Rhonda has an action plan in place. The transition of care coach also assesses Rhonda's support system and monitors her emotional needs. Depending on ongoing needs, the baby will be assigned a pediatric care manager.

## C.29 Use Case 2

**REQUIREMENT: RFP Section**
USE CASE 2
Katy is a 20 year old female who is taking classes at a local community college while living at home with her mother to help take care of her younger brother. Katy's mother works two (2) jobs and has difficulty finding time to shop for and prepare healthy meals. Katy does not assist with grocery shopping or meal preparation. Katy is significantly overweight and rarely exercises. Most of her meals are from fast food restaurants and she only occasionally eats vegetables or fruit.

Recently, Katy became light headed after eating lunch and was taken to an urgent care center by a friend. The provider asked Katy about her symptoms and whether this has happened before. Katy stated that the dizziness happens frequently after meals and she is always thirsty. The provider asked Katy if she has diabetes and Katy stated she did not think so. She told the provider that she has not seen a doctor since she was in middle school. The nurse took Katy's vital signs and a blood glucose reading. Katy's blood glucose reading was elevated and her blood pressure was 162/90. Her BMI was computed to be 32.6. The provider recommended that Katy contact her MCO to find a PCP as soon as possible before her condition worsened and she ended up in the Emergency Room.

Katy contacted her MCO's Enrollee Call Center and explained her situation.

Describe the Vendor's Enrollee engagement process and Care Management. At a minimum, address the following:
a. Evidenced based practices for Care Management;
b. Health Risk Assessment and Care Planning and monitoring;
c. Provider engagement;
d. Cultural competency;
e. Patient engagement and education;
f. Community resources; and
g. Social determinants of health

**Katy, 20 years old, Perry County, Kentucky**

| Care Management | Challenges |
|---|---|
| Level I (Health Promotion and Wellness) | **Physical:** Weight management, signs of diabetes<br>**Behavioral:** She feels overwhelmed<br>**Social Determinants:** Poverty, few nutritious options |

Katy, a 20-year old female living in Perry County, has felt dizzy after meals and increasingly thirsty in recent weeks. During an urgent care visit, the doctor informs Katy that her blood pressure and blood glucose levels are elevated and recommends further follow-up with her PCP. Katy has not seen a PCP since she was in middle school and contacts Enrollee Services to locate a provider. The customer service representative assists Katy in identifying a provider and scheduling her first appointment. He also educates Katy on use of the Nurse Advice Line, care management, and the services offered to her through Molina's Population Health Management program. Katy is interested in learning more.

## 2.a. EVIDENCED-BASED PRACTICES FOR CARE MANAGEMENT

Poor nutrition begins the cycle of obesity and may lead to increased risk of colon cancer (lack of dietary fiber) and cardiovascular risks such as hypertension or vascular disease. These are all endpoints that result from the lack of early prevention. Molina helps Enrollees like Katy to make better life choices and break this cycle. Our goal is to keep Katy engaged and empower her to take charge of her healthcare.

Our **evidence-based practices and clinical guideposts** are core components of our integrated care model, giving us the roadmap for population health management. These practices and guideposts align our care model with the NCQA's population health management model, which emphasizes:

- Data integration
- Population segmentation
- Population assessment
- Targeted interventions
- Network practitioner and provider support
- Tracking and measurement

**Clinical Guideposts**

(Bold indicates those that apply to Katy)

- Asthma
- Coronary artery disease
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Depression
- **Diabetes**
- HIV
- **Hypertension**
- Personality disorder
- Schizophrenia

Before each outreach call to Katy, our care manager completes a pre-call review, which includes a 360-degree, whole-person review of documentation in various systems to familiarize herself with Katy's physical health and behavioral health conditions, utilization patterns, medications, psychosocial factors, potential gaps or barriers to care, demographic data, or changes in conditions. This review allows the care manager to have an overall picture of Katy's needs, provide meaningful and appropriate care management interventions, identify potential areas that may impact care, and implement and follow-up on items in the care plan.

Our clinical guideposts serve as tools for our care managers. The guideposts outline best practices for managing certain conditions, identify disease-specific needs, identify Enrollees' ability to self-manage conditions, and provide opportunities to address gaps in care, such as missed preventive visits or recommended flu shots, and member concerns. In Katy's situation, the care manager will use the hypertension guidepost as a tool to discuss an action plan for monitoring and managing blood pressure, as high blood pressure increases the risk of heart disease and stroke. Best practices include encouraging

medication adherence, a low-sodium diet, and increased physical activity. As a component of reducing high blood pressure, we also discuss the effects of obesity, which contributes to almost 20% of deaths in the United States. We educate Katy about calculating body mass index (or using an online calculator). If weight problems persist, she may need statins to manage obesity, hypertension, and diabetes.

