Public Version –
Technical Proposal






Proposal to the

State of Kansas

for the

KanCare Medicaid & CHIP Capitated Managed Care

Solicitation #: EVT0009267

Closing Date: January 4, 2024 by 2 p.m. CT

Submitted by:
Molina Healthcare of Kansas, Inc.

MOLINA® HEALTHCARE

Title Page

Public Version - Technical Proposal
RFP Number: EVT0009267
Due: January 4, 2024 by 2 p.m. CT

Molina Healthcare of Kansas, Inc.
Aaron Dunkel
Plan President
801 East Douglas,
2nd Floor, PMB # 2688,
Wichita, KS 67202
Tel: 785-631-0377

Table of Contents (Tab 1)

MOLINA HEALTHCARE

Table of Contents (Tab 1)

Transmittal Letter (Tab 2)

MOLINA HEALTHCARE

Aaron Dunkel
Plan President and Chief Executive Officer (CEO)
Molina Healthcare of Kansas, Inc.
801 E. Douglas Ave.,
Floor 2, PMB #2688
Wichita, KS 67202
aaron.dunkel@molinahealthcare.com
Tel: (785) 631-0377

January 4, 2024

Ms. Amanda Acuna
Kansas Department of Administration
Procurement and Contracts
900 SW Jackson, Suite 451-South
Topeka, KS 66612-1286
RE: KanCare Medicaid & CHIP Capitated Managed Care Request for Proposal (RFP # EVT0009267)

Dear Ms. Acuna,

On behalf of Molina Healthcare of Kansas, Inc. (Molina), I would like to thank you for the opportunity to submit a response to the KanCare Medicaid & CHIP Capitated Managed Care Request for Proposal (RFP # EVT0009267).

Per Section 4.3.C, Molina Healthcare of Kansas provides its response to requirements a. to l. below:

a. Molina Healthcare of Kansas, Inc. (Molina) is the prime Contractor. Molina identifies its Subcontractors as:
   - Molina Healthcare, Inc. (parent company)
   - CaremarkPCS Health, LLC (CVS Caremark®) (Pharmacy Benefit management)
   - MARCH® Vision Care (MARCH®) (Vision Benefit management)
   - MTM, Inc. (MTM) (Non-emergency Transportation management)
   - SKYGEN USA, LLC (SKYGEN®) (Dental Benefit management)

b. Molina attests that it is a corporation.

c. Molina attests that no attempt has been made or will be made to induce any other person or firm to submit or not to submit a proposal.

d. Molina attests that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or disability.

e. Molina attests that no cost or pricing information has been included in the transmittal letter or the technical proposal.

f. Molina accepts all provisions found in Attachment 7, Contractual Provisions Attachment DA-146a, which are incorporated by reference and made a part of this Contract.

g. Molina accepts all requirements, terms, and conditions of the RFP.

h. Molina attests it has no actual, apparent, or potential conflict of interest, direct or indirect, that would conflict with the performance of services under this Contract.

i. Molina attests that the person signing the proposal (Aaron Dunkel) is authorized to make decisions as to pricing quoted, and has not participated, and will not participate, in any action contrary to the above statements.

j. There is a reasonable probability that the bidder, Molina Healthcare of Kansas, Inc., will be assisted by our parent company, Molina Healthcare, Inc., in supplying services related to the performance of this Contract. A written certification and authorization from Molina Healthcare, Inc. granting the State and/or federal government the right to examine any directly pertinent books, documents, papers, and records involving such transactions related to the Contract is included in Appendix A § 4.3.C.1.j to our response.

k. Molina agrees that any lost or reduced federal matching money resulting from unacceptable performance in a Contractor task or responsibility defined in the RFP, Contract, or modification shall be accompanied by reductions in state payments to the Contractor.

l. Molina attests that it has not been retained, nor has it retained a person, to solicit or secure a state contract on an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the bidder for the purpose of securing business.

Per RFP § 3.3.7, Disclosure of Proprietary Information, Molina has provided detailed, written documentation in Appendix B § 4.3.5 to our response.

Sincerely,

Aaron Dunkel
Plan President and CEO,
Molina Healthcare of Kansas, Inc.

CERTIFICATION AND AUTHORIZATION

This Certification and Authorization ("Certification") is made by Molina Healthcare, Inc., a for profit Delaware corporation (Parent, hereinafter "MHI") for the benefit of Molina Healthcare of Kansas, Inc., a Kansas for profit corporation, which has applied for or holds a Certificate of Authority as a health maintenance organization (the "Plan").

MHI, in acknowledgement of its role supporting Molina Healthcare of Kansas, Inc. in supplying services related to the performance of the KanCare 2.0 Medicaid Managed Care contract, grants the State of Kansas, including the Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS) the right to examine any directly pertinent books, documents, papers, and records involving such transactions related to the KanCare 2.0 contract.

Molina Healthcare, Inc.

November 22, 2023 By: DocuSigned by: Jeff Barlow 259B977707E8415...

Date Jeff D. Barlow, General Counsel

Appendix B. Disclosure of 1 Information

Pursuant to RFP § 3.3.7, a bidder may request that proposal content that contains proprietary information, legally recognized as such and protected by law, be withheld from open record disclosures. Molina considers the materials marked as "Proprietary" exempt from disclosure pursuant to K.S.A. 45-215 et. seq. and 5 U.S.C. 552(b). The documents sought are valuable, not generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use. The materials marked as "Proprietary" are trade secrets as defined by the Kansas Uniform Trade Secrets Act (K.S.A. §§ 60-3320 et seq.), as information, including a formula, pattern, compilation, program, device, method, technique, or process, that: (i) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use, and (ii) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

Molina contends that the information marked "Proprietary" is not generally known, nor is it reasonably ascertainable and other bidders may obtain economic value from its disclosure or use. Disclosure of our Proprietary information would result in a loss of economic value to Molina by giving the other bidders a competitive advantage during negotiations and negate our ability to competitively negotiate strategic relationships. Additionally, such information is the subject of efforts that are reasonable under the circumstances to maintain its secrecy. Such information is safeguarded by Molina by limiting the information to only those who have a need to know this information relating to this RFP.

Based on the foregoing reasons, Molina considers the materials marked as "Proprietary" to be valuable, not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use and not subject to disclosure under the Kansas Open Records Act.

Executive Summary (Tab 3)

MOLINA HEALTHCARE

Executive Summary

Overview of the Bidder and Relevant Experience

With this RFP, KDHE and Kansas Department of Aging and Disability Services has shown KanCare is looking for MCO partners dedicated to fostering a transformative and supportive environment for Members and Providers. Molina Healthcare of Kansas, Inc.(Molina) is excited for this opportunity to earn that privilege of administering the KanCare program and bringing our comprehensive Medicaid experience and community-informed approach to support and meet the complex health and social needs of each individual and community throughout Kansas. We stand ready to be a partner that is actively engaged in continuous quality improvement to maximize Member health and social outcomes.

In alignment with the State's vision and goals, we aim to improve on Member and Provider experiences. Our goals include developing a broad, open network; **increasing the use of primary care and preventive services;** and establishing strategic local partnerships to identify and **reduce geographic and racial disparities**. Our grassroots approach to understanding the unique health conditions of Kansans has guided the development of solutions in collaboration with Kansas Providers, advocates, and community-based organizations (CBOs).

Introducing Aaron Dunkel, Molina's Plan President and CEO
A fifth-generation Kansan, Mr. Dunkel has a heartfelt commitment to the people and communities of the Sunflower State. Before becoming CEO, Mr. Dunkel held pivotal positions at KDHE, including deputy secretary and chief financial officer. During his time there, Mr. Dunkel played a critical role in formulating and executing policies that enhanced access to and the quality of healthcare services. 102.j.ks23

Our parent company, Molina Healthcare, Inc. (Molina Healthcare), was founded in 1980 by a physician who believed everyone should have access to quality healthcare, no matter who they are or where they live. This mission began in a community clinic providing personalized, whole-person care to low income, uninsured, and often non-English-speaking individuals. Molina Healthcare is now a national managed healthcare leader in 20 states, serving approximately 5.2 million Members across all lines of business. Nearly 90% of Molina Healthcare's business is dedicated to serving Medicaid Members. Key to this commitment is designing a unique health plan that is responsive to specific state needs, rather than recycling the same corporate health plan structure and programs without listening to the voices that matter most. Each Molina health plan is locally staffed and empowered to make appropriate and final decisions based on program needs, unlike in health plan models that operate as corporate branches. While Molina's methodology will be based on local needs and led by staff in Kansas, we will also benefit from the backing of Molina Healthcare and the scale and fiscal stability of public markets it provides. We are proud that no Molina health plan has ever left a state during a contract.

Proposed Approach to Meeting and Exceeding RFP Requirements

Having gained insight into the current KanCare program and challenges facing Members and Providers, we have molded our Kansas-specific approach based on the principles of local control, adaptability, community support, and collaboration. Our Plan President and CEO Aaron Dunkel and his leadership team have traveled extensively throughout Kansas, visiting nearly every county. We met with large health systems, local advocates, small Provider groups, FQHCs, CCBHCs, maternal health experts, safety net clinics, waiver service providers, personal or direct service advocates, and CBOs focused on Member health and social supports. Through multiple conversations with **more than 200 organizations,** we have learned about the unique challenges and needs of Medicaid stakeholders and discussed how we can work together in innovative ways. Throughout our response, we will demonstrate the depth and thoughtfulness of our comprehensive solutions and the people, structure, processes, and technology Molina will bring to achieve sustained improvement.

Improving Member Experience and Satisfaction

At Molina, we commit to being a partner on Members' journeys to better health. Crucial to the process is ensuring that Members feel empowered to take control of their health and wellness goals. One way Molina helps Members take charge of their healthcare is by promoting the use of certified CHWs, including community health representatives, as care coordination extenders and trusted certified translators. Molina will work with CHWs and Providers to identify opportunities to address health disparities in Provider offices; Members will have access to bilingual Molina CHWs to ensure Members are being served in culturally competent ways.

What a Molina Partnership Will Mean for Kansas

- Empowered leadership and flexible program design to scale and pivot solutions
- Value-added positions focused on the diverse and complex needs of Members
- A cohesive, collaborative clinical approach to advance integrated, whole-person care

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[redacted]

Improving Health Outcomes Through Integrated, Whole-person Care

Our Care Coordination Model ensures we deliver consistent, whole-person care by using a comprehensive care coordination portal to get a 360-degree view of each Member to assess and appropriately respond to their needs. Our high-touch, locally based care approach allows us to offer tailored support that meets the unique needs of each Member and their families, regardless of their unique physical health, behavioral health (BH), and LTSS needs or social challenges. By providing ongoing and timely care coordination, we ensure the delivery of essential covered services and support for SDOH needs.

[redacted]

[redacted] Our proposed solution will also provide Members with immediate access to specialized clinical, crisis, and BH supports at home. [redacted]

Co-locating Staff for Integrated Community-based Programs

As we build partnerships, we will identify opportunities to co-locate staff with system partners where there are significant numbers of potential Member interactions. Our goal is to provide spaces where CHWs, community care coordinators, and targeted case managers can provide connections to needed resources and ensure Member access to care coordination in the most rural, underserved, and service-isolated parts of Kansas. [redacted]

Reducing Healthcare Disparities

Eleven of our Medicaid affiliates have received NCQA Health Equity Accreditation, demonstrating our parent company's early adoption of practices that help mitigate the effects of structural racism and implicit bias. KanCare Members living in rural and frontier areas face unique challenges because of limited healthcare infrastructure and shortages of healthcare professionals. We will partner with local Providers and CBOs to address these challenges and mitigate healthcare disparities. For example, we will bring **Molina on the Move** to Kansas. This mobile unit initiative is used in several of our affiliate health plans. Molina on the Move gives Members access to a wide range of in-person healthcare, health literacy, and community-based services through Molina Days and pop-up sites. We will travel to rural locations and community centers, faith-based centers, food banks, homeless shelters, sporting events, and public social services offices to expand access and address rural health disparities.

What a Molina Partnership Will Mean for Kansas

- Increased access to healthcare for Kansans in rural and frontier regions
- Increased health equity for mothers and children from marginalized communities
- Improved care coordination for Members with complex conditions

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Partnering with Providers

Our network development strategy goes beyond simply meeting adequacy standards based on geography and distance/travel times. Most of our Provider meetings were conducted one-on-one, prioritizing local perspectives to ensure a comprehensive understanding of local needs. [redacted] These groups represent the leading voices of Kansas' most clinically complex and high-needs Members, inclusive of those in rural health settings, and their support testifies to the value Molina will bring to Kansas. [redacted]

Expanding Provider Network and Direct Care Workforce Capacity

[redacted]

What a Molina Partnership Will Mean for Kansas

- Trusted relationships with the leading Provider and advocacy organizations in Kansas
- Comprehensive network established to meet all population needs by go-live
- High-touch Provider relations model with no Provider left behind

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[redacted]

Implementing Cost-effective Strategies to Improve Health Outcomes

As we traveled throughout Kansas, we heard a similar refrain—Providers want system reform and reliable, accountable partners. Being this kind of partner involves understanding barriers in the current delivery system and working in collaboration with current Medicaid MCOs to actively provide solutions that address both known and emerging issues. We listened when advocates and Providers throughout Kansas encouraged us to bring VBP to virtually every Provider type.

What a Molina Partnership Will Mean for Kansas

- VBP arrangements for several Provider types
- VBP contract offered to 100% of PCPs from Day 1
- Design that engages Providers and increases quality and efficiency

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Starting on Day 1, 100% of our PCPs will be offered a VBP contract aligned with key State quality goals. Additionally, by go-live, we will have VBP arrangements in place with hospitals, community health centers, CCBHCs; and HCBS, brain injury, SED, and IDD Providers. [redacted]

Ensuring Operational Excellence: No-noise Implementation and Beyond

We acknowledge change can be hard—on Members, on Providers, and on systems of care. In addition to already established relationships, we will have an Implementation team in Kansas who will reinforce our commitment to seamless care coordination through partnerships. We have the right implementation approach, expertise, tools, and models to deliver a smooth implementation, and we will have a well-run managed care plan in Kansas. For example, our affiliate in Nevada achieved a 100% readiness score from the EQRO just 5 months after the start of implementation. We recognize the period following go-live is crucial for ensuring a strong, stable health plan.

[redacted]

Our Implementation team will remain in place after go-live to help proactively resolve issues and ensure Providers and Members enjoy a seamless transition. [redacted]

As Kansas looks to the future, Molina is excited to support the State's vision—as a partner, collaborator, and innovator for KanCare. We stand ready to prove why we serve: because **everything we do is in service of making a difference in people's lives.**

Required Forms (Tab 4)

MOLINA HEALTHCARE

Required Forms (Tab 4)

Per section 4.3.E.1 Required Forms, Molina Healthcare of Kansas, Inc. provides the following required forms:

Attachment Name	Page Number
a. Signature Sheet (Attachment 2)	ATT 4.3.E.1-3
b. Tax Clearance Certificate (Attachment 3)	ATT 4.3.E.1-5
c. Immigration Reform and Control Certification (Attachment 4)	ATT 4.3.E.1-7
d. Policy Regarding Sexual Harassment (Attachment 5)	ATT 4.3.E.1-9
e. Boycott of Israel Form (Attachment 6)	ATT 4.3.E.1-11
f. Completed and signed Event Details document	ATT 4.3.E.1-13
g. Acknowledgment of Amendment(s)	ATT 4.3.E.1-23

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ATTACHMENT 2: SIGNATURE SHEET

Item: KanCare Medicaid & CHIP Capitated Managed Care
Agency: Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Closing Date: January 4, 2024, 2:00 PM CST

By submission of a bid and the signatures affixed thereto, the bidder certifies all products and services proposed in the bid meet or exceed all requirements of this specification as set forth in the request and that all exceptions are clearly identified.

Molina Healthcare of Kansas, Inc.
Legal Name of Person, Firm or Corporation

801 East Douglas, 2nd Floor, PMB # 2688
Mailing Address

Wichita, KS
City & State

67202
Zip

888-562-5442
Toll Free Telephone

785-631-0377
Local Telephone

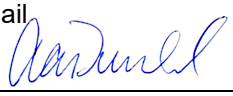
785-631-0377
Cell Phone

833-671-3988
Fax Number

92-3336788
Tax Number

CAUTION: If your tax number is the same as your Social Security Number (SSN), you must leave this line blank. DO NOT enter your SSN on this signature sheet. If your SSN is required to process a Contract award, including any tax clearance requirements, you will be contacted by an authorized representative of the Office of Procurement and Contracts at a later date.

Aaron.Dunkel@molinahealthcare.com
E-Mail


Signature

01/04/23
Date

Aaron Dunkel
Typed Name

Health Plan President and CEO
Title

In the event the **contact for the bidding process** is different from above, indicate contact information below.

Bidding Process Contact Name

Mailing Address | City & State

Zip Code

Toll Free Telephone | Local Telephone

Cell Phone | Fax Number

E-Mail

If **awarded a CONTRACT and purchase orders** are to be directed to an address other than above, indicate mailing address and telephone number below.

Award Contact Name

Mailing Address | City & State

Zip Code

Toll Free Telephone | Local Telephone

Cell Phone | Fax Number

E-Mail

Kansas Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Molina Healthcare of Kansas, Inc.

ISSUE DATE
10/19/2023

TRANSACTION ID
T862-8P7T-KSCR

CONFIRMATION NUMBER
CT7R-TD7F-3DTM

TAX CLEARANCE VALID THROUGH 01/17/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

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ATTACHMENT 4: IMMIGRATION REFORM & CONTROL CERTIFICATION

CERTIFICATION REGARDING IMMIGRATION REFORM & CONTROL

All Contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the Contractor as well as any subcontractor or sub-subcontractor. The usual method of verification is through the Employment Verification (I-9) Form. With the submission of this bid, the Contractor hereby certifies without exception that Contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination and any applicable damages.

Contractor certifies that, should it be awarded a contract by the State, Contractor will comply with all applicable federal and state laws, standards, orders and regulations affecting a person's participation and eligibility in any program or activity undertaken by the Contractor pursuant to this contract. Contractor further certifies that it will remain in compliance throughout the term of the contract.

At the State's request, Contractor is expected to produce to the State any documentation or other such evidence to verify Contractor's compliance with any provision, duty, certification, or the like under the contract.

Contractor agrees to include this Certification in contracts between itself and any subcontractors in connection with the services performed under this contract.

Signature, Title of Contractor

January 4, 2024

Date

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ATTACHMENT 5: POLICY REGARDING SEXUAL HARASSMENT

POLICY REGARDING SEXUAL HARASSMENT

WHEREAS, sexual harassment and retaliation for sexual harassment claims are unacceptable forms of discrimination that must not be tolerated in the workplace; and

WHEREAS, state and federal employment discrimination laws prohibit sexual harassment and retaliation in the workplace; and

WHEREAS, officers and employees of the State of Kansas are entitled to working conditions that are free from sexual harassment, discrimination, and retaliation; and

WHEREAS, the Governor and all officers and employees of the State of Kansas should seek to foster a culture that does not tolerate sexual harassment, retaliation, and unlawful discrimination.

NOW THEREFORE, pursuant to the authority vested in me as Governor of the State of Kansas, I hereby order as follows:

1. All Executive Branch department and agency heads shall have available, and shall regularly review and update at least every three years or more frequently as necessary, their sexual harassment, discrimination, and retaliation policies. Such policies shall include components for confidentiality and anonymous reporting, applicability to intern positions, and training policies.

2. All Executive Branch department and agency heads shall ensure that their employees, interns, and contractors have been notified of the state's policy against sexual harassment, discrimination, or retaliation, and shall further ensure that such persons are aware of the procedures for submitting a complaint of sexual harassment, discrimination, or retaliation, including an anonymous complaint.

3. Executive Branch departments and agencies shall annually require training seminars regarding the policy against sexual harassment, discrimination, or retaliation. All employees shall complete their initial training session pursuant to this order by the end of the current fiscal year.

4. Within ninety (90) days of this order, all Executive Branch employees, interns, and contractors under the jurisdiction of the Office of the Governor shall be provided a written copy of the policy against sexual harassment, discrimination, and retaliation, and they shall execute a document agreeing and acknowledging that they are aware of and will comply with the policy against sexual harassment, discrimination, and retaliation.

5. Matters involving any elected official, department or agency head, or any appointee of the Governor may be investigated by independent legal counsel.

6. The Office of the Governor will require annual mandatory training seminars for all staff, employees, and interns in the office regarding the policy against sexual harassment, discrimination, and retaliation, and shall maintain a record of attendance.

7. Allegations of sexual harassment, discrimination, or retaliation within the Office of the Governor will be investigated promptly, and violations of law or policy shall constitute grounds for disciplinary action, including dismissal.
8. This Order is intended to supplement existing laws and regulations concerning sexual harassment and discrimination, and shall not be interpreted to in any way diminish such laws and regulations. The Order provides conduct requirements for covered persons, and is not intended to create any new right or benefit enforceable against the State of Kansas.
9. Persons seeking to report violations of this Order, or guidance regarding the application or interpretation of this Order, may contact the Office of the Governor regarding such matters.

Agreement to Comply with the Policy Against Sexual Harassment, Discrimination, and Retaliation.

I hereby acknowledge that I have received a copy of the State of Kansas Policy Against Sexual Harassment, Discrimination, and Retaliation established by Executive Order 18-04 and agree to comply with the provisions of this policy.


01/04/24

Signature and Date

Aaron Dunkel

Printed Name

ATTACHMENT 6: BOYCOTT OF ISRAEL FORM

CERTIFICATION OF COMPANY NOT CURRENTLY ENGAGED IN A BOYCOTT OF GOODS OR SERVICES FROM ISRAEL

In accordance with HB 2482, 2018 Legislative Session, the State of Kansas shall not enter into a contract with a Company to acquire or dispose of goods or services with an aggregate price of more than $100,000, unless such Company submits a written certification that such Company is not currently engaged in a boycott of goods or services from Israel that constitutes an integral part of business conducted or sought to be conducted with the State.

As a Contractor entering into a contract with the State of Kansas, it is hereby certified that the Company listed below is not currently engaged in a boycott of Israel as set forth in HB 2482, 2018 Legislature.

Signature, Title of Contractor

January 4, 2024

Date

Aaron Dunkel

Printed Name

Molina Healthcare of Kansas, Inc.

Name of Company

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STATE OF KANSAS
Event Details

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	1
Event Round	**Version**		
1	1		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Event Description
State of Kansas

Kansas Department of Health and Environment
Kansas Department for Aging and Disability Services

General Comments

- **********
0005 - Request for Proposal pursuant to K.S.A. 75-37,102

- **********
Pre-proposal Conference - A mandatory pre-proposal conference will be held at 9:00 AM, on October 16, 2:00, via Zoom:

Please see section 3.2.2 of the Bid documents, for Prebid instructions on how to receive call in information.

Attendance is required for this pre-proposal conference. Failure to attend the pre-bid conference will result in rejection of your bid. Questions requesting clarification of the Bid Event must be submitted electronically (MS Word) to the Procurement Officer (Event Contact) indicated in the bidding instructions, prior to close of business on October 23, 2023. Impromptu questions may be permitted, and spontaneous unofficial answers provided, however bidders should understand that the only official answer or position of the State of Kansas will be presented in writing.

Failure to notify the Procurement Officer (Event Contact) of any conflicts or ambiguities in the Bid Event may result in items being resolved in the best interest of the State. Any modification to this Bid Event as a result of the pre-proposal conference, as well as written answers to written questions, shall be made in writing by addendum and dispatched to all bidders associated to this event. Only written communications are binding.

Answers to questions will be available in the form of an addendum on the Procurement and Contracts' website, http://admin.ks.gov/offices/procurement-contracts

It shall be the responsibility of all participating bidders to acquire any and all addenda and additional information as it is made available from the web site cited above. Vendors/Bidders not initially invited to participate in this Bid Event must notify the Procurement Officer (Event Contact) of their intent to bid at least 24 hours prior to the event's closing date/time. Bidders are required to check the website periodically for any additional information or instructions.

- **********
0008 - Invitation for Bid

- **********
BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE
A “Tax Clearance” is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s).

INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must:
• Go to http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate
• Return to the website the following working day to see if KDOR will issue the certificate
• If issued an official certificate, print it and attach it to your bid response
• If denied a certificate, engage KDOR in a discussion about why a certificate wasn't issued

Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	2
Event Round	**Version**		
1	1		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate.

Information about Tax Registration can be found at the following website:
http://www.ksrevenue.org/busregistration.html

Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award.

In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

- **********

The State of Kansas, as a matter of public policy, encourages anyone doing business with the State of Kansas to take steps to discourage human trafficking. If prospective bidders/vendors/Contractors have any policies or participate in any initiatives that discourage human trafficking the prospective bidder/vendor/Contractor is encouraged to submit same as part of their bid response.

- **********

During the 2012 Session, the Kansas Legislature enacted a Bidder Preference Program which created three (3) bid preferences. To see if you qualify for any of the preferences, please go to the following website for more information:
https://admin.ks.gov/offices/procurement-contracts/bidding--contracts/bidder-programs/certified-business-and-disabled-veteran-owned-business.

To claim this preference, the bid response must include the Preference Request Form and you must respond to the applicable Bidder Preference category in the question under the General Questions section on the following page(s).

****

During the 2014 Session, the Kansas Legislature enacted the Disabled Veteran Owned Business bidder preference program. For more information or to see if you qualify, please go to the following website:
https://admin.ks.gov/offices/procurement-contracts/bidding--contracts/bidder-programs/bidder-preference-program

To claim this preference, the bid response must include a copy of the letter from Procurement and Contracts certifying your company as a Disabled Veteran Owned Business and you must respond to the applicable Disabled Veteran Owned Business category in the question under the General Questions section on the following page(s).

General Questions

Question	UOM	Best	Worst	Response
Please select ONE category from the following list with regard to a Bidder Preference. If selecting a Bidder Preference category, supporting documentation must accompany this bid response. (Note: #3 "State Use Purchases" category does not apply to Requests for Proposals)				**Select One**
Options: Not claiming any Bidder Preference Category				YES
Claiming the Disabled Veteran Owned Business Category				
Claiming the State Use Purchases Bidder Preference Category				
Claiming the Certified Business Bidder Preference Category				

Required: Yes Mandatory Response: No

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	3
Event Round	**Version**		
1	1		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Response Comments

Is a completed Boycott of Israel form included with your bid event submission?

YES

Required: Yes Mandatory Response No

Response Comments

Is a completed Sexual Harassment form included with your bid event submission?

YES

Required: Yes Mandatory Response No

Response Comments

Is a completed Immigration Reform and Control form included with this bid event submission (refer to Appendix B - Terms and Conditions, Event Details document)?

YES

Required: Yes Mandatory Response No

Response Comments

Does your organization accept the State of Kansas terms and conditions as stated?

YES

Required: Yes Mandatory Response No

Response Comments

Is a current Tax Clearance Certificate included with this bid event submission (refer to Appendix B - Terms and Conditions, Event Details document)?

YES

Required: Yes Mandatory Response No

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	4
Event Round	**Version**		
1	1		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Response Comments

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	5
Event Round	**Version**		
1	1		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Line Details

No Bid: ☐

Line: 1 **Item ID:** **Line Qty:** 1.00 **UOM:** Each **Bid Qty:**
Required: No **Reserve Price:** No
Min/Max Qty: No min / No max

Description: KanCare Medicaid and CHIP Capitated Managed Care Services

Question	UOM	Best	Worst	Response
What is your bid price?				N/A

Required: Yes Mandatory Response: No

Response Comments

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	6
Event Round	**Version**		
1	1		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Bidder Information

Firm Name: MOLINA HEALTHCARE OF KANSAS, INC.

Name: AARON DUNKEL **Signature:**  **Date:** 01/04/2024

Phone #: 888-562-5442 **Fax #:** 1-833-671-3988

Street Address: 801 East Douglas, 2nd Floor, PMB # 2688,

City & State: Wichita, KS **Zip Code:** 67202

Email: Aaron.Dunkel@molinahealthcare.com

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	7
Event Round	**Version**		
1	1		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Appendix A - Line Specifications

Line: 1 **Item ID:** **Line Qty:** 1 **UOM:** Each
Description: KanCare Medicaid and CHIP Capitated Managed Care Services

Item Specifications

Manufacturer:			
Mfg Item ID:			
Item Length:	0	**Item Height:**	0
Item Width:	0	**Dimension UOM:**	
Item Volume:	0	**Volume UOM:**	
Item Weight:	0	**Weight UOM:**	
Item Size:		**Item Color:**	

Shipping Information

Schedule:	1	**Ship To:**	Procurement and Contracts
Quantity:	1		Procurement and Contracts
Due Date:	01/09/2024		900 SW Jackson
Freight Terms:			Suite 451 South
Ship Via:			Topeka KS 66612
			United States

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	8
Event Round	**Version**		
1	1		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Appendix B - Terms & Conditions

1. It is the bidder's responsibility to submit questions, acknowledge addenda and attend pre-bid conferences as indicated in this event or attachment(s). When communicating always refer to the Bid Event ID.

2. Conflict of Interest: With the submission of a response for this bidding event, you certify that you do not have any substantial conflict of interest sufficient to influence the bidding process of this event. A conflict of substantial interest is one which a reasonable person would think would compromise the opening bidding process.

3. BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE A "Tax Clearance" is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s). INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must: 1) Go to: http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate; 2) Return to the website the following working day to see if KDOR will issue the certificate; 3) If issued an official certificate, print it and attach it to your bid response; and 4) If denied a certificate, engage KDOR in a discussion about why a certificate wasn't issued. Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response. REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate. Information about Tax Registration can be found at the following website:
http://www.ksrevenue.org/busregistration.html. Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award. In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

4. Immigration and Reform Control Act of 1986 (IRCA): All contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the contractor as well as any subcontractor or sub-contractors. The usual method of verification is through the Employment Verification (I-9) form. With the submission of this bid, the contractor hereby certifies without exception that such contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination for cause and any applicable damages. Unless provided otherwise herein, all contractors are expected to be able to produce for the State any documentation or other such evidence to verify Contractor's IRCA compliance with any provision, duty, certification, or like item under the contract.
Bidders must submit a Certification Regarding Immigration Reform and Control form with every event response. The form can be found at the following website:
http://www.admin.ks.gov/docs/default-source/ofpm/procurement-contracts/irca.doc.

5. Competition: The purpose of this Request is to seek competition. The bidder shall advise Procurement and Contracts if any specification, language or other requirement inadvertently restricts or limits bidding to a single source. Notification shall be in writing and must be received by Procurement and Contracts no later than five (5) business days prior to the event closing date. The Director of Purchases reserves the right to waive minor deviations in the specifications which do not hinder the intent of this Request.

6. Acceptance or Rejection: The State reserves the right to accept or reject any or all bid responses or part of a response; to waive any informalities or technicalities; clarify any ambiguities in responses; modify any criteria in this Event; and unless otherwise specified, to accept any item in a response.

7. Disclosure of Bid Event Content and Proprietary Information: All bid responses become the property of the State of Kansas. The Kansas Open Records Act (K.S.A. 45-215 et seq) requires public information be placed in the public domain at the conclusion of the selection process, and be available for examination by all interested parties. More information on this subject can be found at the following website:
http://admin.ks.gov/offices/chief-counsel/kansas-open-records-act.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	9
Event Round	**Version**		
1	1		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

8. Debarment of State Contractors. Any Contractor who defaults on delivery or does not perform in a satisfactory manner as defined in this Agreement may be barred for a period up to three (3) years, pursuant to K.S.A. 75-37,103, or have its work evaluated for pre-qualification purposes. Contractor shall disclose any conviction or judgment for a criminal or civil offense of any employee, individual or entity which controls a company or organization or will perform work under this Agreement that indicates a lack of business integrity or business honesty. This includes (1) conviction of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract or subcontract or in the performance of such contract or subcontract; (2) conviction under state or federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, or receiving stolen property; (3) conviction under state or federal antitrust statutes; and (4) any other offense the State determines to be so serious and compelling as to affect responsibility as a state contractor. For the purpose of this section, an individual or entity shall be presumed to have control of a company or organization if the individual or entity directly or indirectly, or acting in concert with one or more individuals or entities, owns or controls twenty-five (25) percent or more of its equity, or otherwise controls its management or policies. Failure to disclose an offense may result in disqualification of the Proposal or termination of the Agreement, as determined by the State.

9. Accounts Receivable Set-Off Program: If during the course of this contract the Contractor is found to owe a debt to the State of Kansas, agency payments to the Contractor may be intercepted / setoff by the State of Kansas. Notice of the setoff action will be provided to the Contractor. Pursuant to K.S.A. 75-6201 et seq, Contractor shall have the opportunity to challenge the validity of the debt. If the debt is undisputed, the Contractor shall credit the account of the agency making the payment in an amount equal to the funds intercepted. K.S.A. 75-6201 et seq. allows the Director of Accounts and Reports to set off funds the State of Kansas owes Contractors against debts owed by the contractor to the State of Kansas. Payments set off in this manner constitute lawful payment for services or goods received. The Contractor benefits fully from the payment because its obligation to the State is reduced by the amount subject to setoff.

Last Updated: 01/24/2019

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Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612

Phone: 785-296-2376
Fax: 785-296-7240
https://admin.ks.gov/offices/procurement-contracts

Adam Proffitt, Secretary
Todd Herman, Director

Laura Kelly, Governor

AMENDMENT

Date:	October 20, 2023
Amendment Number:	1
RFP Number:	EVT0009267
Closing Date:	January 4, 2024, 2:00 PM
Procurement Officer: **Telephone:** **E-Mail Address:** **Web Address:**	Amanda Acuna 785-296-5419 Amanda.Acuna@ks.gov http://admin.ks.gov/offices/procurement-and-contracts/
Agency:	Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Item:	KanCare Medicaid & CHIP Capitated Managed Care

Conditions:

1. The deadline for submitting written questions requesting clarifications has been extended to October 27, 2023, by 12 p.m. CT to allow adequate time for review and response.

2. Technical issues were experienced with the following two folders in the KanCare Bidder's Library and have since been resolved.
   a. De-Identified Claims Data
   b. EDI Companion Guides

A signed copy of this Addendum must be submitted with your bid. If your bid response has been returned, submit this Addendum by the closing date indicated above.

I (We) have read and understand this addendum and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Molina Healthcare of Kansas

SIGNED BY: Aaron Dunkel

TITLE: Plan President and CEO DATE: 01/04/2024

It shall be the vendor's responsibility to monitor this website on a regular basis for any changes/addenda.
http://admin.ks.gov/offices/procurement-and-contract

Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612

Department of Administration

Phone: 785-296-2376
Fax: 785-296-7240
https://admin.ks.gov/offices/procurement-contracts

Adam Proffitt, Secretary
Todd Herman, Director

Laura Kelly, Governor

AMENDMENT

Date:	November 28, 2023
Amendment Number:	2
RFP Number:	EVT0009267
Closing Date:	January 4, 2024, 2:00 PM
Procurement Officer: **Telephone:** **E-Mail Address:** **Web Address:**	Amanda Acuna 785-296-5419 Amanda.Acuna@ks.gov http://admin.ks.gov/offices/procurement-and-contracts/
Agency:	Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Item:	KanCare Medicaid & CHIP Capitated Managed Care

Conditions: See response to questions and changes to RFP language below.

A signed copy of this Addendum must be submitted with your bid. If your bid response has been returned, submit this Addendum by the closing date indicated above.

I (We) have read and understand this addendum and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Molina Healthcare of Kansas

SIGNED BY: Aaron Dunkel

TITLE: Plan President and CEO DATE: 01/04/2024

It shall be the vendor's responsibility to monitor this website on a regular basis for any changes/addenda.
http://admin.ks.gov/offices/procurement-and-contract

Evidence of Certificate of Authority (COA) et. al. (Tab 5)

MOLINA HEALTHCARE

KANSAS INSURANCE DEPARTMENT

CERTIFICATE OF AUTHORITY

Company Name:	Molina Healthcare of Kansas, Inc.		
SBS Company Number:	521631705	**State of Domicile:**	Kansas
NAIC Number:		**Effective Date:**	November 28, 2023

Molina Healthcare of Kansas, Inc. is hereby authorized and empowered, through this Certificate of Authority, to transact the following lines of business as a/an HEALTH MAINTENANCE ORGANIZATION:

ACCIDENT & HEALTH

within the state of Kansas, from November 28, 2023, until such certificate is suspended, revoked, or terminated by the Commissioner of Insurance of Kansas.

COMMISSIONER OF INSURANCE OF KANSAS EST. 1871

Vicki Schmidt

Commissioner of Insurance

November 28, 2023

Evidence of Financial Viability/Solvency (Tab 6)

MOLINA HEALTHCARE

4.3.G Evidence of Financial Viability/Solvency (Tab 6)

Per RFP § 4.3.G, Evidence of Financial Viability/Solvency, Molina Healthcare of Kansas, Inc., provides the following required statements to demonstrate that the net worth of Molina Healthcare of Kansas, Inc. exceeds $1.5 million and that Molina Healthcare, Inc., the parent company of Molina Healthcare of Kansas, will bring stability, financial strength, and access to public capital markets to ensure Molina Healthcare of Kansas remains sufficiently capitalized throughout the term of the Contract. Since Molina currently does not have any Medicaid business in Kansas, we have provided an interim financial statement for Molina Healthcare of Kansas for the most recent year as well as an excerpt from Molina Healthcare, Inc.'s Form 10-K, which includes a copy of the audited financial statements of our parent company for the most recent 3 years.

Attachment Name	Page Number
a. Molina Healthcare 2023 interim financial statement. A copy of the interim financial statement for Molina Healthcare of Kansas, Inc for the most recent year.	ATT 4.3.G.1-3
b. Molina Healthcare 2022 10-K. An excerpt from Molina Healthcare, Inc.'s Form 10-K, which includes a copy of the audited financial statements of our parent company for the most recent 3 years.	ATT 4.3.G.1-5

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Molina Healthcare of Kansas, Inc.
Balance Sheet
As of September 30, 2023

Assets

Cash and short term investments	1,799,498
Other assets	610
Total assets	1,800,108

Liabilities and Equity

Stockholders Equity	1,800,108
Total liabilities and equity	1,800,108

Molina Healthcare of Kansas, Inc.
Statement of Profit and Loss
As of September 30, 2023

Revenue and other income		
Interest income	2,306	
Total revenue and other income		2,306
Expenses		
Bank service charges	622	
Total expenses		622
Income before taxes		1,684
Provision for income tax		(404)
Net income		1,280

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2022

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)

(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	MOH	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☒ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐ Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2022, the last business day of our most recently completed second fiscal quarter, was approximately $16.1 billion (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2022).

As of February 10, 2023, approximately 57,900,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2023 Annual Meeting of Stockholders to be held on May 3, 2023, are incorporated by reference into Part III of this Form 10-K, to the extent described therein.

MOLINA HEALTHCARE, INC.

FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2022	2021	2020
	(In millions, except per-share data)		
Revenue:			
Premium revenue	$ 30,883	$ 26,855	$ 18,299
Premium tax revenue	873	787	649
Health insurer fees reimbursed	—	—	271
Marketplace risk corridor judgment	—	—	128
Investment income	143	52	59
Other revenue	75	77	17
Total revenue	31,974	27,771	19,423
Operating expenses:			
Medical care costs	27,175	23,704	15,820
General and administrative expenses	2,311	2,068	1,480
Premium tax expenses	873	787	649
Health insurer fees	—	—	277
Depreciation and amortization	176	131	88
Impairment	208	—	—
Other	58	61	31
Total operating expenses	30,801	26,751	18,345
Operating income	1,173	1,020	1,078
Other expenses, net:			
Interest expense	110	120	102
Other expenses, net	—	25	15
Total other expenses, net	110	145	117
Income before income tax expense	1,063	875	961
Income tax expense	271	216	288
Net income	$ 792	$ 659	$ 673
Net income per share:			
Basic	$ 13.72	$ 11.40	$ 11.40
Diluted	$ 13.55	$ 11.25	$ 11.23
Weighted average shares outstanding:			
Basic	57.8	57.8	59.0
Diluted	58.5	58.6	59.9

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Net income	$ 792	$ 659	$ 673
Other comprehensive (loss) income:			
Unrealized investment (loss) income	(204)	(55)	44
Less: effect of income taxes	(49)	(13)	11
Other comprehensive (loss) income, net of tax	(155)	(42)	33
Comprehensive income	$ 637	$ 617	$ 706

See accompanying notes.

CONSOLIDATED BALANCE SHEETS

	December 31, 2022	December 31, 2021
	(Dollars in millions, except per-share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 4,006	$ 4,438
Investments	3,499	3,202
Receivables	2,302	2,177
Prepaid expenses and other current assets	277	247
Total current assets	10,084	10,064
Property, equipment, and capitalized software, net	259	396
Goodwill and intangible assets, net	1,390	1,252
Restricted investments	238	212
Deferred income taxes	220	106
Other assets	123	179
Total assets	$ 12,314	$ 12,209
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 3,528	$ 3,363
Amounts due government agencies	2,079	2,472
Accounts payable, accrued liabilities and other	889	842
Deferred revenue	359	370
Total current liabilities	6,855	7,047
Long-term debt	2,176	2,173
Finance lease liabilities	215	219
Other long-term liabilities	104	140
Total liabilities	9,350	9,579
Stockholders' equity:		
Common stock, $0.001 par value per share; 150 million shares authorized; outstanding: 58 million shares at each of December 31, 2022, and December 31, 2021	—	—
Preferred stock, $0.001 par value per share; 20 million shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	328	236
Accumulated other comprehensive loss	(160)	(5)
Retained earnings	2,796	2,399
Total stockholders' equity	2,964	2,630
Total liabilities and stockholders' equity	$ 12,314	$ 12,209

See accompanying notes.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive (Loss) Income	Retained Earnings	Total
	Outstanding	Amount				
	(In millions)					
Balance at December 31, 2019	62	$ —	$ 175	$ 4	$ 1,781	$ 1,960
Net income	—	—	—	—	673	673
Common stock purchases	(4)	—	(11)	—	(594)	(605)
Termination of warrants	—	—	(30)	—	—	(30)
Other comprehensive income, net	—	—	—	33	—	33
Share-based compensation	1	—	65	—	—	65
Balance at December 31, 2020	59	—	199	37	1,860	2,096
Net income	—	—	—	—	659	659
Common stock purchases	(1)	—	(2)	—	(120)	(122)
Other comprehensive loss, net	—	—	—	(42)	—	(42)
Share-based compensation	—	—	39	—	—	39
Balance at December 31, 2021	58	—	236	(5)	2,399	2,630
Net income	—	—	—	—	792	792
Common stock purchases	(1)	—	(5)	—	(395)	(400)
Other comprehensive loss, net	—	—	—	(155)	—	(155)
Share-based compensation	1	—	97	—	—	97
Balance at December 31, 2022	58	$ —	$ 328	$ (160)	$ 2,796	$ 2,964

See accompanying notes.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Operating activities:			
Net income	$ 792	$ 659	$ 673
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	176	131	88
Deferred income taxes	(66)	(24)	(19)
Share-based compensation	103	72	57
Loss on debt repayment	—	25	15
Impairment	208	—	—
Other, net	8	33	12
Changes in operating assets and liabilities, net of the effect of acquisitions:			
Receivables	(95)	(415)	(100)
Prepaid expenses and other current assets	(124)	(19)	(16)
Medical claims and benefits payable	153	471	544
Amounts due government agencies	(428)	1,046	446
Accounts payable, accrued liabilities and other	55	138	86
Deferred revenue	(11)	(5)	126
Income taxes	2	7	(14)
Net cash provided by operating activities	773	2,119	1,898
Investing activities:			
Purchases of investments	(1,913)	(2,713)	(670)
Proceeds from sales and maturities of investments	1,398	1,329	1,097
Net cash paid in business combinations	(134)	(129)	(755)
Purchases of property, equipment and capitalized software	(91)	(77)	(74)
Other, net	(50)	(63)	2
Net cash used in investing activities	(790)	(1,653)	(400)
Financing activities:			
Common stock purchases	(400)	(128)	(606)
Common stock withheld to settle employee tax obligations	(54)	(53)	(8)
Contingent consideration liabilities settled	(20)	(20)	—
Proceeds from senior notes offerings, net of issuance costs	—	740	1,429
Repayment of senior notes	—	(723)	(338)
Repayment of term loan facility	—	—	(600)
Proceeds from borrowings under term loan facility	—	—	380
Cash paid for partial termination of warrants	—	—	(30)
Cash paid for partial settlement of conversion option	—	—	(27)
Cash received for partial settlement of call option	—	—	27
Repayment of principal amount of convertible senior notes	—	—	(12)
Other, net	33	1	2
Net cash (used in) provided by financing activities	(441)	(183)	217
Net (decrease) increase in cash and cash equivalents, and restricted cash and cash equivalents	(458)	283	1,715
Cash and cash equivalents, and restricted cash and cash equivalents at beginning of period	4,506	4,223	2,508
Cash and cash equivalents, and restricted cash and cash equivalents at end of period	$ 4,048	$ 4,506	$ 4,223

See accompanying notes.

CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Supplemental cash flow information:			
Cash paid during the period for:			
Income taxes	$ 340	$ 235	$ 321
Interest	$ 108	$ 127	$ 112

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Organization and Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides managed healthcare services under the Medicaid and Medicare programs, and through the state insurance marketplaces (the "Marketplace"). Molina was founded in 1980 as a provider organization serving low-income families in Southern California and reincorporated in Delaware in 2002. We currently have four reportable segments consisting of: 1) Medicaid; 2) Medicare; 3) Marketplace; and 4) Other. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

As of December 31, 2022, we served approximately 5.3 million members eligible for government-sponsored healthcare programs, located across 19 states.

Our state Medicaid contracts typically have terms of three to five years, contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal ("RFP") open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled ("ABD"); and regions or service areas.

In Medicare, we enter into Medicare Advantage-Part D contracts with the Centers for Medicare and Medicaid Services ("CMS") annually, and for dual-eligible plans, we enter into contracts with CMS, in partnership with each state's department of health and human services. Such contracts typically have terms of one to three years.

In Marketplace, we enter into contracts with CMS, which end on December 31 of each year, and must be renewed annually.

Recent Developments

Texas Procurement—Medicaid. On January 27, 2023, the Texas Health and Human Services Commission posted a notice on its website indicating that it was issuing a Notice of Intent to Award to Molina Healthcare of Texas, Inc. a STAR+PLUS ABD contract in each of Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Northeast Texas, and Tarrant Service Areas. The notice follows a proposal that we submitted in June 2022 to continue serving STAR+PLUS members in the same service areas, in response to an RFP posted in March 2022. The start of operations for the new contract is expected to begin in February 2024. Further, in December 2022, the RFP was posted for the TANF and CHIP programs (known as the STAR & CHIP programs, and both existing contracts for Molina), with awards expected in February 2024 and the start of operations in February 2025.

California Procurement—Medicaid. In January 2023, we announced that the California Department of Health Care Services ("DHCS") had confirmed our California health plan's footprint as originally announced in August 2022, including Medi-Cal contract awards in each of Riverside, San Bernardino, Sacramento, and San Diego Counties. In Los Angeles County, we will share membership equally with the current commercial incumbent. The Medi-Cal contracts are expected to commence on January 1, 2024, which enables us to continue serving Medi-Cal members in our existing counties and expand our footprint in Los Angeles County. DHCS has also agreed to grant Molina a contract to offer EAE-SNP products for dual eligible members in Los Angeles County.