During her Health Risk Assessment, Katy tells the care manager she sometimes feels overwhelmed because of her schedule at community college and her responsibility to take care of her brother. Because obesity is often linked to depression, a PHQ-2 depression screening is indicated.

During our new employee orientation and onboarding process, all care managers will be educated on using motivational interviewing techniques to identify and address ambivalence; build and strengthen the Enrollee's personal motivation; understand and meet the Enrollee where they are; and create a behavioral change while maintaining an atmosphere of acceptance, support, and compassion. We will listen to our Enrollees and change our conversational approach with the understanding that Enrollees who identify their internal motivations for change are more likely to be consistent and follow through with their identified personal goals.

## 2.b. HEALTH RISK ASSESSMENT AND CARE PLANNING AND MONITORING

While speaking with the customer service representative, Katy says she is concerned about her health and feels anxious about seeing a doctor. The representative informs her about the benefits of Molina care management, which provides Katy with a care team, collaborating and advocating on her behalf, to help better understand and manage her health concerns. Katy agrees to hear more about the program, and the representative provides a warm transfer to Nicole, a health manager/promoter with our Population Health Management Level I (Health Promotion and Wellness) team. Molina's Population Health Management program is an NCQA-aligned strategy that will emphasize education and preventive care to effect positive changes in Kentucky's greatest areas of need. Nicole introduces herself to Katy and reinforces the benefits of the Health Promotion and Wellness program. While speaking with Katy, Nicole quickly reviews available historical data and observes no PCP visits within the past five years. Nicole partially completes the Health Risk Assessment with Katy, who says she must leave for school and requests a call back next week after she sees her PCP.

Nicole follows up with Katy four days later to explore Katy's understanding of the outcome of the PCP visit. Katy says she visited the PCP and went for blood work, and the PCP informed her she has high blood pressure and prediabetes. "He gave me some blood pressure medicine and told me a lot of stuff about diabetes, but I don't remember," Katy says. "He wants me to do so much, and with everything on my plate, I honestly don't think I have time to keep up with everything he said."

Nicole finishes the Health Risk Assessment with Katy, and then administers condition-specific assessments for diabetes and hypertension. The PHQ-2 depression screening is negative for signs of underlying depression. Together, Nicole and Katy review the assessment findings and identify Katy's prioritized goals. Recognizing Katy's risk of non-adherence to PCP recommendations and that she says she feels overwhelmed, Nicole informs Katy she has recommended a higher level of care management to equip Katy with the tools, support, and education needed to self-manage her health. Together, Katy and Nicole review the assessments and develop the care plan. Nicole introduces Katy to Tom, a Level II (Management of Chronic Conditions) care manager, to assist Katy with ongoing care management needs and support Katy in meeting her identified goals.

## Care Plan

### Katy's Priority Concerns

**Short Term**

| | |
|---|---|
| "Control high blood pressure" | 1 Decrease blood pressure from 162/90 to 130/80 within 3 months |
| "Avoid becoming diabetic" | 1 Take all medications as ordered, and eat a diet low in salt, fat, and carbohydrates and high in fiber<br>2 Start a healthy lifestyle: Eat 2 healthy meals per day low in salt, fat, and carbohydrates and high in fiber; exercise 30–60 minutes 4 days per week<br>3 Lose weight: Lose 15 pounds in 3 months |

**Long Term**

| | |
|---|---|
| "Finish school" | Katy will attend all classes as scheduled and pass each class |

## Interventions

- Increase Katy's access to healthier food options, including referral to God's Pantry Food Bank, which prepares healthy food boxes
- Ask Katy to review Molina "Clear and Easy" booklets on diabetes and the Department's website for Diabetes Prevention and Control Program
- Educate Katy on managing high blood pressure, including medication adherence, timely follow-up with PCP, and lifestyle changes
- Educate Katy on diabetes prevention measures to slow or stop the progression from prediabetes to diabetes
- Offer Katy 13 weeks of membership in WW (Weight Watchers), a value-added service from Molina

## Multidisciplinary Team

Katy | Katy's mother | PCP | Tom, Care Manager | Molina Medical Director | Pharmacist | Molina Community Health Worker

## Referrals

- Refer Katy to a nutritionist who will educate her about how to do the following:
  - Read nutrition labels.
  - Cut out or greatly reduce salt consumption.
  - Identify healthy food choices when grocery shopping or eating out.
  - Create a meal plan to take the guesswork out of meal prep.
- Assist Katy, her little brother, and her mom in applying for the Child Care Assistance program through the Department.
- Refer Katy to the American Diabetes Association for approved health education for prediabetes and access to community resources.

## 2.c. PROVIDER ENGAGEMENT

Upon Katy's enrollment into care management, Molina notifies her PCP of her participation and solicits her PCP's input into care planning activities. Molina's Healthcare Services staff supporting Katy may contact Katy's providers for coordination of services, including appointment scheduling, referrals, information sharing, and, if warranted, for multidisciplinary care team meetings per Katy's preferences.

The provider Web portal also provides tools to identify gaps in care for Katy, including influenza vaccine, missing annual preventive visits, and, if she is diagnosed with diabetes, HEDIS gaps in Comprehensive Diabetic Care.

## 2.d. CULTURAL COMPETENCY

Molina aligns with all 15 Culturally and Linguistically Appropriate Services Office of Minority Health standards in healthcare to ensure all Enrollees who enter the healthcare system receive equal, quality, and effective treatment. With a deep understanding of how Enrollee care can be impacted by cultural considerations, we work with Enrollees, their providers, and other participants in the multidisciplinary care team to coordinate care in alignment with those cultural competency standards. We ensure Katy receives services from high-quality providers at the right place and at the right time. To ensure Katy's needs are met, we take into consideration her concepts on health and healing and her perception of her illness.

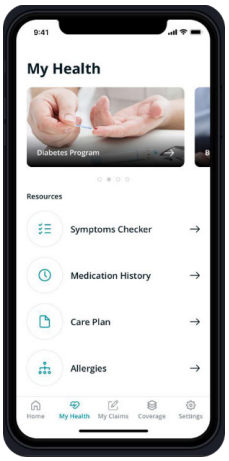
Currently, Katy is overwhelmed to learn about her new diagnosis of high blood pressure, and she also learns she is prediabetic. In assessing her understanding of her healthcare, Katy does not understand what she did wrong to get high blood pressure and prediabetes at such a young age. We work toward understanding her beliefs and values and understand she has strong family ties. She wishes to continue to pursue her education and support her mom with helping care for her younger brother. The care manager takes Katy's beliefs, preferences, and values into consideration to ensure all of Katy's needs are addressed appropriately and supported toward meeting her goals.

## 2.e. PATIENT ENGAGEMENT AND EDUCATION

Katy is an engaged Enrollee, recognizing her healthcare needs and willingly describing her challenges. Tom, our Level II care manager, capitalizes on Katy's willingness to commit to a healthier lifestyle. Katy attended her initial visit with her PCP but missed the follow-up visit two weeks later. Tom uses motivational interviewing techniques to provide an environment of acceptance and understanding for Katy. Tom provides reflective listening and conversational engagement to explore and resolve ambivalence and solicit self-motivational statements. Tom understands that drawing out Katy's internal motivations for change and allowing her to argue for the need to change makes her more likely to be consistent and committed to following through with her identified goals. Weekly contact in the early stages of the Management of Chronic Conditions program keeps Katy on track toward her goals. As she becomes more self-reliant, our outreach is less frequent, although we are available for her to call at any time.

With each contact, Tom and Katy review her progress toward achieving her goals. Tom educates Katy on the risks of uncontrolled blood pressure and informs Katy of benefits available to her, including a $25 gift card for completing an annual preventive screening visit and $50 for completing an annual preventive dental visit. Tom links Katy with a pharmacy that offers home delivery, eliminating a barrier for picking up medications. Tom also provides education on managing high blood pressure, including taking medications as prescribed and reinforcing PCP and nutritionist education on a heart-healthy diet. Tom encourages Katy to monitor her blood pressure daily, maintain a blood pressure log to monitor the effectiveness of her treatment, and show trends to her PCP during each visit. Tom verifies that Katy has a blood pressure cuff easily accessible at home. To assess her understanding of the education provided, Tom encourages Katy to teach back information received, such as identifying three ways to decrease

sodium intake, three foods high in sodium, or two reasons diet and exercise are important in the management of high blood pressure and prediabetes.