New York Acquisition—Medicaid. On October 1, 2022, we closed on our acquisition of the Medicaid Managed Long Term Care business of AgeWell New York ("AgeWell"). See Note 4, "Business Combinations," for further information.

Nebraska Procurement—Medicaid. In September 2022, we announced that our Nebraska health plan had been selected by the Nebraska Department of Health and Human Services to provide health care services to Nebraskans under the state's Medicaid managed care program. The new five-year contract is expected to begin on January 1, 2024, and may be extended for an additional two-years.

Iowa Procurement—Medicaid. In August 2022, we announced that our Iowa health plan had been notified by the Iowa Department of Health and Human Services ("Iowa HHS") of its intent to award a Medicaid managed care contract pursuant to the RFP issued by Iowa HHS in February 2022. The new four-year contract is expected to begin on July 1, 2023, and may be extended for an additional four years.

Mississippi Procurement—Medicaid. In August 2022, we announced that our Mississippi health plan had been notified by the Mississippi Division of Medicaid ("DOM") of its intent to award a Medicaid Coordinated Care Contract for its Mississippi Coordinated Access Program and Mississippi Children's Health Insurance Program pursuant to the Request for Qualifications issued by DOM in December 2021. The four-year contract is expected to begin on July 1, 2023, and may be extended for an additional two years. The award enables us to continue serving Medicaid members across the state.

Wisconsin Acquisition—Medicaid and Medicare. On July 13, 2022, we announced a definitive agreement to acquire substantially all the assets of My Choice Wisconsin ("MCW"). The purchase price for the transaction is approximately $150 million, net of expected tax benefits and required regulatory capital, which we intend to fund with cash on hand. The transaction is subject to receipt of applicable federal and state regulatory approvals, and the satisfaction of other customary closing conditions. We currently expect the transaction to close in mid-2023.

Nevada Procurement—Medicaid. Our new contract in Clark and Washoe Counties commenced on January 1, 2022, and offers health coverage to TANF, CHIP and Medicaid Expansion beneficiaries. This new contract is four years with a potential two-year extension.

Texas Acquisition—Medicaid and Medicare. On January 1, 2022, we closed on our acquisition of Cigna Corporation's Texas Medicaid and Medicare-Medicaid Plan ("MMP") contracts, along with certain operating assets. See Note 4, "Business Combinations," for further information.

Consolidation and Presentation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., and its subsidiaries. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments.

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase. The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the accompanying consolidated balance sheets that sum to the total of the same such amounts presented in the accompanying consolidated statements of cash flows. The restricted cash and cash equivalents presented below are included in "Restricted investments" in the accompanying consolidated balance sheets.

	December 31,		
	2022	2021	2020
	(In millions)		
Cash and cash equivalents	$ 4,006	$ 4,438	$ 4,154
Restricted cash and cash equivalents	42	68	69
Total cash and cash equivalents, and restricted cash and cash equivalents presented in the consolidated statements of cash flows	$ 4,048	$ 4,506	$ 4,223

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale ("AFS") securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity ("HTM") securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses arising from credit-related factors with respect to AFS

and HTM securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method.

Our investment policy requires that all of our investments have final maturities of less than 15 years, or less than 15 years average life for structured securities. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our AFS securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. We monitor our investments for credit-related impairment. For comprehensive discussions of the fair value and classification of our investments, see Note 5, "Fair Value Measurements," and Note 6, "Investments."

Accrued interest receivable relating to our AFS and HTM securities is presented within "Prepaid expenses and other current assets" in the accompanying consolidated balance sheets, and amounted to $35 million and $11 million at December 31, 2022, and 2021, respectively. We do not measure an allowance for credit losses on accrued interest receivable. Instead, we write off accrued interest receivable that has not been collected within 90 days of the interest payment due date. We recognize such write offs as a reversal of investment income. No accrued interest was written off during the year ended December 31, 2022.

Receivables

Receivables consist primarily of premium amounts due from government agencies, which are subject to potential retroactive adjustments. Because substantially all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for credit losses is insignificant. Any amounts determined to be uncollectible are charged to expense when such determination is made.

	December 31,	
	2022	2021
	(In millions)	
Government receivables	$ 1,702	$ 1,566
Pharmacy rebate receivables	291	276
Other	309	335
Total receivables	$ 2,302	$ 2,177

Business Combinations

We account for business combinations using the acquisition method of accounting, which requires us to recognize the assets acquired and the liabilities assumed at their acquisition date fair values. As discussed below, the excess of the purchase consideration transferred over the fair value of the net tangible and intangible assets acquired is recorded as goodwill. While we use our best estimates and assumptions to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period, which may be up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill. Measurement period adjustments are recorded in the period in which they are determined, as if they had been completed at the acquisition date. Upon the conclusion of the final determination of the values of assets acquired or liabilities assumed, or one year after the date of acquisition, whichever comes first, any subsequent adjustments are recorded within our consolidated results of operations.

The purchase price for the acquisition of certain assets of Passport Health Plan, Inc. in 2020 included contingent consideration payable to seller relating to guarantees for minimum operating income in the post-acquisition period in 2020 and minimum membership targets in 2021. The liabilities are recorded at fair value on a recurring basis, which totaled $8 million as of December 31, 2022. For the amounts paid in the year ended December 31, 2022, $20 million has been presented in "Financing activities" in the accompanying consolidated statements of cash flows, with the balance reflected in "Operating activities." We paid the remaining balance of the liabilities, reported in "Accounts payable, accrued liabilities and other" in the accompanying consolidated balance sheets, in January 2023.

Refer to Note 4, "Business Combinations," and Note 9, "Goodwill and Intangible Assets, Net," for further details.

Long-Lived Assets, including Intangible Assets

Long-lived assets consist primarily of property, equipment, capitalized software (see Note 7, “Property, Equipment, and Capitalized Software, Net”), and intangible assets resulting from acquisitions. Long-lived assets are subject to impairment tests when events or circumstances indicate that the asset’s (or asset group’s) carrying value may not be recoverable. Refer to the discussion in “Leases” below for impairment charges related to leasehold improvements and other property and equipment associated with the reduction in leased space used in our business operations. Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at fair value and are then amortized on a straight-line basis over their expected useful lives, generally between five and 16 years.

Determining the fair value of separately identifiable intangible assets requires management to make estimates, which are based on all available information and in some cases assumptions with respect to the timing and amount of future revenues and expenses associated with an asset. Determining the useful life of an intangible asset also requires judgment, as different types of intangible assets will have different useful lives. The most significant intangible asset we typically record in a business combination is contract rights associated with membership assumed. In determining the estimated fair value of the intangible assets, we typically apply the income approach, which discounts the projected future net cash flows using an appropriate discount rate that reflects the risk associated with such projected future cash flows. The most critical assumptions used in determining the fair value of contract rights include forecasted operating margins and the weighted average cost of capital.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset’s (or asset group’s) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators, including the ability of our health plan subsidiaries to obtain the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the greater of the undiscounted cash flows that are expected to result from the use of the asset or related group of assets, or its value under the asset liquidation method. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment. Refer to Note 9, “Goodwill and Intangible Assets, Net,” for further details.

Goodwill

Goodwill represents the excess of the purchase consideration over the fair value of net assets acquired in business combinations. Goodwill is not amortized but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Impairment indicators may include experienced or expected operating cash-flow deterioration or losses, significant losses of membership, loss of state funding, loss of state contracts, and other factors. Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss and adjusted if necessary for the impact of tax-deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit.

When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, the dynamic economic and political environments in which we operate, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of our reporting units exceed their estimated fair values. If our qualitative assessment indicates that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value, we perform the quantitative assessment. We may also elect to bypass the qualitative assessment and proceed directly to the quantitative assessment. We performed a qualitative goodwill assessment of our reporting units, and did not identify any factors indicating that the carrying value of our reporting units exceeded their estimated fair values.

If performing a quantitative assessment, we generally estimate the fair values of our reporting units by applying the income approach, using discounted cash flows. The base year in the reporting units’ discounted cash flows is derived from the annual financial planning cycle, which commences in the fourth quarter of the year. As part of a quantitative assessment, we may also apply the asset liquidation method to estimate the fair value of individual reporting units, which is computed as total assets minus total liabilities, excluding intangible assets and deferred taxes. Finally, we apply a market approach to reconcile the value of our reporting units to our consolidated market value. Under the market approach, we consider publicly-traded comparable company information to determine revenue and earnings multiples which are used to estimate our reporting units’ fair values. The assumptions used are consistent with those used in our long-range business plan and annual planning process. However, if these assumptions differ from actual results, the outcome of our goodwill impairment tests could be adversely affected.

Leases

Right-of-use (“ROU”) assets represent our right to use the underlying assets over the lease term, and lease liabilities represent our obligation for lease payments arising from the related leases. ROU assets and lease liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. Lease terms may include options to extend or terminate the lease when we believe it is reasonably certain that we will exercise such options. If applicable, we account for lease and non-lease components within a lease as a single lease component.

Because most of our leases do not provide an implicit interest rate, we generally use our incremental borrowing rate to determine the present value of lease payments. Lease expenses for operating lease payments are recognized on a straight-line basis over the lease term, and the related ROU assets and liabilities are reduced to the present value of the remaining lease payments at the end of each period. Finance lease payments reduce finance lease liabilities, the related ROU assets are amortized on a straight-line basis over the lease term, and interest expense is recognized using the effective interest method.

The significant majority of our operating leases consist of long-term operating leases for office space. Short-term leases (those with terms of 12 months or less) are not recorded as ROU assets or liabilities in the consolidated balance sheets. For certain leases that represent a portfolio of similar assets, such as a fleet of vehicles, we apply a portfolio approach to account for the related ROU assets and liabilities, rather than account for such assets and the related liabilities individually. A nominal number of our lease agreements include rental payments that adjust periodically for inflation. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants.

In the fourth quarter of 2022, we recognized $192 million of ROU asset impairments in connection with the reduction in leased space to accommodate our move to a remote work environment, including vacating and abandonment of various leased properties. We assessed the ROU assets for impairment as a result of the reduction in leased space used in our business operations, and we engaged a third-party real estate specialist to determine the recoverability of the leased properties, based on estimated fair values. The valuation primarily considered comparable leased properties in each market and the assessment of actual and potential future rental income generated by the ROU assets. For further information, including the amount and location of the ROU assets and lease liabilities recognized in the accompanying consolidated balance sheets, see Note 8, “Leases.”

We also recognized $16 million in impairment charges related to leasehold improvements and other property and equipment associated with the reduction in leased space used in our business operations. Please refer to Note 7, “Property, Equipment, and Capitalized Software, Net” for further discussion.

Medical Claims and Benefits Payable

Medical care costs are recognized in the period in which services are provided and include fee-for-service claims, pharmacy benefits, capitation payments to providers, and various other medically-related costs. Under fee-for-service claims arrangements with providers, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of hospital and physician services. Such medical care costs include amounts paid by us as well as estimated medical claims and benefits payable for costs that were incurred but not paid as of the reporting date (“IBNP”). Pharmacy benefits represent payments for members' prescription drug costs, net of rebates from drug manufacturers. We estimate pharmacy rebates based on historical and current utilization of prescription drugs and contractual provisions. Capitation payments represent monthly contractual fees paid to providers, who are responsible for providing medical care to members, which could include medical or ancillary costs like dental, vision and other supplemental health benefits. Such capitation costs are fixed in advance of the periods covered and are not subject to significant accounting estimates. Other medical care costs include all medically-related administrative costs, amounts due to providers pursuant to risk-sharing or other incentive arrangements, provider claims, and other healthcare expenses. Examples of medically-related administrative costs include expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Additionally, we include an estimate for the cost of settling claims incurred through the reporting date in our medical claims and benefits payable liability.

Medical claims and benefits payable consist mainly of fee-for-service IBNP, unpaid pharmacy claims, capitation costs, other medical costs, including amounts payable to providers pursuant to risk-sharing or other incentive arrangements and amounts payable to providers on behalf of certain state agencies for certain state assessments in which we assume no financial risk. IBNP includes the costs of claims incurred as of the balance sheet date which have been reported to us, and our best estimate of the cost of claims incurred but not yet reported to us. We also include an additional reserve to ensure that our overall IBNP liability is sufficient under moderately adverse

conditions. We reflect changes in these estimates in the consolidated results of operations in the period in which they are determined.

The estimation of the IBNP liability requires a significant degree of judgment in applying actuarial methods, determining the appropriate assumptions and considering numerous factors. Of those factors, we consider estimated completion factors and the assumed healthcare cost trend to be the most critical assumptions. Other relevant factors also include, but are not limited to, healthcare service utilization trends, claim inventory levels, changes in membership, product mix, seasonality, benefit changes or changes in Medicaid fee schedules, provider contract changes, prior authorizations and the incidence of catastrophic or pandemic cases.

Because of the significant degree of judgment involved in estimation of our IBNP liability, there is considerable variability and uncertainty inherent in such estimates. Each reporting period, the recognized IBNP liability represents our best estimate of the total amount of unpaid claims incurred as of the balance sheet date using a consistent methodology in estimating our IBNP liability. We believe our current estimates are reasonable and adequate; however, the development of our estimate is a continuous process that we monitor and update as more complete claims payment information and healthcare cost trend data becomes available. Actual medical care costs may be less than we previously estimated (favorable development) or more than we previously estimated (unfavorable development), and any differences could be material. Any adjustments to reflect favorable development would be recognized as a decrease to medical care costs, and any adjustments to reflect unfavorable development would be recognized as an increase to medical care costs, in the period in which the adjustments are determined.

Refer to Note 10, “Medical Claims and Benefits Payable,” for a table presenting the components of the change in our medical claims and benefits payable, for all periods presented in the accompanying consolidated financial statements.

Premium Revenue Recognition and Amounts Due Government Agencies

Premium revenue is generated from our contracts with state and federal agencies, in connection with our participation in the Medicaid, Medicare, and Marketplace programs. Premium revenue is generally received based on per member per month (“PMPM”) rates established in advance of the periods covered. These premium revenues are recognized in the month that members are entitled to receive healthcare services, and premiums collected in advance are deferred. State Medicaid programs and the federal Medicare program periodically adjust premium rates, including certain components of premium revenue that are subject to accounting estimates and are described below, under “Contractual Provisions That May Adjust or Limit Revenue or Profit,” and “Quality Incentives.”

Contractual Provisions That May Adjust or Limit Revenue or Profit

Many of our contracts contain provisions that may adjust or limit revenue or profit, as described below. Consequently, we recognize premium revenue as it is earned under such provisions. Liabilities accrued for premiums to be returned under such provisions are reported in the aggregate as “Amounts due government agencies” in the accompanying consolidated balance sheets. Categorized by program, such amounts due government agencies included the following:

	December 31,	
	2022	2021
	(In millions)	
Medicaid program:		
Minimum MLR, corridors, and profit sharing	$ 1,145	$ 1,016
Other premium adjustments	482	263
Medicare program:		
Risk adjustment and Part D risk sharing	76	89
Minimum MLR and profit sharing	84	101
Other premium adjustments	27	35
Marketplace program:		
Risk adjustment	230	902
Minimum MLR	2	18
Other premium adjustments	33	48
Total amounts due government agencies	$ 2,079	$ 2,472

Medicaid Program

Minimum MLR and Medical Cost Corridors. A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs as a percentage of premium revenue, or minimum medical loss ratio ("Minimum MLR"). Under certain medical cost corridor provisions, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold.

Beginning in 2020, various states enacted temporary risk corridors in response to the reduced demand for medical services stemming from COVID-19, which have resulted in a reduction of our medical margin. In some cases, these risk corridors were retroactive to earlier periods in 2020, or as early as the beginning of the states' fiscal years in 2019. We have recognized risk corridors that we believe to be probable, and where the ultimate premium amount is reasonably estimable. For the year ended December 31, 2022, we recognized approximately $197 million related to such risk corridors, primarily in the Medicaid segment, compared to $323 million recognized in the year ended December 31, 2021.The decrease in 2022 is due to the elimination of most of the COVID-19 risk corridors.

It is possible that certain states could change the structure of existing risk corridors, implement new risk corridors in the future or discontinue existing risk corridors. Due to these uncertainties, the ultimate outcomes could differ materially from our estimates as a result of changes in facts or further developments, which could have an adverse effect on our consolidated financial position, results of operations, or cash flows.

Profit Sharing. Our contracts with certain states contain profit sharing provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any.

Other Premium Adjustments. State Medicaid programs periodically adjust premium revenues on a retroactive basis for rate changes and changes in membership and eligibility data. In certain states, adjustments are made based on the health status of our members (as measured through a risk score). In these cases, we adjust our premium revenue in the period in which we determine that the adjustment is probable and reasonably estimable, based on our best estimate of the ultimate premium we expect to realize for the period being adjusted.

Medicare Program

Risk Adjustment. Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and CMS practices.

Minimum MLR. The Affordable Care Act ("ACA") established a Minimum MLR of 85% for Medicare. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

Marketplace Program

Risk Adjustment. Under this program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk adjustment payment into the pool if their composite risk scores are below the average risk score (risk adjustment payable), and will receive a risk adjustment payment from the pool if their composite risk scores are above the average risk score (risk adjustment receivable). We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. As of December 31, 2022, Marketplace risk adjustment payables amounted to $230 million and related receivables amounted to $135 million, for a net payable of $95 million. As of December 31, 2021, Marketplace risk adjustment payables amounted to $902 million and related receivables amounted to $7 million, for a net payable of $895 million.

Minimum MLR. The ACA established a Minimum MLR of 80% for the Marketplace. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

Quality Incentives

At many of our health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned only if certain performance measures are met. Such performance measures are generally found in our Medicaid and MMP contracts. Recognition of quality incentive premium revenue is subject to the use of estimates.

Reinsurance

We bear underwriting and reserving risks associated with our health plan subsidiaries. In certain cases, we limit our risk of significant catastrophic losses by maintaining high deductible reinsurance coverage with a highly-rated, unaffiliated insurance company (the "third-party reinsurer"). Because we remain liable for losses in the event the third-party reinsurer is unable to pay its portion of the losses, we continually monitor the third-party reinsurer's financial condition, including its ability to maintain high credit ratings. Intercompany transactions with our captive are eliminated in consolidation.

We report reinsurance premiums as a reduction to premium revenue, while related reinsurance recoveries are reported as a reduction to medical care costs. In certain cases, we participate in state-run reinsurance programs for which no reinsurance premium is paid. Reinsurance premiums amounted to $2 million, $2 million, and $9 million for the years ended December 31, 2022, 2021, and 2020, respectively. Reinsurance recoveries amounted to $35 million, $33 million, and $23 million for the years ended December 31, 2022, 2021, and 2020, respectively. Reinsurance recoverable of $27 million, $51 million, and $30 million, as of December 31, 2022, 2021, and 2020, respectively, is included in "Receivables" in the accompanying consolidated balance sheets.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts to determine if it is probable that a loss will be incurred in the future by reviewing current results and forecasts. For purposes of this assessment, contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. A premium deficiency reserve ("PDR") is recognized if anticipated future medical care and administrative costs exceed anticipated future premium revenue, investment income and reinsurance recoveries.

Income Taxes

We account for income taxes under the asset and liability method. Deferred tax assets and liabilities are determined based on the difference between the financial statement and tax bases of assets and liabilities using enacted tax rates expected to be in effect during the year in which the basis differences reverse. Valuation allowances are established when management determines it is more likely than not that some portion, or all, of the deferred tax assets will not be realized. For further discussion and disclosure, see Note 12, "Income Taxes."

Taxes Based on Premiums

Health Insurer Fee ("HIF"). Under the Affordable Care Act, the federal government imposed an annual fee, or excise tax, on health insurers for each calendar year (the "HIF"). The Further Consolidated Appropriations Act, 2020 repealed the HIF effective for years after 2020.

Premium and Use Tax. Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include reimbursement for the premium tax assessment. We have reported these taxes on a gross basis, as premium tax revenue and as premium tax expenses in the consolidated statements of income.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with final maturities of less than 15 years, or less than 15 years average life for structured securities. Restricted investments are invested principally in cash, cash equivalents, U.S. Treasury securities, and corporate debt securities. Concentration of credit risk with respect to accounts receivable is limited because our payors consist principally of the federal government, and governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in healthcare practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

We operate health plans primarily as a direct contractor with the states, and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a relatively small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. In addition, our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Significant Customers

We receive the majority of our revenues under contracts or subcontracts with state Medicaid managed care programs, which are considered individual external customers. Instances where these contracts were at least 10% of our total premium revenue for the year ended December 31, 2022 were New York with 10.0%, Texas with 12.0% and Washington with 13.6%.

Recent Accounting Pronouncements

Recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission ("SEC") did not have, nor does management expect such pronouncements to have, a significant impact on our present or future consolidated financial statements.

3. Net Income Per Share

The following table sets forth the calculation of basic and diluted net income per share:

	Year Ended December 31,		
	2022	2021	2020
	(In millions, except net income per share)		
Numerator:			
Net income	$ 792	$ 659	$ 673
Denominator:			
Shares outstanding at the beginning of the period	57.9	58.0	61.9
Weighted-average number of shares issued:			
Stock purchases	(0.5)	(0.5)	(3.0)
Stock-based compensation	0.4	0.3	0.1
Denominator for basic net income per share	57.8	57.8	59.0
Effect of dilutive securities: (1)			
Stock-based compensation	0.7	0.8	0.9
Denominator for diluted net income per share	58.5	58.6	59.9
Net income per share - Basic (2)	$ 13.72	$ 11.40	$ 11.40
Net income per share - Diluted (2)	$ 13.55	$ 11.25	$ 11.23

(1) The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would have been anti-dilutive.

(2) Source data for calculations in thousands.

4. Business Combinations

In 2022, we closed on two business combinations primarily in the Medicaid segment, consistent with our growth strategy. For these transactions, we applied the acquisition method of accounting, where the total purchase price was allocated to the tangible and intangible assets acquired and liabilities assumed, based on their fair values as of the acquisition date. The proforma effects of these acquisitions for prior periods were not material to our consolidated results of operations. Costs to complete acquisitions amounted to $2 million in the aggregate for the year ended December 31, 2022, and were recorded as “General and administrative expenses” in the accompanying consolidated statements of income.

AgeWell. On October 1, 2022, we closed on our acquisition of the Medicaid Managed Long Term Care business of AgeWell New York for purchase consideration of approximately $134 million. We acquired membership and a provider network with a fair value of approximately $47 million. We allocated the remaining $87 million of purchase consideration to goodwill, which relates to future economic benefits arising from expected synergies from the use of our existing infrastructure to support the added membership. The goodwill is deductible for income tax purposes.

Cigna. On January 1, 2022, we closed on our acquisition of Cigna Corporation’s Texas Medicaid and Medicare-Medicaid Plan contracts, along with certain operating assets, for purchase consideration of approximately $60 million. Because the closing date fell on a holiday, the purchase price was paid on December 31, 2021 and was recorded to prepaid expenses and other assets. We acquired membership and a provider network with a fair value of approximately $35 million. We allocated the remaining $25 million of purchase consideration to goodwill, primarily in the Medicaid segment, which relates to future economic benefits arising from expected synergies from the use of our existing infrastructure to support the added membership, and from the assembled workforce. The goodwill is deductible for income tax purposes.

The table below presents intangible assets acquired, by major class, for the AgeWell and Cigna acquisitions.

	Fair Value	Life	Weighted-Average Life
	(In millions)	(Years)	(Years)
Contract rights - member list	$ 81	2 - 5	3.7
Provider network	1	2 - 5	4.0
	$ 82		3.7

Affinity. On October 25, 2021, we closed on our acquisition of substantially all of the assets of Affinity Health Plan, Inc., a Medicaid health plan in New York, for purchase consideration of approximately $176 million. In the year ended December 31, 2022, we recorded various measurement period adjustments, including an increase of $12 million to “Medical claims and benefits payable,” and an increase of $4 million to “Amounts due government agencies” net of “Receivables.” In the aggregate, we recorded a net increase of $21 million to goodwill for these measurement period adjustments and various purchase price adjustments, which have been finalized as of December 31, 2022.

5. Fair Value Measurements

We consider the carrying amounts of current assets and current liabilities to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs. Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices for identical securities in active markets.

Level 2 — Directly or Indirectly Observable Inputs. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs. Level 3 financial instruments are valued using unobservable inputs that represent management’s best estimate of what market participants would use in pricing the financial instrument at the measurement date. As of December 31, 2022 and 2021, our Level 3 financial instruments consisted of contingent consideration liabilities.

The net changes in fair value of Level 3 financial instruments are reported in “Other” operating expenses in our consolidated statements of income. In the years ended December 31, 2022 and 2021, we recognized a loss of $4 million and $24 million, respectively, primarily for the increase in the fair value of the contingent consideration liability described below.

Our financial instruments measured at fair value on a recurring basis at December 31, 2022, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 2,184	$ —	$ 2,184	$ —
Mortgage-backed securities	731	—	731	—
Asset-backed securities	288	—	288	—
Municipal securities	149	—	149	—
U.S. Treasury notes	105	—	105	—
Other	42	—	42	—
Total assets	$ 3,499	$ —	$ 3,499	$ —
Contingent consideration liabilities	$ 8	$ —	$ —	$ 8
Total liabilities	$ 8	$ —	$ —	$ 8

Our financial instruments measured at fair value on a recurring basis at December 31, 2021, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,833	$ —	$ 1,833	$ —
Mortgage-backed securities	614	—	614	—
Asset-backed securities	247	—	247	—
Municipal securities	123	—	123	—
U.S. Treasury notes	353	—	353	—
Other	32	—	32	—
Total assets	$ 3,202	$ —	$ 3,202	$ —
Contingent consideration liabilities	$ 47	$ —	$ —	$ 47
Total liabilities	$ 47	$ —	$ —	$ 47

Level 3 Contingent Consideration Liabilities

Our Level 3 financial instruments at December 31, 2022 are comprised solely of contingent consideration liabilities of $8 million, in connection with our 2020 acquisition of certain assets of Passport Health Plan, Inc., a Medicaid health plan in Kentucky. Refer to Note 2, “Significant Accounting Policies—Business Combinations”, for further details. Such liabilities are recorded at fair value on a recurring basis. In 2022, the estimated fair value of contingent purchase consideration increased by approximately $4 million, relating to an operating income guarantee.

In the year ended December 31, 2022, we paid the seller $43 million, of which $23 million was for the remaining half of the consideration due for minimum member enrollment targets and $20 million was for the first payment of the consideration due for the operating income guarantee.

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our notes payable are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	December 31, 2022		December 31, 2021	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	(In millions)			
4.375% Notes due 2028	$ 792	$ 729	$ 791	$ 829
3.875% Notes due 2030	643	554	642	675
3.875% Notes due 2032	741	629	740	760
Total	$ 2,176	$ 1,912	$ 2,173	$ 2,264

6. Investments

Available-for-Sale

We consider all of our investments classified as current assets to be available-for-sale. The following tables summarize our current investments as of the dates indicated:

	December 31, 2022			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 2,303	$ 2	$ 121	$ 2,184
Mortgage-backed securities	787	—	56	731
Asset-backed securities	308	—	20	288
Municipal securities	160	—	11	149
U.S. Treasury notes	106	—	1	105
Other	45	—	3	42
Total	$ 3,709	$ 2	$ 212	$ 3,499

	December 31, 2021			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,836	$ 9	$ 12	$ 1,833
Mortgage-backed securities	616	2	4	614
Asset-backed securities	248	—	1	247
Municipal securities	123	1	1	123
U.S. Treasury notes	353	—	—	353
Other	32	—	—	32
Total	$ 3,208	$ 12	$ 18	$ 3,202

The contractual maturities of our current investments as of December 31, 2022 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 318	$ 315
Due after one year through five years	2,249	2,127
Due after five years through ten years	364	345
Due after ten years	778	712
Total	$ 3,709	$ 3,499

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains amounted $1 million, $10 million and $6 million in the years ended December 31, 2022, 2021 and 2020, respectively, and were reclassified into earnings from other comprehensive income on a net-of-tax basis. Gross realized investment losses amounted to $7 million in the year ended December 31, 2022, and were reclassified into earnings from other comprehensive income on a net-of-tax basis. Gross realized investment losses were insignificant in the years ended December 31, 2021 and 2020.

We have determined that unrealized losses at December 31, 2022 and 2021 primarily resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. Therefore, we determined that an allowance for credit losses was not necessary. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience realized losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2022:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 1,124	$ 45	683	$ 887	$ 76	371
Mortgage-backed securities	395	20	220	319	36	131
Asset-backed securities	161	6	108	118	14	59
Municipal securities	75	4	83	57	7	57
U.S. Treasury notes	88	1	6	—	—	—
Other	15	1	16	17	2	6
Total	$ 1,858	$ 77	1,116	$ 1,398	$ 135	624

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2021:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 1,063	$ 12	395	$ —	$ —	—
Mortgage-backed securities	408	4	146	—	—	—
Asset-backed securities	166	1	75	—	—	—
Municipal securities	69	1	61	—	—	—
Total	$ 1,706	$ 18	677	$ —	$ —	—

Restricted Investments Held-to-Maturity

Pursuant to the regulations governing our state health plan subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in cash, cash equivalents, U.S. Treasury securities, and corporate debt securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulations in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as “Restricted investments” in the accompanying consolidated balance sheets.

We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Our held-to-maturity restricted investments are carried at amortized cost, which approximates fair value, of which $193 million will mature in one year or less, $37 million will mature in one through five years, and $8 million will mature after five years.

The following table presents the balances of restricted investments:

	December 31,	
	2022	2021
	(In millions)	
Cash and cash equivalents	$ 42	$ 68
U.S. Treasury notes	159	144
Corporate debt securities	37	—
Total restricted investments	$ 238	$ 212

7. Property, Equipment, and Capitalized Software, Net

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Software developed for internal use is capitalized. Property and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 to 40 years.

As discussed in Note 2, “Significant Accounting Policies”, the Company recognized an impairment on property and equipment of $16 million associated with our reduction in leased space used in our business operations, in the quarter ended December 31, 2022.

A summary of property, equipment, and capitalized software is as follows:

	December 31,	
	2022	2021
	(In millions)	
Capitalized software	$ 615	$ 547
Property and equipment	221	237
Building and improvements	41	37
Land	5	1
Total cost	882	822
Less: accumulated amortization - capitalized software	(482)	(427)
Less: accumulated depreciation and amortization - property, equipment, building, and improvements	(213)	(205)
Total accumulated depreciation and amortization	(695)	(632)
ROU assets - finance leases	72	206
Property, equipment, and capitalized software, net	$ 259	$ 396

The following table presents all depreciation and amortization recognized in our consolidated statements of income:

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Recorded in depreciation and amortization:			
Amortization of intangible assets	$ 77	$ 49	$ 15
Amortization of capitalized software	54	41	38
Amortization of finance leases	28	25	19
Depreciation and amortization of property, equipment, building, and improvements	17	16	16
Total depreciation and amortization recognized	$ 176	$ 131	$ 88

8. Leases

We are a party to operating and finance leases primarily for our corporate and health plan offices. Our operating leases have remaining lease terms up to 13 years, some of which include options to extend the leases for up to 10 years. As of December 31, 2022, the weighted average remaining operating lease term is 8 years.

Our finance leases have remaining lease terms up to 16 years, some of which include options to extend the leases for up to 25 years. As of December 31, 2022, the weighted average remaining finance lease term is 13 years.

As discussed in Note 2, “Significant Accounting Policies”, the Company recognized $192 million of ROU asset impairments associated with our reduction in leased space used in our business operations in the quarter ended December 31, 2022.

As of December 31, 2022, the weighted-average discount rate used to compute the present value of lease payments was 4.4% for operating lease liabilities, and 6.3% for finance lease liabilities. The components of lease expense for the years ended December 31, 2022, 2021, and 2020 are presented in the following table.

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Operating lease expense	$ 31	$ 34	$ 28
Finance lease expense:			
Amortization of ROU assets	$ 28	$ 25	$ 19
Interest on lease liabilities	15	15	15
Total finance lease expense	$ 43	$ 40	$ 34

Supplemental consolidated cash flow information related to leases follows:

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Cash used in operating activities:			
Operating leases	$ 31	$ 33	$ 30
Finance leases	15	15	15
Cash used in financing activities:			
Finance leases	15	18	9
ROU assets recognized in exchange for lease obligations:			
Operating leases	10	86	28
Finance leases	18	18	7

Supplemental information related to leases, including location of amounts reported in the accompanying consolidated balance sheets, follows:

	December 31,	
	2022	2021
	(In millions)	
Operating leases:		
ROU assets		
Other assets	$ 43	$ 128
Lease liabilities		
Accounts payable and accrued liabilities (current)	$ 41	$ 35
Other long-term liabilities (non-current)	77	99
Total operating lease liabilities	$ 118	$ 134
Finance leases:		
ROU assets		
Property, equipment, and capitalized software, net	$ 72	$ 206
Lease liabilities		
Accounts payable and accrued liabilities (current)	$ 22	$ 15
Finance lease liabilities (non-current)	215	219
Total finance lease liabilities	$ 237	$ 234

Maturities of lease liabilities as of December 31, 2022, were as follows:

	Operating Leases	Finance Leases
	(In millions)	
2023	$ 28	$ 34
2024	22	30
2025	18	26
2026	11	23
2027	9	24
Thereafter	55	219
Subtotal - undiscounted lease payments	143	356
Less imputed interest	(25)	(119)
Total	$ 118	$ 237

9. Goodwill and Intangible Assets, Net

Goodwill

The following table presents the changes in the carrying amounts of goodwill by segment, for the periods presented.

	Medicaid	Medicare	Other	Consolidated
	(In millions)			
Balance, December 31, 2020	$ 489	$ 161	$ 42	$ 692
Acquisitions and measurement period adjustments	280	8	2	290
Balance, December 31, 2021	769	169	44	982
Acquisitions and measurement period adjustments	130	3	—	133
Balance, December 31, 2022	$ 899	$ 172	$ 44	$ 1,115

The changes in the carrying amounts of both goodwill and intangible assets, net, in 2022, were due to the

acquisitions and purchase price adjustments described in Note 4, “Business Combinations.”

Intangible Assets, Net

The following table provides the details of identified intangible assets, by major class, for the periods presented.

	December 31, 2022			December 31, 2021		
	Cost	Accumulated Amortization	Carrying Amount	Cost	Accumulated Amortization	Carrying Amount
			(In millions)			
Contract rights and licenses	$ 507	$ 279	$ 228	$ 426	$ 210	$ 216
Provider networks	57	24	33	56	19	37
Trade names	19	5	14	19	2	17
Total	$ 583	$ 308	$ 275	$ 501	$ 231	$ 270

As of December 31, 2022, we estimate that our intangible asset amortization will be approximately $84 million in 2023, $67 million in 2024, $64 million in 2025, $25 million in 2026, and $13 million in 2027.

10. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable as of the dates indicated.

	December 31,		
	2022	2021	2020
		(In millions)	
Fee-for-service claims incurred but not paid (“IBNP”)	$ 2,597	$ 2,486	$ 1,647
Pharmacy payable	206	219	157
Capitation payable	94	82	70
Other	631	576	528
Magellan Complete Care acquisition opening balance	—	—	294
Total	$ 3,528	$ 3,363	$ 2,696

“Other” medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $228 million, $226 million and $235 million, as of December 31, 2022, 2021, and 2020, respectively.

The following tables present the components of the change in our medical claims and benefits payable for the periods indicated.

	Year Ended December 31, 2022			
	Medicaid	Medicare	Marketplace	Consolidated
	(In millions)			
Medical claims and benefits payable, beginning balance	$ 2,580	$ 404	$ 379	$ 3,363
Components of medical care costs related to:				
Current year	22,097	3,390	1,972	27,459
Prior years	(251)	(32)	(1)	(284)
Total medical care costs	21,846	3,358	1,971	27,175
Payments for medical care costs related to:				
Current year	19,655	2,944	1,746	24,345
Prior years	1,966	361	343	2,670
Total paid	21,621	3,305	2,089	27,015
Acquired balances, net of post-acquisition adjustments	12	—	—	12
Change in non-risk and other provider payables	(2)	(5)	—	(7)
Medical claims and benefits payable, ending balance	$ 2,815	$ 452	$ 261	$ 3,528

	Year Ended December 31, 2021			
	Medicaid	Medicare	Marketplace	Consolidated
	(In millions)			
Medical claims and benefits payable, beginning balance	$ 2,129	$ 392	$ 175	$ 2,696
Components of medical care costs related to:				
Current year	18,321	2,970	2,652	23,943
Prior years	(182)	(39)	(18)	(239)
Total medical care costs	18,139	2,931	2,634	23,704
Payments for medical care costs related to:				
Current year	16,284	2,573	2,291	21,148
Prior years	1,601	340	139	2,080
Total paid	17,885	2,913	2,430	23,228
Acquired balances, net of post-acquisition adjustments	205	(8)	—	197
Change in non-risk and other provider payables	(8)	2	—	(6)
Medical claims and benefits payable, ending balance	$ 2,580	$ 404	$ 379	$ 3,363

	Year Ended December 31, 2020			
	Medicaid	Medicare	Marketplace	Consolidated
	(In millions)			
Medical claims and benefits payable, beginning balance	$ 1,465	$ 267	$ 122	$ 1,854
Components of medical care costs related to:				
Current year	12,545	2,189	1,205	15,939
Prior years	(84)	(28)	(7)	(119)
Total medical care costs	12,461	2,161	1,198	15,820
Payments for medical care costs related to:				
Current year	10,940	1,884	1,047	13,871
Prior years	1,176	233	98	1,507
Total paid	12,116	2,117	1,145	15,378
Acquired balances, net of post-acquisition adjustments	215	79	—	294
Change in non-risk and other provider payables	104	2	—	106
Medical claims and benefits payable, ending balance	$ 2,129	$ 392	$ 175	$ 2,696

The amounts presented for “Components of medical care costs related to: Prior years” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the year varied from the actual liabilities, based on information (principally the payment of claims) developed since those liabilities were first reported.

Our estimates of medical claims and benefits payable recorded at December 31, 2022, 2021 and 2020 developed favorably by approximately $284 million, $239 million and $119 million in 2022, 2021 and 2020, respectively. The favorable prior year development recognized in 2022 was primarily due to lower than expected utilization of medical services by our members and improved operating performance, mainly in the Medicaid segment. Consequently, the ultimate costs recognized in 2022, as claims payments were processed, were lower than our estimates in 2021.

The favorable prior year development recognized in 2021 was primarily due to lower than expected utilization of medical services by our Medicaid members, and to a lesser extent our Medicare and Marketplace members, and improved operating performance. Consequently, the ultimate costs recognized in 2021 were lower than our original estimates in 2020, which was not discernible until additional information was provided, and as claims payments were processed.

The favorable prior year development recognized in 2020 was primarily due to lower than expected utilization of medical services by our Medicaid members, and improved operating performance. Consequently, the ultimate costs recognized in 2020 were lower than our original estimates in 2019, which was not discernible until additional information was provided, and as claims payments were processed.

The following tables provide information about our consolidated incurred and paid claims development as of December 31, 2022, as well as cumulative claims frequency and the total of incurred but not paid claims liabilities. The pattern of incurred and paid claims development is consistent across each of our segments. The cumulative claim frequency is measured by claim event, and includes claims covered under capitated arrangements.

	Incurred Claims and Allocated Claims Adjustment Expenses					
Benefit Year	2020	2021	2022	Total IBNP	Cumulative number of reported claims
	(Unaudited)	(Unaudited)			
			(In millions)		
2020	$ 16,233	$ 16,056	$ 16,000	$ 27	138
2021		24,167	23,979	108	236
2022			27,459	2,453	264
			$ 67,438	$ 2,588	

Cumulative Paid Claims and Allocated Claims Adjustment Expenses			
Benefit Year	2020	2021	2022
	(Unaudited)	(Unaudited)	
		(In millions)	
2020	$ 13,871	$ 16,004	$ 15,973
2021		21,148	23,871
2022			24,345
			$ 64,189

The following table represents a reconciliation of claims development to the aggregate carrying amount of the liability for medical claims and benefits payable.

	2022
	(In millions)
Incurred claims and allocated claims adjustment expenses	$ 67,438
Less: cumulative paid claims and allocated claims adjustment expenses	(64,189)
All outstanding liabilities before 2020	9
Non-risk and other provider payables	270
Medical claims and benefits payable	$ 3,528

11. Debt

Contractual maturities of debt, as of December 31, 2022, are illustrated in the following table. All amounts represent the principal amounts of the debt instruments outstanding.

	Total	2023	2024	2025	2026	2027	Thereafter
				(In millions)			
4.375% Notes due 2028	$ 800	$ —	$ —	$ —	$ —	$ —	$ 800
3.875% Notes due 2030	650	—	—	—	—	—	650
3.875% Notes due 2032	750	—	—	—	—	—	750
Total	$ 2,200	$ —	$ —	$ —	$ —	$ —	$ 2,200

All our debt is held at the parent which is reported in the Other segment. The following table summarizes our outstanding debt obligations, all of which are non-current as of the dates reported below:

	December 31,	
	2022	2021
	(In millions)	
Non-current long-term debt:		
4.375% Notes due 2028	$ 800	$ 800
3.875% Notes due 2030	650	650
3.875% Notes due 2032	750	750
Less: unamortized debt issuance costs	(24)	(27)
Total	$ 2,176	$ 2,173

Credit Agreement

We are party to a credit agreement (the “Credit Agreement”) which includes a revolving credit facility (“Credit Facility”) of $1.0 billion, among other provisions. The Credit Agreement has a term of five years, and all amounts outstanding will be due and payable on June 8, 2025. Borrowings under the Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus in each case, the applicable margin. In addition to interest

payable on the principal amount of indebtedness outstanding from time to time under the Credit Agreement, we are required to pay a quarterly commitment fee.

The Credit Agreement contains customary non-financial and financial covenants. As of December 31, 2022, we were in compliance with all financial and non-financial covenants under the Credit Agreement and other long-term debt. As of December 31, 2022, no amounts were outstanding under the Credit Facility.

Senior Notes

Our senior notes are described below. Each of these notes are senior unsecured obligations of Molina and rank equally in right of payment with all existing and future senior debt, and senior to all existing and future subordinated debt of Molina. In addition, each of the notes contain customary non-financial covenants and change of control provisions.

The indentures governing the senior notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture.

4.375% Notes due 2028. We have $800 million aggregate principal amount of senior notes (the "4.375% Notes") outstanding as of December 31, 2022, which are due June 15, 2028, unless earlier redeemed. Interest, at a rate of 4.375% per annum, is payable semiannually in arrears on June 15 and December 15.

3.875% Notes due 2030. We have $650 million aggregate principal amount of senior notes (the "3.875% Notes due 2030") outstanding as of December 31, 2022, which are due November 15, 2030, unless earlier redeemed. Interest, at a rate of 3.875% per annum, is payable semiannually in arrears on May 15 and November 15.

3.875% Notes due 2032. We have $750 million aggregate principal amount of senior notes (the "3.875% Notes due 2032") outstanding as of December 31, 2022, which are due May 15, 2032, unless earlier redeemed. Interest, at a rate of 3.875% per annum, is payable semiannually in arrears on May 15 and November 15.

12. Income Taxes

Income tax expense for continuing operations consisted of the following:

	Year Ended December 31,		
	2022	2021	2020
		(In millions)	
Current:			
Federal	$ 297	$ 209	$ 281
State	40	31	26
Total current	337	240	307
Deferred:			
Federal	(66)	(17)	(13)
State	—	(7)	(7)
Foreign	—	—	1
Total deferred	(66)	(24)	(19)
Income tax expense	$ 271	$ 216	$ 288

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate for continuing operations is as follows:

	Year Ended December 31,		
	2022	2021	2020
Statutory federal tax (benefit) rate	21.0 %	21.0 %	21.0 %
State income provision (benefit), net of federal benefit	3.0	2.2	1.6
Nondeductible health insurer fee ("HIF")	—	—	6.1
Nondeductible compensation	1.8	1.5	1.1
Other	(0.3)	—	0.2
Effective tax expense rate	25.5 %	24.7 %	30.0 %

The effective tax rate was not impacted by the HIF in 2022 and 2021 given it was repealed for years after 2020. Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, foreign, and local tax laws.

Deferred tax assets and liabilities are classified as non-current. Significant components of our deferred tax assets and liabilities as of December 31, 2022 and 2021 were as follows:

	December 31,	
	2022	2021
	(In millions)	
Accrued expenses and reserve liabilities	$ 96	$ 57
Other accrued medical costs	24	23
Net operating losses	9	13
Unearned premiums	16	17
Lease financing obligation	40	9
Unrealized losses	49	2
Fixed assets and intangibles	9	—
Tax credit carryover	5	5
Other	5	4
Valuation allowance	(18)	(10)
Total deferred income tax assets, net of valuation allowance	235	120
Fixed assets and intangibles	—	(1)
Prepaid expenses	(15)	(13)
Total deferred income tax liabilities	(15)	(14)
Net deferred income tax asset	$ 220	$ 106

At December 31, 2022, we had state net operating loss carryforwards of $95 million, which begin expiring in 2036.

At December 31, 2022, we had foreign net operating loss carryforwards of $8 million, which expire in 2032.

At December 31, 2022, we had foreign tax credit carryovers of $5 million, which expire in 2030.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2022, $18 million of deferred tax assets did not satisfy the recognition criteria. Therefore, we increased our valuation allowance by $8 million, from $10 million at December 31, 2021, to $18 million as of December 31, 2022.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the United States, Puerto Rico, and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Gross unrecognized tax benefits at beginning of period	$ (15)	$ (20)	$ (20)
Settlements	—	5	—
Lapse in statute of limitations	10	—	—
Gross unrecognized tax benefits at end of period	$ (5)	$ (15)	$ (20)

The total amount of unrecognized tax benefits at December 31, 2022, 2021 and 2020 that, if recognized, would affect the effective tax rates is $5 million, $15 million, and $20 million, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by $5 million due to resolution of a state refund claim. The state refund claim will not result in a cash payment for income taxes if our claim is denied.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of December 31, 2022, 2021 and 2020 were insignificant.

We may be subject to examination by the IRS for calendar years after 2018. With a few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local, and Puerto Rico tax examinations for years before 2018.

On August 16, 2022, the Inflation Reduction Act was signed into law. The Inflation Reduction Act includes various tax provisions, which are effective for the tax years beginning on or after January 1, 2023. We do not expect such tax provisions to have a material impact on our consolidated financial results.

13. Stockholders' Equity

Stock Purchase Programs

In November 2022, our board of directors authorized the purchase of up to $500 million, in the aggregate, of our common stock. This new program supersedes the stock purchase program previously approved by our board of directors in September 2021, as described below. This new program will be funded with cash on hand and extends through December 31, 2023. Under this program, pursuant to a Rule 10b5-1 trading plan, we purchased approximately 590,000 shares for $200 million in the fourth quarter of 2022 (average cost of $339.06 per share). No shares have been purchased in 2023.

In September 2021, our board of directors authorized the purchase of up to $500 million, in the aggregate, of our common stock. This program was funded with cash on hand. Under this program, pursuant to a Rule 10b5-1 trading plan, we purchased approximately 658,000 shares for $200 million in the second quarter of 2022 (average cost of $304.13 per share).

Share-Based Compensation

In connection with our employee stock plans, approximately 755,000 shares and 429,000 shares of common stock were issued, net of shares used to settle employees' income tax obligations, during the years ended December 31, 2022, and 2021, respectively. Total share-based compensation expense is reported in "General and administrative expenses" in the accompanying consolidated statements of income, and summarized below.

	Year Ended December 31,					
	2022		2021		2020	
	(In millions)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
RSAs and PSUs (defined below)	$ 97	$ 90	$ 66	$ 62	$ 47	$ 44
Employee stock purchase plan and stock options	6	6	6	6	10	9
Total	$ 103	$ 96	$ 72	$ 68	$ 57	$ 53

Equity Incentive Plan

At December 31, 2022, we had employee equity incentives outstanding under our 2019 Equity Incentive Plan (the "2019 EIP"). The 2019 EIP provides for awards, in the form of restricted stock awards ("RSAs"), performance units ("PSUs"), stock options, and other stock– or cash–based awards, to eligible persons who perform services for us. The 2019 EIP provides for the issuance of up to 2.9 million shares of our common stock.

Stock-based awards. RSAs and PSUs are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. PSUs vest in their entirety at the end of three-year performance periods, if their performance conditions are met. We generally recognize expense for RSAs and PSUs on a straight-line basis. Activity for stock-based awards in the year ended December 31, 2022, is summarized below.

	RSAs	Weighted Average Grant Date Fair Value	PSUs	Weighted Average Grant Date Fair Value
Unvested balance, December 31, 2021	539,117	$ 169.39	275,050	$ 129.99
Granted	237,590	312.27	271,270	214.94
Vested	(224,345)	156.21	(219,674)	137.54
Forfeited	(41,257)	224.96	(13,816)	249.09
Unvested balance, December 31, 2022	511,105	$ 237.10	312,830	$ 193.09

As of December 31, 2022, total unrecognized compensation expense related to unvested RSAs and PSUs was $74 million, and $31 million, respectively, which we expect to recognize over a remaining weighted-average period of 2.0 years, and 0.7 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 9.2% for non-executive employees as of December 31, 2022, based on actual forfeitures over the last 4 years.

The total grant date fair value of awards granted and vested is presented in the following table.

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Granted:			
RSAs	$ 74	$ 65	$ 44
PSUs	43	—	23
Total granted	$ 117	$ 65	$ 67
Vested:			
RSAs	$ 70	$ 53	$ 22
PSUs	69	71	1
Total vested	$ 139	$ 124	$ 23

Stock Options. Stock option awards generally have an exercise price equal to the fair market value of our common stock on the date of grant, vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant. Stock option activity for the year ended December 31, 2022, is summarized below.

	Number of Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
		(Per share)	(In millions)	(Years)
Stock options outstanding as of December 31, 2021	395,000	$ 65.59		
Exercised	(390,000)	66.01		
Stock options outstanding, vested, and exercisable as of December 31, 2022	5,000	33.02	$ 1	0.2

No stock options were granted in 2022, 2021, or 2020, and no stock options were exercised in 2020. As of December 31, 2022, there was no unrecognized compensation expense related to unvested stock options.

Employee Stock Purchase Plans ("ESPP")

Under our ESPP, eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We estimate the fair value of the stock issued using a standard option pricing model. For the years ended December 31, 2022, 2021, and 2020, the inputs to this model were as follows: risk-free interest rates of approximately 0.1% to 2.5%; expected volatility of approximately 29% to 54%, dividend yields of 0%, and an average expected life of 0.5 years.

14. Employee Benefit Plans

We sponsor defined contribution 401(k) plans that cover substantially all employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plans amounted to $45 million, $41 million, and $28 million in the years ended December 31, 2022, 2021, and 2020, respectively.

We also have a non-qualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer portions of their base salary and bonus to provide tax-deferred growth. The deferrals are distributable based upon termination of employment or other periods, as elected under the plan and were $26 million and $23 million as of December 31, 2022 and 2021, respectively.

15. Commitments and Contingencies

Regulatory Capital Requirements and Dividend Restrictions

Our health plans, which are generally operated by our respective wholly owned subsidiaries in those states in which our health plans operate, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. The National Association of Insurance Commissioners ("NAIC"), has adopted rules which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for healthcare coverage. The requirements take the form of risk-based capital ("RBC") rules which may vary from state to state. Regulators in some states may also enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation.

All of the states in which our health plans operate, except California, Florida, Massachusetts and New York, have adopted the RBC rules. The minimum statutory capital requirements in these states is based on a percentage of annualized premium revenue, a percentage of annualized health care costs, a percentage of certain liabilities, or other financial ratios. The RBC rules, if adopted by California, Florida, Massachusetts or New York, could increase the minimum capital required for those states. Our Massachusetts health plan maintains a $35 million performance bond, effective through December 31, 2023, to partially satisfy minimum net worth requirements in that state.

Statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries, which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $3.1 billion at December 31, 2022. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company—Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $375 million and $348 million as of December 31, 2022 and 2021, respectively.

As of December 31, 2022, our health plans had aggregate statutory capital and surplus of approximately $3.3 billion, which was in excess of the required minimum aggregate statutory capital and surplus of approximately $2.3 billion. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

COVID-19 Pandemic

We continue to monitor and assess the estimated operating and financial impact of the COVID-19 pandemic and, as it evolves, we continue to process, assemble, and assess member utilization information. We believe that our cash resources, borrowing capacity available under the Credit Agreement, and cash flow generated from operations will be sufficient to withstand the financial impact of the pandemic, and will enable us to continue to support our operations, regulatory requirements, debt repayment obligations, and capital expenditures for the foreseeable future.

Legal Proceedings

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business including, but not limited to, various employment claims, vendor disputes and provider claims. Some of these legal actions seek monetary damages, including claims for punitive damages, which may not be covered by insurance. We review legal matters and update our estimates of reasonably possible losses and related disclosures, as necessary. We have accrued liabilities for legal matters for which we deem the loss to be both probable and reasonably estimable. These liability estimates could change as a result of further developments of the matters. The outcome of legal actions is inherently uncertain. An adverse determination in one or more of these pending matters could have an adverse effect on our consolidated financial position, results of operations, or cash flows.

Kentucky RFP. On September 4, 2020, Anthem Kentucky Managed Care Plan, Inc. brought an action in Franklin County Circuit Court against the Kentucky Finance and Administration Cabinet, the Kentucky Cabinet for Health and Family Services, and all of the five winning bidder health plans, including our Kentucky health plan. On September 9, 2022, the Kentucky Court of Appeals ruled that, with regard to the earlier Circuit Court ruling granting Anthem relief, the Circuit Court should not have invalidated the 2020 procurement and thus should not have awarded a contract to Anthem. Anthem has sought discretionary review by the Kentucky Supreme Court of the ruling by the Court of Appeals. Pending further Court order, our Kentucky health plan will continue to operate for the foreseeable future under its current Medicaid contract.

Puerto Rico. On August 13, 2021, Molina Healthcare of Puerto Rico, Inc. (“MHPR”) filed a complaint asserting, among other claims, breach of contract against Puerto Rico Health Insurance Administration (“ASES”). On September 13, 2021, ASES filed a counterclaim and a third-party complaint against MHPR and the Company. This matter remains subject to significant additional proceedings, and no prediction can be made as to the outcome.

Professional Liability Insurance

We carry medical professional liability insurance for healthcare services rendered in the primary care institutions that we manage. In addition, we carry managed care errors and omissions insurance for all managed care services that we provide.

16. Segments

We currently have four reportable segments consisting of: 1) Medicaid; 2) Medicare; 3) Marketplace; and 4) Other. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

The Medicaid, Medicare, and Marketplace segments represent the government-funded or sponsored programs under which we offer managed healthcare services. The Other segment, which is insignificant to our consolidated results of operations, includes long-term services and supports consultative services in Wisconsin.

The key metrics used to assess the performance of our Medicaid, Medicare, and Marketplace segments are premium revenue, medical margin and MCR. MCR represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying medical margin, or the amount earned by the Medicaid, Medicare, and Marketplace segments after medical costs are deducted from premium revenue, represents the most important measure of earnings reviewed by management, and is used by our chief executive officer to review results, assess performance, and allocate resources. The key metric used to assess the performance of our Other segment is

service margin. The service margin is equal to service revenue minus cost of service revenue. We do not report total assets by segment since this is not a metric used to assess segment performance or allocate resources.

The following table presents total revenue by segment. Inter-segment revenue was insignificant for all periods presented.

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Total revenue:			
Medicaid	$ 25,783	$ 21,231	$ 15,217
Medicare	3,824	3,379	2,529
Marketplace	2,296	3,091	1,677
Other	71	70	—
Consolidated	$ 31,974	$ 27,771	$ 19,423

The following table reconciles margin by segment to consolidated income before income tax expense:

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Margin:			
Medicaid	$ 2,981	$ 2,322	$ 1,804
Medicare	437	430	351
Marketplace	290	399	324
Other	11	14	—
Total margin	3,719	3,165	2,479
Add: other operating revenues [1]	1,020	846	1,124
Less: other operating expenses [2]	(3,566)	(2,991)	(2,525)
Operating income	1,173	1,020	1,078
Less: other expenses, net	110	145	117
Income before income tax expense	$ 1,063	$ 875	$ 961

(1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, Marketplace risk corridor judgment, investment income and other revenue.
(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, impairment, and other costs.

17. Condensed Financial Information of Registrant

The condensed balance sheets as of December 31, 2022 and 2021, and the related condensed statements of income, comprehensive income and cash flows for each of the three years in the period ended December 31, 2022 for our parent company Molina Healthcare, Inc. (the "Registrant"), are presented below.

Condensed Balance Sheets

	December 31,	
	2022	2021
	(In millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 329	$ 274
Investments	46	74
Due from affiliates	143	74
Prepaid expenses and other current assets	106	142
Total current assets	624	564
Property, equipment, and capitalized software, net	224	349
Goodwill and intangible assets, net	731	699
Investments in subsidiaries	4,142	3,772
Deferred income taxes	37	(18)
Advances to related parties and other assets	78	68
Total assets	$ 5,836	$ 5,434
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable, accrued liabilities and other	$ 448	$ 378
Total current liabilities	448	378
Long-term debt	2,176	2,173
Finance lease liabilities	215	219
Other long-term liabilities	33	34
Total liabilities	2,872	2,804
Stockholders' equity:		
Common stock, $0.001 par value; 150 million shares authorized; outstanding: 58 million shares at each of December 31, 2022 and December 31, 2021	—	—
Preferred stock, $0.001 par value; 20 million shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	328	236
Accumulated other comprehensive loss	(160)	(5)
Retained earnings	2,796	2,399
Total stockholders' equity	2,964	2,630
Total liabilities and stockholders' equity	$ 5,836	$ 5,434

See accompanying notes.

Condensed Statements of Income

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Revenue:			
Administrative services fees	$ 1,826	$ 1,496	$ 1,208
Investment income and other revenue	8	11	13
Total revenue	1,834	1,507	1,221
Expenses:			
General and administrative expenses	1,721	1,424	1,089
Depreciation and amortization	141	98	67
Impairment	138	—	—
Other	—	5	24
Total operating expenses	2,000	1,527	1,180
Operating (loss) income	(166)	(20)	41
Interest expense	110	120	102
Other expenses, net	—	25	15
Total other expenses, net	110	145	117
Loss before income tax benefit and equity in net earnings of subsidiaries	(276)	(165)	(76)
Income tax benefit	(42)	(21)	(5)
Net loss before equity in net earnings of subsidiaries	(234)	(144)	(71)
Equity in net earnings of subsidiaries	1,026	803	744
Net income	$ 792	$ 659	$ 673

Condensed Statements of Comprehensive Income

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Net income	$ 792	$ 659	$ 673
Other comprehensive (loss) income:			
Unrealized investment (loss) income	(204)	(55)	44
Less: effect of income taxes	(49)	(13)	11
Other comprehensive (loss) income, net of tax	(155)	(42)	33
Comprehensive income	$ 637	$ 617	$ 706

See accompanying notes.

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2022	2021	2020
	(In millions)		
Operating activities:			
Net cash provided by operating activities	$ 119	$ 60	$ 67
Investing activities:			
Capital contributions to subsidiaries	(159)	(440)	(107)
Dividends received from subsidiaries	668	564	635
Purchases of investments	(29)	(27)	(188)
Proceeds from sales and maturities of investments	49	21	282
Purchases of property, equipment and capitalized software	(86)	(70)	(74)
Net cash paid in business combinations	—	(263)	(1,028)
Change in amounts due to/from affiliates	(69)	40	(68)
Other, net	3	(3)	3
Net cash provided by (used in) investing activities	377	(178)	(545)
Financing activities:			
Common stock purchases	(400)	(128)	(606)
Common stock withheld to settle employee tax obligations	(54)	(53)	(8)
Contingent consideration liabilities settled	(20)	(20)	—
Proceeds from senior notes offering, net of issuance costs	—	740	1,429
Repayment of senior notes	—	(723)	(338)
Repayment of term loan facility	—	—	(600)
Proceeds from borrowings under term loan facility	—	—	380
Cash paid for partial termination of warrants	—	—	(30)
Cash paid for partial settlement of conversion option	—	—	(27)
Cash received for partial settlement of call option	—	—	27
Repayment of principal amount of convertible notes	—	—	(12)
Other, net	33	1	2
Net cash (used in) provided by financing activities	(441)	(183)	217
Net increase (decrease) in cash and cash equivalents	55	(301)	(261)
Cash and cash equivalents at beginning of period	274	575	836
Cash and cash equivalents at end of period	$ 329	$ 274	$ 575

See accompanying notes.

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation

The Registrant was incorporated in 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for three other state health plans. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B - Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to our subsidiaries pursuant to administrative services agreements that include, but are not limited to, information technology, product development

and administration, underwriting, claims processing, customer service, certain care management services, human resources, marketing, purchasing, risk management, actuarial, finance, accounting, compliance, legal and public relations. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2022, 2021, and 2020 for these services amounted to $1,826 million, $1,496 million, and $1,208 million, respectively, and are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C - Dividends and Capital Contributions

When the Registrant receives dividends from its subsidiaries, such amounts are recorded as a reduction to the investments in the respective subsidiaries.

For all periods presented, the Registrant made capital contributions to certain subsidiaries primarily to comply with minimum net worth requirements and to fund business combinations. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

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Responses to Technical Questions (Tab 7)

MOLINA HEALTHCARE

Qualifications and Experience (Tab 7a)

MOLINA HEALTHCARE

4.3.I.1 Medicaid Managed Care Experience in the Past Five Years

1. Describe the bidder's Medicaid Managed Care experience in the past five (5) years by completing a table that includes the information listed below for each contract.
   a. Name of state and program name.
   b. Start and end date.
   c. Services covered under the contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation).
   d. Covered population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children.
   e. Average number of total member months for the most recent twelve (12) months of the contract (or most recent period if the contract has been in place less than twelve [12] months).
   f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance.
   g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.
   h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed.

Molina Healthcare of Kansas, Inc. (Molina) is a wholly owned subsidiary of Molina Healthcare, Inc. (Molina Healthcare). Molina Healthcare, through its subsidiary health plans in 20 states, serves approximately 5.2 million Members. Nationwide, Molina's affiliate health plans have a proven record of providing services similar to those defined in RFP § 7 and Appendix C to populations of similar scope and complexity, as demonstrated throughout this proposal.

Table 1-1. Molina Healthcare of Arizona, Inc.

a. Name of State and Program Name
State: Arizona | Medicaid state program: Arizona Complete Care
b. Start and End Date
Medicaid: 10/01/2018–Present | Medicare D-SNP: 01/01/2020–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, behavioral health (SMI carve-out), pharmacy, dental, vision, transportation, institutional LTSS, and HCBS | Medicare D-SNP: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy.
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, TANF (SMI carved out), Medicare D-SNP: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX); Aged, Blind or Disabled (ABD); or Medicaid Expansion. Although not a covered population, we have foster care children and youth, former foster care, and adoption assistance assigned as needed during enrollment and initial transition to Medicaid to ensure consistent coverage.
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 49,120 | Medicare D-SNP: 281
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Quality Improvement—CY 2021 Performance Measure Audit—AZ Medicaid	Arizona Health Care Cost Containment System (AHCCCS)	CAP implemented	Date Issued: 06/21/2023

	State Regulatory Notice	and issue closed	Date Closed: 10/11/2023
AHCCCS Notice of Concern—Molina Healthcare PAT File Data Accuracy	AHCCCS External CAP	CAP implemented and issue closed	Date Issued: 01/12/2023 Date Closed: 1/12/2023
AHCCCS Operational Review	AHCCCS External Audit $10,000 fine	CAP implemented and issue pending closure	Date Issued: 05/26/2022 Date Closed: 06/26/2022
Marketing Material Not Requested Prior to Approval—MCC AZ Medicaid	AHCCCS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 09/16/2021 Date Closed: 11/19/2021

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
None	None

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services, including enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (fraud, waste, and abuse (FWA)), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365).
- Arizona State Physician Association (MCC)—credentialing
- Banner Health Network (MCC)—credentialing
- Cobre Valley (MCC)—credentialing
- CaremarkPCS Health, LLC (CVS Caremark®)—pharmacy network, call center, claims, credentialing
- DentaQuest—call center and utilization management (UM)
- District Medical Group (MCC)—credentialing
- HonorHealth (MCC)—credentialing
- Integra Partners—credentialing
- Integrated Medical Services (IMS) (MCC)—credentialing

- Molina Clinical Services Advanced Imaging—UM
- Nationwide Optometry (MCC)—credentialing
- Phoenix Children's Hospital (MCC)—credentialing
- Physical Therapy Provider Network (MCC)—credentialing
- Valleywise Health (MCC)—credentialing
- Veyo, LLC—claims, call center, credentialing, transportation/network
- VSP—call center

Table 1-2. Molina Healthcare of California, Inc.

a. Name of State and Program Name
State: California | Medicaid state program: Medi-Cal Managed Care
b. Start and End Date
Medicaid: • Geographic Managed Care Model: – Sacramento: 01/01/2008–Present – San Diego: 10/01/2010–Present • Two-plan Managed Care Model: – Imperial County: 11/01/2013–Present – Riverside and San Bernardino Counties: 08/01/2006–Present – Los Angeles County (subcontracted under HealthNet): 02/01/1996–Present Medicare D-SNP (Los Angeles, Riverside, San Bernardino, and San Diego): 04/01/2014–Present (MMP transitioned to exclusively aligned enrollment D-SNP as of 01/01/2023–Present.)
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, behavioral health (mild/moderate), transportation, EAE and non-EAE D-SNP, SMAC | Medicare Duals Demonstration: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy.
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, Foster, TANF, Medicare Duals Demonstration: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX), ABD, Medicaid Expansion | LTSS: individuals with physical disabilities, individuals with intellectual and developmental disabilities, and dual-eligible beneficiaries.
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 578,476 | Medicare Duals Demonstration: 7,229

f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Covered CA Performance Evaluation Plan Year 2021—CA Marketplace/Medicaid	Department of Managed Healthcare (DMHC) State Regulatory Notice; $99,199 fine	Fine paid and issue closed	Date Issued: 01/31/2023 Date Closed: 03/29/2023
Quality Sanction Notice—Molina Healthcare of California Partner Plan, Inc.	DMHC Notice of Noncompliance; $117,000 fine	CAP implemented and issue closed	Date Issued: 12/13/2022 Date Closed: 01/15/2023
Health Net Audit—OHC/COB Contested Claims Accuracy Payment Integrity—CA Medicaid	Department of Health Services (DHS) External CAP	CAP implemented and issue closed	Date Issued: 08/19/2022 Date Closed: 01/11/2023
DMHC Notice of Noncompliance	DMHC Notice of Noncompliance; $1,000,000 fine	CAP implemented and issue closed	Date Issued: 06/01/2022 Date Closed: 06/01/2022
Payment Integrity—Non-Contracted Provider Offsets to Recoup Overpayments—CA Marketplace/Medicaid	DMHC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/16/2022 Date Closed: 07/01/2022
Enforcement Matter Number: 20-523	DHS Notice of Noncompliance; $35,000 fine	CAP implemented and issue closed	Date Issued: 06/15/2021 Date Closed: 06/15/2021

Network Management—DMHC MY2019 Network Findings—CA Marketplace/Medicaid	DMHC External CAP	CAP implemented and issue closed	Date Issued: 02/26/2021 Date Closed: 04/09/2021
Network—DHCS Notice of Corrective Action for failure to meet 2020 Network Certification Requirements	DHS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 11/10/2020 Date Closed: 12/30/2020
Encounter—Q2 2020 Non-Compliant Encounter Data Quality Report Card—CA	DMHC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/28/2020 Date Closed: 09/24/2021
EM 19-1278 related to 2015 DMHC Medical Survey and 2017 DMHC Follow-up Survey	DMHC Liquidated Damages: $15,000 fine	Fine paid and issue closed	Date Issued: 07/28/2020 Date Closed: 07/28/2020
DMHC EM 20-003	DMHC Liquidated Damages: $5,000 fine	Fine paid and issue closed	Date Issued: 07/07/2020 Date Closed: 07/07/2020
The Office of Enforcement of the Department of Managed Health Care (Department) is conducting an investigation of management services organization Primary Provider Management Company (PPMC) concerning the above-referenced matter. At this time, the Department has concluded that there is sufficient evidence that violations of the Knox-Keene Health Care Service Plan Act of 1975, as amended, and title 28 of the California Code of Regulations (collectively, the Knox-Keene Act) have occurred, thereby justifying the imposition of an administrative penalty against Molina Healthcare of California in the amount of	DMHC Notice of Noncompliance; $50,000 fine	CAP implemented and issue closed	Date Issued: 06/08/2020 Date Closed: 06/08/2020

$50,000 and corrective action. CA Marketplace/Medicaid			
Molina submitted its 06/2019 Provider network data on 07/11/2019, one day after the 07/10/2019 submission deadline; DHCS is imposing total monetary sanctions in the amount of $1,000.	DHS Notice of Noncompliance; $1,000 fine	CAP implemented and issue closed	Date Issued: 05/11/2020 Date Closed: 12/11/2020
DMHC Enforcement Matter—2016 Timely Access and Network Adequacy—CA Medicaid	DMHC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/27/2020 Date Closed: 06/25/2021
Delegation Oversight—Notice of Non-Filing RBOs—Quarterly Financial Survey Report or Compliance Statement—CA Medicaid	DMHC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/19/2019 Date Closed: 08/23/2019
Delegation Oversight—DMHC Notice of Non-Filing RBO—EasyAccess Care IPA—CA Medicaid	DMHC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/26/2019 Date Closed: 08/23/2019
DMHC Notice of Noncompliance with Intent to Impose Monetary Sanctions for Non-Compliance with DHCS Contract Requirements	DMHC Notice of Noncompliance; $5,000 fine	CAP implemented and issue closed	Date Issued: 07/15/2019 Date Closed: 09/23/2019
DHCS—Notice of Corrective Action Plan and Imposition of Monetary Sanctions for Failure to Meet 2019 Network Certification Requirements	DMHC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/09/2019 Date Closed: 09/30/2019
Delegation Oversight—EHS SynerMed Oversight—CA Marketplace/Medicaid - Items 1 and 3	DMHC Notice of Noncompliance; $100,000 fine	CAP implemented and issue closed	Date Issued: 07/01/2019 Date Closed: 10/28/2019
DMHC issued Enforcement Matter 18-548 for violating the following: the plan acted at a variance with the enrollee's Evidence of Coverage (EOC) in violation of Health and Safety Code section 1386,	DMHC Notice of Noncompliance; $7,500 fine	CAP implemented and issue closed	Date Issued: 02/21/2019 Date Closed: 12/31/2019

subdivision (b)(1) and the plan failed to adequately consider the enrollee's grievance, a violation of section 1368, subdivision (a) (1).			
DMHC issued Enforcement Matter 18-379 for violating the following: for MY2016, the Plan's timely access report contained data reporting errors because the Plan did not properly follow the standardized methodology and the plan failed to accurately calculate the correct number of Providers in a Provider group in violation of section 1367.03, subdivision (f)(3), and Rule 1300.67.2.2. subdivision (g) (2) (G).	DMHC Notice of Noncompliance; $15,000 fine	CAP implemented and issue closed	Date Issued: 02/15/2019 Date Closed: 12/31/2019

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
Between 06/07/2022 and 06/30/2022, Availity, LLC ("Availity®"), a healthcare clearinghouse and Molina business associate, experienced a security incident that occurred in the Molina Provider ePortal via a Single Sign-On (SSO) connection with the Availity Essentials payor portal. The breach affected 87 Members enrolled in Molina Healthcare's California, Florida, New York, Texas, and Virginia health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm
Between 09/17/2021 and 11/05/2021, Regal Medical Group, Inc., a business associate of Molina Healthcare, reported that some undelivered claims checks and related explanations of payment/remittance advices were lost during the USPS mailing process; 22 Molina Healthcare Members were affected by this breach.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other: The business associate implemented corrective action to prevent future breaches.
On 10/28/2019, a remote Molina employee impermissibly orally disclosed PHI about a Member to the employee's family member.	• Notified affected Member(s) • Provided individuals with free credit monitoring

	• Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Other: Created and implemented a corrective action plan
On 07/31/2018, Molina inadvertently misdirected an Appeal Resolution Letter to an unintended recipient in error.	• Notified affected Member(s) • Took steps to mitigate harm • Sanctioned workforce members involved • Trained or retrained workforce members • Other: Implemented corrective action
On 06/29/2018, a Molina workforce member inadvertently mailed a notice of appeal resolution letter to an unintended recipient in error.	• Notified affected Member(s) • Took steps to mitigate harm • Provided individuals with free credit monitoring • Sanctioned workforce members involved • Trained or retrained workforce members
On 04/18/2018, Advanced Medical Reviews, LLC (“AMR”), a business associate of Molina, became aware of a medical reviewer, Spyros Panos, who fraudulently impersonated another licensed physician and who, on 09/01/2013, impermissibly accessed PHI in connection with independent medical reviews conducted by AMR on Molina’s behalf. The breach affected 75 Members across Molina Healthcare’s California, Ohio, Texas, Utah, Washington, and Wisconsin health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other: Required business associate to implement corrective action
On 01/01/2017, Molina inadvertently faxed PHI pertaining to four Members to an unauthorized recipient.	• Notified affected Member(s) • Took steps to mitigate harm • Trained or retrained workforce members • Other: Implemented corrective action

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Access2Care—call center, claims, credentialing (driver validation), sanction monitoring

- Accordant Health Services, a wholly owned subsidiary of CVS Caremark—care management CVS Caremark—PBM—call center, claims
- Alliance Health Systems IPA—claims, credentialing, UM
- Allied Pacific Physicians of California—claims, credentialing, UM
- Alpha Care Medical Group—claims, credentialing, UM
- AltaMed Health Services Corporation—claims, credentialing, UM
- American Logistics—call center, credentialing, driver validation
- American Specialty Health (ASH)—call center, sanction monitoring
- Angeles IPA—claims, credentialing, UM
- Associated Dignity Medical Group, Inc.—claims, credentialing, UM
- Associated Hispanic Physicians IPA—claims, credentialing, UM
- Bella Vista Medical Group—claims, credentialing, UM
- Beverly Community Hospital—claims
- BioIQ—sanction monitoring
- Cal Care IPA, Inc. d/b/a Prospect Medical Group—claims, credentialing, UM
- California Pacific Physicians Medical Group—claims, credentialing, UM
- Cedar Sinai Medical Group—credentialing
- Children's Hospital Los Angeles Medical Group—credentialing
- Children's Primary Care Medical Group, Inc.—credentialing
- Community Care IPA—claims, credentialing, UM
- Delta Dental—call center, claims, credentialing, sanction monitoring, UM
- EasyAccess Care IPA—claims, credentialing, UM
- El Proyecto Del Barrio—claims, credentialing, UM
- Exceptional Care Medical Group, Inc. (ECMG)—claims, credentialing, UM
- Family Health Centers of San Diego—credentialing
- Global Care Medical Group—claims, credentialing, UM
- GN Medical Associates, Inc. d/b/a CareConnect Medical Group—credentialing
- Good Samaritan Hospital—claims
- Health Net Community Solutions, Inc.—claims, credentialing, UM
- Healthcare LA IPA—claims, credentialing, UM
- Healthy New Life Medical Corporation—claims, credentialing, UM
- HearUSA—call center, claims, credentialing, sanction monitoring
- HPN—Desert Oasis Medical Group—claims, credentialing, UM
- HPN—Heritage Victor Valley Medical Group—claims, credentialing, UM
- HPN—High Desert Medical Group—claims, credentialing, UM
- HPN—Lakeside Medical Group—claims, credentialing, and UM
- HPN—Regal Medical Group—claims, credentialing, UM HPN—Sierra Medical Group—claims, credentialing, UM
- Impact IPA—claims, credentialing, UM
- Inland Faculty Medical Group—claims, credentialing, UM
- Integrated Health Partners (CA)—credentialing
- La Salle Medical Associates IPA—claims, credentialing, UM
- Loma Linda University Healthcare (Faculty)—credentialing
- Los Angeles Medical Center IPA d/b/a Prospect Medical Group—claims, credentialing, UM
- March Vision—call center, claims, credentialing, sanction monitoring
- Monterey Park Hospital—claims

- Nivano Physicians Inc.—claims, credentialing, UM
- Noble Community Medical Associates—claims, credentialing, UM
- Operation Samahan—credentialing
- Optum—claims, credentialing, UM
- Pacific Healthcare IPA—claims, credentialing, UM
- Preferred IPA of California—claims, credentialing, UM
- Premier Patient Care—claims, credentialing, UM
- Prospect Medical Group—claims, credentialing, UM
- Providence Holy Cross Medical Center—claims
- Rady Children's Specialists of San Diego—claims, credentialing, UM
- Regent Medical Group, Inc.—claims, credentialing, UM
- River City Medical Group—claims, credentialing, UM
- Scripps Medical Clinics—credentialing
- Seoul Medical Group—claims, credentialing, UM
- Serendib Healthways—claims, credentialing, UM
- Serra Community Medical Clinic—claims, credentialing, UM
- South Atlantic Medical Group—claims, credentialing, UM
- Southern California Children's Healthcare Network—claims, credentialing, UM
- Southern Indian Health Center—credentialing validation
- Southland Advantage Medical Group, Inc.—claims, credentialing, UM
- Southland San Gabriel Valley Medical Group, Inc.—claims, credentialing, UM
- St. Francis Medical Center—claims
- Superior Choice Medical Group—claims, credentialing, UM
- Valley Presbyterian Hospital—claims
- WellSpace Nexus—claims, credentialing, UM

Table 1-3. Molina Healthcare of Florida, Inc.

a. Name of State and Program Name
State: Florida | Medicaid state program: Florida Statewide Medicaid Managed Care (SMMC)
b. Start and End Date
Medicaid: 12/01/2008–Present | Medicare D-SNP: 01/01/2010–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health, transportation, vision, and LTSS | Medicare D-SNP: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy, ambulance Medicaid benefits and services for children in the custody of the Department of Children and Families.
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, Foster Care, TANF, Duals, ABD, LTSS Medicare D-SNP: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX).
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 173,856 | Medicare D-SNP: 1,834
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
LD: LTC Case Record Review Deficiencies Submission 37	Agency for Health Care Administration (AHCA) State Regulatory	Fine paid and issue closed	Date Issued: 09/25/2023 Date Closed: 11/15/2023

	Notice $250 fine		
LD: Failure to Comply with Provider Network Requirements (Ratio, Geographic Access), Update Online Directory, and File Accurate Reports (Q4 2021)	AHCA External Audit; $25,500 fine	Fine paid and issue closed	Date Issued: 08/17/2023 Date Closed: 09/28/2023
AHCA Escalation: PDL Noncompliance 11/2021 and 12/2021	AHCA State Regulatory Notice	CAP implemented and issue closed	Date Issued: 06/16/2023 Date Closed: 07/30/2023
AHCA Escalation: PDL Noncompliance 11/2021 and 12/2021	AHCA State Regulatory Notice	CAP implemented and issue closed	Date Issued: 06/16/2023 Date Closed: 07/30/2023
LD: Failure to Submit PNV File That Meets the Agency's Specs	AHCA State Regulatory Notice; $250 fine	Fine paid and issue closed	Date Issued: 06/01/2023 Date Closed: 06/01/2023
LD: Failure to Comply with Marketing Requirements	AHCA State Regulatory Notice; $7,500 fine	Fine paid and issue closed	Date Issued: 05/24/2023 Date Closed: 05/24/2023
AHCA review of the 06/2022 SAPO had one finding for Expedited authorizations processed outside of two days.	AHCA State Regulatory Notice; $5,000 fine	Fine paid and issue closed	Date Issued: 05/08/2023 Date Closed: 06/05/2023
Two findings found in the 01/2022 Enrollee Complaints, Grievances and Appeals Report.	AHCA External CAP; $200 fine	Fine paid and issue closed	Date Issued: 04/26/2023 Date Closed: 04/26/2023
LD: Failure to Comply with Provider Complaint System Requirements	AHCA Notice of Noncompliance; $1,700 fine	Fine paid and issue closed	Date Issued: 04/10/2023 Date Closed: 04/10/2023

LD: Failure to Provide Covered Services Within Timely Access Standards	AHCA Notice of Noncompliance; $30,000 fine	CAP implemented and issue closed	Date Issued: 02/01/2023 Date Closed: 06/05/2023
LD: Failure to Provide Covered Services Within Timely Access Standards (Q3 2021)	AHCA Notice of Noncompliance; $2,500 fine	CAP implemented and issue closed	Date Issued: 02/01/2023 Date Closed: 06/05/2023
Health Care Services—Failure to Comply with Standards for Timely Service Authorization LD (SAPO Report)—FL Medicaid	AHCA State Regulatory Notice; $30,000 fine	CAP implemented and issue closed	Date Issued: 01/27/2023 Date Closed: 06/05/2023
Appeals and Grievance—Failure to File Accurate Provider Complaint Reports LD—FL Medicaid	AHCA State Regulatory Notice; $2,000 fine	CAP implemented and issue closed	Date Issued: 11/30/2022 Date Closed: 03/10/2023
Health Care Services—Failure to Comply with Standards for Timely Service Authorization Performance Outcome LD—FL Medicaid	AHCA Notice of Noncompliance; $5,000 fine	CAP implemented and issue closed	Date Issued: 11/28/2022 Date Closed: 03/06/2023
Delegation Oversight—Failure to Comply with Transportation Provisions—Timeliness LD—FL Medicaid	AHCA State Regulatory Notice; $1,000 fine	CAP implemented and issue closed	Date Issued: 11/04/2022 Date Closed: 11/04/2022
Community Engagement—Unapproved Community Events—AHCA Escalation—FL Medicaid	AHCA Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/10/2022 Date Closed: 09/26/2022
Health Plan Operation—LD: Failure to Submit a Provider Network File (PNV) with Correct Formatting Protocol—FL Medicaid	AHCA External CAP; $250 fine	CAP implemented and issue closed	Date Issued: 07/21/2022 Date Closed: 04/16/2023
Healthcare Services—LD: Failure to Facilitate Transfers Between Health Care Settings—FL Medicaid	AHCA Notice of Noncompliance; $1,000 fine	CAP implemented and issue closed	Date Issued: 05/11/2022 Date Closed:

			06/18/2022
Potential Liquidated Damages—Pharmacy Services—PDL Compliance Review Findings 2021—FL Medicaid	AHCA Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 05/11/2022 Date Closed: 10/30/2022
MCC—On 04/27/22 the AHCA FL notified Molina of the following: Liquidated Damages for Failure to Meet the Minimum Standards for Calendar Year (CY) 2020 HEDIS® Performance Measures (PM) and Federal Fiscal Year (FFY) 2019-20 Well-Child Visit Rate Requirements.	AHCA External CAP; $729,360 fine	CAP implemented and issue closed	Date Issued: 04/27/2022 Date Closed: 04/27/2022
On 04/27/22 the AHCA FL notified Molina of the following: Liquidated Damages for Failure to Meet the Minimum Standards for Calendar Year (CY) 2020 HEDIS Performance Measures (PM) and Federal Fiscal Year (FFY) 2019-20 Well-Child Visit Rate Requirements.	AHCA Notice of Noncompliance; $373,101 fine	CAP implemented and issue closed	Date Issued: 04/27/2022 Date Closed: 08/29/2022
Several issues identified by AHCA, including Network ratios for 3 months, access issues for 3 months, Provider accepting new Medicaid Members for 3 months, and online directory issues for 2 months	AHCA Notice of Noncompliance; $25,000 fine	CAP implemented and issue closed	Date Issued: 04/22/2022 Date Closed: 04/22/2022
AHCA review of LTC records and findings	AHCA Notice of Noncompliance; $2,000 fine	CAP implemented and issue closed	Date Issued: 03/11/2022 Date Closed: 05/29/2022
Liquidated Damages for Failure to Timely File LTC Critical Incident Report	AHCA Notice of Noncompliance; $500 fine	CAP implemented and issue closed	Date Issued: 03/09/2022 Date Closed: 05/29/2022
Appeals & Grievances (A&G)—AHCA Escalation: Q4 2021 Provider Complaint Report—FL Medicaid	AHCA State Regulatory Notice	CAP implemented and issue closed	Date Issued: 02/17/2022 Date Closed: 05/25/2022

Growth & Community Engagement—Potential LD: Marketing Event Not Reported & AHCA Approved—FL Medicaid	AHCA Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/26/2022 Date Closed: 01/26/2022
Encounter—LD Escalation—Legacy Specialty Encounter Rates—FL Medicaid	AHCA CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 01/07/2022 Date Closed: 01/07/2022
Liquidated Damages—Failure to Comply with Transportation Reports—FL Medicaid	AHCA External CAP; $3,000 fine	CAP implemented and issue closed	Date Issued: 12/01/2021 Date Closed: 01/08/2022
MCC Liquidated Damages—Failure to Comply with Transportation Provisions (04/2021 and 05/2021)	AHCA Notice of Noncompliance; $2,000 fine	CAP implemented and issue closed	Date Issued: 11/30/2021 Date Closed: 11/30/2021
Liquidated Damages for Failure to Timely Report All Suspected or Confirmed Instances of Fraud or Abuse	AHCA Notice of Noncompliance; $24,900 fine	CAP implemented and issue closed	Date Issued: 10/11/2021 Date Closed: 11/12/2021
Risk: AHCA Report Findings Q42021—Provider Complaint—Delegation Oversight iCare (AHCA Escalation)—FL Medicaid	AHCA CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 10/01/2021 Date Closed: 04/10/2022
Health Plan Operations—Liquidated Damages Midwife Secret Shopper—FL Medicaid	AHCA CMS Regulatory Notice; $6,000 fine	CAP implemented and issue closed	Date Issued: 08/26/2021 Date Closed: 08/26/2021
Liquidated Damages—Failure to Comply with Provider Network Requirements, Timely Access Standards, Update Online Directory and File Accurate Reports (Behavioral Health Network Review—Q4 2020)—FL Medicaid	AHCA Notice of Noncompliance; $18,000 fine	CAP implemented and issue closed	Date Issued: 08/19/2021 Date Closed: 08/19/2021
MCC—Liquidated Damages—Failure to Provide Covered Services Within	AHCA External CAP; $500 fine	CAP implemented	Date Issued: 08/19/2021

the Timely Access Standards (Behavioral Health Network Review—Q4 2020)		and issue closed	Date Closed: 08/19/2021
Liquidated Damages—Midwife Secret Shopper—FL Medicaid	AHCA Notice of Noncompliance; $6,000 fine	CAP implemented and issue closed	Date Issued: 08/04/2021 Date Closed: 10/05/2022
Liquidated Damages—Failure to Comply with Encounter Data Submission Requirements Regarding Accuracy (01/2021)	AHCA State Regulatory Notice; $2,000 fine	CAP implemented and issue closed	Date Issued: 07/12/2021 Date Closed: 08/26/2021
Liquidated Damages for Long-Term Care Case Record Review Deficiencies (Submission 28)	AHCA State Regulatory Notice; $14,500 fine	CAP implemented and issue closed	Date Issued: 06/28/2021 Date Closed: 07/29/2021
Liquidated Damages for Failure to File Required Reports Timely (Suspected/Confirmed Waste Report)	AHCA State Regulatory Notice; $500 fine	CAP implemented and issue closed	Date Issued: 06/01/2021 Date Closed: 07/08/2021
Information Technology—Failure to Provide Covered Services with Reasonable Promptness (Prescribed Drugs) LD—FL Medicaid	AHCA Notice of Noncompliance; $47,825 fine	CAP implemented and issue closed	Date Issued: 02/15/2021 Date Closed: 04/02/2021
Delegation Oversight—MRx Encounters Data Accuracy Did Not Meet 95%—FL Medicaid	AHCA External CAP	CAP implemented and issue closed	Date Issued: 02/11/2021 Date Closed: 07/30/2021
Liquidated Damages—Failure to Comply with Provider Network Standards (Network Adequacy 08/2020)	AHCA Notice of Noncompliance; $3,000 fine	CAP implemented and issue closed	Date Issued: 02/05/2021 Date Closed: 04/13/2021
MCC Liquidated Damages—Failure to Comply with Provider Network Requirements—FL Medicaid	AHCA Notice of Noncompliance; $15,000 fine	CAP implemented and issue closed	Date Issued: 02/05/2021 Date Closed: 02/05/2021

LD—Failure to File Accurate Reports (Provider Complaint/Appeal Reports Q2 2020)	AHCA Notice of Noncompliance; $3,000 fine	CAP implemented and issue closed	Date Issued: 01/15/2021 Date Closed: 01/15/2021
Delegation Oversight—Data Accuracy Submitted by Veyo—FL Medicaid	AHCA Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/13/2021 Date Closed: 04/09/2021
Network Management LD—Failure to Update Online Directory and File Accurate Reports—FL Medicaid	AHCA Notice of Noncompliance; $12,000 fine	CAP implemented and issue closed	Date Issued: 01/11/2021 Date Closed: 02/13/2021
MCC—Liquidated Damages—for Failure to Comply with Provider Network Standards (Regional Provider Ratios—08/2020)	AHCA Notice of Noncompliance; $1,000 fine	CAP implemented and issue closed	Date Issued: 01/08/2021 Date Closed: 01/08/2021
MCC—Liquidated Damages—for Failure to Meet Minimum Standards for Calendar Year (CY) 2019 HEDIS Performance Measures (PM)	AHCA External CAP; $153,830 fine	Fine paid and issue closed	Date Issued: 12/04/2020 Date Closed: 12/04/2020
MCC—Liquidated Damages—Failure to Comply with Encounter Data Submission Requirements Regarding Accuracy (08/2020)	AHCA CMS Regulatory Notice; $1,000 fine	Fine paid and issue closed	Date Issued: 12/11/2020 Date Closed: 12/11/2020
HCS LTC—LD Case Record Submission 27—FL Medicaid	AHCA State Regulatory Notice; $1,750 fine	Fine paid and issue closed	Date Issued: 12/14/2020 Date Closed: 12/14/2020
Case Management DRTS Targeted Monitoring—Desk Review Audit Findings—FL Medicaid	AHCA Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 10/27/2020 Date Closed: 10/27/2020
MCC—Liquidated Damages—Failure to Comply with Contract Timeframes with Providers (Provider	AHCA CMS Regulatory	Fine paid and issue closed	Date Issued: 09/01/2020

Complaint/Appeal Reports—Quarter 1 2020)	Notice; $2,000 fine		Date Closed: 09/01/2020
Liquidated Damages—Long Term Care Case Record Review Deficiencies—FL Medicaid	AHCA Notice of Noncompliance; $23,250 fine	Fine paid and issue closed	Date Issued: 08/21/2020 Date Closed: 08/21/2020
MCC SMI—LD: Failure to Comply with Provider Network Standards—Accepting New Patients	AHCA Liquidated Damages: $1,000 fine	Fine paid and issue closed	Date Issued: 08/07/2020 Date Closed: 08/07/2020
LD—Failure to Comply with Encounter Data Submission Requirements—CVS Encounter Issue	AHCA Notice of Noncompliance; $1,000 fine	Fine paid and issue closed	Date Issued: 07/13/2020 Date Closed: 07/12/2020
Encounter Failure to Comply with Data Encounter Submission—Timeliness Liquidated Damages—FL Medicaid	AHCA Notice of Noncompliance; $1,000 fine	Fine paid and issue closed	Date Issued: 06/08/2020 Date Closed: 06/08/2020
On 03/05/2020, MHF submitted a Provider Network File (PNV) that was imported correctly but had two errors on the PG file that caused all PG records to fail, causing the upload to fail, resulting in a non-submission.	AHCA State Regulatory Notice; $250 fine	Fine paid and issue closed	Date Issued: 03/10/2020 Date Closed: 03/10/2020
On 07/01/2019, MHF submitted information to the Agency that a Provider would be terminated from our Network effective 06/30/2019. MHF continued to report this Provider on the PNV through 09/26/2019.	AHCA State Regulatory Notice; $1,000 fine	Fine paid and issue closed	Date Issued: 03/10/2020 Date Closed: 03/10/2020
Liquidated Damages for Failure to Comply with Marketing Requirements (Unapproved Marketing Material)	AHCA Notice of Noncompliance; $2,500 fine	Fine paid and issue closed	Date Issued: 03/06/2020 Date Closed: 03/06/2020
Several deficiencies noted on LD from state (page 3)	AHCA State Regulatory Notice; $51,750 fine	Fine paid and issue closed	Date Issued: 03/06/2020 Date Closed:

			03/06/2020
MCC—Liquidated Damages—Failure to Comply with Marketing Requirements	AHCA State Regulatory Notice; $2,500 fine	Fine paid and issue closed	Date Issued: 03/06/2020 Date Closed: 03/06/2020
Liquidated Damages for Failure to Update Online Directory (09/2019)	AHCA Notice of Noncompliance; $2,000 fine	Fine paid and issue closed	Date Issued: 12/20/2019 Date Closed: 12/20/2019
Liquidated Damages for Long Term Care Case Record Review Deficiencies	AHCA Notice of Noncompliance; $74,500 fine	Fine paid and issue closed	Date Issued: 12/19/2019 Date Closed: 12/19/2019
Case Management—Liquidated Damages LTC Record Review Deficiencies—Submission 24, 25, 26—FL Medicaid	AHCA Notice of Noncompliance; $149,500 fine	CAP implemented and issue closed	Date Issued: 12/19/2019 Date Closed: 12/19/2019
Liquidated Damages for Failure to Comply with Provider Network Standards, Update Online Directory and File Accurate Reports (Pediatric Therapists Ad Hoc)	AHCA Notice of Noncompliance; $16,000 fine	Fine paid and issue closed	Date Issued: 12/16/2019 Date Closed: 12/16/2019
Liquidated Damages for Failure to Report a Critical Incident to Adult Protective Services	AHCA Notice of Noncompliance; $5,000 fine	Fine paid and issue closed	Date Issued: 12/16/2019 Date Closed: 12/16/2019
MCC—Liquidated Damages for Failure to File Accurate Reports (Pediatric Therapists Ad Hoc)	AHCA Notice of Noncompliance; $1,000 fine	Fine paid and issue closed	Date Issued: 12/16/2019 Date Closed: 12/16/2019
Liquidated Damages for Inaccurate or Incorrect System Information Resulting in Inappropriate Adjudication of Claims/Incorrect Payment	AHCA Notice of Noncompliance; $86,600 fine	Fine paid and issue closed	Date Issued: 12/06/2019 Date Closed: 12/06/2019
MCC—Liquidated Damages for Inaccurate or Incorrect System Information Resulting in	AHCA Notice of	Fine paid and issue closed	Date Issued: 12/06/2019