Working together, Tom and Katy recognize multiple stressors present in Katy's life. Katy is focused on completing higher education; she is newly diagnosed with hypertension and prediabetes; she helps care for her younger brother; and she has limited time for herself. To address these factors, Tom educates Katy on stress management techniques, including appropriate management of time, getting 5–8 hours of sleep every night, getting organized, and increasing physical activity. Tom praises Katy for carving out 30–60 minutes daily to increase physical activity by scheduling "play" time with her younger brother (e.g., riding a bike, jumping rope) and reinforces the benefits of daily exercise on her health and weight-loss goals.

Katy says she is receptive to communicating by text message and is informed about Molina Mobile, our newly enhanced mobile app. Katy can use the app to view her care plan and appointments, her medical history, and educational materials about diabetes, hypertension, and weight management. Molina Mobile also features two-way messaging between Enrollees and care managers. Katy occasionally messages Tom about small progress she has made, and Tom takes the opportunity to send quick, "Way to go!" or other positive reinforcement notes.

## 2.f. COMMUNITY RESOURCES

Tom connects Katy to local resources supporting her main health concern of healthy eating. This includes information about SNAP and an introduction to God's Pantry Food Bank and Feeding Kentucky. Molina and God's Pantry Food Bank will screen for food insecurity at health clinics and provide food boxes that address Enrollees' health needs.

Tom educates Katy on the Check, Change, Control tracker on the American Heart Association's website, so she can self-monitor and track blood pressure readings at home. The site offers more information on the risks of uncontrolled blood pressure and highlights lifestyle changes to improve her quality of life and decrease her risk of associated complications.

Tom reviews information and resources found in the Department's Diabetes Prevention and Control Program as part of the prediabetes education, including linking Katy with CDC-recognized diabetes prevention programs in Kentucky. Tom also assists Katy in gathering information passes for her and her brother to The Pavilion, a local fitness facility.

## 2.g. SOCIAL DETERMINANTS OF HEALTH

Katy is affected by several social determinants of health. She lives in rural Perry County, and access can be difficult both for healthcare and for healthy food options. Her family's finances are limited; she and her mother share a car, meaning it is not always available at her convenience. Many of her peers and others in the community have eating habits that can lead to poor health outcomes, so she must be vigilant to achieve her goals.

Table C.30-2 addresses the social determinants of health that affect Katy, as well as solutions:

**Table C.30-2. Social Determinants of Health—Use Case 2**

| Katy's Challenge | Solutions |
|---|---|
| Availability of resources to meet her needs | • Access to healthy food (God's Pantry Food Bank, Feeding Kentucky, education on grocery shopping and healthier restaurant options)<br>• Support and guidance to stay in college<br>• WW (Weight Watchers)<br>• Assist Katy's mother with link to child care assistance program |
| Access to healthcare services | • Educate on the use of urgent care clinics, telehealth, and calling the PCP and care manager to triage symptoms and move appointments up as needed<br>• Educate on use of the Nurse Advice Line |
| Health literacy | • Ensure that communications, whether written or spoken, are delivered in a manner that she can understand despite limited knowledge of her condition<br>• Use motivational interviewing to ensure that Katy knows about<br>– Reading prescription bottles and knowing how to take medications appropriately<br>– Provider recommendations post-visit<br>– Understanding the urgent and emergent symptoms of poorly controlled diabetes and high blood pressure, and having a plan of action to address each |

## OUTCOMES

Katy has participated in Level II care management for three months now. She checks her blood pressure at least three times a week and maintains a blood pressure log revealing blood pressure readings averaging 118/78–130/82 over the last month. Repeat lab testing last week also revealed an improvement in her prediabetes with a hemoglobin A1c decreasing to 6.0 from 6.3. The lab results also revealed normal renal functioning and an improvement in her triglyceride and cholesterol levels.

Katy has participated in WW (Weight Watchers) and has lost 11 pounds in the last three months, improving her body mass index from 32.6 to 30.7. She says she is pleased with her progress. She continues using the free Google Fit app to monitor her movement and track her goals using her Android phone's sensors and is excited to report her shirt sizes have gone down from a 2XL to an XL. She reports feeling more energetic and continues to receive praise from her family and others in the community.