Inappropriate Adjudication of Claims/Incorrect Payment	Noncompliance; $300 fine		Date Closed: 12/06/2019
AHCA issued a Liquidated Damages notice of noncompliance for Long Term Care Case Record Review Deficiencies (Submission 23)	AHCA Notice of Noncompliance; $3,000 fine	Fine paid and issue closed	Date Issued: 11/08/2019 Date Closed: 11/08/2019
MCC Liquidated Damages—Failure to Submit a Provider Network File that Meets the Agency's Specifications	AHCA Notice of Noncompliance; $250 fine	Fine paid and issue closed	Date Issued: 11/18/2019 Date Closed: 11/18/2019
MCC—Liquidated Damages for Failure to Submit a Provider Network File that Meets the Agency's Specifications	AHCA Notice of Noncompliance; $250 fine	Fine paid and issue closed	Date Issued: 10/18/2019 Date Closed: 10/18/2019
MFL received a Liquidated Damage in the amount of $2,750—Long term care case review record deficiencies	AHCA Liquidated Damages: $2,750 fine	Fine paid and issue closed	Date Issued: 07/31/2019 Date Closed: 07/31/2019
MFL received a Liquidated Damage in the amount of $2000—Failure to Comply with Provider Network standards (Regional Provider Ratios—05/2019)	AHCA Liquidated Damages: $2,000 fine	Fine paid and issue closed	Date Issued: 07/25/2019 Date Closed: 07/25/2019
MCC—Liquidated Damages for Failure to Comply with Provider Network Standards (Regional Provider Ratios)	AHCA Liquidated Damages: $8,000 fine	Fine paid and issue closed	Date Issued: 05/21/2019 Date Closed: 05/21/2019
MFL received a Liquidated Damage in the amount of $4,000—Failure to Comply with Provider Network Standards (Regional Provider Ratios)	AHCA Liquidated Damages: $4,000 fine	CAP implemented and issue closed	Date Issued: 05/21/2019 Date Closed: 05/21/2019
LDs for Failure to Comply with Claims Processing Requirements (Crossover Claims) —IP Hospital—FL Medicaid	AHCA Liquidated Damages: $30,000 fine	Fine paid and issue closed	Date Issued: 05/20/2019 Date Closed: 05/20/2019

MCC—Liquidated Damages for Failure to Comply with Marketing Requirements	AHCA Notice of Noncompliance; $12,500 fine	CAP implemented and issue closed	Date Issued: 05/16/2019 Date Closed: 05/16/2019
AHCA issued a liquidated damages notice of noncompliance for failure to produce accurate reports related to enrollee complaints, grievances and appeals with a fine in the amount of $3,000.	AHCA Notice of Noncompliance; $3,000 fine	CAP implemented and issue closed	Date Issued: 04/19/2019 Date Closed: 04/19/2019
AHCA issued a liquidated damages notice of noncompliance due to not correctly identifying comprehensive timely completion for the initial face-to-face assessment. MFL self-reported this issue to AHCA which found 61 Members had been impacted in 11/2018.	AHCA Notice of Noncompliance; $152,500 fine	CAP implemented and issue closed	Date Issued: 04/19/2019 Date Closed: 04/19/2019
A&G—Reporting Inaccuracies—Liquidated Damages Medicaid—FL (579S)	AHCA Notice of Noncompliance; $3,000 fine	CAP implemented and issue closed	Date Issued: 04/19/2019 Date Closed: 04/19/2019
MFL received a Liquidated Damage in the amount of $250—Failure to Submit a Provider Network file that meets the Agency's specifications.	AHCA Notice of Noncompliance; $250 fine	CAP implemented and issue closed	Date Issued: 04/15/2019 Date Closed: 07/16/2019
AHCA issued a liquidated damages notice of noncompliance for failing to report a LTC Critical Incident report to the AHCA immediately upon occurrence and no later than 24 hours after the detection or notification.	AHCA State Regulatory Notice; $500 fine	CAP implemented and issue closed	Date Issued: 04/15/2019 Date Closed: 04/15/2019
Network Management—Provider Network Verification File Failed to meet required specifications—Liquidated Damages—FL Medicaid (568S)	AHCA Notice of Noncompliance; $6,250 fine	CAP implemented and issue closed	Date Issued: 03/28/2019 Date Closed: 08/29/2019
MFL received a Liquidated Damage in the amount of $16,250 for Failure to Comply with Enrollee Notice Requirements (Enrollee Complaints,	AHCA Notice of Noncompliance; $16,250 fine	CAP implemented and issue closed	Date Issued: 02/18/2019 Date Closed:

Grievances, and Appeals Report 2nd & 3rd Quarter 2018).			02/18/2019
MFL received a Liquidated Damage in the amount of $2,000 for Failure to Provide Transportation Services	AHCA Notice of Noncompliance; $2,000 fine	CAP implemented and issue closed	Date Issued: 02/18/2019 Date Closed: 02/18/2019
MFL received a Liquidated Damage in the amount of $500—Failure to Timely File a LTC Critical Incident Report	AHCA Notice of Noncompliance; $500 fine	CAP implemented and issue closed	Date Issued: 02/18/2019 Date Closed: 02/18/2019
MFL received a Liquidated Damage in the amount of $6,000 for the late submission of the AFAAR by 4 days (due on 09/04/2018 and submitted on 09/07/2018) at the rate of $2,000 per day.	AHCA Notice of Noncompliance; $6,000 fine	CAP implemented and issue closed	Date Issued: 02/14/2019 Date Closed: 02/14/2019
Received Liquidated Damages letter from Agency for HealthCare Administration (AHCA) for Long Term Care Case record review deficiencies with a fine amount of $18,000.	AHCA Notice of Noncompliance; $18,000 fine	CAP implemented and issue closed	Date Issued: 12/28/2018 Date Closed: 12/28/2018
Long Term Care (LTC) 834 File Inaccuracies—FL Medicaid (494S)	AHCA Notice of Noncompliance; $54,750 fine	CAP implemented and issue closed	Date Issued: 12/14/2018 Date Closed: 12/14/2018
MCC—Liquidated Damages for Failure to File Ad Hoc Reports Timely and Failure to File Accurate Reports (Continuity of Care Data Sharing Reports)	AHCA Notice of Noncompliance; $5,500 fine	CAP implemented and issue closed	Date Issued: 11/08/2018 Date Closed: 11/08/2018
MCC—Liquidated Damages for Failure to Meet the Minimum Standards for Calendar Year (CY) 2017 HEDIS Performance Measures (PM) and Federal Fiscal Year (FFY) 2016-17 Child Health Check-Up (CHCUP) Rate Requirements	AHCA Notice of Noncompliance; $2,118,500 fine	CAP implemented and issue closed	Date Issued: 11/08/2018 Date Closed: 11/08/2018
Received Liquidated Damages letter from Agency for HealthCare Administration (AHCA) of the PNV	AHCA Notice of	CAP implemented	Date Issued: 10/01/2018

Files. Molina failed to meet the Provider network standards specified in the Contract. LD Damages letter CASE #2018014578. Letter Dated 10/01/2018.	Noncompliance; $34,000 fine	and issue closed	Date Closed: 10/1/2018
MCC—Liquidated Damages for Failure to Comply with Provider Network Standards (Regional Provider Ratios)	AHCA Notice of Noncompliance; $10,000 fine	CAP implemented and issue closed	Date Issued: 10/01/2018 Date Closed: 10/01/2018

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 12/30/2022 Best Foot Forward, a business associate of Molina, reported that a Best Foot Forward employee exfiltrated PHI pertaining to 2 Members.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm
Between 06/07/2022 and 06/30/2022, Availity, LLC ("Availity"), a healthcare clearinghouse and Molina business associate experienced a security incident that occurred in the Molina Provider ePortal via a Single Sign-On (SSO) connection with the Availity Essentials payor portal. The breach affected 87 Members enrolled in Molina Healthcare's California, Florida, New York, Texas, and Virginia health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm
On 12/06/2021, Beacon Health Options ("Beacon"), Molina's vendor and business associate, experienced a security (malware) incident related to their email network, which resulted in a breach.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Required business associate to implement corrective action
On 08/19/2020, Molina inadvertently misdirected a package containing PHI pertaining to 2 Members to an incorrect address.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members • Other: Corrected the Members' addresses in Molina's system and requested that the currently

	enrolled affected Member update their address with the state Medicaid program
On 08/03/2018, Molina inadvertently mailed a health plan ID card to an incorrect address for the intended recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved • Took steps to mitigate harm • Trained or retrained workforce members • Other: Molina verified the Member's address and updated the address in our system.
On 01/16/2018, Molina business associate, Beacon lost an Appeal Letter.	• Notified affected Member(s) • Other: Required business associate to mitigate the incident and implement corrective action

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Access2Care—NEMT
- Coastal Care—home health, DME, home infusion
- Consumer Direct for Florida—participant direction
- CVS Caremark—PBM, pharmacy services
- HealthNetworkOne—therapy services
- Hear USA—hearing services
- iCare Health Solutions—vision services

Table 1-4. Molina Healthcare of Utah, Inc., d/b/a Molina Healthcare of Idaho

a. Name of State and Program Name
State: Idaho | Medicaid state program: Idaho Medicaid Plus (IMPlus) and Idaho Medicare Medicaid Coordinated Plan (MMCP)
b. Start and End Date
Medicaid: 01/01/2018–Present | Medicare D-SNP: 01/01/2006–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health, LTSS | Medicare D-SNP: medical, pharmacy, behavioral health, vision | Other: skilled nursing facility
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
ABD Duals, Medicare D-SNP: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX) LTSS: There are three eligibility categories (Rate Codes): • Rate Code 14: Developmental Disability Waiver • Rate Code 15: Aged and Disabled Waiver • Rate Code 17: Skilled Nursing Facilities (Long Term Care) or ICF/IID Facilities
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
IMPlus Medicaid: 4,785 | Medicare D-SNP: 725 | MMCP (Medicare & Medicaid): 6,034
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
FQHC HCA Billing Issues ID MMP Medicaid	IDHW Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/31/2023 Date Closed:

			12/08/2023
Configuration—Government Contracts—Incorrect Rejected Claims Payment and Untimely Government Contracts Communication—ID MMP—Medicaid	IDHW Notice of Noncompliance; $300 fine	CAP implemented and issue closed	Date Issued: 12/21/2022 Date Closed: 06/13/2023
Claims—Incorrect Skilled Nursing Facility Reimbursement Rates—ID Medicaid	IDHW Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/28/2022 Date Closed: 11/09/2023
Special Investigations Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—Multistate	IDHW External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date Closed: 02/07/2022
Payment Integrity IDHW External CAP—Failure to Pay Claims Correctly—ID Medicaid	IDHW Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/19/2022 Date Closed: 04/15/2022
Idaho Encounters Untimely Submissions due to IDHW not using an Industry Standard 837—Medicaid	IDHW Notice of Noncompliance; $500 fine	CAP implemented and issue closed	Date Issued: 01/08/2021 Date Closed: 03/15/2021
ENR—Untimely Dis-enrollment—ID MMCP Medicaid	IDHW Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/03/2020 Date Closed: 12/11/2020
IDHW—Individual Care Plan	IDHW Liquidated Damages	CAP implemented and issue closed	Date Issued: 09/12/2019 Date Closed: 09/12/2019
Provider Services—Claims Payment Issues for Behavioral Health Providers—ID Medicaid	IDHW Liquidated Damages	CAP implemented and issue closed	Date Issued: 07/01/2019 Date Closed: 12/30/2020

Member Assessment Team (MAT) out of compliance with HRAs—ID Medicaid—Medicare	Idaho Department of Health and Welfare (IDHW) Liquidated Damages: $66,000 fine	CAP implemented and issue closed	Date Issued: 02/21/2019 Date Closed: 06/11/2019

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
None	None

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365).
- Access2Care—NEMT
- American Specialty Health—fitness—call center
- Kootenai Health (ID)—credentialing
- IHC (Intermountain Healthcare)—credentialing
- Online Care Network—credentialing
- St. Luke's Health System—credentialing
- Tri-State Memorial Hospital—credentialing
- University of Utah Medical Group (UUMG)—credentialing
- Valley Mental Health (Valley Behavioral Health)—credentialing
- Accordant Health Services, a wholly owned subsidiary of CVS Caremark—care management
- Healthmap—case management
- Molina Clinical Services (MCS) Advanced Imaging—UM
- MCS Enterprise Medicare Unit—UM
- Papa—call center
- VSP—call center, claims, credentialing

Table 1-5. Molina Healthcare of Illinois, Inc.

a. Name of State and Program Name
State: Illinois | Medicaid state program: HealthChoice Illinois Medicaid
b. Start and End Date
Medicaid: 01/01/2018–Present | Medicare D-SNP: 01/01/2006–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health, dental, transportation, LTSS Medicare Duals Demonstration: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy, ambulance
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
Moms & Babies (Mothers and Children), TANF, ABD, MLTSS, HCBS Waivers (Aging, Persons with Disabilities, Traumatic Brain Injury, HIV, Supportive Living), ACA Expansion, Special Needs Children, Foster Children LTSS: Aging Pop: 65+ and ≥ 29 Determination of Need (DON) Score; Persons with Disabilities: disability diagnosis, age <65, ≥ 29 DON Score; HIV: HIV Diagnosis, ≥ 29 DON; TBI: Diagnosis of TBI, <65, ≥ 29 DON; SLP: Living in SLP, ≥ 29 DON; MLTSS: dual eligible for Medicare Primary/Medicaid set as Secondary Although not a covered population, we have foster care children and youth, former foster care, and adoption assistance assigned as needed when there is a medical rationale for a child to seek care outside of that health plan's network.
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 351,678 | Medicare Duals Demonstration: 16,494
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct

Sanction of $20,000 for failure to provide a written response/resolution in 30 calendar days for several Provider disputes	Illinois Healthcare and Family Services (HFS) State Regulatory Notice; $20,000 fine	Fine paid and issue closed	Date Issued: 10/12/2023 Date Closed: 10/12/2023
Sanction of $5,000 for failure to submit timely the PCP Reassignment Ad Hoc Report request	HFS CMS Regulatory Notice; $5,000 fine	Fine paid and issue closed	Date Issued: 06/08/2023 Date Closed: 06/08/2023
Q1 2023 HSW Sanction Letter—IL Medicaid	HFS State Regulatory Notice; $50,000 fine	Fine paid and issue closed	Date Issued: 06/05/2023 Date Closed: 06/05/2023
Molina MMAI EUM 2022 Eval 4 Sanction Letter—IL	HFS State Regulatory Notice; $50,000 fine	CAP implemented and issue closed	Date Issued: 05/12/2023 Date Closed: 05/12/2023
IL Medicaid Sanction for Failure to Submit July QBR Executive Summaries in a Timely Fashion	Illinois Department of Health Services (DHS) Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/21/2021 Date Closed: 07/21/2021
Health Plan Ops—Monitor and increase Encounter threshold percentages—IL Medicaid	HFS External CAP; $100,000 fine	CAP implemented and issue closed	Date Issued: 04/05/2021 Date Closed: 05/13/2021
Sanction—Vendor Management/GC – Allocation of Monies to BEP Authorized Vendors—IL MMP—Medicaid	DHS External CAP; $2,300,000 fine	Fine paid and issue closed	Date Issued: 12/10/2020 Date Closed: 03/21/2021
(563S) Finance—Missing Information in Report to Department of Insurance—IL Medicaid	HFS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/02/2019 Date Closed: 08/09/2019

Molina Healthcare of Illinois failed to file the 2018 Health Risk-Based Capital Report within the time frame required by Section 5/35A-10 of the Illinois Insurance Code (215 ILCS 5/35A-10). Due to the untimely filing a civil penalty of $800 must be paid. Per the notice, the civil penalty is $200 per day for each day that the Health Risk-Based Capital Report is not received after a postmark date of 03/01/2019.	HFS Liquidated Damages: $800 fine	CAP implemented and issue closed	Date Issued: 03/05/2019 Date Closed: 03/05/2019

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 03/23/2022, a Molina Healthcare workforce member inadvertently faxed PHI pertaining to 1 Member to an unauthorized recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
Between 05/07/2021 and 05/12/2021, a workforce member of Carenet Healthcare Systems ("Carenet"), a Molina Healthcare vendor and business associate, allowed a family Member to impermissibly access PHI in Carenet's systems. This breach affected a total of 7 Molina Healthcare Members in the following states: Illinois (1); Kentucky (2); Ohio (2); and South Carolina (2).	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members • Other: Required the business associate to implement corrective action
On 04/22/2021, Molina Healthcare inadvertently misdirected a Member ID Card sent via USPS to an unauthorized recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other: Corrected the Member's address within Molina's systems
On 02/05/2021, MTM, a vendor and business associate of Molina, inadvertently left voicemails	• Notified affected Member(s) • Took steps to mitigate harm • Other: Business associate retrained their staff involved in the breach, and business associate

containing the PHI of two Members, which caused a breach.	removed the incorrect phone numbers from their systems.
On 10/29/2020, Molina Healthcare inadvertently misdirected a letter containing PHI to an unintended recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 10/02/2020, a Molina business associate, Toppan Merrill, inadvertently misdirected a Care Plan to an unintended recipient in error.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Revised business associate contracts • Took steps to mitigate harm • Other: Business associate implemented corrective action.
On 11/27/2019, Molina Healthcare was unable to locate PHI sent to Molina Healthcare via mail by a healthcare Provider. The lost information pertained to an appeal of a denied claim.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members
On 02/12/2019, a Molina employee impermissibly accessed 1 Member's record without a business need to do so.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 07/02/2018, a Molina business associate inadvertently disclosed 1 Member's PHI, in error, to an unintended individual.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other: Required business associate to implement corrective action
On 01/01/2018, CVS Caremark ("CVS") a business associate of Molina, experienced a data file processing error, which resulted in the unauthorized disclosure of PHI pertaining to 4 Members enrolled in Molina's Illinois, Ohio, Washington, and Michigan health plans.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other: Required the business associate to mitigate the incident and implement corrective action to help prevent future incidents

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support

(clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365).

- Avensis—vision
- Carenet—triage/Nurse Advice Line (24/7/365)
- Chrysalis—BH crisis line
- CVS Caremark—PBM
- DentaQuest—dental
- GLOBO—telehealth services, translation services
- HealPros—compliance sanction monitoring
- Healthmap—case management, compliance sanction monitoring
- Molina Clinical Services (MCS) Advance Imaging—UM
- MCS Enterprise Medicare Unit—UM
- MTM—transportation
- VSP—claims, compliance sanction monitoring

Table 1-6. Molina Healthcare of Iowa, Inc.

a. Name of State and Program Name
State: Iowa | Medicaid state program: Iowa Health Link
b. Start and End Date
Medicaid: 07/01/2023–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medical, pharmacy, behavioral health, dental, vision, transportation
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
• American Indian individuals • Individuals who have been screened and diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Early Detection Program (BCCEDP) or by any Provider or entity whose screening activities BCCEDP has elected to include • Children ages 1 to 18 eligible in accordance with income at or below 167% FPL • Children in foster care, subsidized adoption, or subsidized guardianship if the Agency is wholly or partially responsible for their support • Former foster children under age 26 • Healthy and Well Kids in Iowa (Hawki) • Individuals eligible for HCBS services • Individuals under age 21 who were in state-sponsored foster care on their 18th birthday with income under 254% FPL • Infants under age 1 • Institutionalized individuals (hospital, NF, psychiatric institution, or ICF/ID) • Iowa Health and Wellness Plan (IHAWP) • Children with special needs • Medicaid for Employed People with Disabilities (MEPD) • Child under age 21 with a special need for whom there is a non-IV-E adoption assistance agreement in effect • Parents and other caretaker relatives • Pregnant women with income at or below 375% FPL • Reasonable classifications of individuals under age 21 • SSI recipients • Individuals who receive State Supplementary Assistance • Transitional Medical Assistance
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
July: 214,542 | August: 197,807 | September: 185,471 | October: 174,807

f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Files Not Delivered Timely or Accurately to Regulators—IA Medicaid	IA DHHS External Audit	CAP implemented and issue closed	Date Issued: 09/06/2023 Date Closed: 12/08/2023
IT BAS—Non-Encrypted Files Submission to Regulator DHHS—IA Medicaid	IA Department of Health and Human Services (DHHS) External Audit	CAP currently being implemented	Date Issued: 08/11/2023 Date Closed: Pending Correction

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 09/26/2023, a Molina Healthcare employee verbally disclosed PHI about a Member to an unauthorized party.	• Notified affected Member(s) • Provided individual(s) with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 09/25/2023, an unauthorized person(s) temporarily gained access to a Molina employee's email account and certain work files associated with the account. This affected 1,648 Members.	• Notified affected Member(s) • Provided individual(s) with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Access2Care—NEMT
- Aperture Health—NCQA-certified credentialing verification organization
- Auracom—translation services, primarily verbal
- Avera Health—Subcontractor-for credentialing only
- Carenet—administers 24/7/365 Nurse Advice Line
- Catholic Health Partners Initiative—Subcontractor-for credentialing only
- Change Healthcare Technologies, LLC—risk adjustment analytics, claims payment and communication, EDI services, pharmacy file exchanges
- Cotiviti, LLC—payment integrity services
- CVS—pharmacy/PBM
- Equian (Optum)—subrogation/third-party liability
- GLOBO Language Solutions, LLC—oral translation services vendor/call center connect
- Great River Health—Subcontractor-for credentialing only
- Gunderson Health (GLAS)—Subcontractor-for credentialing only
- Infosys (Enrollment)—enrollment services
- Infosys (Payment Integrity)—COB validation/verification
- March Vision—vision services
- Medimore (Unity Point)—Subcontractor-for credentialing only
- Mercy One—Subcontractor-for credentialing only
- Methodist Health Partners—Subcontractor-for credentialing only
- Molina Clinical Services—conducts disease management, high-risk OB case management, and advanced imaging and transplant utilization review
- Nations—over-the-counter benefit
- O'Neil Digital Solutions—print/mail service provider that does mail Member or Provider-facing correspondence and print language translator
- OptumInsight, Inc.—payment integrity services/data analytic/upfront claims processing
- Paramount Health Options—Subcontractor-for credentialing only
- Performant—Data mining & COB collections from commercial carrier, chart audits
- Quitline—Smoking Cessation education and coaching
- Sanford Health—Subcontractor-for credentialing only
- SecureCare—Subcontractor-for credentialing only
- Syrtis (Rx COB)—COB validation/verification
- Teladoc®—Subcontractor-for credentialing only
- University of Iowa—Subcontractor-for credentialing only

- Veridian-Consumer Choice Option (CCO) solution—consumer-directed services (financial management services)

Table 1-7. Molina Healthcare of Kentucky, Inc.

a. Name of State and Program Name
State: Kentucky | Medicaid state program: Kentucky Medicaid Program (KMP)
b. Start and End Date
Medicaid: 01/01/2021–Present | Medicare D-SNP: 01/01/2022–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health, dental, vision, other: hearing | Medicare D-SNP: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy, ambulance
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, TANF, Medicare D-SNP: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX), ABD, Medicaid Expansion Although not a covered population, we have foster care children and youth, former foster care, and adoption assistance assigned as needed during enrollment and initial transition to Medicaid to ensure consistent coverage.
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 341,361 | Medicare D-SNP: 2,073
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Encounters Penalties—KY—June	KY Department for Medicaid Services (DMS) External Audit; $26,405 fine	Fine paid and issue closed	Date Issued: 08/04/2023 Date Closed:

			08/04/2023
Accounts Payable—NONC DMS External CAP PP2023PB Late PBM Invoices—KY Medicaid	KY DMS External Audit	CAP currently being implemented	Date Issued: 08/03/2023 Date Closed: Pending Correction
Finance—KY Health Plan failed to promptly release escrowed Provider funds as directed by DMS—KY Medicaid	KY DMS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/17/2023 Date Closed: 10/26/2023
Encounters Penalties—KY—May	KY DMS State Regulatory Notice; $42,175 fine	Fine paid and issue closed	Date Issued: 06/19/2023 Date Closed: 06/19/2023
Encounter Penalties—Kentucky—April	KY DMS State Regulatory Notice; $83,650 fine	Fine paid and issue closed	Date Issued: 05/22/2023 Date Closed: 05/22/2023
Payment Integrity—Department for Medicaid Services (DMS) Notice of Noncompliance/Failure to Suspend and Escrow Payment Following Credible Allegation of Fraud by DMS	KY DMS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 05/01/2023 Date Closed: 09/20/2023
Encounter Penalties—Kentucky—March	KY DMS External CAP; $57,455 fine	Fine paid and issue closed	Date Issued: 04/17/2023 Date Closed: 04/17/2023
IT—Failure to Validate Successful Transmission of Files—KY Medicaid	KY DMS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 03/31/2023 Date Closed: 06/24/2023
Encounter Penalties—Kentucky—February	KY DMS External CAP; $26,725 fine	Fine paid and issue closed	Date Issued: 03/20/2023 Date Closed:

			03/20/2023
Delegation Oversight—Avesis 834 File Issues—KY Medicaid/Medicare	KY DMS External CAP	CAP implemented and issue closed	Date Issued: 03/19/2023 Date Closed: 06/28/2023
Payment Integrity—Third Party Liability Payment Process Failure—KY Medicaid	KY DMS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/14/2023 Date Closed: 09/12/2023
KY Encounter Penalties Report—01/2023	KY DMS Notice of Noncompliance; $73,540 fine	Fine paid and issue closed	Date Issued: 02/20/2023 Date Closed: 02/20/2023
KY Encounter Penalties Report—12/2022	KY DMS State Regulatory Notice; $154,960 fine	Fine paid and issue closed	Date Issued: 01/23/2023 Date Closed: 01/23/2023
Molina Healthcare, Inc., EIM—Paid Claims Listing Submission to KY DMS Contained Errors—KY Medicaid	KY DMS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 11/30/2022 Date Closed: 04/10/2023
KY Encounter Penalties 10/2022	KY DMS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 11/21/2022 Date Closed: 11/21/2023
KY Encounter Penalties 09/2022	KY DMS Notice of Noncompliance; $64,005 fine	CAP implemented and issue closed	Date Issued: 10/24/2022 Date Closed: 10/24/2022
Health Plan Operations—External Independent Third-Party Review (EITR) Requests Processed and Reported Untimely—KY Medicaid	KY DMS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 10/11/2022 Date Closed: 04/14/2023

KY Encounter Penalties August 2022	KY DMS Notice of Noncompliance; $39,855 fine	CAP implemented and issue closed	Date Issued: 09/23/2022 Date Closed: 09/23/2022
KY—Encounter Penalties	KY DMS Notice of Noncompliance; $773,879 fine	CAP implemented and issue closed	Date Issued: 08/12/2022 Date Closed: 08/12/2022
Vendor Management—Avesis—Inaccurate Provider Term Report—KY Medicaid	KY DMS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/27/2022 Date Closed: 07/27/2022
Passport Health Plan—Encounter Penalties	KY DMS Notice of Noncompliance; $340,585 fine	CAP implemented and issue closed	Date Issued: 07/18/2022 Date Closed: 07/18/2022
Network Management—DMS LOC Regarding Provider Terminations Not Reported Pursuant to Contract—KY Medicaid	KY DMS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/28/2022 Date Closed: 04/21/2023
KY Encounter Penalties 05/2022	KY DMS Notice of Noncompliance; $223,520 fine	CAP implemented and issue closed	Date Issued: 06/27/2022 Date Closed: 06/27/2022
KY Encounter Penalties 09/2022	KY DMS Warning Letter; $140,335 fine	CAP implemented and issue closed	Date Issued: 05/13/2022 Date Closed: 05/13/2022
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $319,415 fine	CAP implemented and issue closed	Date Issued: 04/18/2022 Date Closed: 04/18/2022
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $333,785 fine	CAP implemented and issue closed	Date Issued: 03/22/2022 Date Closed:

			03/22/2022
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $352,770 fine	CAP implemented and issue closed	Date Issued: 02/22/2022 Date Closed: 02/22/2022
Special Investigations Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—Multistate	CMS External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date Closed: 02/07/2022
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $336,635 fine	CAP implemented and issue closed	Date Issued: 01/18/2022 Date Closed: 01/18/2022
Liquidated Damages—Encounters—KY Medicaid	KY DMS CMS Regulatory Notice; $192,795 fine	CAP implemented and issue closed	Date Issued: 12/21/2021 Date Closed: 12/21/2021
Payment Integrity (FWA)—Penalty and CAP—Availability and Access to Data—KY Medicaid	KY DMS Notice of Noncompliance; $5,0000 fine	CAP implemented and issue closed	Date Issued: 12/20/2021 Date Closed: 03/05/2022
SIU Letter of Concern—KY Medicaid	KY DMS External CAP	CAP implemented and issue closed	Date Issued: 12/10/2021 Date Closed: 12/10/2021
Liquidated Damages—Encounters—KY Medicaid	KY DMS External CAP; $363,515 fine	CAP implemented and issue closed	Date Issued: 11/30/2021 Date Closed: 11/30/2021
Health Plan Ops—Encounter Duplicates Causing Liquidated Damages—KY Medicaid	KY DMS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 11/01/2021 Date Closed: 11/01/2021

Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $243,580 fine	CAP implemented and issue closed	Date Issued: 10/19/2021 Date Closed: 10/19/2021
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $169,725 fine	CAP implemented and issue closed	Date Issued: 09/20/2021 Date Closed: 09/20/2021
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $118,335 fine	CAP implemented and issue closed	Date Issued: 08/20/2021 Date Closed: 08/20/2021
Health Plan Ops—Encounter Data Penalties—KY Medicaid	KY DMS Notice of Noncompliance; $125,335 fine	CAP implemented and issue closed	Date Issued: 08/20/2021 Date Closed: 08/20/2021
Provider Relations—External Independent Review—Letter of Concern—KY Medicaid	KY DMS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/19/2021 Date Closed: 02/10/2022
Provider Network/Claims Configuration—DMS Letter of Concern of Provider Configuration Causing Unpaid Claims—KY Medicaid	KY DMS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/27/2021 Date Closed: 10/14/2021
Passport Health Plan—Encounter Penalties	KY DMS State Regulatory Notice; $98,390 fine	CAP implemented and issue closed	Date Issued: 07/19/2021 Date Closed: 11/18/2021
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $80,930 fine	CAP implemented and issue closed	Date Issued: 06/24/2021 Date Closed: 06/24/2021
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $44,445 fine	CAP implemented	Date Issued: 05/21/2021

		and issue closed	Date Closed: 05/21/2021
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $194,250 fine	CAP implemented and issue closed	Date Issued: 04/21/2021 Date Closed: 04/21/2021
Liquidated Damages—Encounters—KY Medicaid	KY DMS Notice of Noncompliance; $25,895 fine	CAP implemented and issue closed	Date Issued: 03/25/2021 Date Closed: 03/25/2021
Liquidated Damages—Encounters—KY Medicaid	KY DMS External CAP; $21,674 fine	CAP implemented and issue closed	Date Issued: 02/19/2021 Date Closed: 2/19/2021

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 12/01/2022, a Molina Healthcare workforce member inadvertently faxed PHI pertaining to one Member to an unknown fax number.	• Notified affected Member(s) • Provided individual(s) with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 10/21/2022, a Molina healthcare workforce member inadvertently sent pre-populated request of information (ROI) forms to multiple Members in error.	• Notified affected Member(s) • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
Between 06/28/2022 and 07/13/2022, O'Neil Digital Solutions, LLC ("O'Neil"), a Molina Healthcare print and fulfillment vendor and business associate, inadvertently misdirected Member ID cards to incorrect addresses via the USPS. The names of 8,283 affected Members in Kentucky and Ohio were inadvertently associated with other unrelated Members'	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members

addresses due to the business associate's data processing issue.	
On 04/04/2022, a Molina employee inadvertently placed a Member's care plan into an envelope addressed and mailed to another Member.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
Between 05/07/2021 and 05/12/2021, a workforce member of Carenet Healthcare Systems ("Carenet"), a Molina Healthcare vendor and business associate, allowed a family Member to impermissibly access PHI in Carenet's systems. This breach affected a total of seven Molina Healthcare Members in the following states: Illinois (1); Kentucky (2); Ohio (2); and South Carolina (2).	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members • Other: Required the business associate to implement corrective action

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Avesis Third Party Administrators, Inc.—dental services, claims, call center, UM, credentialing
- Carenet Health—24/7/365 Nurse Advice Line, BH Crisis Line, HRA, quality Member engagement activities & VAB
- CVS—Accordant Care–care management
- DentaQuest—dental services, claims, call center, UM, credentialing
- Evolent Health—transition services agreement
- GLOBO—translation services
- March Vision Care Group, Inc.—vision services, claims, credentialing, call center
- MedImpact—pharmacy services
- New Century Health—clinical services, UM, Provider call center
- Periscope—DME
- Progeny Health—case management, UM
- Teladoc—telehealth

Table 1-8. Molina Healthcare of Massachusetts, Inc.

a. Name of State and Program Name
State: Massachusetts | Medicaid State Program: MassHealth
b. Start and End Date
Medicaid FIDE D-SNP: 02/19/2003–Present | Medicare FIDE D-SNP: 08/01/2004–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health (BH), dental, transportation, LTSS | Medicare D-SNP: medical, pharmacy, BH, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy, ambulance
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
Medicaid: CHIP, foster care, TANF | Dual, Medicare D-SNP: individuals who are entitled to both Medicare (Title XVIII) and medical assistance from a state plan under Medicaid (Title XIX)
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid FIDE D-SNP: 1,435 | Medicare FIDE D-SNP: 12,700
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
None	None	None	None

*Molina has a process to implement and monitor corrective actions in response to potential or confirmed noncompliance of employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including regulatory contract requirements, and Federal, state, and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery, with a 30-/60-/90-day evidence of compliance.

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
None	None

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services, including enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, IT services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, Nurse Advice Line (24/7/365)
- American Specialty Health Fitness—fitness and exercise services
- Beth Israel Deaconess Physician Organization—credentialing
- Boston Medical Center—credentialing
- Brigham and Women's Hospital—partner credentialing
- CVS Caremark®—claims, Member/Provider Services Call Centers
- Dana-Farber Cancer Institute—credentialing
- DentaQuest—call center, claims, credentialing, UM)
- Integra—credentialing
- Massachusetts General Hospital—partner credentialing
- Molina Clinical Services Advanced Imaging—UM
- North Shore Medical Center—partner credentialing
- Tufts Medical Center—credentialing
- UMass Memorial Medical Group—credentialing

Table 1-9. Molina Healthcare of Michigan, Inc.

a. Name of State and Program Name
State: Michigan | Medicaid State Program: Michigan Comprehensive Healthcare Program
b. Start and End Date
Medicaid: 01/01/2000–Present; Medicare D-SNP: 01/01/2006–Present; Medicare Duals Demonstration: 05/01/2015–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health (BH; mild/moderate outpatient only), transportation, dental | Medicare D-SNP and Duals Demonstration: medical, pharmacy, BH, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy | Duals Demonstration only: LTSS
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, CSHCS, foster care, TANF, Medicare D-SNP | Duals Demonstration: individuals who are entitled to both Medicare (Title XVIII) and medical assistance from a state plan under Medicaid (Title XIX), ABD, Medicaid expansion
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 399,296 | Medicare D-SNP: 15,161 | Medicare Duals Demonstration: 12,484
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
ENC Validation Health Plan Corrective Action—MI Medicaid	Michigan Department of Health & Human Services	CAP implemented and issue closed	Date Issued: 04/19/2023 Date Closed: 05/26/2023

	(MDHHS) External CAP		
Claims Processing (non-pharmacy)	MDHHS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/01/2022 Date Closed: 07/01/2022
Special Investigation Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—multistate	External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date Closed: 02/07/2022
Program Integrity—Quarterly Report MI 6.1–6.8	MDHHS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 11/01/2021 Date Closed: 11/01/2021
External CAP—MI Medicaid—Provider Directory Errors	MDHHS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 09/07/2021 Date Closed: 09/07/2021
External CAP—MI Medicaid—EQR Secret Shopper	MDHHS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 08/31/2021 Date Closed: 08/31/2021
MI 6.8 OIG Program Integrity Report	MDHHS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/01/2021 Date Closed: 10/09/2021
MDHHS—HSAG Dental Secret Shopper—MI MMP—Medicaid	MDHHS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/26/2021 Date Closed: 08/28/2021
MDHHS—HSAG Focused Compliance Review—06/2021—MI MMP—Medicaid	MI Medicaid State Regulatory Notice	CAP implemented and issue closed	Date Issued: 06/01/2021 Date Closed: 06/01/2021

MI 6.10 OIG Annual Program Integrity Report	MDHHS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 06/01/2021 Date Closed: 06/01/2021
MI 5.8 Third-Party Subrogation Requests	MDHHS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 05/01/2021 Date Closed: 05/01/2021
OIG Program Integrity—Fraud Compliance Plan MI 6.9	MDHHS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/01/2021 Date Closed: 04/01/2021
MDHHS Encounters—Reporting COB Incorrectly on Encounter Submissions for Both Medicaid health plan and ICO Encounters—MI MMP—Medicaid	MDHHS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/17/2021 Date Closed: 08/28/2021
MI 2.6 Provider Directory	MDHHS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/01/2021 Date Closed: 10/09/2021
Prior Authorization Timeliness—Pharmacy	MDHHS Liquidated Damages	CAP implemented and issue closed	Date Issued: 06/18/2019 Date Closed: 08/16/2019

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 07/26/2023, MDHHS sent Molina enrollment files that included one Member's SSN in the name field for the Member. As a consequence, Molina sent correspondence to the Member via USPS that included their SSN in the name field of the correspondence, visible to USPS.	• Notified affected Member(s) • Provided individual(s) with free credit monitoring • Took steps to mitigate harm

On 1/26/2022, PHI and other PII stored on the personal computer of a licensed health insurance broker and Molina Healthcare business associate, was compromised as a result of a cybersecurity incident that affected 20 Members.	• Notified affected Member(s) • Provided individual with free credit monitoring • Terminated the relationship with the health insurance broker
On 02/18/2021, a Molina Healthcare workforce member inadvertently misdirected a fax containing PHI to an unintended recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 02/10/2021, a Molina workforce member inadvertently misdirected a prior authorization document to an unintended recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 12/23/2020, a Molina workforce member inadvertently transmitted a Member's PHI to an unintended recipient via fax.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members
On 12/23/2020, a Molina employee inadvertently sent a Member's PHI via fax to an unintended recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 10/14/2020, a Molina employee inadvertently misdirected a prior authorization determination containing PHI for one Member to an unknown unintended recipient.	• Notified affected Member(s) • Provided individual with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 10/10/2019, Molina staff misplaced Member information containing PHI within a Molina	• Notified affected Member(s) • Revised policies and procedures

facility. Molina received the information via USPS from a healthcare Provider.	• Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members • Other—Implemented CAP
On 08/30/2019, Molina inadvertently mailed a Member's PHI to an unintended recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm
On 06/26/2019 a Molina employee impermissibly accessed the PHI of one Member.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved • Took steps to mitigate harm • Trained or retrained workforce members
Between 06/14/2019 and 10/10/2019, Molina staff misplaced Member information containing PHI within a Molina facility. Molina received the information via USPS from a healthcare Provider.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Revised policies and procedures • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members • Other—Implemented CAP
On 5/30/2019, Molina inadvertently misdirected an EOB to an unintended recipient.	• Notified affected Member(s) • Took steps to mitigate harm • Provided individuals with free credit monitoring
On 12/27/2018, Molina misdirected the medical records of 30 Members unintentionally through its mailing processes.	• Notified affected Member(s) • Took steps to mitigate harm • Implemented CAP
On 01/01/2018, CVS Caremark® ("CVS"), a business associate of Molina, experienced a data file processing error that resulted in the unauthorized disclosure of PHI pertaining to four Members enrolled Molina's Illinois, Ohio, Washington, and Michigan affiliates.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required the business associate to mitigate the incident and implement corrective action to help prevent future incidents
On 05/23/2018, Cognizant Technology Solutions ("Cognizant"), a business associate of Molina,	• Notified affected Member(s) • Provided individuals with free credit monitoring

mistakenly mailed one Molina ID card to an unauthorized recipient.	• Took steps to mitigate harm • Other—Required business associate to implement corrective action

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services, including enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, IT services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, Nurse Advice Line (24/7/365)
- Access2Care—transportation vendor
- Accordant® Health Services, a wholly owned subsidiary of CVS Caremark®—care management
- Ascension Borgess—credentialing
- Beaumont ACO—credentialing
- CVS—PBM
- Genesys PHO—credentialing
- Henry Ford—credentialing
- Huron Valley Physicians Association—credentialing
- Integrated Health Partners—credentialing
- Jackson Health Network—credentialing
- Maximus—enrollment vendor
- McLaren Physician Partners—credentialing
- Mercy Health–Toledo—credentialing
- MetroHealth—credentialing
- Mid-Michigan—credentialing
- Oakland Physician Network Services—credentialing
- SKYGEN—dental claims, call center, network management, grievances and appeals, UM, credentialing
- St. John Ascension—credentialing
- United Outstanding Physicians—credentialing
- United Physicians—credentialing
- University of Michigan—credentialing
- Vision Services Plan—vision claims, call center, network management, UM, credentialing

Table 1-10. Molina Healthcare of Mississippi, Inc.

a. Name of State and Program Name
State: Mississippi | Medicaid State Program: MississippiCAN (Coordinated Access Network); Mississippi CHIP
b. Start and End Date
MississippiCAN: 07/01/2017–Present ; Mississippi CHIP: 09/01/2019–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medical, pharmacy, behavioral health, vision, transportation
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, pregnant women, foster care, TANF, ABD
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
94,615 (includes both MississippiCAN and CHIP)
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Member Address Changes Issued to DOM—MS Medicaid	Mississippi Division of Medicaid (DOM) State Regulatory Notice	CAP implemented and issue closed	Date Issued: 09/14/2023 Date Closed: 09/14/2023
Payment Integrity—SIU—Inconsistent Providers Investigations and Complaint Report/Errors—MS Medicaid	MS DOM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/15/2023 Date Closed:

			08/18/2023
Community Engagement—Incorrect New Member Card Report—Naming Convention, Incorrect Data and Submission Timeliness—MS Medicaid	MS DOM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/20/2022 Date Closed: 11/07/2022
Encounters Accuracy CY20 Fine—Claims Payment	MS DOM Notice of Noncompliance; $3,591 fine	CAP implemented and issue closed	Date Issued: 06/20/2022 Date Closed: 07/30/2022
Quality Improvement—Health Education—Prevention Work Plan—Insufficient Oversight of Established and Planned Activity Reporting—(Quarterly report)—MS Medicaid	MS DOM State Regulatory Notice	CAP implemented and issue closed	Date Issued: 06/20/2022 Date Closed: 08/12/2022
Grievances & Appeals/Member & Provider Contact Center/Enterprise Info Management—Provider Complaint and Appeal Report—MS Medicaid	MS DOM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/15/2022 Date Closed: 10/18/2022
Network Management—Incorrect Claims Payment—MS Medicaid	MS DOM Notice of Noncompliance; $3,591 fine	CAP implemented and issue closed	Date Issued: 05/20/2022 Date Closed: 05/20/2022
Liquidated Damages and CAP for Contact Center Abandonment Rates	MS DOM Notice of Noncompliance; $90,000 fine	CAP implemented and issue closed	Date Issued: 03/29/2022 Date Closed: 04/29/2022
Contact Center—Inconsistent Staff Training—MS Medicaid	MS DOM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/24/2022 Date Closed: 01/23/2023
Member & Provider Contact Center—Insufficient Staff Training—MS Medicaid	MS DOM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/14/2022 Date Closed: 07/06/2022

Healthcare Services—Discrepancies with Hospice Provider Detail Reports—MS Medicaid	MS DOM State Regulatory Notice	CAP implemented and issue closed	Date Issued: 02/21/2022 Date Closed: 05/18/2022
Inappropriate Pattern of Claim Denials—MS Medicaid	MS DOM CMS Regulatory Notice; $500,000 fine	CAP implemented and issue closed	Date Issued: 08/25/2021 Date Closed: 01/31/2022
Claims—MississippiCAN Section 16(D) and CHIP Section 15 (D) Notice of Deficiency—MS Medicaid	MS DOM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/19/2021 Date Closed: 02/19/2021
Health Plan Ops—Failure to Meet Threshold for Encounter Data Submission—MS Medicaid	MS DOM Notice of Noncompliance; $93,000 fine	Fine paid and issue closed	Date Issued: 11/19/2020 Date Closed: 04/01/2021
FIN—Timeliness of Mississippi Hospital Access Program Payment—MS Medicaid	MS DOM CMS Regulatory Notice; $3,750 fine	Fine paid and issue closed	Date Issued: 09/11/2020 Date Closed: 06/01/2021
Claims—Payment Timeliness Delegated Entities—Notice of Deficiency—MS Medicaid	MS DOM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/29/2020 Date Closed: 01/29/2020
Delegation Oversight—Late Insure Kids Now Provider Data Report—Liquidated Damages MS	MS DOM Notice of Noncompliance; $3,000 fine	CAP implemented and issue closed	Date Issued: 11/25/2019 Date Closed: 03/29/2020
Grievances & Appeals—Late 2-H Reporting Noncompliance—Liquidated Damages MS	MS DOM Notice of Non-MS DOM Compliance; $26,100 fine	CAP implemented and issue closed	Date Issued: 11/22/2019 Date Closed: 05/15/2020
(591S) Encounters—Deficiency in Data Submission Notice of Noncompliance—Medicare MS	MS DOM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 05/17/2019 Date Closed: 07/31/2019

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 07/15/2021, ProgenyHealth, a Molina Healthcare business associate, inadvertently sent correspondence, which contained PHI pertaining to one Member, to an incorrect address.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—ProgenyHealth, retrained its staff on applicable policies and procedures

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services, including enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, IT services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, Nurse Advice Line (24/7/365)
- CVS Caremark®—pharmacy services
- March Vision Care—call center, compliance sanction monitoring, claims, credentialing
- MTM—call center, compliance sanction monitoring, claims, driver validation
- Progeny, LLC—care management, UM
- SKYGEN—call center, compliance sanction monitoring, claims, credentialing, UM

Table 1-11. Molina Healthcare of Nevada, Inc.

a. Name of State and Program Name
State: Nevada | Medicaid State Program: Medicaid managed care service areas: Washoe County and Clark County
b. Start and End Date
Medicaid: 01/01/2022–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, aged-out foster care, TANF, Medicaid expansion, D-SNP (Clark and Washoe counties)
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 128,760 (includes CHIP)
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Special Investigation Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—Multistate	CMS External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date Closed: 02/07/2022

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
None	None

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services, including enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, IT services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, Nurse Advice Line (24/7/365)
- CVS—PBM
- Healthmap—case management
- New Century Health—UM, call center
- Renown Health—credentialing
- UNLV Medicine—credentialing
- VSP—call center, claims, credentialing

Table 1-12. Molina Healthcare of New Mexico, Inc.