To support her continued weight loss goals, better manage her high blood pressure and prediabetes, and ensure she also takes proactive measures to ensure her little brother remains healthy, Katy has continued to carve out 30–60 minutes every day to play with her little brother and get physically active together, including riding bikes, walking, jumping rope, and playing tag. She has also followed the nutritionist's meal plan outlined several times per week. Katy still eats from fast food chains 2–3 times per week but chooses healthier food options when eating out. She requests no added salt, avoids fried foods, chooses foods higher in dietary fiber, and eats salads or fruit in place of fries. Katy continues to attend classes and completes each assigned paper and test with a passing grade.

## C.29 Use Case 3

**REQUIREMENT: RFP Section**
USE CASE 3
The Vendor is implementing a two-year initiative to improve outcomes by addressing a variety of health behaviors (e.g., tobacco use and diet) and social determinants of health in the southeast region of Kentucky. The Vendor has enrolled several primary care and multi-specialty provider groups in the area to participate in the initiative and has developed relationships with various community agencies to support the effort. The Vendor has identified five (five) quality measures for which providers will receive incentives for meeting targeted improvements. The quality measures emphasize physical and behavioral health integration, social determinants of health, and critical community resources. The Vendor intends to make initial incentive payments 14 months after the start of the initiative. Six (6) months into the project, a multi-specialty provider group's Administrator met with the Vendor to discuss challenges the group is encountering with the initiative and to raise concerns about reporting. This provider group has 50 participating practitioners, including Advanced Practice Nurses, in four different locations. Specifically, challenges are as follows:
- Some practitioners in the group are very engaged while others are not interested in supporting the effort, indicating it is too complicated and administratively burdensome as the group is also participating with similar initiatives being implemented by the other contracted Medicaid MCOs, but that have different required measures.
- The provider group has a new electronic health record (EHR) system and experienced numerous onboarding issues that haven't yet been resolved. In addition, the provider group does not plan to contribute or retrieve information from KHIE until the EHR issues are resolved. The provider group does receive ADT data from Southeastern Kentucky Medical Center and the Baptist Health hospitals.
- The Administrator has made multiple attempts to outreach to a community housing agency that the MCO indicated is supporting the effort to discuss opportunities to collaborate; however, the agency has not returned calls.
- Enrollee compliance is lower than anticipated. Follow up and other outreach has been difficult due to Enrollees not returning calls and also incorrect Enrollee contact information.
- The Administrator is frustrated that the MCO had not provided feedback on the first set of required reports that were submitted three months after project initiation. Communication has been minimal and the Administrator is concerned about lack of support.

The Administrator and practice leadership are concerned with the extended timeframe for incentive payments and the ability to impact providers' behaviors.

Describe the Vendor's approach in addressing the Provider's concerns. At a minimum, address the following:
a. Provider engagement at local, regional, and statewide levels;
b. Provider education, communications, and support;
c. Simplification of provider administrative burden;
d. Enrollee engagement; and
e. Vendor assessment of internal operation challenges and mitigation strategies.

Molina has entered the Commonwealth in full support of the Department's goals of improving health outcomes by addressing lifestyle factors. We began a two-year initiative to achieve health improvements in southeast Kentucky, tying provider incentives to performance in five measures related to physical health and behavioral health integration, social determinants of health, and critical community resources.

The experience and barriers shared by the administrator and practice leadership are immediately escalated within Molina's Network leadership to address the specific concerns raised by the practice and establish a long-term partnership between the Molina and practice teams. A meeting at the practice is quickly scheduled to bring all key members of both teams together to discuss the issues, share best practices, brainstorm solutions, and establish relationships between the teams to aid in the success of the practice and this initiative.

***We know providers are the most vital link in our efforts to improve population health.*** Their concerns are our concerns, and our successes are their successes—which is why we launched the ***It Matters to Molina program***. As a key component of this program, we support this provider group with two Molina Network teams with different tasks but the same mission: make providers feel valued, provide individualized support, and evolve to true partnership between our providers and Molina.

**Provider services representatives** serve as the first point of contact. All providers receive a direct contact for a specific provider services representative specializing in their service type who communicates regularly with them, including visiting their offices when helpful to the provider. These representatives spend 80% of their time in the field, lead training and orientation sessions, and attend provider association

meetings and regional meetings. For a provider group of this size, our provider services representatives also hold a quarterly Joint Operating Committee meeting.

Our ***Provider Engagement Team*** works with providers who have value-based payment contracts. The team provides data and support aimed at helping providers achieve benchmarks and increase their incentive payments.

Despite these communication channels, our initiative is not going as well as we had hoped with this group, which because of its size and scope, plays a key role in our efforts to address Enrollee lifestyle factors and improve health outcomes in southeast Kentucky. During the meeting, and in anticipation of recommended next steps and solutions, we explain how we will address the providers' stated issues with solutions, though we will remain flexible to providers' changing needs.

## 3.a. PROVIDER ENGAGEMENT AT LOCAL, REGIONAL, AND STATEWIDE LEVELS

**Provider Issue #1**

Too complicated … other Medicaid MCOs have different required measures

**Molina Solution**

Create and lead a workgroup of all MCOs, with input from key providers, to standardize measures

The biggest obstacle to success, for both Molina and the provider group, is the inconsistency in measures reported across MCOs. In the short term, we pledge to work with the practice to provide useful tools and resources, based on their feedback, to bolster the practice's understanding and confidence in their ability to participate in this initiative.

From there, we host a roundtable discussion to get feedback from all providers. Other groups report that they face a similar issue. We follow up with other MCOs in the Commonwealth and determine that provider participation in similar initiatives is lower than expected. Molina offers to lead a Commonwealth-wide workgroup to set agreed-upon measures throughout the southeast region in consultation with key providers. We host meetings at our southeast regional office and appoint a member of our Provider Engagement team as the point person for this effort. An MCO-aligned program will include key elements to maximize adoption and success:

- Common metrics that have been agreed upon by all MCOs and provider stakeholders. They will include key indicators of population health, with an additional focus on the health and social needs of southeast Kentucky. Metrics will be vetted to ensure compliance with federal regulations.
- Standardized reporting across MCOs to allow providers to streamline their processes and bring more Enrollees into the population health management effort.

Our proposal to create a universal set of incentive measures is based on our belief in the NCQA Population Health Management model. Our strategy for accomplishing this task is based on similar projects in other states.

In Illinois, for years, providers were required to fill out separate applications to be credentialed by each of the nine MCOs in the State. In 2018, Molina led an MCO collaboration to create a Universal Roster Template. ***They worked with all MCOs to identify the essential elements that should be required; after building consensus and consulting providers and the state, we created the online application tool.*** Providers are now credentialed for all MCOs as soon as they complete the online application and receive approval from the state.

Our Illinois Provider Engagement team, which is the model for our team in Kentucky, created collaboration with and among providers. It specializes in targeted support with the goal of improving provider education through collaboration and incentives. The Illinois plan identified 11 facilities, serving a combined total of more than 100,000 of their members. These facilities all had high costs and low quality as determined by HEDIS and other measures. Our Illinois affiliate began quarterly meetings with each facility individually, discussing ideas to improve efficiency, reviewing results, and setting

expectations for the next quarter. In addition to education, they emphasized a pay-for-performance plan tied to quality benchmarks.

Providers have embraced the idea of partnership through the Provider Engagement team, and their willingness to share ideas has helped them improve the program for the entire group's benefit, with steps including:

- Sharing an ED opioid-reduction tool with all participating facilities.
- Observing an organizing a successful discharge planning process for behavioral health patients at one hospital, and then communicated those best practices to other hospitals.
- Reviewing vaccine promotion strategies at each facility and suggested an improved process incorporating the best ideas from each one; vaccination rates have improved in this group.

Their dialogue has also led to process improvements for Molina enterprise wide. Molina Healthcare of Illinois embedded care managers at each of the 11 initial facilities. These care managers partner with discharge planners and the facilities' care teams, coordinating follow-up care and scheduling appointments while members are still in the hospital. The presence of these care managers has led to increases in member satisfaction and decreased inpatient and ED admission rates, as shown in Table C.30-3.

**Table C.30-3. Molina Healthcare of Illinois Facility Utilization Reductions—Use Case 3**

| Facility | 2017 | 2018 | Difference | 2017 | 2018 | Difference |
|---|---|---|---|---|---|---|
| | Inpatient Admissions Per 1,000 Enrollees | | | Emergency Department Admissions Per 1,000 Enrollees | | |
| OSF | 152 | 126 | **-17.5%** | 819 | 791 | **-3.5%** |
| Heartland | 163 | 129 | **-20.9%** | 1,093 | 929 | **-15%** |
| Advocate | 101 | 90 | **-11%** | 654 | 656 | **+0.2%** |
| Carle | 1,459 | 1,055 | **-44.99%** | 262 | 144 | **-27.7%** |
| SIHF/Touchette | 1262 | 1,180 | **-14.48%** | 126 | 108 | **-6.5%** |

Providers in Kentucky agree to participate in this project with us—a testament to our efforts to build a presence throughout the Commonwealth. We place a high priority on meeting providers at their convenience. We attend all regional provider and association meetings, we host quarterly meetings of the Provider Advisory Council, we visit large provider groups and health systems at their offices to conduct training and open forums, and we host meetings at one of our six Molina One-Stop Help Centers located across Kentucky. Introducing ourselves to the Commonwealth was essential to our goal of building a successful health plan.