a. Name of State and Program Name
State: New Mexico | Medicaid State Program: Centennial Care
b. Start and End Date
Medicaid: 02/01/2013–12/31/2018 | Medicare D-SNP: 01/01/2014–12/31/2020 New Mexico Human Services Department has announced its intention to award a Medicaid managed care contract to Molina's New Mexico affiliate health plan, Molina Healthcare of New Mexico. The go-live date for Molina Healthcare of New Mexico's new Medicaid contract is expected to be 07/01/2024.
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health (BH), dental, vision, transportation, other: LTC | Medicare: D-SNP, medical, pharmacy, BH, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
Foster care, TANF, duals, LTC | Medicare: D-SNP, LTC, ABD, Medicaid expansion | LTSS: Individuals with physical disabilities, IDD, and dual eligible beneficiaries
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: N/A, 0 | Medicare D-SNP: N/A, 0
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Special Investigation Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—Multistate	CMS External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date

			Closed: 02/07/2022

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 01/07/2019, a Molina employee had their home burglarized; items stolen included a Member log. This affected 23 Members.	• Notified affected Member(s) • Took steps to mitigate harm • Trained or retrained workforce members
Molina Healthcare ("Molina") was notified on 12/27/2018, by Equian, a vendor and business associate of Molina, that its Subcontractor, Wolverine Solutions Group ("Wolverine") experienced a ransomware security incident on or about 08/23/2018. The subject Wolverine security incident affected Members across several different covered entities, including Molina. The breach affected 895 Members enrolled in Molina's New Mexico, Ohio, Puerto Rico, South Carolina, Texas, and Washington affiliated health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required business associate to implement corrective action(s)
On 12/22/2017, Molina inadvertently misdirected an ID card to an unintended recipient.	• Notified affected Member(s) • Took steps to mitigate harm • Other—Implemented corrective action
On 12/22/2017, Molina inadvertently misdirected correspondence pertaining to one Member to an unintended recipient.	• Notified affected Member(s) • Took steps to mitigate harm
On 12/20/2017, Molina inadvertently misdirected a document containing PHI pertaining to one Member to an unintended recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved • Took steps to mitigate harm • Trained or retrained workforce members

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services, including enrollment and eligibility services, financial services (actuarial support), healthcare services support

(clinical support/guidance), human resources, IT services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, Nurse Advice Line (24/7/365)

- Accordant® Health Services, wholly owned subsidiary of CVS Caremark®—care management
- American Current Care, PA, d/b/a Concentra Urgent Care—credentialing services
- CVS Caremark—PBM services
- DentaQuest, National Insurance Company, Inc.—dental services
- Electronic Caregiver, Inc.—remote patient monitoring
- March Vision Care—vision services
- Medical Review Institute of America—pharmacy and health review determinations
- National Eldercare, Inc.—NEMT Non-Metro New Mexico Area Agency on Aging—shared care coordination delegation
- Nor-Lea Hospital District—credentialing services
- Occupational Health Centers of the Southwest, PA, d/b/a Concentra Medical Center—credentialing services
- Presbyterian Medical Services—credentialing services
- ProgenyHealth, LLC—neonatal UM/case management
- San Juan IPA—credentialing services
- Superior Ambulance Service, Inc., d/b/a Superior Medical Transportation—NEMT
- University of New Mexico Health Sciences Center—credentialing services
- White Sands Healthcare System, LLC—credentialing services

Table 1-13. Molina Healthcare of New York, Inc.

a. Name of State and Program Name
State: New York | Medicaid State Program: New York Medicaid Managed Care
b. Start and End Date
Medicaid: • New York Medicaid Managed Care: 03/19/2019–Present • New York Medicaid CHIP: 03/01/2014–Present • Medicaid Health and Recovery Plan (HARP): 03/01/2019–Present Medicare D-SNP: 01/01/2007
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health (BH), dental | Medicare D-SNP: medical, pharmacy, BH, dental, vision, transportation, hearing, skilled nursing facility, physical therapy | Specialty Services for Children/Youth in Foster Care: Foster care carve-out in 07/2021 through Article 29-I licensure authorizes voluntary foster care agencies to provide core health-related services that include nursing, skill building, Medicaid treatment planning and discharge planning, clinical consultation and supervision, and managed care liaison/administrator services.
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, foster care, TANF, Medicare D-SNP: individuals who are entitled to both Medicare (Title XVIII) and medical assistance from a state plan under Medicaid (Title XIX), ABD, Medicaid expansion, Medicaid HARP; Members who qualify are chronically addicted and/or have behavioral issues
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid (including HARP): 321,821 | CHIP: 16,822 | Essential Plan: 66,774 | Medicare D-SNP: 26,162; *MAP*: 155
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Q1 2023, Q3 2022 EDQ Timeliness and Completeness Letter	NY State Department of Health (NYSDOH) External Audit; $24,998 fine	Fine paid and issue closed	Date Issued: 08/01/2023 Date Closed: 08/01/2023
Q1 2023, Q3 2022 EDQ Timeliness and Completeness Letter	NYSDOH External Audit; $1,420 fine	Fine paid and issue closed	Date Issued: 08/01/2023 Date Closed: 08/01/2023
SWHNY Uniform Assessment System for NY Medicaid	NYSDOH State Regulatory Notice	Fine paid and issue closed	Date Issued: 07/26/2023 Date Closed: 07/26/2023
Q4 2022 Timeliness and Q2 2022 Completeness Penalty Statement of Deficiency—SWH NY Medicaid	NYSDOH State Regulatory Notice; $70,341 fine	Fine paid and issue closed	Date Issued: 06/13/2023 Date Closed: 06/13/2023
Q4 2022, Q2 2022 EDQ Penalty Collection	NYSDOH External CAP; $70,341 fine	Fine paid and issue closed	Date Issued: 04/28/2023 Date Closed: 04/28/2023
Q4 2022, Q2 2022 EDQ Penalty Collection	NYSDOH External CAP; $25,568 fine	Fine paid and issue closed	Date Issued: 04/28/2023| Date Closed: 04/28/2023
Q4 2022, Q2 2022 Completeness Penalty SOD	NYSDOH External CAP; $313,193 fine	Final (NYS waived penalty)	Date Issued: 04/28/2023 Date Closed: 04/28/2023
Q3 2022, Q1 2022 EDQ Timeliness and Completeness for Plan ID 2932896—NY SWH	NYSDOH State Regulatory Notice	CAP implemented and issue closed	Date Issued: 02/14/2023 Date Closed: 02/14/2023

Q3 2022, Q1 2022 EDQ Timeliness and Completeness for Plan ID 4342292—Molina Healthcare of New York	NYSDOH Notice of Noncompliance; $49,630 fine	Fine paid and issue closed	Date Issued: 02/14/2023 Date Closed: 02/14/2023
Claims—Health Plan Operations—NYS Dept. of Mental Health (OMH) Claims Underpayment—NY—Medicaid	NYSDOH Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/09/2023 Date Closed: 02/09/2023
Q2 2022, Q4 2021 EDQ Penalty Collection	NYSDOH State Regulatory Notice; $19,230 fine	Fine paid and issue closed	Date Issued: 01/25/2023 Date Closed: 01/25/2023
MH Parity—Phase I, II, III—Actions Occurred Prior to Acquisition by Molina	NYSDOH Notice of Noncompliance; $1,230,000 fine	Fine paid and issue closed	Date Issued: 01/19/2023 Date Closed: 01/19/2023
MH Parity—Phase I, II, III	NYSDOH External CAP; $444,000 fine	Fine paid and issue closed	Date Issued: 01/19/2023 Date Closed: 01/19/2023
EDQ Q2 2022, Q4 2021	NYSDOH Notice of Noncompliance; $2,190 fine	Fine paid and issue closed	Date Issued: 01/18/2023 Date Closed: 1/18/2023
Statement of Deficiency for Underfunded NYS Escrow Fund—Senior Whole Health of NY	NYSDOH Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 11/23/2022 Date Closed: 11/23/2022
Encounter Data Quality Statement of Deficiency Letters Q1 2022 Timeliness—Q3 2021 Completeness	NYSDOH Notice of Noncompliance; $180,837 fine	CAP implemented and issue closed	Date Issued: 09/12/2022 Date Closed: 09/12/2022
Molina Healthcare of New York, Inc.—Statement of Deficiency for	NYSDOH CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 08/26/2022

Underfunded NYS Escrow Fund—NY Medicaid			Date Closed: 08/26/2022
Affinity Monetary Penalty	NYSDOH Notice of Noncompliance; $598,215 fine	Attorney-client	Date Issued: 07/14/2022 Date Closed: 07/14/2022
DOH Civil Penalties Matter—NY—Affinity	NYSDOH Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/07/2022 Date Closed: 07/07/2022
Encounters Accuracy CY20 Fine—Affinity—Actions Occurred Prior to Acquisition by Molina	NYSDOH Notice of Noncompliance; $15,738,161 fine	Fine paid and issue closed	Date Issued: 06/20/2022 Date Closed: 06/20/2022
Encounters Accuracy CY20 Fine—SWH	NYSDOH Notice of Noncompliance; $2,440,053 fine	Fine paid and issue closed	Date Issued: 06/20/2022 Date Closed: 06/20/2022
Encounters Accuracy CY20 Fine—Molina NY	NYSDOH Notice of Noncompliance; $347,069 fine	Fine paid and issue closed	Date Issued: 06/20/2022 Date Closed: 06/20/2022
NYSDOH—Failure to Meet MLR Requirements—Affinity—Actions Occurred Prior to Acquisition by Molina	NYSDOH Notice of Noncompliance; $8,317,445 fine	CAP implemented and issue closed	Date Issued: 05/23/2022 Date Closed: 05/23/2022
NYSDOH—Failure to Meet MLR Requirements	NYSDOH Notice of Noncompliance; $312,892 fine	CAP implemented and issue closed	Date Issued: 05/23/2022 Date Closed: 05/23/2022
Molina 2020 PDS PAAS Focus Survey Results—NY Medicaid	NYSDOH Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 05/19/2022 Date Closed: 05/19/2022

Affinity 2020 PDS PAAS Focus Survey Results—NY Medicaid—Actions Occurred Prior to Acquisition by Molina	NYSDOH State Regulatory Notice	CAP implemented and issue closed	Date Issued: 05/19/2022 Date Closed: 05/19/2022
NYSDOH—Molina EDQ Q3 2021 Timeliness Penalty Collection Notice	NYSDOH Notice of Noncompliance; $103,049 fine	CAP implemented and issue closed	Date Issued: 04/29/2022 Date Closed: 04/29/2022
Pharmacy—Sexual Dysfunction-Erectile Dysfunction (SD-ED) Drugs—NY Medicaid	NYSDOH Warning Letter	CAP implemented and issue closed	Date Issued: 04/01/2022 Date Closed: 04/01/2022
Liquidated Damages—Senior Whole Health Encounter Data Quality Statement of Deficiency Q3 2021—NY Medicaid	NYSDOH State Regulatory Notice; $895 fine	CAP implemented and issue closed	Date Issued: 02/18/2022 Date Closed: 02/18/2022
Managed LTC—Focused Survey Internal Appeal and Fair Hearing Management Practices Senior Whole Health of New York—Senior Whole Health	NYSDOH External CAP	CAP implemented and issue closed	Date Issued: 02/09/2022 Date Closed: 02/09/2022
Special Investigation Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—Multistate	CMS External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date Closed: 02/07/2022
Encounter Data Quality Statement of Deficiency Letters Q2 2021 Performance Measures—SWH	NY Department of Medicaid External Audit; $222,876 fine	Fine paid and issue closed	Date Issued: 12/21/2021 Date Closed: 12/21/2021
NYSDOH—Failed Encounter Data Quality Performance Measures	NY Department of Medicaid Notice of Noncompliance; $9,100 fine	CAP implemented and issue closed	Date Issued: 08/20/2021 Date Closed: 08/20/2021
Enrollment—2019 CHP Audit Medicaid NY	NY Department of Medicaid Liquidated	Fine paid and issue closed	Date Issued: 11/05/2020

	Damages: $2,524 fine		Date Closed: 11/05/2020
*Molina has a process to implement and monitor corrective actions in response to potential or confirmed noncompliance of employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including regulatory contract requirements, and Federal, state, and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery, with a 30-/60-/90-day evidence of compliance.			

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
Healthplex, a former business associate and dental benefits Subcontractor of Molina, reported that on 02/23/2023 and 03/07/2023, a bad actor impermissibly accessed and exfiltrated 7,702 Members' PHI related to dental benefits and services from its business associates and affiliate, Managed Care of North America.	• Notified affected Member(s) • Provided individual(s) with free credit monitoring • Took steps to mitigate harm • Provided business associate with additional training on HIPAA requirements
Change Healthcare, Inc. ("CHC"), a business associate of Molina Healthcare of New York, Inc. and Senior Whole Health of New York, Inc. (collectively "Molina"), reported that, from 07/1/2022 through 07/12/2022, an unauthorized user of the Change ProviderNet Portal impermissibly accessed explanation of payment (EOP) information for Molina Healthcare of New York and Senior Whole Health of New York by Molina Healthcare. Of the 1,068 Members affected by the breach, three Members' EOPs were impermissibly accessed as a result of this security incident.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm
Between 7/7/2022 and 06/30/2022, Availity® LLC ("Availity"), a healthcare clearinghouse and Molina business associate, experienced a security incident that occurred in the Molina Provider e-portal via an SSO connection with the Availity Essentials payer portal. The breach affected 87 Members enrolled in Molina's	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm

California, Florida, New York, Texas, and Virginia affiliate health plans.	
On 4/26/2022, Molina misdirected three Molina Healthcare of New York Affinity Members' PHI to an unauthorized recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm
On 11/13/2020, a Molina Healthcare workforce member inadvertently sent a fax containing PHI to an unintended recipient.	• Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 10/28/2020, RR Donnelly & Sons, a Molina Healthcare business associate, inadvertently mailed a Member's ID card to an unauthorized recipient.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Provided Member with a new ID card

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services, including enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, IT services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, Nurse Advice Line (24/7/365)
- LSSI Claimsnet—claims clearinghouse
- Optum®—payment integrity
- CES—payment integrity
- MCG Health, LLC—clinical criteria (LOCUS/CALOCUS)
- ECHO Payment—Provider reimbursement
- Psych Hub™—media platform for MH education (Provider)
- Sapphire Digital—Provider online directory
- CVS Caremark®—MSA and IPA (pharmacy)
- Monroe Plan for Care—MSA-CM
- Monroe Plan IPA—network
- YourCare IPA—network
- DentaQuest—MSA and IPA (dental)
- Superior Vision—MSA and IPA (vision)
- Progeny—UM-NICU
- FAIR Health—cost calculator

- Advomas—ESRD primacy (TPHI)
- InstaMed—Member accounts receivable
- 3M/Treo—risk adjustment
- Cotiviti—DRG validation, data mining
- Penstock—data mining
- Syrtis—Rx claims data mining
- HCFS—FWA software

Table 1-14. Molina Healthcare of Ohio, Inc.

a. Name of State and Program Name
State: Ohio | Medicaid state program: Ohio Medicaid Managed Care
b. Start and End Date
Ohio Medicaid Managed Care: 12/01/2005–Present | Medicare: *Medicare D-SNP*: 01/01/2021–Present; *Medicare Duals Demonstration*: 05/01/2014–Present
c. Services Covered Under the Contract (e.g., physical health, Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, behavioral health, dental, vision, transportation | Medicare D-SNP and Duals Demonstration: medical, pharmacy, behavioral health, dental, vision, transportation, others: hearing, skilled nursing facility, physical therapy
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, Foster, TANF, Medicare D-SNP, Duals Demonstration: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX), ABD, IDD, Medicaid Expansion
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 364,539 | Medicare MAPD: 470 | Medicare D-SNP: 2,167 | Medicare Duals Demonstration: MyCare Opt In = 15,578; MyCare Opt Out = 13,912
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Pharmacy September UMTD Empty File—OH Medicaid	Ohio Department of Medicaid (ODM) State	CAP implemented and issue closed	Date Issued: 09/20/2023 Date Closed: 09/20/2023

	Regulatory Notice		
OH_MOLINA Noncompliance Provider Panel Q3 2023	ODM State Regulatory Notice; $4,000 fine	Fine paid and issue closed	Date Issued: 09/18/2023 Date Closed: 09/18/2023
MOLINA Noncompliance Provider Panel Q2 2023	ODM State Regulatory Notice; $5,000 fine	Fine paid and issue closed	Date Issued: 05/12/2023 Date Closed: 05/12/2023
Noncompliance—MCOP—HEDIS 2019–2021—OH Medicaid	ODM State Regulatory Notice $66,164 fine	Fine paid and issue closed	Date Issued: 04/14/2023 Date Closed: 04/14/2023
Noncompliance—MMC—HEDIS 2019–2021—OH Medicaid	ODM External CAP; $472,089 fine	Fine paid and issue closed	Date Issued: 04/14/2023 Date Closed: 04/14/2023
Noncompliance Provider Panel Q1 2023– OH—Medicaid	ODM External CAP; $4,000 fine	Fine paid and issue closed	Date Issued: 02/14/2023 Date Closed: 02/14/2023
Pharmacy Monthly PA File Inaccurate Submission to ODM OH Medicaid	ODM CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 12/12/2022 Date Closed: 12/12/2022
Notice of Noncompliance Provider Panel OH Medicaid	ODM External CAP; $3,000 fine	CAP implemented and issue closed	Date Issued: 11/28/2022 Date Closed: 11/28/2022
Notice of Noncompliance Provider Panel OH Medicaid	ODM Notice of Noncompliance; $2,000 fine	CAP implemented and issue closed	Date Issued: 08/17/2022 Date Closed: 08/17/2022

Health Plan Operations-Failure to Comply with Specifications for the Managed Care Provider Network (MCPN) File. OH MMP-Medicaid	ODM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/28/2022 Date Closed: 06/28/2022
HCS—BH Coordinated Services Program (Pharmacy lock-in program) Data Submission Requirements OH Medicaid	ODM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/27/2022 Date Closed: 06/27/2022
The Office of Managed Care Ohio Medicaid issued a Notice of Noncompliance on 04/25/22 indicating that as of 04/04/2022, Molina did not meet minimum Provider panel requirements in the following areas-counties: Putnam dentists, Warren inpatient psych, Huron dentists. A non-refundable sanction of $2,000 was imposed.	ODM External CAP; $2,000 fine	CAP implemented and issue closed	Date Issued: 04/25/2022 Date Closed: 04/25/2022
Payment Integrity—ODM Notification of Noncompliance—Claims Payment Systemic Error—OH Medicaid	ODM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/10/2022 Date Closed: 02/10/2022
Special Investigation Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—Multistate	CMS External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date Closed: 02/07/2022
ODM Notification of Noncompliance/Remedial Action—OH Medicaid	ODM External CAP	CAP implemented and issue closed	Date Issued: 02/03/2022 Date Closed: 02/03/2022
Notice of Noncompliance Notice for Late Submission	ODM External CAP	CAP implemented and issue closed	Date Issued: 01/27/2022 Date Closed: 01/27/2022
UM and Appeal ODM File Issues MMP Medicaid OH	ODM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 09/02/2021 Date Closed:

			09/02/2021
ODM—Notice of Noncompliance-Provider Panel Requirements	ODM Notice of Noncompliance; $3,000 fine	CAP implemented and issue closed	Date Issued: 08/12/2021 Date Closed: 10/01/2021
HCS-UM Failure to Follow ODM Guidance re: Denying a Non-contracted Provider from Providing a Service. OH Medicaid MMP	ODM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/12/2021 Date Closed: 08/12/2021
ODM—Notice of Noncompliance—Provider Panel	ODM CMS Regulatory Notice; $2,000 fine	CAP implemented and issue closed	Date Issued: 07/21/2021 Date Closed: 10/01/2021
ODM—Notice of Noncompliance—Provider Panel Requirements	ODM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 05/12/2021 Date Closed: 10/01/2021
ODM Unified Preferred Drug List (UPDL) Q42020	ODM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/10/2021 Date Closed: 04/01/2021
ODM—Notice of Noncompliance—Provider Panel Requirements	ODM Notice of Noncompliance $2,000 fine	CAP implemented and issue closed	Date Issued: 03/03/2021 Date Closed: 03/03/2021
Pharmacy ODM Unified Preferred Drug List (UPDL) in Q32020—OH Medicaid	ODM External Audit	CAP implemented and issue closed	Date Issued: 12/01/2020 Date Closed: 01/03/2021
Notice of noncompliance action for late submission of response to Healthtrack Provider complaints.	ODM State Regulatory Notice; $2,800 fine	CAP implemented and issue closed	Date Issued: 04/08/2020 Date Closed: 04/08/2020

ODM—Performance Measures	ODM Notice of Noncompliance $742,651 fine	CAP implemented and issue closed	Date Issued: 09/20/2019 Date Closed: 09/20/2019
Failure to meet Ohio Provider panel requirements	ODM Notice of Noncompliance; $8,000 fine	CAP implemented and issue closed	Date Issued: 09/09/2019 Date Closed: 09/09/2019
Notice of noncompliance/remedial action regarding issues related to claims payment systemic errors (CPSE) reporting	ODM Liquidated Damages	CAP implemented and issue closed	Date Issued: 05/29/2019 Date Closed: 05/29/2019
Failure to meet Provider panel requirements in the region(s) for which Molina holds a Provider agreement.	ODM Liquidated Damages: $12,000 fine	CAP implemented and issue closed	Date Issued: 05/08/2019 Date Closed: 05/08/2019
(595) Provider Services—Failure to meet Provider panel requirements with a fine from ODM—Medicaid OH	ODM External CAP; $14,000 fine	CAP implemented and issue closed	Date Issued: 04/11/2019 Date Closed: 08/21/2021
Payment Integrity—Payment Recovery Error—TORT Inquiry—Equian—OH ODM Medicaid	ODM Notice of Noncompliance; $14,000 fine	CAP implemented and issue closed	Date Issued: 03/27/2019 Date Closed: 07/31/2019
Failure to meet Provider panel requirements in the region(s) for which Molina holds a Provider agreement.	ODM Liquidated Damages; $350,891 fine	CAP implemented and issue closed	Date Issued: 02/22/2019 Date Closed: 11/25/2019
Molina has received a notice of non-compliance for SFY2018 (CY2017) MCP Quality Measures Results (PQI 16: Lower Extremity Amputation, Patients w/Diabetes). ODM will impose a refundable fine in the amount of $350,891.	ODM Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/16/2019 Date Closed: 01/16/2019

The Bureau of Managed Care Compliance and Oversight (BMCCO) identified the following issues related to Molina meeting the utilization management file instructions/submission specifications: Utilization Management: • Molina is currently listing the Medicaid medical necessity rule and only that rule when a service is covered primarily by CMS; however, Molina should only be listing the CMS rule. Molina is required to only list the correct, primary supporting CMS regulation. • Molina is reporting the CMS member identification rather than the MMIS billing number of the Member on prior authorization records provided to the BMCCO. Most of these are dental records. • Molina has an ongoing issue with files rejecting for bad records or improper structure. Molina is not following the file specifications provided by BMCCO. • Molina records contain insufficient Provider request narrative information. Records often do not identify the number of home health or private duty nursing hours, or the number of home-delivered meals requested. The hours or amount requested should be documented in the request or narrative.	ODM Notice of Noncompliance; $342,686 fine	CAP implemented and issue closed	Date Issued: 12/21/2018 Date Closed: 12/21/2018
Molina has received a notice of noncompliance for SFY2018 (CY2017) MCP Quality Measures Results for use of multiple concurrent antipsychotics in children and adolescents). ODM notes this measure is included in the Quality Withhold program for SFY 2019, therefore while it will be documented as noncompliant with the SFY 2018	ODM Notice of Noncompliance; $14,000 fine	CAP implemented and issue closed	Date Issued: 10/26/2018 Date Closed: 10/26/2018

standard, the monetary sanction of $342,686 will not be imposed.			
*Molina has a process to implement and monitor corrective actions in response to potential or confirmed noncompliance on employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including but not limited to regulatory contract requirements, and Federal, state, and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery with a 30-/60-/90-day evidence of compliance.			

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 02/10/2023, a Molina healthcare workforce member inadvertently mailed an appeal summary to an incorrect Member.	• Notified affected Member(s) • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
Between 06/28/2022 and 07/13/2022, O'Neil Digital Solutions, LLC ("O'Neil"), a Molina Healthcare print and fulfillment vendor and business associate, inadvertently misdirected Member ID cards to incorrect addresses via the USPS. Due to this error, 8,283 affected Members' names in Kentucky and Ohio were inadvertently associated with other unrelated Members' addresses due to the business associate's data processing issue.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members
On 03/07/2022, CVS Caremark, a PBM and business associate of Molina Healthcare, inadvertently mailed PHI pertaining to one individual to an unintended recipient.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm
On 08/27/2021, a Molina Healthcare workforce member inadvertently misdirected an email containing PHI to an intended recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
Between 05/07/2021 and 05/12/2021, a workforce member of Carenet	• Notified affected Member(s)

Healthcare Systems ("Carenet"), a Molina Healthcare vendor and business associate, allowed a family Member to impermissibly access PHI in Carenet's systems. This breach affected a total of 7 Molina Healthcare Members in the following states: Illinois (1); Kentucky (2); Ohio (2), and South Carolina (2).	• Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members • Other—Required the business associate to implement corrective action.
On 04/10/2020, Molina inadvertently sent a fax containing PHI, intended for a covered entity Provider, to an unintended recipient in error.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 12/17/2018, Molina inadvertently misdirected 2 pieces of correspondence pertaining to one individual to unintended recipients.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved • Took steps to mitigate harm • Trained or retrained workforce members
On 10/02/2018, an employee of Nationwide Children's Hospital, a healthcare Provider and business associate of Molina Healthcare of Ohio, Inc., inadvertently left a file containing PHI on top of his car, which resulted in the loss of the information as it was not recovered.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Business associate counseled the responsible workforce member.
Molina Healthcare ("Molina") was notified on 12/27/2018 by Equian, a vendor and business associate of Molina, that its Subcontractor, Wolverine Solutions Group ("Wolverine") experienced a ransomware security incident on or about 09/23/2018. The subject Wolverine security incident affected Members across several different covered entities, including Molina. The breach affected 895 Members enrolled in Molina's New Mexico, Ohio, Puerto Rico, South Carolina, Texas, and Washington health plans.	• Notified affected member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required business associate to implement corrective action(s)
On 04/18/2018, Advanced Medical Reviews, LLC ("AMR"), a business associate of Molina, became aware of	• Notified affected member(s) • Provided business associate with additional training on HIPAA requirements

a medical reviewer, Spyros Panos, who fraudulently impersonated another licensed physician and who, on 09/01/2013, impermissibly accessed PHI in connection with independent medical reviews conducted by AMR on Molina's behalf. The breach affected 75 Members across Molina's California, Ohio, Texas, Utah, Washington, and Wisconsin health plans.	• Provided individuals with free credit monitoring • Took steps to mitigate harm • Other: Required business associate to implement corrective action
On 8/3/2018, Molina inadvertently misdirected correspondence containing PHI pertaining to two individuals in error.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved • Took steps to mitigate harm • Trained or retrained workforce members
On 01/01/2018, CVS Caremark ("CVS"), a business associate of Molina, experienced a data file processing error, which resulted in the unauthorized disclosure of PHI pertaining to four Members enrolled in Molina's Illinois, Ohio, Washington, and Michigan health plans.	• Notified affected member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required the business associate to mitigate the incident and implement corrective action to help prevent future incidents

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Access2Care—call center, claims, driver validation
- Accordant Health Services, a wholly owned subsidiary of CVS Caremark—care management
- Area Agency on Aging, PSA 2 (a.k.a. Dayton AAA)—case management: LTSS, compliance sanction monitoring
- Cardinal Health Partners—credentialing
- Central OH AAA (a.k.a. Columbus AAA)—case management: long-term services & support, compliance-sanction monitoring
- Comprehensive Post-Acute Network (CPAN)—credentialing
- Cornerstone Alliance, Inc.—credentialing

- Council on Aging of Southwestern Ohio (a.k.a. Southwest AAA)—case management: long-term services and support, compliance sanction monitoring
- Firelands Physicians Regional Healthcare—credentialing
- Fremont Hospital/Physician Organization, Inc. (d/b/a Cooperative Care)—credentialing
- King's Daughters Medical Center (OH)—credentialing
- Lake Health—credentialing
- Management and Network Services—credentialing
- March Vision Care—call center, claims
- Mercy Health System—credentialing
- MetroHealth System – credentialing
- Nationwide Children's Hospital (Partners for Kids) (a.k.a. Children's Hospital and Physicians' Network)—case management, credentialing
- New Century Health—UM
- Ohio Health—credentialing
- Ohio State University Physicians—credentialing
- Papa—call center
- Progeny—case management, UM
- Public Partnership, LLC—financial management services
- Pure Healthcare, LLC—case management
- SKYGEN—call center, claims, UM
- Summa Health Network—credentialing
- University Hospital Health System (UHHS)—credentialing
- University of Toledo Physicians, LLC—credentialing
- West Virginia United Health System, Inc.—credentialing

Table 1-15. Molina Healthcare of Puerto Rico, Inc.

a. Name of State and Program Name
State: Puerto Rico | Medicaid state program: Vital
b. Start and End Date
Government Health Plan Contract: 04/01/2015–10/31/2018 | Plan Vital Contract: 11/01/2018–10/31/2020
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: physical health, behavioral health, pharmacy, dental (carve-out)
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
Adults, Pregnant, TANF, Children (Medicaid), Children (CHIP), Newborn, Dual-eligible individuals
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
N/A, 0
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Notice of Intent to Impose Sanctions to Molina Puerto Rico	Puerto Rico Health Insurance Administration CMS Regulatory Notice; $525,000 fine	Fine under appeal.	Date Issued: 01/22/2022 Date Closed: Pending Closure
The Administracion de Seguros de Salud (ASES) issued a Notice of	Puerto Rico Health Insurance Administration Notice of	CAP implemented and issue closed	Date Issued: 04/25/2019

Imposition of Sanctions for Inaccurate Network Provider List Reports from 09/28/2018–11/30/2018 for MHPR.	Noncompliance; $1,375,000 fine		Date Closed: 04/25/2019
A&G—4Q18 MHPR MD Appeals—Medicaid Puerto Rico	Puerto Rico Health Insurance Administration Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/25/2019 Date Closed: 04/06/2018
Date Closed: Molina has a process to implement and monitor corrective actions in response to potential or confirmed noncompliance on employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including but not limited to regulatory contract requirements, and Federal, state and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery with a 30-/60-/90-day evidence of compliance.			

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 07/07/2020, a Molina Healthcare workforce member inadvertently sent an email containing PHI pertaining to three Members to an unauthorized email recipient.	• Notified affected Member(s) • Sanctioned workforce members involved (including termination)
On 10/19/2018, Persocard, a Molina Healthcare business associate, inadvertently misdirected two Member ID cards to an unauthorized recipient because of human error.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members • Other—Required business associate to implement corrective action
On 10/11/2018, Molina mailed a health plan ID card to the address on file for the intended recipient. The address was incorrect, and the mail was returned. Molina received the envelope used to transmit the ID card back via USPS; however, the ID card was not returned and was presumed to be lost.	• Notified affected Member(s) • Took steps to mitigate harm • Other—Molina updated the individual's mailing address in our systems.
Molina Healthcare ("Molina") was notified on 12/27/2018 by Equian, a vendor and business associate of Molina, that its Subcontractor, Wolverine	• Notified affected Member(s)

Solutions Group ("Wolverine") experienced a ransomware security incident on or about 9/23/2018. The subject Wolverine security incident affected Members across several different covered entities, including Molina. The breach affected 895 Members enrolled in Molina's New Mexico, Ohio, Puerto Rico, South Carolina, Texas, and Washington health plans.	• Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required business associate to implement corrective action(s)
On 08/22/2018, Delta Dental misdirected two EOBs	• Notified affected Member(s) • Required the business associate to implement corrective action(s).

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Delta Dental—dental benefit management
- Jaye, Inc. (d/b/a TeleMedik)—call center services and Nurse Advice Line
- Uticorp—inpatient hospital review
- FHCHS of Puerto Rico, Inc.—Behavioral Health crisis line

Table 1-16. Molina Healthcare of South Carolina, Inc.

Medicaid Managed Care Experience #16
Molina Healthcare of South Carolina, Inc.
a. Name of State and Program Name
State: South Carolina | Medicaid state program: South Carolina Healthy Connections
b. Start and End Date
Medicaid: 01/01/2014–Present | Medicare: *Medicare D-SNP*: 01/01/2020–Present; *Medicare Duals Demonstration*: 02/01/2015–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health, other: foster | Medicare D-SNP and Duals Demonstration: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, TANF, Medicare D-SNP and Duals Demonstration: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX), ABD. Although not a covered population, we have foster care children and youth, former foster care, and adoption assistance assigned as needed during enrollment and initial transition to Medicaid to ensure consistent coverage.
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 187,690 | Medicare D-SNP: 2,160 | Medicare Duals Demonstration: 3,742
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct

Network Management- Network Adequacy—Rehabilitative Behavioral Health Services—SC Medicaid	SC Department of Medicaid External CAP	CAP implemented and issue closed	Date Issued: 04/20/2023 Date Closed: 04/20/2023
Health Plan Operations—EQR Audit—Accuracy of Provider Directory Information—SC Medicaid	SC Department of Medicaid Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/05/2022 Date Closed: 07/05/2022
Contact Center—Performance Report Not Complying with Template Reporting Requirements—SC Medicaid	SC Department of Medicaid Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/16/2022 Date Closed: 03/16/2022

*Molina has a process to implement and monitor corrective actions in response to potential or confirmed noncompliance on employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including but not limited to regulatory contract requirements, and Federal, state, and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery with a 30-/60-/90-day evidence of compliance.

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
Between 08/26/2021 and 08/27/2021, a Molina Healthcare workforce member inadvertently posted a photo on LinkedIn that contained the names and addresses of two Members in error.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
Between 05/07/2021 and 05/12/2021, a workforce member of Carenet Healthcare Systems ("Carenet"), a Molina Healthcare vendor and business associate, allowed a family Member to impermissibly access PHI in Carenet's systems. This breach affected a total of seven Molina Healthcare Members in the following states: Illinois (1); Kentucky (2); Ohio (2), and South Carolina (2).	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members

	• Other—Required the business associate to implement corrective action.
Molina Healthcare ("Molina") was notified on 12/27/2018 by Equian, a vendor and business associate of Molina, that its Subcontractor, Wolverine Solutions Group ("Wolverine") experienced a ransomware security incident on or about 09/23/2018. The subject Wolverine security incident affected Members across several different covered entities, including Molina. The breach affected 895 Members enrolled in Molina's New Mexico, Ohio, Puerto Rico, South Carolina, Texas, and Washington health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required business associate to implement corrective action(s)

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Accordant Health Services, a wholly owned subsidiary of CVS Caremark—care management
- American Specialty Health Acupuncture/Chiropractic—call center, claims, credentialing
- Anderson Medical (AnMed)—credentialing
- Atrium Health—credentialing
- Augusta University—credentialing
- Bon Secours St. Francis—credentialing
- Healthmap—case management
- Lexington Health—credentialing
- March Vision Care—claims, credentialing, call center
- Medical University of South Carolina (MUSC)—credentialing
- Papa—call center
- Prisma Health-Upstate—credentialing
- Prisma Midlands—credentialing
- Regional Health Plus (RHP)—credentialing
- Roper St. Francis—credentialing
- Signify Health—credentialing
- VSP—call center, claims, credentialing

Table 1-17. Molina Healthcare of Texas, Inc.

a. Name of State and Program Name
State: Texas | Medicaid state program: Texas Uniform Managed Care
b. Start and End Date
Medicaid: • STAR and CHIP & CHIP Perinate 09/01/06–Present • STAR+PLUS 02/01/2007–Present Medicare: • Medicare Duals Demonstration: 03/01/2015–Present • Medicare D-SNP: 01/01/2015–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health, transportation, LTSS (STAR+PLUS) Medicare D-SNP and Duals Demonstration: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, Former Foster, Adoption Assistance, TANF, Children's Medicaid, Pregnant Women, SSI adults, Dual Eligible, Adults receiving LTSS, Individuals in a 1915 C waiver (Acute care only), MBCC, Medicare D-SNP and Duals Demonstration: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX), ABD STAR+PLUS: adults 21 and older with disabilities, those with IDD, individuals who meet a nursing home level of care and quality for home- and community-based waiver services, individuals enrolled in a 1915C waiver, individuals in nursing home, individuals with SSI and dual eligible. Children in STAR may be eligible for private duty nursing through the comprehensive care program.
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Uniform Managed Care Contract (STAR, STAR+PLUS and CHIP): 233,547 | CHIP Rural Service Area: 4,690 | STAR+PLUS Expansion: 37,804 | STAR+PLUS Medicaid Rural Service Area: 16,801 | Medicare-Medicaid Plan: 11,144 | DSNP: 4,683

f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Notice of Liquidated Damages	Health and Human Services Commission (HHSC) State Regulatory Notice; $20,000 fine	Fine paid and issue closed	Date Issued: 10/31/2023 Date Closed: 10/31/2023
External Audit—Health Care Services—UR LTSS STAR PLUS Initiation—TX Medicaid	HHSC External Audit	CAP implemented and issue closed	Date Issued: 09/01/2023 Date Closed: 09/01/2023
Health Plan Operations—External CAP/Noncompliance of Billing Provider NPI in Comparative Analysis SFY2023 Q3—TX Medicaid	HHSC CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/05/2023 Date Closed: 07/05/2023
Health Plan Operations/Claims—External CAP EA-1394/Noncompliance of Ambulance Claims Oversight—TX Medicaid	HHSC CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/05/2023 Date Closed: 07/05/2023
Network Adequacy Distance	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 12/30/2022

			Date Closed: 12/30/2022
SFY2018–2020 UMR Liquidated Damages—TX	HHSC Notice of Noncompliance; $2,400,000 fine	CAP implemented and issue closed	Date Issued: 11/23/2022 Date Closed: 11/23/2022
CHIP, STAR Adult, STAR+PLUS Initial Outpatient BH Visit within 14 Calendar Days	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 11/03/2022 Date Closed: 11/03/2022
HHSC Fines—SFY 2021 Q1 Preliminary LD Findings—TX Medicaid	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 10/18/2022 Date Closed: 10/18/2022
Performance Indicator Dashboard Quality Measures	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 10/03/2022 Date Closed: 10/03/2022
SFY22 UR LTSS STAR+PLUS REVIEW	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 10/03/2022 Date Closed: 10/03/2022
2020 FSR Report AUP	HHSC CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 09/02/2022 Date Closed:

			09/02/2022
2018 FSR Report AUPs	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/02/2022 Date Closed: 08/02/2022
Access to Care PCP AA 14 Days STAR Child	HHSC State Regulatory Notice	CAP implemented and issue closed	Date Issued: 08/02/2022 Date Closed: 08/02/2022
HHSC Fines—SFY 2021 Q4 Notice—TX Medicaid	HHSC Notice of Noncompliance; $14,400 fine	CAP implemented and issue closed	Date Issued: 07/01/2022 Date Closed: 07/01/2022
HHSC Fines—SFY 2021 Q3 Notice—TX Medicaid	HHSC Notice of Noncompliance; $76,100 fine	CAP implemented and issue closed	Date Issued: 06/14/2022 Date Closed: 06/14/2022
Frew Timely Checkup	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/06/2022 Date Closed: 06/06/2022
HHSC Fines—SFY 2021 Q1 Notice—TX Medicaid	HHSC Notice of Noncompliance; $2,125 fine	CAP implemented and issue closed	Date Issued: 02/25/2022 Date Closed: 02/25/2022

Appointment Availability—Prenatal	HHSC External CAP	CAP implemented and issue closed	Date Issued: 02/05/2022 Date Closed: 02/05/2022
HHSC Fines—SFY 2021 Q2 Notice—TX Medicaid	HHSC External CAP; $75,125 fine	CAP implemented and issue closed	Date Issued: 01/31/2022 Date Closed: 01/31/2022
Member/Provider Contact Center—Failure to Meet Provider Hotline Call Abandonment Rate and Average Hold Time—TX Medicaid	HHSC CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 11/08/2021 Date Closed: 11/08/2021
Call Abandonment Rate and Average Hold Time	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 09/28/2021 Date Closed: 09/28/2021
Utilization Review	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/29/2021 Date Closed: 07/29/2021
Frew Timely THSteps Medical Checkups	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 05/27/2021 Date Closed: 05/27/2021
Performance Indicator Dashboard Standards	HHSC Notice of Noncompliance	CAP implemented	Date Issued:

		and issue closed	05/25/2021 Date Closed: 05/25/2021
Network Adequacy Distance	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/30/2021 Date Closed: 04/30/2021
SFY 2017 FSR AUP	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/12/2021 Date Closed: 03/12/2021
Outlier Nursing Facility Claims and Adjustments	HHSC External CAP	CAP implemented and issue closed	12/09/2020 Date Closed: 12/09/2020
Utilization Management Review (UMR) LTSS	HHSC State Regulatory Notice	CAP implemented and issue closed	Date Issued: 10/26/2020 Date Closed: 10/26/2020
Claims Encounters	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/09/2020 Date Closed: 06/09/2020
Notice of Noncompliance Appointment Availability 2019—Vision TX	HHSC State Regulatory Notice	CAP implemented and issue closed	Date Issued: 05/01/2020 Date Closed:

			05/01/2020
Performance Indicator Dashboard Standards	HHSC State Regulatory Notice	CAP implemented and issue closed	Date Issued: 03/17/2020 Date Closed: 03/17/2020
Operational Review—UR	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/25/2020 Date Closed: 02/25/2020
Notice of Noncompliance Timely THSteps Medical Checkups SFY2017	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/07/2020 Date Closed: 01/07/2020
Notice of Noncompliance Molina—Agreed Upon Procedures (AUP) for SFY2015 & SFY2016 CAP information ID# 13372	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 12/04/2019 Date Closed: 12/04/2019
Texas HHSC SFY 2018 Q4—Non-compliance findings	HHSC Notice of Noncompliance; $74,825 fine	CAP implemented and issue closed	Date Issued: 11/19/2019 Date Closed: 11/19/2019
Notice of Noncompliance HHSC MCCO Operational Review—ID #13254	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 11/06/2019 Date Closed: 11/06/2019

HHSC issued a liquidated damage to MHT for SFY 2018 Q3: 03/01/2018–05/31/2018	HHSC Notice of Noncompliance; $59,963 fine	CAP implemented and issue closed	Date Issued: 10/16/2019 Date Closed: 10/16/2019
Texas HHSC SFY 2019 Q3—Noncompliance findings	HHSC Notice of Noncompliance; $122,513 fine	CAP implemented and issue closed	Date Issued: 10/15/2019 Date Closed: 10/15/2019
Notice of Noncompliance HHSC OIG Pharmacy Benefit Manager (PBM) Audit Findings ID# 12868	HHSC Liquidated Damages	CAP implemented and issue closed	Date Issued: 07/31/2019 Date Closed: 07/31/2019
Notice of Noncompliance HHSC OIG Pharmacy Benefit Manager (PBM) Audit Findings ID #12868	HHSC Liquidated Damages	CAP implemented and issue closed	Date Issued: 07/31/2019 Date Closed: 07/31/2019
HHSC issued a liquidated damage to MHT for Performance Review Deficiencies in Q2 SFY 2018 for multiple areas with an associated fine.	HHSC Notice of Noncompliance; $155,600 fine	CAP implemented and issue closed	Date Issued: 04/25/2019 Date Closed: 04/25/2019
HHSC issued a liquidated damage to MHT for Performance Review Deficiencies in Q1 SFY 2018 for multiple areas with an associated fine.	HHSC Notice of Noncompliance; $57,600 fine	CAP implemented and issue closed	Date Issued: 04/25/2019 Date Closed: 04/25/2019

Notice of Noncompliance Network Adequacy Distance SFY 2019 Q2 2019—ID# 12577	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/23/2019 Date Closed: 04/23/2019
HHSC Notice of Noncompliance—STAR+PLUS MMP material non-compliance with contractual performance requirements under Section 12.02 after a review Of Q42017 reports. HHSC found 27 non-compliance issues related to inaccurate reports, claims payment issues, incorrect payment holds, Member complaint timeliness, encounter data submission, and inaccurate OIG responses.	HHSC CMS Regulatory Notice; $97,071 fine	CAP implemented and issue closed	Date Issued: 03/22/2019 Date Closed: 03/22/2019
Corrective Action Plan (CAP) Request—2018 Appointment Availability—Vision	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/08/2019 Date Closed: 03/08/2019
MHT received a notification of a fine received from Texas TDI totaling $500,000. The fine is related to a prompt pay violation identified in the 2017 Triennial audit that was promptly corrected by MHT and an associated fine of $4 million.	Texas Department of Insurance Notice of Noncompliance; $500,000 fine	CAP implemented and issue closed	Date Issued: 01/31/2019 Date Closed: 01/31/2019
Network Management—Notice of Noncompliance HHSC Texas—2018 Prenatal Appointment Availability (500S)	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/11/2019 Date Closed: 01/11/2019
Managed Care Compliance and Operations (MCCO) conducted a prenatal appointment availability	HHSC Notice of Noncompliance	CAP implemented	Date Issued: 01/01/2019

study on Molina Healthcare of Texas and found the following deficiency: failure to perform within the established thresholds for the appointment wait time standards as required.		and issue closed	Date Closed: 01/01/2019
Notice of Noncompliance SFY 2018 Q4 Network Adequacy Time or Distance—TX Medicaid	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 12/17/2018 Date Closed: 12/17/2018
Network Management—Network Adequacy Notice of Noncompliance (Q4 2018 and Q2 2019) Medicaid—TX (473S)	HHSC Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 11/15/2018 Date Closed: 11/15/2018

*Molina has a process to implement and monitor corrective actions in response to potential or confirmed non-compliance on employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including but not limited to regulatory contract requirements, and Federal, state, and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery with a 30-/60-/90-day evidence of compliance.

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
Between 06/07/2022 and 06/30/2022, Availity, LLC ("Availity"), a healthcare clearinghouse and Molina business associate, experienced a security incident that occurred in the Molina Provider ePortal via a Single Sign-On (SSO) connection with the Availity Essentials payer portal. The breach affected 87 Members enrolled in Molina's	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm

California, Florida, New York, Texas, and Virginia health plans.	
Molina Healthcare ("Molina") was notified on 12/27/2018 by Equian, a vendor and business associate of Molina, that its Subcontractor, Wolverine Solutions Group ("Wolverine") experienced a ransomware security incident on or about 09/23/2018. The subject Wolverine security incident affected Members across several different covered entities, including Molina. The breach affected 895 Members enrolled in Molina's New Mexico, Ohio, Puerto Rico, South Carolina, Texas, and Washington health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other-required business associate to implement corrective action(s)
On 04/18/2018, Advanced Medical Reviews, LLC ("AMR"), a business associate of Molina, became aware of a medical reviewer, Spyros Panos, who fraudulently impersonated another licensed physician and who, on 09/01/2013, impermissibly accessed PHI in connection with independent medical reviews conducted by AMR on Molina's behalf. The breach affected 75 Members across Molina's California, Ohio, Texas, Utah, Washington, and Wisconsin health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required business associate to implement corrective action
h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed	
• Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment	

analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Access2Care, LLC—non-emergency medical transportation
- CaremarkPCS Health, LLC (CVS Caremark)—pharmacy benefits management, pharmacy claim processing, and delegated networks
- DentaQuest—dental
- Envolve Vision of Texas, Inc.—vision
- Oceangate Reinsurance, Inc.—reinsurance
- Texas Association of Health Plans (TAHP)—Provider credentialing verification organization

Table 1-18. Molina Healthcare of Utah, Inc.

a. Name of State and Program Name
State: Utah | Medicaid state program: Utah Integrated Healthcare
b. Start and End Date
Medicaid: *Utah Integrated Healthcare*: 04/01/1997–Present; *Utah Integrated Healthcare–CHIP*: 07/01/1998–Present; *Utah Medicaid Integrated Healthcare–Behavioral Health*: 01/01/2020–Present | Medicare D-SNP: 01/01/2006–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health | Medicare D-SNP: medical, pharmacy, behavioral health, dental, vision, transportation, hearing, skilled nursing facility
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, TANF, Medicare D-SNP, ABD, Medicaid Expansion Although not a covered population, we have foster care children and youth, former foster care, and adoption assistance assigned as needed during enrollment and initial transition to Medicaid to ensure consistent coverage.
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 88,133 | Medicare D-SNP: 9,500
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Enrollment—Untimely SLAs and Eligibility Verification Inaccuracies—UT Marketplace and Medicaid	Utah Department of Medicaid Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/22/2022

			Date Closed: 06/03/2022
Special Investigation Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—Multistate	CMS External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date Closed: 02/07/2022

*Molina has a process to implement and monitor corrective actions in response to potential or confirmed noncompliance on employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including but not limited to regulatory contract requirements, and Federal, state, and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery with a 30-/60-/90-day evidence of compliance.