One of our most consistently successful methods of receiving feedback and making process improvements is ***It Matters to Molina*** program. Begun in 2014 in our affiliate plan in Ohio, this program engages providers through a variety of methods, including in-person meetings, phone dialogue, email, and comment cards, allowing providers to offer candid feedback and suggestions about our processes and our personnel. In Kentucky, we offer an expanded ***It Matters to Molina*** that includes monthly open forums via WebEx and face-to-face conversations and meeting at Molina One-Stop Help Centers. Providers in remote location can use this opportunity to ask any questions and offer suggestions for improvement.

## 3.b. PROVIDER EDUCATION, COMMUNICATIONS, AND SUPPORT

**Provider Issue #2**

Don't plan to contribute or retrieve information until electronic health record issues are resolved

**Molina Solution**

Leverage network relationships in Kentucky and elsewhere to find training resource for provider

Molina takes steps to help the practice through a difficult transition to electronic health records:

- The Molina provider services representative assigned to the group visits the practice and learns from the administrator and others what the key barriers are to completing the implementation.
- The Molina provider services representative contacts Molina colleagues and asks them to find other network providers in the Commonwealth who use this system and connects them to practices using the same electronic health records to share lessons learned and challenges.
- When we cannot locate a network provider in Kentucky that uses this system, we contact our affiliate plan in Ohio, which finds a network provider in the southern part of the state.
- Our provider services representatives in Kentucky and Ohio serve as go-betweens to set up a visit by the Kentucky provider's office staff for an information-sharing and training/Q&A session.

The Ohio group's offer of assistance is greatly appreciated by both the Kentucky group and by Molina. It is another example of the kind of collaboration we have achieved through our commitment to professional service and communication. In a similar example, in 2018, one provider in Mississippi allowed us to test our system linkages before implementation. This step was part of our testing strategy and helped to make sure our contracts were configured correctly, and we were ready to pay claims correctly. Because our provider services representatives had been in the field meeting with providers for months before the go-live date, we had earned the trust of this provider.

Our provider services representatives deliver comprehensive training and onboarding to all providers who join the Molina network. Training highlights include:

- New provider orientation and Molina provider Web portal training for both physical and behavioral health providers, ensuring that providers have the tools and knowledge to participate in the program and meet the needs of Enrollees
- Provision of an annual Behavioral Health Toolkit for providers that includes education, best practices, and support around management of common behavioral health conditions

Our provider services representatives continue to engage with providers as long as they are in the Molina network. All provider requests and inquiries must be answered within two business days. We serve as a go-between for providers as they encounter various departments within Molina and throughout the healthcare system.

Training is ongoing, and transparency is crucial. We heard from providers that they are not informed about correct coding edits and are frustrated when they do not know which edits are being applied. Our Ohio plan maintains a grid on the provider website that shows all correct coding edits in use for the health plan. We maintain a similar grid for our Kentucky providers.

## 3.c. SIMPLIFICATION OF PROVIDER ADMINISTRATIVE BURDEN

**Provider Issue #3**

The community housing agency hasn't returned our calls

**Molina Solution**

Assign provider services representative as lead in resolving issue, review agency's responsibilities, escalate to plan leadership if necessary

The practice's ability to engage with the community housing agency is a critical need for remediation. This issue is especially significant to Molina as it relates to Enrollees' housing security, a social determinant of health that we screen for and our care team makes a priority of addressing.

To ensure swift resolution of this agency's unresponsiveness:

- Molina assigns a lead provider services representative that works with the housing agency.
- Our lead provider services respresentative contacts the housing agency to understand reasons for their unresponsiveness and to review roles and responsibilities.
- The lead provider services representative convenes a meeting between the primary contacts at the housing agency and provider group to ensure a process is established/reinforced to ensure timely access to housing resources for the provider group.
- The lead provider services representative remains in regular contact with the primary contact at the provider group to ensure the situation is resolved.
- If the issue remains unresolved, the lead provider services representative escalates it to Molina leadership for further action with the housing agency, which may include an additional service-level agreement that specifies a maximum response time to the practice's inquiries, performance surveys completed by practices, a corrective action plan, and, if unsuccessful, engagement of a new housing agency.