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 5/5/2020, Molina Healthcare inadvertently mailed a letter and an individualized care plan to an unintended recipient.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Trained or retrained workforce members
On 07/22/2019, an MHU Nurse Practitioner lost a Retina Vue camera that contained PHI pertaining to eight MHU Members.	• Notified affected Member(s) • Trained or retrained workforce members • Provided individuals with free credit monitoring • Sanctioned workforce members involved • Took steps to mitigate harm • Other—Created and implemented a corrective action plan
On 01/30/2019, Molina inadvertently misdirected letters intended for one Member to an incorrect address, which was received by an unintended recipient in error.	• Notified affected Member(s) • Took steps to mitigate harm
On 04/18/2018, Advanced Medical Reviews, LLC ("AMR"), a business associate of Molina, became aware of a medical reviewer, Spyros Panos, who fraudulently impersonated another licensed physician and who,	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm

on 9/1/2013, impermissibly accessed PHI in connection with independent medical reviews conducted by AMR on Molina's behalf. The breach affected 75 Members across Molina's California, Ohio, Texas, Utah, Washington, and Wisconsin health plans.	• Other—Required business associate to implement corrective action

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Accordant Health Services, a wholly owned subsidiary of CVS Caremark—care management
- Granger Medical Clinic—credentialing
- Healthmap—case management
- IHC (Intermountain Healthcare)—credentialing
- Molina Clinical Services (MCS) Advanced Imaging—UM
- Molina Clinical Services Enterprise Medicare Unit—UM
- Online Care Network—credentialing
- Papa—call center
- St. Luke's Health System—credentialing
- Tri-State Memorial Hospital—credentialing
- University of Utah Medical Group (UUMG)—credentialing
- Valley Mental Health (Valley Behavioral Health)—credentialing
- VSP—call center, claims, credentialing

Table 1-19. Molina Healthcare of Virginia, LLC

a. Name of State and Program Name
State: Virginia | Medicaid state program: Virginia Medallion 4.0, Commonwealth Coordinated Care Plus
b. Start and End Date
Medicaid: *Virginia Medallion 4.0*: 08/01/2017–Present; *Virginia Coordinate Care Plus (CCC+)*: 07/01/2017–Present | Medicare: *Medicare D-SNP*: 01/01/2020–Present; *Medicare Advantage*: 01/01/2023–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health, vision, transportation, LTSS | Medicare D-SNP: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, SNF, physical therapy
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, Foster, TANF, Duals, Medicare D-SNP: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX), ABD, I/DD, HCBS, LTSS, Children and Youth with Special Health Care Needs (CYSCN)
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 137,146 | Medicare D-SNP: 1,354
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Service Authorization Performance	The Department of Medical Assistance Services	CAP implemented and issue closed	Date Issued: 09/08/2023 Date Closed:

	(DMAS) State Regulatory Notice; $15,000 fine		11/05/2023
Member Written Materials	DMAS External Audit	CAP implemented and issue closed	Date Issued: 08/07/2023 Date Closed: 08/07/2023
IT—Inaccurate MCO Claims Report—VA Medicaid	DMAS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/12/2023 Date Closed: 10/23/2023
Healthcare Services—Inaccurate Foster Care Barrier Report—VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/12/2023 Date Closed: 10/23/2023
Service Authorization Performance	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/12/2023 Date Closed: 11/05/2023
Healthcare Services—LTSS Portal Submission Timeliness—VA Medicaid	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 06/26/2023 Date Closed: 11/06/2023
Delegation Oversight—Veyo Call Center Metric Not Met—VA Medicaid	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 06/12/2023 Date Closed: 06/12/2023
Community Mental Health Rehabilitation Services (CMHRS) Service Authorizations and Registrations—Monthly	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 06/12/2023 Date Closed: 07/26/2023
IT BAS Provider File—MCO Network—Quarterly Late Submission	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 06/12/2023 Date Closed: 11/22/2023

Providers Failing Accreditation/Credentialing & Terminations—Quarterly Late Submission VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/12/2023 Date Closed: 12/05/2023
Healthcare Services—Case Management - Inappropriate Waiver Enrollment—DMAS CAP—VA Medicaid	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 05/11/2023 Date Closed: 08/11/2023
MCO Data Inventory—Biannual	DMAS External CAP	CAP implemented and issue closed	Date Issued: 05/05/2023 Date Closed: 09/11/2023
Claims Processing and Payment MIP—Childrens Therapy Concept	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/12/2023 Date Closed: 06/07/2023
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/10/2023 Date Closed: 04/10/2023
Delegation Oversight—Veyo Call Center Regulatory Report Discrepancy—VA Medicaid	DMAS External CAP	CAP implemented and issue closed	Date Issued: 04/06/2023 Date Closed: 09/20/2023
BOI Annual Report Late Submission	DMAS External CAP	CAP implemented and issue closed	Date Issued: 04/06/2023 Date Closed: 05/10/2023
CMHRS Service Authorization Failed TAT—02/2023	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/06/2023 Date Closed: 05/10/2023
Claims Payment Denials for T1019 and T1005	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 03/22/2023 Date Closed:

			04/26/2023
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/06/2023 Date Closed: 03/06/2023
Timeliness Response for Information	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 03/06/2023 Date Closed: 03/06/2023
Service Authorization Performance	DMAS External CAP	CAP implemented and issue closed	Date Issued: 03/03/2023 Date Closed: 03/03/2023
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/03/2023 Date Closed: 03/03/2023
Claims Processing Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/22/2023 Date Closed: 02/22/2023
Service Authorization Performance	DMAS External CAP	CAP implemented and issue closed	Date Issued: 02/03/2023 Date Closed: 02/03/2023
LTSS Portal Submission	DMAS External CAP	CAP implemented and issue closed	Date Issued: 02/02/2023 Date Closed: 02/02/2023
Initial HRA for CCC Plus Waiver Members	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/27/2023 Date Closed: 01/27/2023

Notice of Noncompliance (NoNC)—Untimely Portal Updates—Case ID #20687	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/06/2023 Date Closed: 01/06/2023
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/05/2023 Date Closed: 01/05/2023
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/02/2023 Date Closed: 01/02/2023
Service Authorization Performance	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 12/09/2022 Date Closed: 12/09/2022
Failure to Respond Timely	DMAS External CAP	CAP implemented and issue closed	Date Issued: 12/08/2022 Date Closed: 12/08/2022
Molina MIP Provider Notification Case ID 20667	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 11/21/2022 Date Closed: 11/21/2022
DMAS CAP Inappropriate Waiver Enrollment—Case ID #20627	DMAS CMS Regulatory Notice $15,000 fine	CAP implemented and issue closed	Date Issued: 11/10/2022 Date Closed: 11/10/2022
Service Authorization Performance	DMAS Notice of Noncompliance $15,000 fine	CAP implemented and issue closed	Date Issued: 10/07/2022 Date Closed: 10/07/2022
IT Care Management—CRMS Data Quality Reviews—VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 09/23/2022

			Date Closed: 09/23/2022
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/15/2022 Date Closed: 08/15/2022
Inaccurate Data Submission	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/26/2022 Date Closed: 07/26/2022
Inaccurate Data Submission	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/21/2022 Date Closed: 07/21/2022
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/15/2022 Date Closed: 07/15/2022
Pharmacy Coding Error for the Dispensation of Generic Medication Brand Drug Preferred. Notice of Noncompliance—VA Medicaid	DMAS Notice of Noncompliance; $15,000 fine	CAP implemented and issue closed	Date Issued: 07/13/2022 Date Closed: 07/13/2022
HCS—Timely Processing of Expedited and Standard Prior Authorizations Not Met. DMAS Warning Letter—MCC VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/08/2022 Date Closed: 07/08/2022
Service Authorization Performance	DMAS State Regulatory Notice $5,000 fine	CAP implemented and issue closed	Date Issued: 06/15/2022 Date Closed: 06/15/2022
Pharmacy Data Performance	DMAS Notice of Noncompliance; $46,079 fine	CAP implemented and issue closed	Date Issued: 06/08/2022 Date Closed: 06/08/2022

Service Authorization Performance	DMAS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 05/16/2022 Date Closed: 05/16/2022
Service Authorization Performance	DMAS Notice of Noncompliance; $5,000 fine	CAP implemented and issue closed	Date Issued: 05/16/2022 Date Closed: 05/16/2022
Network Management Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/30/2022 Date Closed: 04/30/2022
Service Authorization Performance	DMAS Notice of Noncompliance; $5,000 fine	CAP implemented and issue closed	Date Issued: 04/18/2022 Date Closed: 04/18/2022
Enrollment Data Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/15/2022 Date Closed: 04/15/2022
Call Center Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/13/2022 Date Closed: 04/13/2022
Inaccurate Data Submission	DMAS Warning Letter	CAP implemented and issue closed	Date Issued: 03/31/2022 Date Closed: 03/31/2022
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/15/2022 Date Closed: 03/15/2022
Inaccurate Data Submission	DMAS External CAP	CAP implemented and issue closed	Date Issued: 03/15/2022

			Date Closed: 03/15/2022
Call Center Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/15/2022 Date Closed: 03/15/2022
Call Center Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/15/2022 Date Closed: 03/15/2022
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 03/15/2022 Date Closed: 03/15/2022
Call Center Performance	DMAS External CAP; $5,000 fine	CAP implemented and issue closed	Date Issued: 02/15/2022 Date Closed: 02/15/2022
Call Center Performance	DMAS Notice of Noncompliance; $5,000 fine	CAP implemented and issue closed	Date Issued: 02/15/2022 Date Closed: 02/15/2022
Inaccurate Data Submission	DMAS External CAP	CAP implemented and issue closed	Date Issued: 02/15/2022 Date Closed: 02/15/2022
Service Authorization Performance	DMAS External CAP; $5,000 fine	CAP implemented and issue closed	Date Issued: 02/15/2022 Date Closed: 02/15/2022
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/15/2022 Date Closed: 02/15/2022

LTSS Service Authorization	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/14/2022 Date Closed: 02/14/2022
Call Center Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/14/2022 Date Closed: 02/14/2022
Network Management Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/31/2022 Date Closed: 01/31/2022
Service Authorization Performance	DMAS External CAP	CAP implemented and issue closed	Date Issued: 01/18/2022 Date Closed: 01/18/2022
Network Management-Pediatrics Network Inadequacy-Notice of Noncompliance VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/06/2022 Date Closed: 01/06/2022
Encounters Data Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 12/20/2021 Date Closed: 12/20/2021
Call Center Performance	DMAS External CAP	CAP implemented and issue closed	Date Issued: 12/15/2021 Date Closed: 12/15/2021
Call Center Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 12/15/2021 Date Closed: 12/15/2021
Call Center Performance	DMAS External CAP	CAP implemented and issue closed	Date Issued: 12/15/2021 Date Closed:

			12/15/2021
Network Management Performance	DMAS External CAP	CAP implemented and issue closed	Date Issued: 12/15/2021 Date Closed: 12/15/2021
Service Authorization Performance	DMAS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 12/15/2021 Date Closed: 12/15/2021
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 12/02/2021 Date Closed: 12/02/2021
Care Coordinator Ratios	DMAS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 10/20/2021 Date Closed: 10/20/2021
Call Center Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 10/15/2021 Date Closed: 10/15/2021
Call Center Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 10/08/2021 Date Closed: 10/08/2021
Call Center Performance	DMAS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 09/15/2021 Date Closed: 09/15/2021
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 09/15/2021 Date Closed: 09/15/2021

Call Center Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/15/2021 Date Closed: 08/15/2021
Call Center Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/15/2021 Date Closed: 08/15/2021
Service Authorization Performance	DMAS External CAP	CAP implemented and issue closed	Date Issued: 08/15/2021 Date Closed: 08/15/2021
Network Management Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 08/02/2021 Date Closed: 08/02/2021
LTSS Service Authorization	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/20/2021 Date Closed: 07/20/2021
LTSS Service Authorization	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/20/2021 Date Closed: 07/20/2021
Call Center Performance	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/15/2021 Date Closed: 07/15/2021
Call Center Performance	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/15/2021 Date Closed: 07/15/2021
Service Authorization Performance	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 07/15/2021 Date Closed:

			7/15/2021
Service Authorization Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/08/2021 Date Closed: 02/08/2021
HCS Health Risk Assessments—Timeliness Notice of Non-Compliance—MCC VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/29/2021 Date Closed: 01/29/2021
Pharmacy Data Performance	DMAS Liquidated Damages	CAP implemented and issue closed	Date Issued: 11/10/2020 Date Closed: 11/10/2020
Service Authorization Performance	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 09/15/2020 Date Closed: 09/15/2020
Service Authorization Performance	DMAS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 09/14/2020 Date Closed: 09/14/2020
Claims Processing Performance	DMAS Liquidated Damages: $1,000 fine	Fine paid and issue closed	Date Issued: 08/24/2020 Date Closed: 08/24/2020
Inaccurate Data Submission	DMAS External Audit	CAP implemented and issue closed	Date Issued: 08/07/2020 Date Closed: 08/07/2020
Inaccurate Data Submission	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 07/06/2020 Date Closed: 07/06/2020

Encounters Data Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/17/2020 Date Closed: 06/17/2020
Health Care Services—Data Submission Errors—Maternal Care Report—MCC VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/05/2020 Date Closed: 06/05/2020
Health Care Services—Data Submission Errors—Providers Failing Accreditation—MCC VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 06/05/2020 Date Closed: 06/05/2020
Health Care Services—Data Submission Errors—Family Planning & Well-Woman Summary Report—MCC VA Medicaid	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 05/08/2020 Date Closed: 05/08/2020
Magellan—Data Submission Errors—Foster Care and Adoption Assistance Member Care Coordination Report—VA Medicaid	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 05/08/2020 Date Closed: 05/08/2020
Encounters Data Performance	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 04/08/2020 Date Closed: 04/08/2020
Inaccurate Data Submission	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 03/16/2020 Date Closed: 03/16/2020
Enhanced Services	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/27/2020 Date Closed: 02/27/2020
Inaccurate Data Submission—Appeals Case Summary	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/18/2020 Date Closed:

			02/18/2020
Inaccurate Data Submission—Encounters	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/18/2020 Date Closed: 02/18/2020
Encounters Data Performance	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/11/2020 Date Closed: 02/11/2020
Encounters Data Performance	DMAS State Regulatory Notice	CAP implemented and issue closed	Date Issued: 02/11/2020 Date Closed: 02/11/2020
Inaccurate Data Submission—Encounters	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/15/2020 Date Closed: 01/15/2020
Inaccurate Data Submission	DMAS CMS Regulatory Notice	CAP implemented and issue closed	Date Issued: 01/14/2020 Date Closed: 01/14/2020
Pharmacy—Missing Data Submission—Prior Authorizations—NCPDP Transfer Standard Weekly Report—MCC VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/14/2020 Date Closed: 01/14/2020
Provider Network—Data Submission Errors—Providers Failing Accreditation/Credentialing & Terminations—MCC VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 12/13/2019 Date Closed: 12/12/2019
Appeals and Grievances—Appeals Decision TAT Noncompliant—MCC VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 11/12/2019 Date Closed: 11/12/2019

Appeals and Grievances—Data Submission Errors—MCC VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 10/09/2019 Date Closed: 10/09/2019
Provider Network—Missing Data Submission—Provider Network File—MCC VA Medicaid	DMAS Liquidated Damages	CAP implemented and issue closed	Date Issued: 09/11/2019 Date Closed: 09/11/2019
Contact Center—Call Center Statistics Data Submission Error—MCC VA Medicaid	DMAS Liquidated Damages	CAP implemented and issue closed	Date Issued: 08/26/2019 Date Closed: 08/26/2019
Claims—Data Submission Errors—MCO Claims Report—MCC VA Medicaid	DMAS Liquidated Damages	CAP implemented and issue closed	Date Issued: 08/06/2019 Date Closed: 08/06/2019
Health Care Services—Late Data Submission—MCO Member Health Screening P&P Annual Report—MCC VA Medicaid	DMAS Liquidated Damages	CAP implemented and issue closed	Date Issued: 06/13/2019 Date Closed: 06/13/2019
Health Care Services—Late Data Submission—Member Health Screening—MCC VA Medicaid	DMAS Liquidated Damages	CAP implemented and issue closed	Date Issued: 06/13/2019 Date Closed: 06/13/2019
Claims—Early Intervention (EI) Services Claims Non-Compliant TAT—MCC VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 04/26/2019 Date Closed: 04/26/2019
Magellan—Non-Emergency Transportation Vendor Issue—VA Medicaid	DMAS Liquidated Damages	CAP implemented and issue closed	Date Issued: 03/14/2019 Date Closed: 03/14/2019
Magellan CCC Plus Program—Waiver Payments—VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/14/2019 Date Closed:

			02/14/2019
Magellan MIP—Data Integrity and Untimely Authorizations—VA Medicaid	DMAS Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 02/13/2019 Date Closed: 02/13/2019

*Molina has a process to implement and monitor corrective actions in response to potential or confirmed noncompliance on employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including but not limited to regulatory contract requirements, and Federal, state, and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery with a 30-/60-/90-day evidence of compliance.

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 06/14/2023, a Molina Healthcare workforce member inadvertently sent an email containing PHI to the wrong email address.	• Notified affected Member(s) • Provided individual(s) with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members
On 02/06/2023, a State of Virginia Department of Social Services (DSS) employee merged two Medicaid participant records with similar names, dates of birth, and Medicaid ID numbers. As a result, the Virginia Department of Medicaid Assistance Services (DMAS) sent incorrect eligibility files to Molina in error. As a result of this data error, Molina inadvertently misdirected information pertaining to one of the affected participants to the other affected participant.	• Notified affected Member(s) • Provided individual(s) with free credit monitoring • Took steps to mitigate harm
On 11/02/2022, Molina Healthcare inadvertently misdirected a Member ID card sent via USPS to an unauthorized recipient.	• Notified affected Member(s) • Provided individual(s) with free credit monitoring • Sanctioned workforce members involved (including termination) • Took steps to mitigate harm • Trained or retrained workforce members

Between 06/07/2022 and 06/30/2022, Availity, LLC (“Availity”), a healthcare clearinghouse and Molina business associate, experienced a security incident that occurred in the Molina Provider ePortal via a Single Sign-On (SSO) connection with the Availity Essentials payor portal. The breach affected 87 Members enrolled in Molina's California, Florida, New York, Texas, and Virginia health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- CaremarkPCS Health, LLC d/b/a CVS Caremark—prescription drugs
- MTM—Transportation
- Northeast Pennsylvania Center for Independent Living (aka ACES$)—finance
- VSP Vision Care, Inc.—vision

Table 1-20. Molina Healthcare of Washington, Inc.

a. Name of State and Program Name
State: Washington | Medicaid state program: Washington State Apple Health Integrated Managed Care
b. Start and End Date
Medicaid: 01/01/2000–Present | Medicare D-SNP: 01/01/2006–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, pharmacy, behavioral health, pharmacy | Medicare D-SNP: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, TANF, Medicare D-SNP: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX), ABD, I/DD, Medicaid Expansion | LTSS: Older adults (65+), individuals with physical disabilities, individuals with intellectual and developmental disabilities, and dual-eligible beneficiaries. Although not a covered population, we have foster care children and youth, former foster care, and adoption assistance assigned as needed during enrollment and initial transition to Medicaid to ensure consistent coverage.
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 1,015,032 | Medicare D-SNP: 14,250
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct

Notice of Imposition of Sanctions, Imposition of Liquidated Damages—WA	WA State Health Care Authority (HCA) State Regulatory Notice; $120,036 fine	Under Appeal	Date Issued: 09/20/2023 Date Closed: Fine Under Appeal
Pharmacy—2023 TEAMonitor Review—Action Files (Denials/Pharmacy)—WA Medicaid	WA HCA State Regulatory Notice	CAP implemented and issue closed	Date Issued: 03/27/2023 Date Closed: 06/27/2023
The HCA asserted the cost data submitted by Molina was inaccurate for CY 2020 and 2021. This was disputed by Molina, but nevertheless, it was settled.	WA HCA Notice of Noncompliance; $500,000 fine	Settled and paid without admitting liability	Date Issued: 09/27/2022 Date Closed: 09/27/2022
WA Healthcare Authority (HCA) Notice of Directive to Submit a Corrective Action Plan and Imposition of Fines	WA HCA Notice of Noncompliance; $200,000 fine	CAP implemented and issue closed	Date Issued: 06/01/2022 Date Closed: 07/06/2022
Special Investigation Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—Multistate	CMS External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date Closed: 02/07/2022
Notice of Final Audit Report and Imposition of Sanctions	Office of the Insurance Commissioner (OIC) Notice of Noncompliance; $297,000 fine	CAP implemented and issue closed	Date Issued: 04/21/2021 Date Closed: 04/21/2021
Intent to Impose Non-performance Penalty for late encounter submission	OIC External Audit; $25,000 fine	Fine paid and issue closed	Date Issued: 11/30/2020 Date Closed: 11/30/2020
Consent order—A consent order was issued by the WA OIC which identified deficiencies in the plan for anesthesia network adequacy; mammograms; OIC Complaint responses (untimely and inadequate); ER Deductible	OIC Notice of Noncompliance; $400,000 fine	CAP implemented and issue closed	Date Issued: 05/02/2019 Date Closed: 06/02/2020

Accumulator and Denial of Autism Therapy; Improper Appeal Processes and Incorrect Provider List; and Retroactive termination due to invoicing error.			

*Molina has a process to implement and monitor corrective actions in response to potential or confirmed noncompliance on employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including but not limited to regulatory contract requirements, and Federal, state, and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery with a 30-/60-/90-day evidence of compliance.

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
Molina Healthcare ("Molina") was notified on 12/27/2018 by Equian, a vendor and business associate of Molina, that its Subcontractor, Wolverine Solutions Group ("Wolverine"), experienced a ransomware security incident on or about 9/23/2018. The subject Wolverine security incident affected Members across several different covered entities, including Molina. The breach affected 895 Members enrolled in Molina's New Mexico, Ohio, Puerto Rico, South Carolina, Texas, and Washington health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required business associate to implement corrective action(s)
On 04/18/2018, Advanced Medical Reviews, LLC ("AMR"), a business associate of Molina, became aware of a medical reviewer, Spyros Panos, who fraudulently impersonated another licensed physician and who, on 09/01/2013, impermissibly accessed PHI in connection with independent medical reviews conducted by AMR on Molina's behalf. The breach affected 75 Members across Molina's California, Ohio, Texas, Utah, Washington, and Wisconsin health plans.	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required business associate to implement corrective action
On 01/01/2018, CVS Caremark ("CVS"), a business associate of Molina, experienced a data file processing error, which resulted in the unauthorized disclosure of PHI pertaining to four Members enrolled Molina's Illinois, Ohio, Washington, and Michigan health plans.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required the business associate to mitigate the incident and implement

	corrective action to help prevent future incidents

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Accordant Health Services, a wholly owned subsidiary of CVS Caremark—care management
- American Specialty Health Acute/Chiro—call center, claims, credentialing, UM
- American Specialty Health Fitness—fitness and exercise services
- Beacon Health Options (WA)—credentialing
- CDR Associates LLC—payment integrity services
- Children's University Medical Group—credentialing
- CIOX Health, LLC—PHI
- Columbia Valley Community Health—credentialing
- ConfluenceHealth/Wenatchee Valley Hospital—credentialing
- CVS Caremark—PBM services
- Equian, LLC—third-party subrogation services
- Evergreen Medical Group——credentialing
- Franciscan Medical Group—credentialing
- Great Rivers—credentialing, crisis line
- Greater Columbia—credentialing, crisis line
- Harborview Medical Center—credentialing
- Healthmap—case management
- Kadlec Regional Medical Center—credentialing
- Kaiser Foundation Health Plan of the Northwest—credentialing, claims, UM, pharmacy
- Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative)—credentialing
- King County—credentialing
- Kootenai Health (WA)—credentialing
- Legacy Health—credentialing
- March Vision—vision services
- Molina Clinical Services (MCS) Advanced Imaging—UM
- MCS Enterprise Medicare Unit—UM
- Medigence Health—credentialing, call center
- Molina Healthcare—health plan administrative services
- MultiCare Health Systems—credentialing
- NeighborCare Health—credentialing
- New Century Health—UM

- North Sound—credentialing
- Northwest Hospital Medical Center—credentialing
- Northwest Newborn Specialists, P.C. d/b/a Pediatrix Medical Group of Oregon—credentialing
- Obstetrix Medical Group of Washington, P.S.—credentialing
- Olympic Medical Center—credentialing
- Optum Insight—claims processing, billing services
- Oregon Health Science University—credentialing
- Optum – claims processing, billing services
- Pacific Medical Clinics—credentialing
- PacMed—credentialing
- Papa—call center
- PeaceHealth St. John—credentialing
- PeaceHealth St. Joseph Hospital—credentialing
- PeaceHealth SW WA—credentialing
- Pediatrix Cardiology of Washington, P.C d/b/a Northwest Children's Heart Care—credentialing
- Pediatrix Medical Group of Washington, Inc. P.S.—credentialing
- Physician's Care Network PolyClinic—credentialing, professional services
- Proliance Surgeons, Inc.—credentialing
- Providence Health & Services—credentialing
- Public Health Seattle & King County—credentialing
- Rockwood Clinic—credentialing
- Salish—credentialing, crisis line
- Seattle Children's Hospital—credentialing
- Signify Health—credentialing
- Skagit Regional Health—credentialing
- Spokane County—credentialing, crisis line
- Swedish Health Services—credentialing
- The Everett Clinic—credentialing
- The Periscope Group—Member services
- The Vancouver Clinic—credentialing
- Therapeutic Associates, Inc.—credentialing
- Thurston-Mason—credentialing, crisis line
- Tri-State Memorial Hospital—credentialing
- University of Washington (UW) Medical Center—credentialing
- UW Medical Center Allied Health—credentialing
- UW Physicians—credentialing
- Valley Medical Center—credentialing
- VSP—call center, claims, credentialing
- Walla Walla Clinic—credentialing
- Washington Rural Health Collaborative–Arbor Health, Morton Hospital—credentialing
- Washington Rural Health Collaborative–Forks Community Hospital—credentialing
- Washington Rural Health Collaborative–Jefferson Healthcare—credentialing
- Washington Rural Health Collaborative–Klickitat Valley Hospital—credentialing
- Washington Rural Health Collaborative–Lincoln Hospitals and Clinics—credentialing

- Washington Rural Health Collaborative–Mason General Hospital—credentialing
- Washington Rural Health Collaborative–Newport Hospital and Health Services—credentialing
- Washington Rural Health Collaborative–Ocean Beach Hospital—credentialing
- Washington Rural Health Collaborative–Prosser Memorial Hospital—credentialing
- Washington Rural Health Collaborative–Skyline Hospital—credentialing
- Washington Rural Health Collaborative–Snoqualmie Valley Hospital—credentialing
- Wenatchee Valley Hospital, d/b/a Confluence Health—credentialing
- Western Washington Medical Group—credentialing
- Yakima Valley Farm Workers—credentialing

Table 1-21. Molina Healthcare of Wisconsin, Inc.

a. Name of State and Program Name
State: Wisconsin | Medicaid state program: Supplemental Security Income (SSI)-Related Medicaid and BadgerCare Plus
b. Start and End Date
Medicaid: 09/01/2010–Present | Medicare D-SNP: 01/01/2014–Present
c. Services Covered Under the Contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation)
Medicaid: medical, behavioral health, dental in the following counties: Milwaukee, Waukesha, Racine, Kenosha, Ozaukee and Washington (rest of the state is FFS) | Medicare D-SNP: medical, pharmacy, behavioral health, dental, vision, transportation, other: hearing, skilled nursing facility, physical therapy | Molina also offers supplemental benefits: OTC, Fitness, supplemental Chiropractic, meals, Personal Emergency Response Services (PERS), podiatry and Special Supplemental Benefits for Chronically Ill (SSBCI) benefits, such as Food and Produce, Pest Control, Non-Medicare Covered Genetic Test Kits, Service Animal Supplies, Mental Health and Wellness Apps and Non-Medical Transportation.
d. Covered Population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children)
CHIP, TANF, Duals, Medicare D-SNP: individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX), ABD, Community Living Alliance (CLA) | LTSS: Medicaid-only and dual-eligible individuals in Wisconsin who are 18 years of age or older and are elderly, disabled, or have an intellectual or developmental disability.
e. Average Number of Total Member Months for the Most Recent Twelve (12) Months of the Contract (or most recent period if the contract has been in place less than twelve [12] months)
Medicaid: 73,152 | Medicare DSNP: 1,016
f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance

Description	State/Contract Holder Action	Molina's Corrective Actions	Length of Time to Correct
Special Investigation Unit FWA Referral and Deconfliction Performance—Medicaid/MMP—Multistate	CMS External CAP	CAP implemented and issue closed	Date Issued: 02/07/2022 Date Closed: 02/07/2022
2019 Metastar HNA WI DHS Penalty	WI DHS Notice of Noncompliance; $77,715 fine	CAP implemented and issue closed	Date Issued: 01/19/2021 Date Closed: 01/19/2021
Access payment errors for the period 03/2012–11/2012 to multiple Providers	Wisconsin Department of Health Services (DHS) Notice of Noncompliance	CAP implemented and issue closed	Date Issued: 01/31/2019 Date Closed: 01/31/2019

*Molina has a process to implement and monitor corrective actions in response to potential or confirmed noncompliance on employees at Molina Healthcare, Inc., including its subsidiaries and affiliates (collectively "Molina"), who deviate from company rules, program requirements, and standards, including but not limited to regulatory contract requirements, and Federal, state, and local laws, rules, and regulations. All Molina corrective actions require remediation within 30 calendar days of discovery with a 30-/60-/90-day evidence of compliance.

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Description	Molina's Corrective Actions
On 09/13/2018, Molina inadvertently mailed correspondence containing PHI pertaining to one individual to an unintended recipient in error.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved • Took steps to mitigate harm • Trained or retrained workforce members
On 07/16/2018 Molina inadvertently misdirected a fax containing PHI pertaining to one individual to an unauthorized recipient in error.	• Notified affected Member(s) • Provided individuals with free credit monitoring • Sanctioned workforce members involved • Took steps to mitigate harm • Trained or retrained workforce members
On 04/18/2018, Advanced Medical Reviews, LLC ("AMR"), a business associate of Molina, became aware of	• Notified affected Member(s) • Provided business associate with additional training on HIPAA requirements

a medical reviewer, Spyros Panos, who fraudulently impersonated another licensed physician and who, on 09/01/2013, impermissibly accessed PHI in connection with independent medical reviews conducted by AMR on Molina's behalf. The breach affected 75 Members across Molina's California, Ohio, Texas, Utah, Washington, and Wisconsin health plans.	• Provided individuals with free credit monitoring • Took steps to mitigate harm • Other—Required business associate to implement corrective action
On 01/11/2018, Molina inadvertently mailed two Member ID cards and a PCP assignment letter to an unintended recipient.	• Notified affected Member(s) • Took steps to mitigate harm • Provided individuals with free credit monitoring • Other—Implemented corrective action to help prevent future occurrences

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

- Molina Healthcare—health plan administrative services including: enrollment and eligibility services, financial services (actuarial support), healthcare services support (clinical support/guidance), human resources, information technology services (claims/encounters processing, plan data management), legal services, marketing and public relations, Member cellular support services, Member/Provider overflow call support, pharmacy operational support, print and fulfillment services, program integrity support (FWA), Provider credentialing support, online Provider directory services, risk adjustment analytic services, telehealth services, translation services, triage/Nurse Advice Line (24/7/365)
- Access2Care—D-SNP (claims, driver validation, compliance–sanction monitoring)
- Accordant Health Services, a wholly owned subsidiary of CVS Caremark—care management
- Advocate Aurora Healthcare, Inc.—credentialing
- American Specialty Health Fitness—D-SNP (sanction monitoring, call center)
- Aperture—credentialing, sanction monitoring
- Aperture Credentialing, LLC—credentialing services
- Ascension Wisconsin—Affinity Healthcare—credentialing
- Ascension Wisconsin—Columbia St. Mary's (CSM)—credentialing
- Ascension Wisconsin—Wheaton Franciscan Healthcare of Southeast Wisconsin—credentialing
- BayCare Clinic—credentialing
- Bellin Health Partners (Dickinson County)—credentialing
- BioIQ—compliance, sanction monitoring
- Careington—credentialing, compliance, sanction monitoring
- Carenet—NAL
- Change Healthcare Solutions—EDI services
- Children's Hospital and Health System—credentialing

- Cognizant Technology Solutions US Corporation—EDI
- Concentra—credentialing
- Cotiviti, LLC—payment integrity
- Council for Affordable Quality Healthcare (CAQH)—COB
- Delta Dental—compliance-sanction monitoring, call center, credentialing, claims, UM
- Door County Medical Center—credentialing
- FirstSource Transaction Services, LLC—claims processing and adjustment
- GLOBO—interpretation/translation
- Health Management Systems, Inc.—payment integrity
- Healthcare Fraud Shield—FWA
- Healthmap—compliance-sanction monitoring, case management
- HearUSA—compliance-sanction monitoring, call center, claims, credentialing
- HSHS/Prevea—credentialing
- Liberty Creative Solutions—print vendor
- March Vision Care—call center
- March Vision Care—compliance-sanction monitoring, call center, claims, credentialing
- Molina Clinical Services Advanced Imaging—UM
- Marshfield Clinic Health Systems—credentialing
- Medical College of Wisconsin—credentialing
- Meriter Hospital—credentialing
- Merrill Communications, LLC—print and fulfillment
- Nations—compliance, sanction monitoring
- O'Neil Digital Solutions, LLC—print vendor
- Optum—TPL, payment integrity
- Papa—call center, sanction monitoring, compliance
- Performant—pre and post pay COB editing and billing work
- Premium Healthcare/ThedaCare—credentialing
- RR Donnelley & Sons Company—print and fulfillment
- SKYGEN—compliance-sanction monitoring, call center, claims, credentialing, UM
- Solera—sanction monitoring
- Syrtis—COB
- University of WI Healthcare (UW Health)—credentialing
- Watertown Regional Medical Center—credentialing

4.3.I.2 Innovative Approach Successfully Implemented in a Program Similar to KanCare to Improve Timely Completion of Member Health Screens

2. Describe an innovative approach the bidder successfully implemented in a program similar to KanCare that the bidder will use to improve timely completion of Member Health Screens in the KanCare program. Include the following in the bidder's response:

a. A description of the innovative approach and targeted outcomes.
b. How the bidder measured and monitored improvement.
c. Lessons learned.
d. The measurable improvement achieved; and why the bidder anticipates the approach will be successful for improving timely completion of Member Health Screens in the KanCare program.
e. The projected impact on the KanCare program.

Molina uses Member Health Screens as a critical method for identifying Members who will benefit from care coordination activities, such as actively and timely addressing SDOH needs. Each Member touchpoint is an opportunity to provide education and assess the Member to make sure any immediate needs—especially SDOH needs like housing —are being properly addressed. These touch points are essential for identifying those Members that require a full Health Risk Assessment (HRA) and Needs Assessment.

Completing HRAs Promptly
In our Iowa affiliate, **93% of new Members received an HRA within the first 90 days** exceeding the state's requirement of 70%.
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Our Medicaid affiliates' almost 30 years of experience serving approximately 4.8 million Medicaid Members in 18 states has given Molina a solid foundation for how best to reach out and engage Members in a person-centered, targeted, and tailored manner to meet their individual needs and preferences. We will bring the lessons learned and best practices from our experience nationwide to ensure timely Health Screens for the effective provision of healthcare services for all KanCare Members. Our goal is to reach Members as quickly as possible to best understand their needs and enhance the Member experience.

a. Innovative Approach and Targeted Outcomes

In 2022, our Florida affiliate used multiple strategies to ensure that Members participate in Health Screens. In addition to their standard approach of providing Members with multiple options to complete their Health Screen, including by phone, mail, online, text, or in person, they implemented additional strategies to increase completion rates. Their multimodal approach includes system and process innovations and focused interventions for hard-to-reach Members. The approach taken was targeted to maximize the number of Members who had completed Health Screens. Our Florida affiliate focused on accessing Members where they are and engaging them where they feel comfortable.

Molina has developed alerts and flags in our system which are displayed within the health screen dashboard that allows our Member Outreach Relationship Experience team and all Member-facing staff to see which Members have outstanding gaps in Health Screen completions. When Member-facing staff receive an alert for a Member with an incomplete screen, they transfer the Member to the **Member Outreach Relationship Experience** team who will conduct the Health Screen.

Our Member Outreach Relationship Experience team reaches out to Members with gaps in Health Screen completion using multiple channels—mail, phone, secure email, and text— to complete the Health Screen and remind them to schedule important healthcare appointments for services like well-visits to help them overcome potential barriers to receiving care, like scheduling transportation.

To increase engagement with Members who are hard to reach, our Florida affiliate started a pilot program with Best Foot Forward in 2020 and fully implemented the program in 2022. This program is designed to leverage **Best Foot Forward** to help identify Members whom our affiliate has not been able to reach and assist in linking them to needed healthcare services and completing Health Screens. Best Foot Forward performs these functions:

- They will use extensive location services for Members' current contact information, including the Member's current phone numbers and addresses. A phone-based contact initiative is then used to initiate contact with Members.
- While engaged with the Member, their staff will educate the Member on our affiliate's benefits with a focus on the value of selecting the PCP.
- The Member will be asked to grant permission to transfer them to our Florida affiliate's Member services call center. From there, the Member will be directed to complete the initial Health Screen, using the dedicated phone line referenced above.

As another approach to finding hard-to-reach Members, our Florida affiliate deployed a dedicated **Molina Community Health Worker** (Molina CHW) team for Health Screen completion and coordination of care. They broadened stratification methodology to focus on Members who have one or more of the top 10 chronic physical health and behavioral health (BH) conditions. Once Members were identified, our affiliate's Molina CHWs used their knowledge of the community and available resources to assist high-needs Members by conducting timely outreach and engagement activities to ensure they completed a Health Screen, including identifying additional interventions, such as the need for SDOH referrals. They meet with Members wherever they can be engaged, such as in their homes, nursing facilities, shelters, or doctor's offices. After locating a Member, Molina CHWs work with them to schedule a meeting with their Care Coordinator to complete the Health Screen.

b. How Molina's Affiliate Measured and Monitored Improvement

Molina recognizes the importance of measuring and monitoring the performance and effectiveness of timely Health Screen completion given the significant impact it has on Member care, Member outcomes, and population health. To ensure comprehensive measuring and monitoring, our systems incorporate data from multiple sources and track engagement rates, including timely screenings and completion rates. Our Florida affiliate tracks and measures Health Screen completion via a daily operational dashboard using a rapid-cycle process improvement approach. To ensure that Health Screens are tracked appropriately, they track the percentage of timely Health Screen completions. They also monitor completion rates monthly to identify opportunities to inform continuous system improvements.

c. Lessons Learned

Although our Florida affiliate was meeting service level agreement requirements for completing Health Screens, they saw an opportunity to increase completion rates, especially in the hard-to-

reach population. They drew on our nationwide experience by consulting with affiliate health plans serving similar populations and challenges to identify opportunities to improve engagement. After trying different approaches, they learned the innovative approach described above proved successful. We will bring these proven strategies to the State to engage and help KanCare Members complete Health Screens in a timely manner.

d. Measurable Improvement Achieved

By using innovative approaches to reach and engage Members and their Providers, our Florida affiliate's **Member completion rate for Health Screens increased by 123%** from the third to the fourth quarter of 2022. These improvements have continued in 2023. Our Florida affiliate has significantly increased their ability to connect with Members, recognize Member needs sooner, and better connect them with appropriate services and supports.

e. Projected Impact on the KanCare Program

We are dedicated to meeting the 80% requirement by the end of Contract Year 1. In Year 2 and beyond, our goal will be to continue to see year-over-year improvements of 5% as we become a recognized and visible partner to Members and Providers. We will diligently monitor our progress toward these goals and adjust our efforts as we identify methods that demonstrate higher levels of impact with Members we serve in the State.

As a Medicaid MCO for almost 30 years, we understand the difficulties in getting Member buy-in on completing the initial and subsequent annual Health Screens. With an 80% completion requirement in the State, we realize that, even with using historical claims data every other year, we will need to take every opportunity to engage with Members, ensuring we have current and accurate contact information. We will use the strategies listed below to create as many touch points as possible to increase Member awareness of their benefits and make the Health Screen process as simple and easy as possible for Members within the time frames established in RFP § 7.4.2.

Molina Insights Platform Supports Use of Health Screen Data

For the KanCare program, we will load completed Member Health Screen data into Molina Insights, our predictive modeling platform, to support risk stratification, care coordination, and care planning. Once complete and digitized, Member Health Screens will be automatically available to Care Coordination staff in our Care Coordination platform and posted to the Provider portal for external entities, such as PCPs and members of the interdisciplinary team, to access.

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Increasing Screening Rates for Members Through Telephonic and Telehealth Contacts

Practicing patient-centeredness, our Member Outreach Relationship Experience team will use the Welcome Call to complete the Health Screen with the Member.

- **Telephonic Outreach.** Instead of an automated outbound call, our dedicated Member Outreach Relationship Experience team will go beyond Contract requirements and make **6 outreach calls** to Members within 10 days. Understanding that we may not reach some Members in this time frame, this team will continue these outbound calls beyond the 10-day deadline, making a call at least every 10 days for up to 90 days. During the call, our Member Outreach Experience Team will educate Members about the initial Health Screen process and, if the Member is amenable, complete the brief assessment by phone.
- **In-person Visits and Televisits.** Molina staff will meet Members in person, in the setting of the Member's choice, or using the Member's preferred contact method to build rapport with

Members. Our staff will assess a Member's current care needs and measure progress toward their care goals.

Increasing Screening Rates for Members by Meeting Them Where They Are

We use several strategies to connect with Members in the setting of their choice. A few of these initiatives include:

- [redacted]

[redacted]

Increasing Screening Rates for Members Through Member Self-service and Incentives

Often Members are most easily able to complete the Health Screen at a timing of their choosing. We provide options for Members to call in or, with the State's approval, fill out the Health Screen electronically.

- [redacted]
- **Welcome Packet.** A Welcome Packet will provide culturally and linguistically appropriate information useful to new Members, including information about the initial Member Health Screen and who to contact to complete the Health Screen. A Welcome Letter will explain the importance of the Health Screen and the processes involved for Health Screen completion, as well as the incentive Members can receive.
- **Electronic Health Screens.** Our Medicaid affiliates have had great results with online Health Screen completion on our Member portal. With the State's approval, we will send an electronic Health Screen form to the Member and follow up via phone to verify the Health Screen results, complying with the State's requirement. We will schedule an in-person visit to complete the HRA.
- **Secure Member Portal and My Molina App.** Molina's secure Member portal and **My Molina app** will provide targeted, intelligent pop-up reminders and emails for Members who have not completed the initial and annual Health Screen. These pop-ups and emails will include the phone number for the Member Outreach Relationship Experience team and a reminder about the Health Screen incentive.
- **Social Media.** We will post on social media accounts about completing the initial Health Screen and the associated incentive for doing so.

Increasing Screening Rates for Members Through Community-based Staff and Resources

We know community resources play an important part in our Members' lives. We will partner with community organizations to help us complete Health Screens with Members.

- **Health Screens with Trusted Providers and Community Partners.** We will assess the willingness and capacity of trusted Providers and community partners to support initial Health Screen completion responsibilities, moving screening completion closer to the point of care and service. We will identify Providers who see a significant panel of Molina Members who haven't completed Health Screens and approach them about partnering with us to facilitate Health Screen completions during their Member engagements. We will partner with **Keona Health** to automate scheduling Health Screen appointments with our trusted Providers and community-based organizations (CBOs). Our Care Coordinators will work with those Providers and CBOs to share information in real-time to verify Health Screen responses.
- **Health Screens at Community Events.** We will partner with **Heart to Heart International** and other trusted CBOs to complete Health Screens at community events, with Molina's Care Coordinators validating responses remotely using shared screens.
- **Health Screens in Collaboration with NEMT Providers.** We will provide our transportation vendor with a list of Members with Health Screening gaps. If a Member with a gap requests transportation, the NEMT driver would work with the Member to complete the Health Screen. Molina Care Coordinators will evaluate all Health Screens completed by the drivers.

We are confident our multimodal approach for Kansas, leveraging our Florida affiliate's recent innovative approaches and enhanced by successful techniques used by other affiliates, will yield a similar impact on the KanCare program, resulting in high Member engagement and timely Health Screen completions. Our commitment to continuous program improvement will allow us to adjust our approach over time to best engage Members to complete Health Screens.

Identifying Member needs and our support to address those needs, whether through Molina or through community partners and supports, is key to Members' improved health, and drives our commitment to completing Member Health Screens through the appropriate dedication of resources and efforts.

4.3.I.3 Collaborative, Adaptable, and Supportive Partnerships with the State, Providers, Medicaid Fiscal Agent and Other MCOs to Achieve the State's Vision and Goals

3. The State is seeking to contract with MCOs that will be collaborative, adaptable, and supportive partners with the State, Providers, Medicaid Fiscal Agent, and each other to achieve the State's vision and goals for the KanCare program. Describe the actions the bidder will take to be an effective partner. Include specific examples of the bidder's experience with such partnering in a program similar to KanCare and how that experience will be leveraged to promote partnering in KanCare.

Actions Molina Will Take to be an Effective Partner

Even before becoming a KanCare MCO, Molina has embraced a spirit of collaboration and adaptability in our approach to designing and building a health plan made for the State. Rather than retrofitting a standard model from another state, we've spent thousands of hours crossing the State of Kansas and learning about the unique challenges and needs of Medicaid stakeholders. From those learnings, we've molded our KanCare-specific approach with a focus on local control, adaptability, community supports, and collaboration. Our Medicaid affiliates operate in a spirit of collaboration, transparency and partnership—one we will model to forward the State's vision and goals for the KanCare program. Effective people, structure, processes, and technology will guide the development and implementation of informed, purposeful actions.

People—Employing a Local, Hands-on Staffing Approach to Foster Collaboration

Our actions will be guided by a community-based approach to proactively solicit feedback from the State, Providers, the Medicaid fiscal agent, MCOs, and others, such as community-based organizations (CBOs), trade associations, and faith-based organizations, that play a role in advancing the State's vision and goals.

> I truly believe that in partnering with Molina, together we can ensure families are able to access existing resources, and we can ensure families are accessing these resources sooner! I am excited about the opportunities to further invest in building capacity for quality programs like Healthy Families America, which are vital to the health of our communities today [and] well into the future.
>
> *Gail Cozadd,*
> *CEO, Kansas Children's Service League*
>
> 077.a.ks23

A ground-level approach permeates throughout Molina beginning with our Plan President and Chief Executive Officer (CEO), Aaron Dunkel. In preparation for this RFP, Mr. Dunkel and other Molina leadership met in person with various State agencies, key stakeholders, Providers, Provider associations, and advocates over the last year to seek opportunities to improve collaborative efforts for every population served through KanCare. We attended State legislative oversight committee meetings and all KDHE stakeholder listening sessions to hear firsthand what improvements need to be made to better serve Members and Providers in the KanCare program. Mr. Dunkel will have full autonomy for decision-making, facilitating prompt response to issues and concerns, and fostering a more adaptable and collaborative approach for KDHE and other system partners.

Complementing Mr. Dunkel's efforts, Molina has actively engaged more than 200 organizations across the State, including the Community Care Network of Kansas (CCNK), Association of Community Mental Health Centers of Kansas (ACMHCK), InterHab, Kansas Health Care Association, LeadingAge Kansas, and Kansas Association of Area Agencies on Aging and Disabilities, just to name a few. Connecting with these and other key Providers, CBOs, and

advocacy organizations helped inform our health plan design, develop collaborative and ongoing working relationships, and build strong partnerships for success. Laying this groundwork early not only informed how we built our health plan, but also positions us for future cooperative efforts with other MCOs, Subcontractors, State agencies, and key stakeholders.

We designed our leadership and staffing structure to support cross-functional collaboration with the State, including KDHE, KDADS, and DCF as well as with entities and programs that support Members and Providers. This includes engagement of top-level staff with State leadership as well as liaison staff across the organization designated to work with State and community agencies. We will maintain ongoing, top-level relationships with State officials that involve our CEO, Medical Director/Chief Medical Officer (CMO), Behavioral Health Medical Officer/Medical Director (BH-CMO), Chief Operating Officer, Chief Financial Officer, Program Integrity Manager, Compliance Officer, Tribal Liaison, and others.

Structure—Ongoing Engagement and Open Communication Drives Innovation

To enhance collaboration, we will prioritize formal and informal communication, knowledge sharing, and the design, implementation, and evaluation of strategies, across the system of care. We will foster this collaborative approach with the State, Providers, the Medicaid fiscal agent, MCOs, CBOs, and other key stakeholders through open and transparent communications. We will both lead and participate in regular meetings with the State and other MCOs. These meetings will serve as a forum for discussing policy changes, addressing concerns, and aligning design and implementation actions that reflect emerging trends and industry best practices.

Our high-touch approach will engage Providers and solicit their insight and feedback to meaningfully inform our actions relating to our network design and the services we provide, such as claims processing and Provider payment. We will proactively solicit feedback through Provider Forums, which we will hold quarterly for the first two years, exceeding Contract requirements. Our **You Matter to Molina** Provider support and engagement program offers Providers a direct connection to Molina where they can share ideas and improvement opportunities to reduce administrative burden on Providers.

Mr. Dunkel will hold CEO-led listening sessions with Providers, including sessions dedicated to specialized groups, such as behavioral health (BH) and rural Providers, where they can directly connect with Molina leadership. Held in person with an option to participate virtually, Providers can easily attend these quarterly sessions, offer their feedback, and ask questions.

Processes—Adaptable Processes Allow Molina to Quickly Pivot to Enhance Our Effectiveness as a Partner

We know that to be successful in achieving the State's vision and goals requires the ability to quickly adapt to respond to factors such as policy changes, local nuances, and emerging trends. For example, our approach to KanCare's new community care coordination requirements made us shift from the traditional care coordination model—one we were able to make with ease, as we had already built collaborative relationships with the State's CCBHCs and community care coordination partners, described further below. Our processes blend continuous quality improvement with innovative community-based solutions to optimize impact. Molina's proven quality improvement process facilitates an agile response to retool and refine approaches based on outcomes that tie to the State's vision and goals, such as emergency department (ED) and

inpatient utilization, addressing Member SDOH needs, and Provider and Member experience and satisfaction. Adaptability is critical when working with complex populations, like those served through KanCare. For example, we learned that current KanCare MCOs implement strict policies on authorizing wheelchairs for children, and as they age, parents are often left struggling to find a wheelchair that fits their children. Our clinical policy leadership is already reviewing this challenge to ensure our policies are appropriately adapted to meet this unique need, so Members have a more seamless experience.

Technology—Sharing Meaningful and Actionable Data and Information with Partners

[redacted]

Establishing Effective Partnerships Across the State

We've laid the initial groundwork for establishing effective, long-term partnerships across the State that we will leverage to help achieve the State's vision and goals for the KanCare program. Our approach focuses on continual engagement as we listen and learn about challenges and opportunities and ways Molina can effectively address them.

Partnering with the State

We proactively sought to develop an understanding of the State's entities and systems and explored and engaged with agencies over the past year to recognize pain points and opportunities for meaningful collaboration between Molina and other entities and programs. We used this intelligence to develop processes and procedures and assign senior staff to ensure close collaboration with the State's key agencies and their funded programs to comply with RFP § 7.1.7, Cooperation with Other Agencies. This is one of the reasons why Mr. Dunkel was selected to lead our health plan. Our parent company knows that health plan leadership with deep knowledge of the State and longstanding connections helps us build sustainable, collaborative relationships with key stakeholders, and ultimately, helps us build an effective MCO.

We know that before we can earn the State's trust and advance its programmatic goals, we need to prove ourselves. We will do so through flawless pre-implementation readiness, no-noise execution, and an ongoing responsive, ready-to-serve MCO. Over the past two decades, our Medicaid affiliates have successfully implemented more than a dozen new statewide Medicaid programs, receiving positive feedback from state regulators. We will meet early and often with the State, as well as other key stakeholders and current MCOs, to plan for implementation activities, such as standardizing and automating Member care transition information. This approach—which we've already prepared to deploy in the State—has helped every Molina Medicaid affiliate pass operational readiness requirements before go-live.

This experience demonstrates how we will listen, learn, adapt, and collaborate with the State and stakeholders to best serve the KanCare Medicaid populations, including those who are dual eligible and being served by waiver programs. We will track our work and interactions with other

agencies and, as part of our reporting, will regularly provide evidence of our collaborative accomplishments. Other key partnerships we will deploy are summarized below.

Coordination with KDADS and Agencies Conducting Level of Care Assessments for HCBS Waivers. Molina has identified several ways to foster engagement with KDADS, including designated staff to build relationships and data sharing to support more integrated care. We look to partner with KDADS to make sure State residents experience smooth transitions from KDADS programs to similar services under KanCare. We will also build a strong partnership with the Kansas Council on Developmental Disabilities (KCDD) and work with KCDD leadership and service coordinators to ensure that Members are supported when accessing KanCare benefits. Molina understands that close relationships with KCDD leadership will help ensure that coordination of services through the KanCare program and waiver services is done with Member choice in mind. We will partner with KCDD to help support Member access to appropriate transportation and educational and workforce opportunities.

> Molina's [Molina Healthcare of Illinois] responsiveness is exemplary. When our Department presents an issue that requires a managed care response, Molina is typically the first plan at the table to propose solutions. Molina has a superior track record delivering person-centered care coordination. Their team understands Members' needs and targets interventions effectively. This is evident in Molina's strong quality performance, and in their willingness to tackle social determinants of health by working with Members to address housing needs.
>
> *Kelly Cunningham*
> *Administrator, Division of Medical Programs, Illinois Department of Healthcare and Family Services* 077.b.ks23

Coordination with DCF. Molina has met with Providers who work with children and families, who also work with and communicate with both DCF and KDHE programs, to ensure delivery of KDHE services covered under KanCare. Through our partnerships with Providers and DCF case managers, we will coordinate services to identify areas of overlap and opportunities, including family preservation. This coordination of services includes regular case rounds on complex cases to help ensure children aren't left sleeping in an office as their only option, data sharing protocols so everyone in the system has appropriate access to a child's full record of care, and dedicated staff to serve foster children.

Coordination and Cooperation with Local Health Departments. Molina Medicaid affiliates have successfully collaborated with local health department programs, such as Parents as Teachers® and Home Visiting, to develop referral protocols, sponsor community events, and collaborate on how to better engage and empower Members. Molina also proactively creates connections across system partners, including local health departments, to offer services such as adoption support and family preservation services. We will coordinate and partner with KDHE's Maternal and Child Health team to better understand how we can work together to improve health outcomes. We will host immunization events with local health departments, work with them to find an appropriate way to transport health department shots to Provider offices for injections, and bring our mobile unit to community events while qualified Division of Public Health professionals ride along for injecting.

Coordination with WIC. We will devote effort to Member support and education aimed at driving WIC enrollment and enhanced services available to Members who are part of the WIC program, including transportation services and access to perinatal care management. For example, we have established a partnership with the Kansas State University (K-State) Research

and Extension office to help individuals make good choices within the prescribed guidelines of the WIC program and provide nutrition education and classes to make the best use of food benefits. Additionally, we will leverage our partnership with **Pacify** to provide Members with a 24/7/365 virtual prenatal support app. Molina will collaborate with WIC to help promote their program and the Pacify app. Pacify includes breastfeeding and lactation video support in both English and Spanish, prenatal care reminders, additional EPSDT/well-child reminders, and general education on the importance of preventive care screenings.

Coordination with Other Programs, Such as Those Funded Under Title V, the Older Americans Act, ADA, and IDEA. Molina will prioritize partnerships with CBOs, home visiting programs, and doula services. Molina is developing specific community-informed programs through our partnerships with CBOs across the State, such as the Healthy Families America, Kansas State Alliance of YMCAs, El Centro of Topeka, Doulas of Douglas County, Kansas Birth Justice Society, among others. **Molina has partnered with Greenbush Education Center to expand the Parents as Teachers program.** Molina's investment will expand program capacity and foster connections to assist in the early identification and engagement of families who will benefit from home visiting programs.

Molina is also partnering with organizations such as the Kansas Intellectual and Developmental Disabilities Research Center, Disability Rights Center of Kansas, AARP Kansas, and other organizations that support and advocate for the elderly and individuals with IDD. Molina values the information and nuance that organizations that advocate for Members in all walks of life can bring to our staff—we use their knowledge and experience to inform and improve our processes as we continue the integration of physical health and BH.

Coordination with Justice Systems in Kansas, Including KDOC and Juvenile Justice. In anticipation of the release of this RFP, Molina held numerous meetings to understand KDOC's reentry program to identify opportunities to collaborate with the State and CBOs to identify best practices to support Members and their families as transitions occur. We understand both adult and juvenile Members engaged with any justice-involved program require additional support to ensure successful reentry into the community. [redacted]

Coordination with LEAs. We will partner with the State Department of Education, school district administrations, and school nurses to supply EPSDT education and provide a direct connection to Molina to refer Members who need help accessing services, including those who are part of an individualized education plan. We will partner with their service coordinator to ensure KanCare-covered services in the individualized family service plan are provided and will continue to partner with the service coordinator to support the family in their service plan goals.

Partnering with Providers

Across our Medicaid affiliates, we bring a strong history of building substantial partnerships with Providers to support best practices, increase transparency, reward value, expand access to

services, and improve health outcomes. Our groundwork over the past year has revealed the unique mix of urban, rural, and frontier regions in the State, and the challenges the healthcare landscape presents to accessing care. To address those challenges, we have reached out to forge relationships with Providers and Provider associations across the State through face-to-face, on-the-ground conversations. These relationships will not be siloed to an office in Topeka but rather, will include ongoing in-person visits and regular listening sessions with those organizations to cultivate and foster trust.

Our strategy starts with tapping into existing Provider networks which are vital to implementing a strong Medicaid managed care program. To advance the State's vision and goals, we have reached out to the Provider networks described below to establish partnerships and develop collaborative approaches. [redacted]

[redacted]

> Together, we believe our partnership will facilitate delegated care coordination, which will avoid duplication, maximize outcomes in the OneCare Kansas program, and improve individual and population health outcomes, including addressing SDOH and health equity. … Community Care wholeheartedly supports Molina's KanCare RFP response and looks forward to a strong partnership that will yield transformed health and lives of Kansans.
>
> *Sonja Bachus, MJ*
> *CEO, CCNK*

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[redacted]

Kansas Partner

[redacted]

[redacted]

Local Healthcare Providers. We will partner with State Providers and community agencies to identify and deliver interventions that are culturally relevant, address root causes specific to the population, and align efforts across the physical health, BH, and social services continuum. We will engage Providers and community partners, such as Hunter Health and United Methodist Health Ministry Fund, for critical insights into the lived experience of the community and the Members we serve.

Indian Health Service Clinics and Tribally Operated Facilities. Molina continuously looks for opportunities to improve collaboration with IHCPs to ensure their satisfaction with our processes. We have developed innovative approaches, informed by our Medicaid affiliates' experience, which we will customize around what we have learned through discussions with the largest tribe health administrator, Prairie Band Potawatomi Nation, the Haskell Indian Health Center, and the Kansas State University (K-State) Research and Extension program's tribal liaison. For example, we recognize that tribal communities have come together to establish the Four Tribal Principles of Sustaining Health—Beliefs and Spirituality, Resiliency/Way of Life, Self-determination, and Sovereignty/Tribal Governance. [redacted]

Foster Care Case Management Providers (CMPs). Our leadership team has met with child-placing agencies and other organizations that support children and youth in foster care to identify opportunities to increase collaboration and remove potential roadblocks to providing appropriate levels of care, including BH. We have already built in data sharing and collaborative protocols on how we will work with CMPs on individual cases, as well as thinking through broader shared challenges of placements for children with complex BH and physical health needs.

Partnering with the Medicaid Fiscal Agent

Molina's parent company owned a fiscal intermediary for 9 years and brings a team of experts with more than 25 years of experience in the industry. Our Medicaid affiliates continually solicit feedback from their state's contracted fiscal agents to improve data exchange processes, coordinating regularly and meeting routinely to discuss issues, possible solutions, and upcoming changes. Our parent company also has extensive experience conducting testing with fiscal agents to maintain quality control when initiating new programs or deploying system changes, which we will replicate under the KanCare program.

We will work with KDHE and its fiscal agent to set up files for exchanging all data and testing for accuracy, including receipt of the US Public Health Service file, as well as credentialing files via the State's Provider enrollment system. We will also work with the fiscal agent to develop and implement protocols and processes regarding the resolution of Member grievances, appeals, and State Fair Hearings and Provider grievances, reconsiderations, appeals, and State Fair Hearings. Additionally, we will work with the fiscal agent on overpayment recovery, resolving rebates within 60 days of the dispute notice, directing Members to the KanCare eligibility clearinghouse for disenrollment requests, and sending Provider information to the fiscal agent for monthly updates. We will also maintain cross-functional workgroups that meet monthly to review trends that may indicate a need to report escalations to the fiscal agent.

Partnering with Other MCOs

We will tap into the experience and best practices of our Medicaid affiliates that partner with other MCOs to streamline and standardize processes, improve efficiency, and drive success.

Collaborating on Member Health Plan Changes. Molina will assume a leadership role among KanCare MCOs to ensure collaboration and continuity when serving Members during a transition. Through timely, automated, standardized, and comprehensive data sharing, we will ensure critical information is accessible to a receiving MCO. Transparent data sharing with all stakeholders in Members' care is critical to ensuring the process is seamless for every Member. Once validated, we will push data we receive from other MCOs to Providers and other entities involved in Member care to ensure timely access to care and a flawless transition. We will ensure ongoing collaboration to meet the Member's needs for healthcare services among all stakeholders. We will be responsive and considerate in all our interactions and activities to ensure all Members' access to healthcare and continuity of care is not delayed.

Ensuring Seamless Transitions and Transfer of Information with Other MCOs. Using best practices from our Medicaid affiliates, Molina's person-centered approach will ensure Members have a seamless transition between MCOs. We will collaborate with other MCOs, State agencies, Subcontractors, tribes, and community Providers to support Members' needs and coordinate care and services throughout the transition. Molina will collaborate and coordinate care through warm handoffs to facilitate a rapid, safe, and supportive transition. The Care Coordination team will adopt and build on existing care plans, ensure the availability of preapproved services within our network, and make sure those services are in place upon transition.

Reducing Administrative Burden. Molina will work with other health plans to find areas where we can standardize across all MCOs, such as coordinating with the State to standardize performance measures and Provider forms, credentialing forms, and pre-operation forms to ease the administrative burden on Members and Providers. For example, our Illinois affiliate works with other MCOs to implement a streamlined roster update process to ensure one consistent way to communicate updates to all MCOs.

Conducting Statewide PIPs. In the State, our Quality team and executive leadership will actively participate in collaborative workgroups with KanCare MCOs to identify and implement effective solutions, share best practices, align Member and Provider messaging, and support early identification of delivery system issues that may impede success.

Examples of Partnership Experience in Programs Similar to KanCare

Molina will tap into the best practices and lessons learned from our Medicaid health plan affiliates across the country to develop meaningful partnerships across the State.

Partnering with State Agencies in Other Medicaid Programs

In response to the Virginia Department of Corrections' Early Release Program, in 2022 our Virginia affiliate created an internal pilot program to work with the Department of Corrections to

> Molina [Healthcare of Virginia] strongly collaborates with the Virginia Department of Medical Assistance Services (DMAS) and is involved with agency key priorities that include improving foster care, doula benefit implementation and rollout, Project BRAVO (restructuring of BH services), delivery of COVID-19 vaccinations (including vaccine hesitancy), immunizations, and maternal and child health initiatives.
>
> *Daniel Plain*
> *Division Director, Health Care Services, DMAS*
> 077.d.ks23

ensure individuals received the support they needed to access care. Our affiliate's model used Peer Support Specialists to reach out to individuals, establish relationships, and connect them to our affiliate's dedicated Justice System Liaison with the Department of Corrections. This program resulted in high Member touch points, which promoted both Member engagement in healthcare services and successful rehabilitation back into the community to avoid justice system reentry. An analysis of this pilot program found that of the 163 continuously enrolled Members (6 months pre pilot and 6 months post pilot), there was a 41% reduction in spend as a result of 53% reduction in inpatient BH utilization and 15% reduction in ED utilization. This model is one we aim to replicate with our approach to justice-involved individuals entering our KanCare MCO upon release, described above in Partnering with the State.

Molina's Iowa affiliate partners with EveryStep, a large central Iowa Title V entity, to expand their culturally competent nurse home visiting program for pregnant women to additional counties. Our affiliate also complements the Iowa Department of Public Health's doula pilot programs in several counties by delivering value-added coverage for doula services. Our affiliate coordinates with the Iowa Department of Public Health to ensure delivery is connected to local Title V and public health agencies—together, they educate local Providers about the value of doula services. We looked at this model in Kansas as we sought to expand access to CHWs, as described above in Partnering with Providers.

Our Nevada affiliate and the Nevada Division of Child & Family Services have joined forces to develop a program alternative for youth aging out of the foster care system. This option will provide continued case management to the foster care population aging out of the system, leveraging CHWs and SDOH programs. They are also evaluating using peers who have aged out of foster care to provide Member and family support. Starting in 2019, our California affiliate coordinated with local California Children's Services (CCS) agencies to develop a program to address gaps in care for youth aging out of CCS at age 21. These Members have ongoing, multispecialty care needs, and many identify as underrepresented minorities who face health inequities. After they choose to join the program, Members receive ongoing intensive case management to address any barriers to care. One key goal is to safely keep Members, who reside throughout California, in the outpatient care setting and avoid hospital stays. Our affiliate's Medical Director of Pediatrics and CCS Support Team conduct biweekly interdisciplinary team meetings, which include CCS Case Managers, to discuss ongoing Member care issues. Recent analysis shows this targeted intervention resulted in a 36% reduction in hospital admissions for Members in the program. Both our Nevada and California affiliates' experience helped shape our approach to children aging out of foster care in Kansas, which includes specialized collaborative approaches with the CMP and DCF to ensure every child's health record is portable and easy to access as they transition to adulthood, and that every child aging out has dedicated care coordination services carrying them through their age-out period.

Our Washington affiliate worked with Washington State Health Care Authority to implement a wraparound support model for high-needs youth and families. They led a workgroup to bring key stakeholders together, including Providers and other MCOs, to address systemic barriers, identify root causes, propose and implement solutions, share best practices, and improve the system's responsiveness. Positive outcomes included new care access points, such as telehealth for family therapy and crisis response triage. This experience informs our relationship with the children's BH system in Kansas and helps identify gaps in the system that we seek to fill through enhanced rates for expansion of evidence-based services with key Providers.

Partnering with Medicaid Fiscal Agents in Other Medicaid Programs

Our Florida affiliate meets at least monthly with Gainwell, the State's fiscal agent, to discuss the encounters submission process. This open communication and collaboration enhance the health plan's ability to meet encounters submission requirements and swiftly resolve issues as they arise. For example, when our Florida affiliate identified that encounters were being inaccurately denied as duplicates by the Florida MMIS, they shared this information with the fiscal agent, providing examples and a recommended remediation strategy. As a result, a Florida MMIS modification was implemented that led to a 7.5% improvement in the number of our affiliate's duplicate denials each week. We will apply similar discipline in our approach with KanCare's fiscal agent using dedicated staff.

Partnering with MCOs in Other Medicaid Programs

Our Texas affiliate has been instrumental in an ongoing statewide MCO collaboration for NEMT. The state's 11 MCOs contract with a single NEMT Subcontractor. The MCOs have designated three health plans, including our affiliate, to serve as lead coordinators, organizing meetings and representing the MCOs' interests with the Subcontractor. During the COVID-19 pandemic, the MCOs shared feedback related to drivers refusing to transport COVID-19-positive clients. Our affiliate and the remaining MCOs worked together with the NEMT Subcontractor to remove transportation barriers to care. The group developed a systemwide driver incentive program to support the safe transport of Members.

In October, our Kentucky affiliate joined forces with fellow Medicaid MCOs and NASCEND™, an innovative clinical solution, education, and technology company, to implement a grant awarded by the Kentucky Association of Health Plans. The three-year, $750,000 award will extend the Medicaid program's reach to rural Kentucky hospitals to decrease infant transfers to urban facilities, reducing family stress and improving patient-provider relationships by retaining local care and resources. The program will serve at least 500 infants each year and contribute to an estimated cost savings of at least $2.83 million annually. Similarly, our Arizona affiliate partners with the state and other MCOs annually to reinvest dollars into housing initiatives, since we understand that housing is part of healthcare. As Molina examines the best approach to our $2 million annual reinvestment commitment in Kansas, we will collaborate with partners to help expand the reach of those dollars. Molina's affiliates also have extensive experience collaborating with Medicaid agencies and other MCOs in conducting statewide PIPs. Our Washington affiliate, for example, collaborated with the other MCOs in the state on the ED Information Exchange PIP. When a Medicaid Member arrived in an ED, a scan of MCO data determined if the Member had a history of inappropriate ED use. In the first year of the program, **the collaborative PIP saved the state $34 million dollars through a 10% reduction in ED visits and a 24% reduction in prescriptions for controlled substances**.

Member Experience (Tab 7b)

MOLINA HEALTHCARE

4.3.I.4 Encouraging and Engaging KanCare Members to Actively Participate in Their Healthcare and Meet Personally Defined Health and Wellness Goals

4. Describe the bidder's approach to encouraging and engaging KanCare Members to actively participate in their health care and meet their personally-defined health and wellness goals and cross service system needs. Provide an example of a strategy the bidder has successfully used in a program similar to KanCare, including the impact of the approach on outcomes.

To achieve successful Member health outcomes and promote their well-being, we understand that effective Member engagement and support are vital. Molina takes a proactive approach to eliminating barriers to engagement using, for example, Care Coordinators, Molina Community Health Workers (Molina CHWs), and Peer Support Specialists to help Members meet their personally defined health and wellness goals.

As an organization focused on serving Medicaid populations nationwide, we recognize barriers to participation can vary by health status, Medicaid population cohort, geography, cultural background, and family structure. For example, participation by youth in foster care differs from participation by seniors in a nursing facility (NF). Our person-centered, relationship-based approach honors Members' individual needs and preferences, enabling meaningful engagement that allows us to remove barriers and encourage, empower, and support active Member participation in their healthcare journey.

Overarching Strategy

We engage Members from the moment they enroll, focusing on how best to interact with them and eliminating communication barriers early. We then assess their current healthcare status and respond quickly to urgent issues, like SDOH barriers, inpatient admissions, or emergency department visits. We will use 834 enrollment file information from former MCOs, authorization requests, outpatient Providers, family members, placement notifications, county child welfare and juvenile justice caseworkers, and other resources to proactively learn about Members' needs, so we can connect them to care and help them meet their goals.

While Molina provides individualized support and encouragement, our experience has led us to develop beneficial strategies for some categories of care, such as Members with behavioral health (BH) needs; certain Member population cohorts, such as youth and pregnant Members; and Members in specific social contexts, such as those experiencing homelessness. When applicable, we incorporate those strategies into our Member engagements to help them be successful in meeting their unique care needs.

In addition to assessing healthcare status, our trained Molina CHWs assess the Member's preferences and comfort with various technologies that might aid their participation in their healthcare. Molina knows technology can be an asset or a barrier in a Member's healthcare journey and, like their care needs, it is crucial to individualize technology's role in a Member's care to engage the Member and provide them with tools that will encourage active participation.

We cap our overarching engagement strategy with a participation incentive program. Like the rest of our engagement strategy, we tailor the incentive program to the Member. For example, pregnant Members receive a crib, car seat, or booster seat for completing a prenatal visit during

their first trimester and a $25 gift card for attending a postpartum visit. Our goal is to encourage Members to engage in their healthcare and receive positive reinforcement when they do.

The following sections provide more detail on these strategies and examples of their positive impact on programs similar to KanCare. This list is not all-inclusive but represents a sampling of the many ways we work with Members and their families, if appropriate, to eliminate barriers.

Encouraging Participation Through Multimodal Communication Paths

We offer all Members a choice of how they wish to interact with us to minimize frustration and eliminate communication barriers. We use various modalities and opportunities aligned with their preferences, including both traditional and digital methods. Member Services Call Center Representatives conduct a Welcome Call, dialing at different times of day to increase the odds of connecting to Members, so we can learn their preferences. If we don't connect, we will send a letter asking them to contact us at their earliest convenience. We flag the Member as "unable to reach" within our system, so we can request the Member's preferences should they call us back.

Molina uses local resources and on-the-ground staff, such as our Molina CHWs who live in the communities they serve. CHWs play a significant role in influencing Members to access healthcare resources. They use their local expertise to locate and engage hard-to-reach Members through visits to locations they frequent and Provider appointments. **From June 2023 to September 2023, Molina CHWs in our Virginia affiliate conducted** nearly 1,300 drive-bys, resulting in a 20% success rate in locating and establishing contact with hard-to-reach Members.

Our partners, such as **Best Foot Forward**, which specializes in locating and identifying hard-to-reach individuals, will also help us locate and connect to Members. Using proven location tools and strategies, Best Foot Forward's efforts have had a 51% success rate of finding hard-to-reach Members for our affiliate health plans and helped make this crucial first interaction possible.

We will also provide Members with convenient access to adaptive communication services, such as qualified American Sign Language interpreters; TTY/TDD lines; and information in alternative formats, such as braille, large print, and audio, upon request.

Supportive Call Center. Our integrated, toll-free line is dedicated to providing comprehensive support for KanCare Members, including for their physical health, BH, LTSS, and SDOH needs. Member Services Call Center Representatives proactively assist in removing Member barriers. For example, if a Member expresses difficulty in finding a Provider, the Member Services Call Center Representative will call doctors' offices while keeping the Member on the line, facilitating appointment scheduling. As another example, if a Member calls in expressing SDOH needs, such as food, housing, or transportation, our Member Services Call Center Representative will connect them with necessary support services via our SDOH platform. Molina will provide all Members and legally authorized representatives with access to our dedicated, toll-free multilingual 24/7/365 Nurse Advice Line to assist them in obtaining non-emergent care and access to our Member Crisis Line.

Online Resources. Members have access to our website, which meets the requirements of Section 504 of the Rehabilitation Act, Section 508, and W3C's Web Content Accessibility Guidelines. Our many online resources are proven to improve health literacy and empower

Members to navigate their healthcare independently, set personal goals, and make informed healthcare decisions. Digital resources include our Member Handbook, website, portal, newsletters, and My Molina app, which offer general information about program benefits. Our locally-based Materials Review Committee will ensure our Member materials are accurate and culturally competent; comply with content and language requirements; read at a fifth-grade level (according to Flesch-Kincaid index policies); do not defraud, mislead, or confuse the Member; and are easily accessible.

We incentivize Members to remain engaged in care coordination activities through tailored, specialized care coordination value-added benefits and telehealth BH solutions, such as the **BeMe app**, which improves outcomes for teens with anxiety, depression, and gender dysphoria.

Expanding Access Through Our Network

Access is the most overwhelming barrier to a Member's healthcare participation. Our KanCare Network Development and Management Plan ensures Members have uninterrupted access to care that meets their physical health, BH, and LTSS needs, as well as cultural, ethnic, language, and SDOH needs and addresses health disparities. Our parent company recently launched affiliate health plans in Nevada and Iowa with qualified Provider networks ready on Day 1 of go-live. Establishing a high-touch, transparent engagement approach that earned Providers' trust was a significant factor in those plans' success. We will leverage their best practices and insights gained from hundreds of conversations with State Providers to deliver a fully compliant KanCare network that gives Members the care they need when and where they need it.

As of August 2023, 63 counties in the State are designated as medically underserved. Furthermore, 52 counties had fewer than 5 doctors in their network in 2021, and 14 counties had only 1 or no doctors within their borders. To address access barriers due to geography and low Provider availability, we will offer solutions that bring services directly to Members by collaborating with community-based organizations (CBOs) and State agencies and offering Provider incentives. For example, we will host [redacted]

Molina embraces telehealth solutions and telemonitoring to provide Members with 24/7/365 access to high-quality care and transform how they receive care in all parts of the State. Our telehealth program leverages proven remote technologies to offer Members healthcare services across a wide spectrum of health disciplines, including physical health and BH services. For example, we are partnering with **Children's Mercy Hospital, the University of Kansas Health System, and other Providers** to increase telehealth access.

Engaging Members to be Participants in Their Healthcare by Addressing SDOH

We approach Members with an understanding that health behaviors and lifestyle choices are often influenced by SDOH. We recognize KanCare Members' challenges, including transportation barriers, limited food access, and a lack of access to healthcare Providers, particularly in rural areas. We intend to break down these barriers by initiating connections early and often, personalizing communication methods, and leveraging existing relationships with

established CBO partners and organizations that Members trust, such as **NAMI, Big Tent Coalition of Kansas, Disability Rights Center of Kansas, and Kansas Mental Health Coalition**.

For example, Molina identifies Members who may be experiencing homelessness, are precariously housed or transient through direct referrals from Member-facing entities, data mining, and risk stratification. Specific populations may be more susceptible to experiencing housing insecurity, such as children aging/aged out of foster care, American Indian Members, individuals with SPMI and SUD, Members transitioning out of hospital stays/residential treatment, and those with complex needs. [redacted] We have started discussions with appropriate housing authorities with a plan for collaboration on identifying Members experiencing homelessness. We share our data with CHWs/community health representatives (CHRs), Peer Support Specialists, and delegated partners whenever possible to support outreach and engagement to assist Members in navigating the unique challenges housing insecurity presents.

Similarly, we recognize the multiple challenges justice-involved Members face, including reluctance to interact with "the systems." We engage Members while they are still incarcerated to allow time to build trust with specialized Care Coordinators and help ensure a successful transition to the community. We will closely monitor the daily 834 files and other data sources (such as reports from the KDOC's pre-release team) for eligibility span changes and track booking and release dates to target care coordination, outreach, and engagement. We will obtain data-sharing and coordination agreements with counties, detention centers, and justice systems to share health information about the Member to help generate the Transition of Care Plan and Health Risk Assessment (HRA). The Transition of Care Plan will include a scheduled HRA and document ongoing health and community benefit needs; continuation of Medicaid eligibility; dedicated staff, housing, financial, and safety needs; and an interpersonal and social skills assessment. The Transition of Care Plan will be incorporated into the Member's Plan of Service after an HRA is completed in a State-approved setting.

Another critical component of Molina's outreach strategy for this population is to dedicate specialized staff. An assigned staff member will be the single point of contact to communicate with the prisons, jails, and detention facilities, and facilitate direct or delegated care coordination processes systemwide for all justice-involved Members. As a part of the Care Coordination team, we will reach out prior to release to ensure a completed Transition of Care Plan pre-release and post-incarceration. [redacted]

Encouragement by Meeting Diverse Cultural/Linguistic Needs of KanCare Members

Molina has designed every aspect of our State operations to reduce inequalities and disparities and emphasize Member choice, access, safety, independence, and responsibility. We promote the delivery of culturally competent services to all Members, including those with LEP, diverse

cultural and ethnic backgrounds, and physical or cognitive disabilities, as well as individuals who are poor, homeless, or part of a minority population group, such as LGBTQ.

All Molina written, digital, and printed materials are available in multiple languages as well as prevalent non-English languages upon request and include taglines (in large print in the top 15 non-English languages), explaining the availability of oral and written interpretation services and how to request such services per the State's requirements. Additionally, interpretation will be available 24/7/365 in more than 250 languages at no cost to the Member. Interpreters have advanced healthcare-focused training, enabling them to communicate clearly with Members about complex health-related needs.

Our Member services call center will offer an automated telephone menu of options in English and Spanish, and bilingual call center staff to support Spanish-speaking Members. We can also connect Members who speak other languages to interpreter services 24/7/365. We continuously monitor Member needs and adjust our language services to remove language barriers.

Engaging Members in Their Healthcare Through In-person, Field-based Staff

Once we identify a Member's needs, we will connect them to the right resources for their situation, such as care coordination, Housing Services and Supports Specialists, or CBOs with intimate knowledge of the communities they serve. Their expertise aids us in creating impactful initiatives and programs that resonate with Members. We will increase engagement and Member participation through collaboration with CBOs that Members already engage with and trust.

CHWs/CHRs and Peer Support Specialists. Individuals with lived experience are our most effective community connections with Members. These trusted local resources engage Members in care coordination. Our Care Coordinators use a person-centered approach to develop care plans to define Members' holistic needs, goals, and preferences, ensuring the plan includes the appropriate support for individuals. The Plan of Service development process allows the Care Coordinator and Member to explore all possible topics related to the Member's immediate and future healthcare goals. Our approach focuses on putting the Member at the center of the care planning process, so they control all decision-making.

Proven Success with Molina Affiliates' CHWs
Molina CHWs have proven beneficial in other markets. One Molina Medicaid affiliate achieved a **25% reduction in Member ED visits and hospital admissions** in the first year of the program.

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Molina CHWs are longtime Members of the communities they serve, so they understand their community's culture, language, and norms. Their firsthand experience allows them to engage Members in a way that encourages them to share their personal goals. Molina CHWs can effectively connect Members to community-based resources, education, advocacy, and social support services. They will also be able to assist Members with housing, food, clothing, transportation, scheduling appointments, and identifying community advocates for eligibility/financial needs. Molina CHWs will also meet Members in person who may have a risk or need and have not responded to our phone and other outreach attempts. These interactions will allow Molina CHWs to continue to integrate Molina into local communities and will also serve as a resource for feedback on health plan access issues that may otherwise be overlooked.

Peer Support Specialists. These trusted, community-based workers are critical members of our Care Coordination team and our integrated whole-person care approach, connecting the Member to CBOs, mentors, and health advocates. Since Peer Support Specialists live in the communities they serve, they naturally bridge the racial, cultural, and linguistic barriers that often exist. These individuals effectively assist Members in navigating the healthcare system to help meet Members' goals, removing SDOH barriers and providing health education to empower Members to self-direct their own care.

Growth and Community Engagement Team. Deeply rooted in their communities, our Growth and Community Engagement team regularly engages with Members and their families, Providers, CBOs, and other stakeholders. Staff proudly represent Molina within their communities and participate in various impactful initiatives, such as facilitating health fairs, baby showers, back-to-school events, immigrant and refugee support, and more. **We ensure our commitment extends beyond financial contributions.** We genuinely listen to the community's needs and strive to help Members achieve their goals. Whether lending a helping hand, sponsoring events, or bringing together cross-system partners for collaboration, this team is integral to building meaningful community relationships. For example, Molina has partnered with **El Centro of Topeka**, a nonprofit whose mission is to strengthen primarily Hispanic/Latino communities through educational, social, and economic opportunities.

> **Kansas Engagement**
> We are encouraged by Molina's dedication and community connectedness to improve culturally appropriate access to care. Molina's experience and expertise in providing culturally sensitive, evidence-based programs and healthcare education will help improve health inequities for all children and families in Kansas.
>
> *Lalo Muñoz*
> *Executive Director,*
> *El Centro of Topeka*
>
> 065.a.ks23

Engaging Active Participants in Healthcare Through Education/Health Literacy

Our affiliates have found focused educational campaigns valuable to inform Members about the importance of scheduling and keeping appointments. We will leverage the same proven approach in Kansas to educate Members we serve in KanCare. Molina will educate Members on the importance of using preventive care services following evidence-based standards. We will contact any Member who hasn't yet received preventive care services or has no claims activity within the past year to schedule preventive care. All Members will have access to our prevention and wellness programs based on need, access to community engagement events, and connection to our community partners through our SDOH platform to address social service needs.

In 2022, our Virginia affiliate conducted a series of outreach campaigns to educate Members on the importance of receiving necessary services and offered to schedule appointments on the Member's behalf. For example, they conducted a call campaign to educate Members on the importance of completing an annual eye exam and helped to schedule appointments. Of the Members called, **24% were provided with education and scheduling assistance**. **Of those Members, 7% received additional eye exams due to abnormal results and were able to receive timely care.** Our affiliate also launched a targeted campaign on the importance of timely immunizations for children and to assist with scheduling appointments for well-child visits. From outreach to 790 Members, our Virginia affiliate was able to **assist with scheduling appointments for 21% of these Members.**

Removing Barriers for Pregnant and Postpartum Members and Care for Premature Babies

We contact pregnant Members transitioning into Molina within 7 to 10 days to ensure continuity of care and schedule an HRA to engage them in care coordination and assist in selecting a PCP. Pregnant woman can choose their OB as their PCP. We prioritize continuity of care for transitioning Members to ensure they can stay with existing Providers and align them to Molina's care coordination services like the High-risk OB/NICU Care Coordination program.

Our dedicated Maternal Health Care Coordinators, who are trauma-informed and culturally competent, reach out to all newly identified pregnant or postpartum Members within 7 to 10 days of enrollment or upon notification of a Member's pregnancy to complete an HRA. One of our main strategies for outreach and engagement is enhanced early identification. To increase early detection rates, Molina uses all available HIE and 834 enrollment file data and also leverages our strategic partnerships. These proven, local, and national advanced analytics organizations supplement our ability to identify maternal health needs as soon as possible to ensure earlier engagement in care coordination. Additionally, we incentivize Providers, FQHCs, OB/GYNs, and PCPs to report Member pregnancies online, using easy-to-use forms via our Provider portal and EHR data exchanges.

Our Pregnancy Dashboard tracks outreach status and risk level, so we can effectively coordinate with Providers and delegated care coordination entities. Molina CHWs/CHRs and doulas help us find pregnant or postpartum Members and engage them in completing an HRA and participating in care coordination. We are also introducing numerous tools to support pregnant and postpartum Members and keep them engaged in care coordination. One such example is through **Pacify**, a virtual tool that allows 24/7/365 access to real-time bilingual, video support for pregnancy-related questions, lactation consultations, and newborn care concerns.

Molina's healthy food programs support high-risk pregnant Members with chronic conditions and postpartum mothers by addressing food insecurity, a critical SDOH that impacts post-discharge health outcomes. Using data from our affiliated health plans, we found that providing transitional meals reduced **Member inpatient utilization by 70% and average medical costs by 39% over 9 months.** Among Members reporting high levels of food insecurity, **inpatient hospitalization declined by 85% for black Members and 89% for Latino Members**.

Individuals with Chronic and/or Complex Physical Health Conditions

We align VBP partnerships with key Providers, CBOs, and core service agencies to bridge treatment gaps in the child and adult treatment systems and to delegate care coordination to trusted, local resources, as appropriate. We also partner with CBOs—such as the **Kansas Statewide Homeless Coalition's transition aged youth program, O'Connell Children's Center,** and **Bloom House Youth Services**—to teach life skills and engage Members aging into adulthood. Care Coordinators offer value-added benefits including specialized care coordination services aimed at helping Members adhere to the Transition of Care Plan and support successful integration into adulthood.

We support adult Members by providing information and education to empower self-management and independence. We provide access to various evidence-based programs for adults with chronic conditions that provide knowledge and skills to improve symptom management and promote healthy behaviors.

Individuals Who Are Transplant Recipients or on a Transplant Waiting List

Molina supports transplant recipients and waitlisted Members before and after their procedure. We help Members manage chronic conditions to ensure they are ready when they receive notice they have been selected for a transplant. We continue to support the Member post-surgery with challenges such as medication management and affordability, sustained sobriety, and more.

Eliminating Technology as a Barrier to KanCare Members

KanCare Members will have varying levels of comfort with and access to technology, including the Internet. We remain cognizant of Member choice and encourage, but do not force, Members to try using certain tools and software. Molina will use every avenue—from the digital highway to in-person appointments—to ensure all Members have consistent and efficient care planning. As an extension of our care coordination activities, **Molina CHWs will ask Members at the first contact about their comfort level using technology and offer to connect them to a device if they choose to interact with us in that way**. All phones are pre-programmed with Molina information, the assigned Care Coordinator's phone number, the My Molina app, and the ability to access telehealth services. Our CHW will train the Member using effective methods of communication to ensure they understand how to navigate the device and any online tools. They will also involve the Member's caregiver or authorized representative, as appropriate.

We respect Members' wishes if they don't want to or can't use electronic devices (e.g., due to a lack of access in a rural area). Care Coordinators, hired from the communities where Members live, will work with these Members to determine the best method of ongoing contact to ensure consistent and efficient care planning, provide services, and provide related documentation. We will work with community partners, including NFs with Members residing in them, to develop optimal outreach, so technology is not a barrier to accessing quality care. We build the Member's preferred engagement method into our care coordination activities and document it accordingly.

Empowering and Assisting KanCare Waiver Populations

Molina's approach is to immediately assign Members in waiver programs to a culturally aware Care Coordinator and schedule an HRA. We will assign a single Care Coordinator to coordinate benefits and care, reducing barriers and administrative burden for Members and Providers, ultimately providing the foundation for a trusted relationship. This approach eliminates

confusion and the feeling that a Member is always retelling their story to someone new and also promotes a holistic Member view.

Care coordination is even more crucial for Members in waiver programs. We will closely monitor Members being served in waiver programs to ensure high-touch transitions when barriers can derail care and engagement. We will monitor enrollment to request timely level-of-care packets, ICF/IDD abstracts, care plans, and any related waiver assessments. We increase outreach rates through delegated partner agreements with organizations specializing in IDD to help Molina and Providers reach out and engage Members early, particularly when there is a change in health status.

We will work side-by-side with Members who have cognitive deficiencies and disabilities in all aspects of their care to support personal decision-making and informed choice. Care Coordinators complete training in motivational interviewing, person-centered planning, assessment administration, understanding IDD, informed decision-making, assistive devices/aids technology, and home modifications. If we identify an issue, we work in collaboration with the Member, their family (if appropriate), and CBOs to remove impediments to accessing the appropriate care they desire and deserve.

For IDD population Members in particular, we will tailor our evidence-based outreach strategies using plain language and the Member's preferred communication modalities. We also will work closely with the Department of Health, Center for Developmental Disabilities, school-based health centers, the Member's HCBS coordinator, and community partners to meet Members where they are. We will engage Members, their caregivers and families, and care coordination delegates through trusted Providers and CBOs to help individuals gain life skills, learn, and work in their community. For Members under age 21, we prioritize EPSDT screenings and coordination of benefits performed by a home visiting Provider.

To maintain ongoing support for Members and their families, our industry-leading analytics support proactive outreach and engagement as Member needs change. Through data mining reviews, we closely monitor for changes in health conditions and Medicare/SSI eligibility to prioritize our outreach and engage Members early in care coordination. We achieve our highest engagement rates with elderly or disabled Members who need LTSS when we establish a relationship and strengthen it over time. With the Member's consent, we work with their family and direct caregivers to facilitate engagement and eliminate barriers to care, keeping the Member-centered care plan at the forefront. We have also engaged CBOs to ensure they deploy culturally appropriate LTSS throughout the State and support Members in their healthcare journey. We will align the Member's preferred community benefit services or an HCBS Waiver program, if deemed appropriate.

Cross-system Collaboration

Coordination of care takes concerted dedication and an ability to coordinate across the multifaceted systems of Providers, organizations, and programs to create a supportive system of care for individual Members and their families. We will work diligently across system partners to ensure Members have access to the services they need. For example, we will collaborate closely with DCF and its CMPs for children/youth in foster care, as well as the justice systems, including

KDOC and Juvenile Services. We know collaboration with these institutions is vital to connecting Members to care and reducing recidivism. One affiliate created an internal program with their local Department of Corrections to facilitate smooth transitions, including Peer Support Specialists. High-touch communication with Members promoted both Member engagement in healthcare services and successful rehabilitation back into the community. **Out of the 318 Members served, none were reincarcerated as of September 2023.**

Molina's transportation benefits also help facilitate Members' access to cross-system services, including SDOH services from CBOs and other community partners. We will offer one-way and round-trip rides, in addition to covered medical, dental, and pharmacy trips, to help Members get to WIC offices or to local government agencies, employment offices, and human services appointments. We will also offer trips to SDOH resources such as grocery stores and food banks.

Molina Affiliates' Examples of Successful Member Engagement Strategies

Our Virginia affiliate has been serving Medicaid Members since 2017, engaging Members in innovative ways to support Member independence and empower them to take control of their own health and wellness. Our affiliate has achieved significant improvements in outcomes by focusing on personalized outreach strategies that consider individual Member circumstances and needs. The positive results in Virginia are a testament to this comprehensive approach, driving increased engagement and leading to overall improved health outcomes.

Conducting a Population Health Analysis. Our Virginia affiliate discovered the central region of Virginia had a low rate of well-child visits. To investigate further, they delved into the data and found a gap specifically for infants from birth to 12 months. Through root cause analysis, they determined expectant and new mothers needed more engagement to understand the significance of well-child visits and to help them access the necessary care for their babies. Recognizing the impact of postpartum engagement on maternal and child health outcomes, they used postpartum care gap data to focus the affiliate's telephone outreach efforts. The aim was to prioritize postpartum depression screenings and newborn and well-child visits, and assist Members with scheduling appointments whenever necessary. Along with their statewide baby showers and other maternity engagement strategies, **these initiatives resulted in a 17% improvement in well-child visits for the specified cohort in 2023 and a 25% improvement in overall well-child visits as well**.