Our provider services representatives, our Provider Engagement team, our embedded care managers, and the rest of our team continually observe provider operations and seek feedback on how we can help. Often, the matter is simple; in one California high-volume facility, we instituted a formal policy of not contacting hospital staff during certain afternoon hours because it is their busiest time of day.

Other measures have been far more significant:

- In California, our affiliate's Emergency Department Support Unit (EDSU) streamlined the authorization process to solve provider frustration with delays, denials, and disputes. ***Molina is the only MCO that has created a specific department to address this major provider issue.*** The EDSU involves a staff of nurses available by phone 24 hours a day, seven days a week specifically to communicate with providers about members in the ED and whether they should be admitted. When the program started, Molina Healthcare of California made two pledges to EDs: 1) They would always get a live voice on the phone when they called, and 2) the program would never increase administrative burden at any time. ***The EDSU has led to a 48% decrease in members returning to the ED within 30 days in the facility where they launched the pilot program in 2016.*** Other facilities report similar results. Based on this success, our California affiliate now offers EDSU support to every ED in the state, regardless of whether they are part of the contracted network or located in one of the regions they serve.
- In Washington, our affiliate collaborated with the other MCOs in the state on the Emergency Department Information Exchange. Using a vendor's software tool, Molina Healthcare of Washington configured their data to align with that of other MCOs. When a Medicaid member arrived in an ED, the program quickly searched the data to determine if the member had a history of inappropriate ED utilization. ***In the first year of the program, ED visits reduced by 10%, controlled substance prescriptions reduced by 24%, and the state saved $34 million.***

## 3.d. ENROLLEE ENGAGEMENT

Current contact information for Enrollees is a barrier not unique to Kentucky. Recognizing the critical need for accurate Enrollee information, Molina has launched a variety of solutions:

> **Provider Issue #4**
>
> Enrollees don't return calls, and their contact information is incorrect

> **Molina Solution**
>
> Leverage innovative enterprise-wide tools and staff deployment to find Enrollees and re-establish healthcare services

- **MOSAIC**, a tool developed by Molina, provides our customer service representatives with phone numbers from multiple sources—such as claims, pharmacy, PCP changes, subcontractor data—on one screen for primary and secondary contacts; aided by this tool, our affiliate plan in Ohio located 98.03% of its members.
- **The Enrollee Locator Team** mines data and contacts shelters, CBOs, and other locations to find high-risk/high-needs Enrollees.
- **Molina Community Health Workers**, our field-based team, search for Enrollees at the last known address and other sites Enrollees might frequent.

When we reach Enrollees, we remind them of the importance of follow-up and preventive care and offer to schedule appointments and coordinate transportation. We also offer incentives for the completion of some services, such as EPSDT.

## 3.e. ASSESSMENT OF INTERNAL OPERATIONS AND MITIGATION STRATEGIES

Molina understands the value of receiving and giving feedback, especially as an initiative is operationalized. In this case, we have a key responsibility to partner with practices to ensure the success of this initiative. In preparation for meeting with the practice, we share feedback on reports and discuss a plan for enhanced communication to ensure the practice has support throughout this initiative. The plan includes:

> **Provider Issue #5**
>
> The MCO has not provided feedback on reports … communication has been minimal

> **Molina Solution**
>
> Provider services representative and director meet regularly until provider group is satisfied with relationship

- A primary provider services representative contact for the practice who will coordinate with all Molina teams for the various components of the relationship, including this initiative
- The primary provider services representative and provider services director hold meetings at a regular and frequent cadence (recommending every two weeks) until the group is satisfied with the relationship, at which point the meeting frequency will be reduced to a mutually agreeable schedule
- Meetings will include a log of issues with updated status and action items
- The Provider Enagement team will visit offices for refresher training on the provider scorecard self-tracking tool and will establish a mechanism to share feedback on regular report submissions

The administrator accepts this action plan. After two months, the group is satisfied that we have repaired the relationship. During this two-month period, Molina surveyed other provider groups in the region to determine whether this problem was widespread. After soliciting feedback from dozens of providers, we conclude that this was an isolated incident. Our provider services director writes a memo to all staff emphasizing the importance of every relationship.

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