Ramping Up Participation in Molina on the Move program. In 2022, our Mississippi affiliate began partnering with local organizations to host mobile health clinics focused on outreach to and assisting traditionally underserved populations. These mobile health clinics have touched the lives of approximately 2,500 Members by hosting EPSDT screenings, immunizations, vaccinations, vision/dental services, and education in their local communities. Their mobile unit has made positive changes in the lives of approximately 64,000 Members by traveling to multiple locations in the state, collaborating with more than 60 community partners that include schools, community colleges, and universities; Children's Defense Fund; Red Cross; local authorities; and others. **Between March and August 2023 (an 88-day period), we closed 315 HEDIS® gaps.**

We look forward to tailoring our affiliates' successes and other innovations to the needs of KanCare Members to engage them in achieving their personal health and wellness goals.

4.3.I.5 Soliciting and Reviewing Feedback from KanCare Members and Their Families, and Using Feedback to Improve Member and Family Experience and the KanCare Program

5. Describe the bidder's approach to soliciting and reviewing feedback from KanCare Members and their families and using this feedback to improve Member and family experience and the KanCare program.

Using a Member-centric approach, Molina actively seeks and incorporates feedback from Members and their families to continuously improve our services, innovate our programs, and increase Member satisfaction. In Kansas, we will engage KanCare Members and their families through various means, including our Member Advisory Committee, focus groups, sponsored State meetings (including those of the Medical Care Advisory Committee and the Robert G. [Bob] Bethell Joint Committee on Home and Community Based Services and KanCare Oversight), association meetings, and community programs, all of which has proven to be effective in affiliate health plans. We will also analyze and monitor survey results, call center trends, Member Advocate communications, and grievances and appeals data to ensure delivery of culturally competent and easily understandable information. We believe every interaction is an opportunity to gather valuable insight, and we strive to make the feedback process as easy as possible, ensuring information channels are accessible to all.

Molina's Approach to Soliciting and Reviewing Member and Family Feedback

Our approach to soliciting and reviewing Member/family feedback begins by being deeply ingrained in the communities we serve. Molina felt it critical to engage with Kansas stakeholders to develop our Kansas-specific MCO approach. To that end, we held more than 200 meetings in Kansas in 2023 and participated in and volunteered at various events and conferences, such as NAMIWalks Kansas and the Kansas Center for Rural Health's Inaugural Rural Maternal Health Symposium. Attendance presented the opportunity to listen to Members and their families, stakeholders, and Providers, and that feedback informs the design of our KanCare program.

For example, in October 2023 at the Power Up! InterHab Conference, Member Advocates shared the challenges Members often experience under current MCO practices in accessing equipment needed to thrive. Many children remain in their wheelchairs longer than is medically appropriate, as their bodies change and grow. Molina will put in place expedited prior authorization processes to secure essential DME for Members. [redacted] Listening is the first step; to enact change, we investigate, develop solutions with the needs in mind, and then act.

Methods Molina Uses to Solicit Feedback for Program Development and Improvement

To measure our success, Molina continuously reviews our programs and services from the Member's perspective. We use a variety of methods to invite and encourage Member feedback.

Member Advisory Committee

Diverse Member and stakeholder feedback is critical to understanding the Member experience firsthand and improving outreach, education, and engagement for Members and their families.

Molina's Member Advisory Committee serves as a critical two-way avenue to obtain direct feedback from Members on informational materials, establish education and outreach priorities, and identify service gaps and unmet health needs.

Molina has designed our KanCare Member Advisory Committee to meet all Kansas requirements. With our Growth and Community Engagement team's oversight, the committee will provide a collaborative, inclusive environment to encourage honest feedback and input on program development, Member materials, website features/ease of use, value-added benefits, and more. The committee will have a diverse membership, including Members receiving LTSS and behavioral health (BH) services, authorized representatives, caregivers, and advocates (e.g., for IDD) with unique backgrounds and circumstances. We are capturing self-reported sexual orientation and gender identity data from our Member portal/My Molina app to proactively identify Members interested in representing these populations on our Member Advisory Committee.

We have designed the committee structure to ensure bidirectional communication and ease in sharing feedback among all participants, to support connection and collaboration. We will use various meeting formats, such as informational seminars. We will also include health equity as an agenda topic for at least two meetings per year.

Using best practices, Molina staff, such as Housing Services and Supports Specialists, will attend committee meetings and serve as on-site resources for meeting Members' SDOH needs. We will equip Members by offering training in using Molina tools to locate services for themselves. These interactions help inform improvements and design based on real-world needs and applications. We will also include community-based organization (CBO) partners—such as NAMI KS, Kansas Statewide Homeless Coalition, Harvesters, Catholic Charities Southwest Kansas—to help address Member needs that may arise during meetings.

Molina will hold Member Advisory Committee meetings in convenient and easily accessible locations in geographical areas that allow for high Member participation rates. We will also rotate locations to gain more Member and informal caregiver involvement, and to represent varying geographical and access needs. To ensure equitable access to participants and ensure representation across the State, we will also offer both in-person and virtual attendance options, mailing printed meeting materials in advance of the Member Advisory Committee meeting to maximize participation.

Focused Workgroups

Molina affiliates have substantial experience using focused workgroups to meaningfully engage Members and inform health plan activities. By collaborating with stakeholders like CBOs, faith-based organizations, Providers, State agencies, and schools to identify opportunities, we can gather a substantial and broad range of feedback. For example, our Virginia affiliate partnered with their commonwealth's health department to convene a series of focus groups with pregnant and postpartum Members, maternal and child health Providers, doulas, and other community stakeholders. This collaboration helped our affiliate assess and develop best practices and outreach efforts for maternal health, adolescent health, and chronic disease management programs throughout the commonwealth. We will replicate this workgroup approach in Kansas to gain local insight and remain better informed of community needs.

Molina affiliates have had success using in-person focus groups to gather feedback on and understand BH needs within communities. Recognizing that sharing challenging personal experiences can be traumatic, we will invite BH therapists to attend focus groups in person and be available to support Members who need professional BH support privately. We will also consciously expand our community relationships in Kansas to include additional stakeholders—such as those in the school, justice, and the foster care systems—and focus meetings on topics such as child welfare, family preservation, and BH/physical health integration**.**

Participation in Association Forums

Molina participates in multiple association forums to hear their perspective on Member issues. These forums include those of the Kansas Hospital Association and Provider associations such as InterHab, Kansas Health Care Association and advocacy organizations, KanCare Advocates Network, Kansas Community Health Worker Coalition, Kansas Family Advisory Network, Children's Alliance of Kansas, and Kansas Appleseed. We will ensure appropriate staff participation—including attendance by our Member Advocates, Provider Representatives, and senior-level executives—to listen to participant voices and experiences. This firsthand feedback is crucial to understanding and addressing barriers unintentionally created by MCOs that may hinder access to or delivery of quality healthcare services. Participation also will provide us with opportunities to engage specific Member populations more effectively.

In an example of our success with this approach, our Ohio affiliate conducted a survey with the Public Children Services Association of Ohio, which serves as guardians for children in custody. The survey's goal was to obtain feedback on how the affiliate could best serve those children and their foster families. Survey results led to the development of a Welcome Packet customized for foster families. The packet provides tailored information for children transitioning into custody, as well as for the guardians coordinating their care. Materials include a "Meet the Molina Team" brochure, which lists the varied pediatric expertise of the Care Coordination team across multiple healthcare settings, and an FAQ guide developed with feedback from the Molina team that regularly supports children and their guardians/foster parents. We will use this packet in Kansas to help support and inform foster children and their guardians.

Member Advocate Feedback

To provide an even more targeted feedback loop, Molina Member Advocates in Kansas will obtain and deliver Member feedback on our KanCare program design. We will hire at least two Member Advocates who are well versed in working with all of our populations, including Members receiving LTSS and BH care. This staff will coordinate with schools, community agencies, State agencies, and Member advocacy groups to gather Member feedback, with a special emphasis on our most high-needs populations, including foster children. Member Advocates will also work with local CBOs to acquire knowledge of and insight into the healthcare needs of specific Member sets. Member Advocates will meet with the Leadership team at least quarterly to inform and recommend policies and procedures based on the feedback gathered.

Member Surveys

Molina also uses traditional tools, such as Member surveys, to capture feedback and monitor our delivery according to the high-quality standards for the Member experience. Survey results provide us insight into Member needs and levels of satisfaction, and provide data for analysis, informed decisions, improvements, and innovations.

Real-time surveys provide insight into Member satisfaction with call center services or the My Molina app. During post-call surveys, Member Services Call Center Representatives ask whether they resolved the reason for the Member's call and if the Member was treated with courtesy and respect. They ask Members to complete a **Net Promoter Score** survey, which asks how likely the Member is to recommend Molina to friends or family.

Molina affiliates also survey to specifically assess Member experience with care management and to ensure Members are always treated with respect. Our definition of respect includes the receipt of patient-centered support, such as assistance in understanding and adhering to Provider treatment plans, finding services, and addressing the Member's concerns. Our affiliates also issue specialized care management surveys to Members receiving LTSS, to better understand the population's specific needs and if they are being met. These surveys will be incorporated into our Kansas health plan operations as tools for providing feedback and monitoring and improving service.

Annual CAHPS® and HCBS experience surveys—conducted in accordance with State and NCQA requirements—enable Molina to assess Member perceptions of their access to care and to compare our scores to national benchmarks. Our Kansas CAHPS survey will include a statistically significant sample of Members receiving both HCBS and BH services. Per RFP § 7.9.10.F, we will also conduct a Member satisfaction survey specifically with the KanCare SUD population, incorporating questions into the CAHPS survey instrument as needed and as instructed by the State.

Using Feedback to Improve the Member Experience

At Molina, we understand the importance of Member feedback in driving and guiding our strategies and initiatives to enhance the Member experience. We will use our collaborative approach, described here, in Kansas. This collaborative approach involves key personnel, to ensure a comprehensive understanding of Members' needs.

Our Quality Management (QM) Director leads this approach by working closely with staff who receive qualitative feedback directly from Members and can provide valuable insights into their experiences. For example, the QM Director facilitates cross-functional workgroups comprising representatives from various departments to discuss feedback. These workgroups collaborate to design and develop interventions that directly tackle the identified issues, ensuring a comprehensive, coordinated approach.

We combine this qualitative feedback with quantitative feedback, analyzing this data as it relates to the Member experience, for example, grievances and appeals trends. Using this data-driven approach, we can identify areas where Members may face challenges, such as access issues, value-added benefits, or network gaps.

Data-driven Insights and Advanced Analytics for an Informed Approach

Using advanced data analytics, Molina investigates Member inquiries, concerns, and utilization trends to understand issues important to Members and how we can better engage with Members. For example, we collect and analyze data, and report on first-call resolution rates; this provides valuable insight into our ability to meet Members' needs in one phone call.

We also monitor call-reason codes to track and identify trends in Member-call drivers and assess the quality and efficiency of our engagement approach. We then take appropriate action as required. For example, when one of our affiliates identified a higher volume of calls related to ID cards and PCP changes in early 2023, their call center initiated an inbound and outbound campaign to educate Members on how to access and request ID cards and select a PCP who best fit their needs. During the call, the affiliate also took the opportunity to educate Members on our Member portal's capabilities to address future ID requests and PCP changes.

Member Feedback in Action
Recently, our affiliates received Member feedback describing the challenges of finding critical information. In response, Molina launched a series of short "how-to" Welcome Videos on topics such as how to change a PCP, how to request an ID card, how to register for the Member portal, and how to use the My Molina app. Since launching the program in November 2022, more than 44,000 Members have viewed the 1.5-minute step-by-step registration video on YouTube. 058.ks23

In addition, **supplemental advanced speech-analytics technology** provides valuable information related to the Member experience and their behavior when they speak with our call center. Through identification of words spoken and call topics, and data on Member sentiment trends, we perform detailed quality improvement analyses. When we combine these analyses with direct Member feedback via Net Promoter Score surveys, it creates a multifaceted strategy to ensure the quality and accuracy of information provided to Members and enhances Member satisfaction.

Feedback for Continuous Improvement of Member Services Call Center Representative Performance and the Member Experience

To ensure Members have an experience of the highest quality, Molina reviews call center representative performance on a daily, weekly, monthly, and quarterly cadence, with a special focus on new Member Services Call Center Representatives. We document those performance results in monthly scorecards and use call monitoring results to provide one-on-one feedback, coaching, and performance management. We store all call evaluations and use a real-time dashboard to aggregate areas of opportunity related to specific criteria (e.g., empathy, telephone etiquette, product knowledge, and accuracy of responses). Member Services Call Center Representatives continue to learn and improve by listening to the feedback we provide them. This feedback includes replaying and discussing recorded calls, combined with real-time coaching, team huddles, and a group chat room. This established feedback loop to our Learning and Development team further enhances Member Services Call Center Representative training content and, ultimately, the quality of services Members experience.

Member Grievance System

The grievance process offers an additional window into the Member experience. Member Advocates will work with Grievances and Appeals staff to review all grievances received via any avenue, identifying trends or major areas of concern. This review includes grievances received through informal methods such as emails to staff or at community events. The review helps us better understand the Member experience, examine root causes, and improve our Member engagement approach. Member Advocates will also track social media comments and reviews, and will proactively reach out if appropriate and necessary.

Using Feedback to Improve the KanCare Program

Our approach is not just to collect feedback, but to put it to beneficial use. By proactively soliciting feedback from Members and their families, we can better understand their needs and deliver exceptional healthcare services to meet those needs. Outlined below are examples of our affiliate health plans using feedback to improve the overall program.

Example 1. Our California affiliate identified a large Provider serving 60% of their enrolled population in one rural community, but based on Member feedback, learned that it was difficult to obtain timely appointments. The Provider was performing below the 50th percentile for selected quality measures, including well-child visits and adolescent well-visits. Our affiliate's Clinical, Network, and Quality teams met with the Provider's clinical leadership during Joint Operating Committee meetings to discuss quality performance.
Feedback and Recommendations. The affiliate learned during this meeting that the Provider needed financial support to expand appointment availability and welcomed actionable care gap reports and strategies for patient and family engagement.
Outcomes. The Provider group and our affiliate participated in a monthslong clinical collaboration. The affiliate implemented numerous interventions—including providing up-front supportive payments—to enable the Provider to extend their clinic hours and conduct patient calls. In four months, the Provider was able to increase appointment availability resulting in a similar increase in their adherence with well-child visits **by 33% and adolescent well-visits by 25%.**

Example 2. After identifying disparities in HEDIS® results for Postpartum Care for black Members, our California affiliate conducted Member outreach to assess barriers to care.
Feedback and Recommendations. Member feedback revealed black Members experienced far more SDOH barriers to care, including lack of transportation, lack of childcare, and poor alignment of Member schedules with Provider office hours.
Outcomes. Our affiliate brought services to postpartum Members in their homes through Molina Care Connections nurse practitioners. Their efforts **reduced the disparity among black Members by 37%.**

Example 3. In response to feedback gathered through a Member Advisory Committee, our Ohio affiliate analyzed screening results from Health Risk Assessments and found that more than 18% of Members reported issues with the health plan's NEMT value-added benefit.
Feedback and Recommendations. Members and caregivers shared feedback that trip exclusions (such as trips to the pharmacy) adversely impacted health and well-being and that they were unable to see a vehicle's location in real time using their mobile app.
Outcomes. The affiliate expanded the NEMT benefit to cover trips to the pharmacy and to other medical facilities. Molina's Transportation Trip Management app was developed to enable Members to see a vehicle's location in real time via GPS mapping. The affiliate made additional improvements based on the health plan's analysis of journey mapping. They streamlined workflows, enhanced employee training, trained staff, and empowered them to facilitate authorization of trips after Members met their annual trip limit. They also revised Member materials to answer common questions. As a result, our affiliate reported **99.96% complaint-free transport, and 91% of Members surveyed reported being satisfied** with Molina's NEMT benefit.

4.3.I.6 Approach to the Provider Directory

6. Describe the bidder's approaches related to the following with respect to the bidder's Provider directory for KanCare:
a. The elements of information included, beyond those specified in the RFP, for each participating Provider.
b. The bidder's approach to developing, maintaining, validating, and monitoring the accuracy of the information in its Provider directory.
c. The features of the bidder's online, electronic Provider directory that promote Member usability.
d. The bidder's strategies to reduce Provider burden associated with providing information to create and maintain an up-to-date Provider directory.

Maintaining an accurate and reliable Provider Directory has been a challenge in the managed care industry. We have heard about frustrations with the maintenance and accuracy of Kansas' health plans Provider directories during our meetings with Medicaid Providers and Member advocacy groups and during public listening sessions. To address this issue, we use multiple strategies to proactively ensure the accuracy of source data that feeds into the directory. **Our locally based Provider Relations staff will use each interaction to review the accuracy of their Provider-assigned panels and ensure our Provider data is as current as possible**. Our goal is to enable all Members to find local Providers who meet their unique needs and preferences quickly, easily, and conveniently. Our strategies combine high-tech and high-touch approaches to develop, monitor, update, and distribute the directory.

a. Elements of Information Included in the Provider Directory

We include all of the **required elements, as well as additional elements,** for each participating Provider in our Provider Directory. We include optional elements in our affiliates' directories, such as:

- **Customer ratings.** The Provider directories used in our Washington and California affiliates allow Members to provide feedback and comments about their experiences with a Provider. We will bring this capability to Kansas Members.
- **Insurance plans accepted by each Provider.** Members can easily identify Providers who accept their Medicaid- or D-SNP-specific plans and programs, for more seamless access to services.
- **Special needs accommodations.** Members can view all the ADA building access accommodations that are available, guaranteeing accessibility for individuals with specific challenges and ensuring inclusivity of healthcare services. We collect this information in numerous ways, such as during site visits.
- **Public transportation availability.** Each Provider profile will include a link for Members to identify the public transportation or bike infrastructure in proximity to the Provider's office.

Using Member Feedback to Develop the Provider Directory
Provider Directory development is informed by recommendations from our parent company's Provider Directory Ambassador Workgroup, which includes participants responsible for directory development from Molina and our affiliate health plans, as well as national Provider data subject matter experts.
The workgroup evaluates Member feedback and identifies best practices to increase utilization and improve ease of use across all Member subgroups.
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Molina will also offer expanded Provider Directory elements, including:

- **Telemedicine availability.** Members can access convenient and flexible Provider services that offer telemedicine options.
- **Cultural competency training.** Members can identify Providers who have undergone training in offering culturally competent services.
- **Transportation scheduling.** Members can use the Provider Directory through our My Molina app and connect directly to a Provider's office to schedule transportation to and from their healthcare appointments.

Supporting Members' Cultural and Linguistic Preferences

Molina recognizes some Members may feel more comfortable seeing a Provider who reflects their own cultural, ethnic, and linguistic backgrounds. Additionally, studies indicate that when physicians and patients share the same race and ethnicity, patients are more comfortable sharing health information, causing their health outcomes to improve due to factors such as increased time spent with their Provider, medication adherence, shared decision-making, and reduced implicit bias. As a result, some of our affiliate health plans, such as Molina Healthcare of Nevada, ask Providers to voluntarily submit their race and ethnicity information, and to the extent they feel comfortable sharing, the health plan includes this data in the Provider Directory. With the State's approval, we will take this same approach in Kansas.

As required in the Contract, our online Provider Directory will also link to Providers' websites to support additional Member review and choice. Our Provider Relations staff take this data element one step further and encourage Providers to describe their background and personal story on their websites, outlining the level to which they provide **effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.**

b. Approach to Developing and Maintaining the Provider Directory, and to Validating and Monitoring the Accuracy of Information

Our Network Management and Contracting Director will oversee directory development, monitoring, accuracy, updates, and accessibility. Additionally, we will establish a designated team to ensure ongoing compliance. This team will be responsible for maintaining, monitoring, and validating Provider data accuracy and making regular updates to the Provider Directory.

Developing the Provider Directory

We will develop our Provider Directory to incorporate all required elements and comply with all other KanCare program requirements. Accurate, comprehensive, and up-to-date information about our Providers helps Members make the right choices based on their healthcare needs and cultural, linguistic, and other preferences.

We provide Members with a highly searchable, accessible, user-friendly online Provider Directory, available in desktop, tablet, and mobile formats. This online version offers an easy, intuitive search experience for Members to review Provider information by type, distance, and specialty, empowering Member choice through validated, comprehensive, and accurate data. We developed our user interface design using predictive analytics and decision science that accounts for the Member experience and how they engage with online platforms. Directory use patterns assist with determining search options and navigation patterns, and the delivery of easy-to-

understand Provider profile information. Our printed directories feature 12-point font, and Members have access to free alternative formats, including large-type and braille. For Members with limited or no access to technology, we will print and mail a directory within five business days. **As a standard practice, our online Provider Directory is updated daily to provide Members with the most accurate Provider information.** We update our printed Provider Directory every 30 days.

We will continuously look for opportunities to improve our Provider Directory. Our parent company's **Provider Directory Ambassador Workgroup** recently sought feedback from Providers on the structure used for our affiliates' Provider Directory, Members, and other stakeholders. The workgroup received Provider feedback requesting a more efficient method for sharing real-time demographic updates. In response, the workgroup designed and launched new functionality for the online Provider Directory and Provider portal, to allow specialists and other Providers to make demographic updates online. They also added functionality to the online Provider Directory enabling Members to report Provider demographic changes. This workgroup will continue to serve as a forum to discuss direct feedback from stakeholders, Providers, and Members as we enhance our directory on an ongoing basis.

Maintaining the Provider Directory

Molina knows successful Member–Provider relationships are built on trust and mutual respect. That trust is created when a Provider delivers individualized care in a culturally and linguistically appropriate manner. We maintain comprehensive, accurate information, so Members can make informed choices and find the Provider who best fits their needs. We maintain and update all Provider data in our core administrative system, Molina Administrative Platform (MAP), which feeds the directory. We will promptly ingest updated Provider data received via the State's master file within two business days of the receipt of Provider information. Our online version of the Provider Directory is updated nightly to incorporate all changes to Provider records.

If at any point, our team identifies a potential discrepancy in the Provider data we have on file through regular data validation and monitoring, described in the next section, we take immediate action. The Provider's dedicated Provider Representative will conduct outreach to confirm whether updates are needed and, if so, request the Provider update their information on file with the State. We will also create a flag in our system with the alternate data and monitor future State files to ensure the change is made, following up with the Provider as necessary. This approach will help ensure that timely corrections are made to Provider information in the system in accordance with RFP § 7.10.8.F.2.

Validating and Monitoring Data Accuracy for the Provider Directory

To validate and monitor data accuracy, we have developed a quality loop process that incorporates methods, such as data validation through the CAQH® attestation process; scheduled and ad hoc outreach to Providers to monitor for needed corrections; audits to monitor staff accuracy in putting corrections into our system; and feedback from Molina staff and Members. These strategies proactively ensure the accuracy of source data that feeds the directory, as outlined further below:

Ensuring Data Accuracy Through Use of a Centralized Tool.
All Molina staff will have access to a centralized tool to report Provider data errors, such as a

wrong phone number or if the Provider does not routinely practice at the location listed, to the Provider Data Management team. These errors may be uncovered during staff interactions with Providers and Members or through other activities.

Proactively Identifying Inaccurate Information

- We will use our **Secret Shopper Call** program to monitor and identify directory data accuracy issues. Previous secret shopper audits used in our affiliate health plans have identified inaccurate phone numbers and addresses, which their Provider Representatives corrected by contacting the Provider to validate information.

Using Member Feedback on Inaccurate Data. Our online directory will allow Members and anyone viewing the public Provider Directory to report Provider changes directly in the directory. Our Provider Representatives will contact the Provider to ensure the change is valid before requesting they make the appropriate update in the State's system.

Prior to Contract go-live, our parent company is also implementing an innovative data-cleansing process that uses public data to identify and correct inaccurate information and apply address standardization. Our Provider Relations staff will follow up with Providers on identified inaccuracies to validate information and inform them about how to report updates to the State.

c. Features of Our Online Provider Directory That Promote Member Usability

Molina's online directory delivers Provider profile information through its highly intuitive search capability. The directory uses a responsive web design and is optimized to support multiple device formats (desktops, tablets, and phones), which means Members can engage with the same site screens on devices of any size. We provide a notice to all new Members within five business days of enrollment and annually thereafter about how to access the directory online or request a free hard copy. Our online Provider Directory search functions and features include:

- **Availability in multiple languages.** Our online directory is easily and conveniently accessible to all Members, regardless of language spoken or literacy level. The online directory is readily available in 11 languages, including Spanish, Vietnamese, and Chinese. If a language need is not supported by our directory, we offer translation and interpreter services in 350 languages. The content we use in our directory does not exceed the sixth-grade reading level, as defined by the Flesch-Kincaid index, and adheres to plain language guidelines to ensure cultural sensitivity and readability. Member Services Call Center Representatives conduct three-way calls with our oral interpretation vendor to address the language needs of Members who do not speak or read English. We also offer locally based care management extenders—such as

Molina Community Health Workers and Peer Support Specialists—who assist Members in using the directory (e.g., by reading directory information aloud to the Member).

- **Accessibility.** We employ usage studies to determine optimal fonts, colors, and contrast, ensuring the directories are inclusive and easy to read for all Members. Our directory includes contrasted, readable fonts that can adjust to a larger size for Members with vision impairments and for those who are deaf or have limited hearing.
- **Superior search flexibility.** The search function intuitively connects words and phrases, which is beneficial for individuals with low literacy and helps them navigate more complex medical terminology. For example, typing "eye doctor" or "heart doctor" provides results for ophthalmologists and cardiologists.
- **Intuitive navigation.** Users can navigate to a targeted Provider profile in three clicks or less and use easy-to-identify tabs and appropriate drill-down links that expedite information delivery. Each Provider's profile offers a "Provider Highlights" section at the top, with key information, such as the Provider's address, phone number, fluency in any languages, and open/closed panel status. Members can find additional information—including hours of operation, ADA accessibility, accreditations, specialties, and expertise—via a navigation bar located on the left side of every profile.
- **Banner alerts.** The online directory uses banner alerts to inform Members about valuable information, updates, tips, and tricks before they start searching.
- **Easy Provider category search.** Members can search across our entire network for a selected service type, such as medical care, eye care, pharmacy, hospital, urgent care, and walk-in clinics. They can choose to search for a specific Provider type, like a cardiologist or internal medicine doctor, and can filter that search by Provider gender, supported languages, telehealth options, affiliated hospitals, cultural competency training completion, and whether or not they are accepting new patients, including the number of additional Members that the Provider is willing and able to accommodate.

Monitoring Member Use Patterns to Assess Usability

We monitor Members' directory use patterns to determine optimal search options and navigation patterns and aid the delivery of easy-to-understand Provider profile information. We track sources of Member feedback to monitor Member usage, such as hits the directory receives.

- **Member Questions/Complaints.** We monitor Member questions and complaints to identify issues with directory layout, readability, accessibility, and usefulness that inform development of directory changes. Members can also report inaccurate Provider data right in the directory.
- **Online Survey**. We recently added a usability survey to our online directory to solicit Member feedback, such as ease of finding a Provider or understanding the language used.
- **Member Advisory Committee.** As our affiliates have done in other markets, we will engage our local Member Advisory Committee to assist in a review of our directory for layout readability and usefulness of information.

d. Strategies to Reduce Provider Burden Associated with an Up-to-Date Provider Directory

At Molina, we are dedicated to being innovative and finding efficient solutions to reduce Provider burden associated with maintaining an up-to-date and accurate Provider Directory. From our experience and listening to feedback from Providers, Members, and stakeholders in Kansas and other markets, we understand the importance of accurate Provider information as well as the challenges faced by Providers to update their information for all the State's MCO.

We will also conduct comprehensive outreach initiatives and on-site visits to ensure the accuracy of the data in our Provider Directory. During these Provider on-site visits, we will provide demographic checklists that will make it easy for Providers to verify the information we have on file and address any discrepancies or changes that may arise. This proactive approach allows us to maintain a reliable and up-to-date Provider Directory for our network. We will also offer self-service capabilities that empower Providers to submit changes easily. Providers can use our Provider portal or submit a Provider roster form to our Provider Relations staff to update their information. We will educate Providers on the importance of updating their data on file with the State and monitor future State files to ensure necessary updates are made.

Innovation to Reduce Provider Burden

We have listened to Providers and stakeholders in Kansas, and we know that MCO collaboration is key to reducing Provider administrative burden. As a result, **we propose an all-MCO, cross-collaborative effort to develop solutions to reduce burden and improve Provider data accuracy.**

Universal Roster for Providers

In Illinois, our affiliate health plan developed a universal roster form for Providers as a way to keep information current and minimize burden. Leveraging this experience, we will lead the way in Kansas to create a centralized mechanism for Providers to update their information on an ongoing basis.

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Our affiliates have extensive experience in creating innovative and collaborative solutions with other MCOs to reduce Provider burden, and we will leverage that experience in Kansas. For example, our Illinois affiliate took an active role in creating a new system to streamline the Provider roster update process. Previously, Providers had to complete separate forms for each of the nine MCOs operating in the state. The frustrations of Illinois Providers at that time matched what Kansas Providers are presently experiencing: MCOs took too long to complete the process and did not communicate status during the wait, resulting in negative consequences, including unnecessary claims denials.

In 2018, our affiliate and another health plan worked together to develop the universal roster form for Illinois. They consulted Providers and all MCOs to standardize the information requested, and our affiliate led training sessions throughout the state to introduce the new system. In the first 6 months of implementation, the time for loading Providers into the system decreased from 60 days to 30 days. The system remains in place today and is an effective tool to reduce Provider burden across all MCOs. Working together, we can create a streamlined, centralized process to achieve greater efficiency and effectiveness in managing Provider data in Kansas.

Integrated, Whole-Person Care (Tab 7c)

MOLINA HEALTHCARE

4.3.I.7 Proposed MCO Staffed Care Coordination Model for KanCare

7. Describe the bidder's proposed MCO staffed Care Coordination model for KanCare and include the following in the bidder's response:

a. The bidder's proposed care coordinator staff distribution and location.
b. The bidder's approach to avoiding duplication of Care Coordination with delegated or other models of Care Coordination (e.g., Community Care Coordination, targeted case management [TCM], Certified Community Behavioral Health Clinic [CCBHC], OneCare Kansas).
c. The roles, responsibilities, and functions for staff performing Care Coordination responsibilities.
d. The bidder's approach and strategies to effectively engaging Members, particularly those who may be more challenging to engage, to participate in Care Coordination.
e. The bidder's proposed Care Coordination caseload ratios, process for establishing ratios, and the approach for monitoring to ensure ratios are adequate to meet Care Coordination requirements.
f. Case assignment considerations and how the bidder monitors and manages vacancies to ensure Members' continuity of care.
g. How the bidder's Care Coordination program will identify and support the needs of Members who are not on a 1915(c) HCBS Waiver and have a temporary or transitional need for Care Coordination.
h. How the bidder's Care Coordination program interfaces with its disease management resources and activities.
i. The bidder's processes and systems that will be used to share and exchange information with those involved in the care and treatment of the KanCare Member to optimize integrated, longitudinal, whole-person care.
j. The bidder's approach to monitoring and ensuring that KanCare Members receive necessary services, supports, and resources necessary to improve individual and population outcomes.

Molina's Staffed Care Coordination Model for KanCare

Built on a foundation of person-centered and equitable system-of-care principles, our Molina staffed Care Coordination Model ensures every Member is empowered and supported to access the fully integrated array of preventive care and treatment interventions, supports, and services. Our flexible, collaborative, data-driven approach to care coordination is led by a fully integrated, local clinical leadership team that includes our Medical Director (CMO), Behavioral Health Medical Officer/Medical Director (BH-CMO), Care Coordination Director, and LTSS Clinical Officer, and is supported by specialized, value-added staff selected specifically to meet the holistic care coordination needs of Kansas Members.

Our approach to developing a tailored Care Coordination Model starts with best practices garnered from almost 30 years of our parent company's experience serving Medicaid Members like those in KanCare. Our parent company's experience is further enriched by expertise with complex populations such as individuals with disabilities, those receiving a variety of waiver services, and those in foster care. Because our parent company grew out of a Provider-led, community clinic with the primary focus of removing barriers to quality healthcare for the

surrounding underserved immigrant community, we are deeply familiar with the needs of Members and Providers and the importance of local care to improve health outcomes.

Molina staff will be entrenched in local communities, leveraging our proven grassroots approach to community collaboration that continues to propel our success. Although our extensive experience will bring valuable benefits to Kansas stakeholders, we know that developing a Care Coordination Model for Kansas takes more than just national expertise; it is critical to understand the needs and resources within the system of care across Kansas communities and to implement a model to fit those exact needs, **building from within the existing system**.

Molina personnel, including Community Engagement and in-house Care Coordination staff, have spent **a year engaging with Kansas stakeholders**, ensuring we listened and learned before coming to the table with solutions to tackle complex, longitudinal Member needs. Across Kansas, we have met with a plethora of organizations—**more than 200**—including the Kansas Association of Area Agencies on Aging and Disabilities (AAA), Community Developmental Disability Organization (CDDO), Center for Independent Living (CIL), NAMI Kansas, Minds Matter, Community Care Network of Kansas (CCNK), Kansas Care Network, CCBHCs, FQHCs, RHCs, health systems, and other care coordination entities. Too often, we heard from stakeholders that care coordination today is conducted in siloes. What we learned is the importance to stakeholders of a staffed Care Coordination Model that is flexible and collaborative. We know that successful care coordination can't be siloed. It can't be corporate or commercial. Quality care is collaborative, person-centered, and local. It takes concerted dedication and strategic capability to arrange for and coordinate care across the multifaceted systems of Providers, organizations, and Medicaid adjacent programs to work as a supportive system of care for individual Members and their families. This is the value Molina brings to Kansas.

These critical on-the-ground connections informed the development of our staffed Care Coordination Model and strategies to streamline care coordination, case management, disease management (DM), discharge planning, and transition planning activities while providing integrated, accessible, and value-driven healthcare. As we met with Kansas organizations, we began designing a blended staffed and delegated community care coordination model. Once the KanCare RFP and Scope of Services was released, a deep analysis of KanCare Contract requirements, including those outlined in Contract appendices, especially Appendix L, the State's Quality Management Strategy, and other State and Federal regulatory documents, helped enhance our understanding and refine our design and approach. By leveraging these critical inputs and new, innovative partnerships with community organizations and State agencies, our proposed staffed Care Coordination Model for KanCare ensures proactive, individualized, and collaborative system partnerships, prioritizing Member choice and culturally appropriate care to best serve Members under the next Contract. Below, we highlight proven processes and tools that will support our Care Coordination staff to be successful in supporting KanCare Members.

Processes and Tools for Person-centered, Collaborative, and Community-driven Care

The core of our model, highlighted in **Exhibit 7-1**, ensures that every Member, regardless of risk level or needs, has an ongoing source of appropriate care coordination, so they receive necessary covered and SDOH services in a whole-person, supportive, efficient, and timely manner. Our staffed Care Coordination Model includes detailed processes for ensuring every component necessary for effective care coordination is completed. It includes workflows and processes for ensuring timely and effective assessments, stratification of every Member into an appropriate level of care coordination, tools for effective service planning, ongoing monitoring and quality improvement, integration of DM and transitional care coordination, and customized protocols for each specialized population in care coordination, such as those for transition-age foster youth or pregnant Members.

Molina invests in collaboration tools and technological infrastructure to ensure efficient collaboration across system-of-care partners—including Providers, community organizations, and interdisciplinary team members—through real-time data sharing, with Member permission. Our Care Coordination Portal enables real-time, bidirectional, and HIPAA-compliant data sharing, so care team members have secure access to current Member needs, gaps, progress,

assessments, and Plan of Service/Person-Centered Service Plans (PCSPs). Integrated Provider data, including ADT alerts and HIT/HIE, helps us to identify Members in need of timely follow-up and to connect with their Providers to support continuity of care. We also benefit from integrated system alerts with Provider practices, such as through our Provider Notify program, which will generate automatic care gap alerts through their EHR systems.

[redacted]

As part of our care coordination approach, we develop strong partnerships, and couple them with innovative solutions, to unify the stakeholders that support various aspects of a Member's health and well-being, ultimately leading to improved outcomes. [redacted]

Molina appreciates the tremendous advantages of reducing silos and engaging in cross-collaborations that support the betterment of Kansans' health and well-being. When we coordinate efforts, our programs and coordinating agencies have better success, and Members have fewer barriers to care and achieve better outcomes. Within the remainder of our response, we continue to describe our staffed care coordination approach as we respond to subparts a–j.

a. Molina's Care Coordination Staff Distribution and Locations

[redacted]

Molina's Care Coordination Staff Distribution

The distribution of our staffed Care Coordination Model takes into consideration the unique circumstances of Members residing within urban, rural, and frontier areas and the varied cultural and social needs of KanCare Members, as well as each population outlined in Appendix L. We will track, monitor, and adjust our approach to accommodate any changes, such as membership growth or the addition of any new populations. Molina's staffed Care Coordination Model is shown in **Exhibit 7-2**.

Molina's Care Coordination Staff Location

Our affiliates' experience working across rural and frontier areas—including in states such as Iowa, Texas, Idaho, Illinois, Kentucky, and Ohio—has taught us the importance of recruiting Care Coordination staff from the communities they serve to ensure a local presence for Members, Providers, community organizations, and agencies, and to mirror the composition of the local membership to help build trust for effective care coordination. Most Care Coordination staff will be located where there are the greatest numbers of supported Member interactions, such as in the Kansas City metropolitan area and surrounding counties, including Sedgwick County, but we will ensure distribution across the State. Our approach results in hiring passionate Care Coordination staff expert in navigating community resources to support Members' care.

[redacted]

[redacted]

b. Approach to Avoiding Duplication of Care Coordination with Delegated Care Coordination Entities (Community care coordinators, TCM, CCBHCs, OCK)

Our affiliates' experience uniquely positions Molina to effectively partner with care coordination organizations to facilitate timely access to care and services. For example, in California and other states, our affiliates work

with health home delegated models similar to OneCare Kansas (OCK), and our affiliates in Ohio and Massachusetts delegate elements of community care coordination to AAAs or similar agencies. We've learned to always place the Member at the center of our efforts and to maintain ultimate accountability for the quality, outcomes, and overall performance of care coordination—no matter who is delivering the care.

Molina's clearly defined processes ensure we identify the most appropriate source of care coordination for each Member through multiple methods, including the Health Screen, HRA, Needs Assessments, predictive analytics and risk stratification, Member preferences, and information, such as if the Member is in a HCBS Waiver. We connect Members to Molina Care Coordination, community care coordination, TCM, CCBHC, and/or OCK, depending on the results of this process, and we formally designate a person or entity as primarily responsible for coordinating the Member's services, which may change as the Member's needs and risk levels change (e.g., due to pregnancy, SUD recovery). If a community care coordinator has responsibility, Molina actively supports them and ensures the Member's care and needs are met through strong communication and collaboration across all care coordinator types**.** Our collaborative process includes the elements described below.

Sharing Data. Advanced technology supports collaboration between entities, helping to develop strategies that collectively improve outcomes and deliver the right care, without duplication. Molina regularly communicates with and informs each entity of changes to their Member roster through our Care Coordination Portal, where we can exchange Member information, with Member permission, in real time. [redacted]

Interventions and Care Planning. Molina Care Coordinators collaborate with delegated and community care coordinators to assist in interpreting screening and assessment results, to advise on additional assessments, to approve Plans of Service/PCSPs, to adjust the type and frequency of interventions, and to participate in care planning, as appropriate.

SDOH, Education, and Monitoring. Molina Care Coordinators will work with community care coordinators and delegated entities to provide education, including on Member self-direction, and the resources, services, and supports available through Molina and our contracted Provider network. They also provide health and safety monitoring and referrals to community resources and non-Medicaid supports, like employment and housing. We will collaborate to make sure Members receive SDOH supports identified in the Plan of Service/PCSP, without duplication.

Oversight and Monitoring. As part of pre-delegation activities, our Subcontractor Oversight Manager ensures all policies, procedures, and training materials align with Molina's care coordination documentation, and the delegated entity or Subcontractor is approved by Molina's Oversight Committee before implementation. Monthly, each entity will submit operational reports to demonstrate they are completing non-duplicative activities, and we will meet with

entities to review cases and process improvement opportunities. At least annually, the Molina Subcontractor Oversight Manager will complete a delegation oversight audit and provide feedback if there is evidence of duplication, modifying processes and training as needed.

c. Roles, Responsibilities, and Functions for Staff Performing Care Coordination

Molina's Care Coordination Model will meet the requirements in RFP § 7.4, Care Coordination, and RFP § 7.4.6, Care Coordination Roles and Responsibilities. Our Care Coordination Director will be responsible for implementing Molina's Care Coordination Model and will report directly to CEO, Aaron Dunkel. The Care Coordination Director, CMO, and BH-CMO, along with the Health Services Director, and Care Coordination staff will be a fully integrated, local team with a mix of clinical and nonclinical staff to maximize improved Member health outcomes. Our licensed and qualified nurses, social workers, specialists, and Molina CHWs are trained in the principles of **trauma-informed care, person-centered thinking, strengths-based assessment and planning, cultural competency, and motivational interviewing.** This experienced team will deliver holistic care coordination and will collaborate across the system of care to promote safety, Member choice, independence, and community integration, ensuring that all Members have access to appropriate services and the initiatives we will bring to Kansas.

Molina Care Coordinators will ensure Members identified for care coordination services receive appropriate assessments, service planning, and ongoing monitoring, either through conducting those functions themselves or partnering with TCM, CCC or CCBHC to monitor and oversee each step of the care coordination process. Care Coordinators, with support of care coordination extenders including CHWs/CHRs, Peers and SDOH specialists of varying types, work with Members to identify goals and needs, and then connect Members to those available physical health, behavioral health, ancillary, LTSS and social services.

Care Coordination supervisory staff monitor Molina Insights for identification and stratification of Members into care coordination levels and assign appropriate Care Coordinators. Care Coordination staff also ensure all Members have access to our DM programs (weight management, chronic condition management) as needed; access to community engagement events; and connection to our community partners through our SDOH platform. We will provide educational opportunities to increase health literacy and will support connection to recommended wellness and preventive services (EPSDT, well-visits). Molina Care Coordinators will provide contact information, including a direct phone number, for Members, or how to contact their designated person or entity, as appropriate. Our Care Coordination Model distributes our Care Coordination staff across population types, in alignment with Appendix L, as highlighted below.

Care Coordination Staffing Model: Members Enrolled in an HCBS Waiver

[redacted]

[redacted] Our Care Coordination Model supports full integration of physical health, BH, LTSS, and SDOH to eliminate fragmentation of care, which is especially important for FE and BI Members. Our Care Coordination staff streamline interactions between internal teams, Providers, and targeted case managers or community care coordinators, promoting highly effective collaboration across disciplines. The primary point of contact for the Member will perform condition-specific assessments to ensure that we have a full understanding of the Member's medical and BH conditions, their functional status, any SDOH barriers, and the HCBS that would allow them to live as independently as possible based on their individual strengths, needs, and preferences. All roles and responsibilities are performed in alignment with Appendix L.

A Molina Care Coordinator always is responsible for ensuring a PCSP or Plan of Service is developed, regardless of who is creating it – the Molina Care Coordinator, TCM or CCC. Our training and oversight ensures that a Member's PCSP or Plan of Service is developed using a person-centered planning process, understanding behavior as a communication method, especially for Members with IDD or BI. Care planning supports full access to the greater community and ensures Members enrolled in a Medicaid HCBS Waiver receive services in the community with the same degree of access as individuals who are not in a Medicaid HCBS Waiver. Care Coordinators also engage Members, caregivers, and Members' families through trusted Providers, for example ABA Providers, and CBOs. Our tailored, evidence-based outreach strategies for Members enrolled in an HCBS Waiver use plain language and the Member's preferred communication modalities.

Community Partnerships for Specialized Support

Care Coordinators will be able to connect Members to **InterHab members**, who focus on providing services to Members with IDDs; Molina is developing a VBP pilot for residential and day-support Providers for preventive physical health and dental services, appropriate ED utilization and community integration to address social isolation and loneliness. They can also connect Members to **Minds Matter** to assist Members who have experienced a brain injury (BI). For members with Autism, Care Coordinators can link children 6-12 to the clinically validated gaming app, **Mightier™** to address emotional regulation challenges. 105.b.ks23

Care Coordination Staffing Model: Members Within Facilities

[redacted]

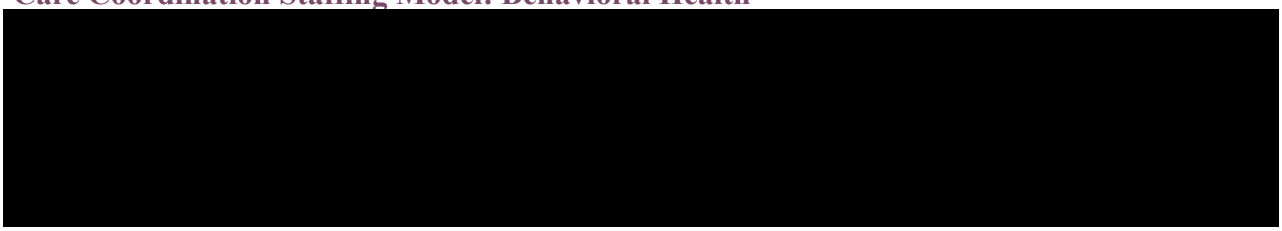
The purpose of **Molina's Transition of Care program** is to educate and empower Members and their caregivers to effectively manage condition(s) and to support the transition to a less restrictive environment, as appropriate. Our Transitions of Care program ensures a smooth, well-supported

Of the approximately **384,500 Members** Molina Healthcare serves in 13 MLTSS programs nationwide, **94% live in community settings.** 105.c.ks23

transition for all Members being discharged from qualified institutions, including nursing facility (NF), NF for mental health, ICF/IDD, State hospital, psychiatric hospital/State Institution Alternative, PRTF, and SUD residential treatment facility. Molina will coordinate with these facilities to obtain the most current Member information (labs, medications, therapy evaluations), to establish data sharing protocols, and to assign specific transition staff to high-volume facilities, promoting relationship-building to improve collaborative discharge planning.

Molina's Transition of Care Coordinator will initiate and participate in the transition process for Members eligible for the State's institutional transition process and/or the State's Money Follows the Person program. Transition of Care Coordinators will be expert in facilitating and coordinating care transitions across continuum of care settings and throughout the Member's life. By identifying and engaging Members early, our Coordinators provide education to Members and their caregivers/guardians regarding their admitting condition, symptoms and management, and post-discharge follow-up with their Providers or as directed by the discharging physician.

Care Coordination Staffing Model: Behavioral Health



Our proven MH/SUD Model of Care supports adults and children with BH needs and includes an integrated, team-based approach in which Members' voices are respected and their strengths are

explored and validated. Overseen by the BH-CMO and Behavior Supports Director, this team includes BH Care Coordinators (RNs and licensed clinical social workers) as well as specialized staff to support the array of BH needs, including crisis support.

Molina will contract with CCBHCs to provide care coordination to Members with BH needs, including children with SED who are not enrolled in the SED Waiver. Once a Member is connected with a CCBHC, Molina's BH Care Coordinator partners with the CCBHC to conduct follow-up, as needed, to ensure the Member receives appropriate, holistic services. This collaboration includes access to Molina's SDOH platform and community-based staff, such the Housing Services and Supports Specialists.

Community Partnerships for Specialized Support

Benchmark Human Services to provide Members with complex BH and IDD, complementing CCBHCs and IDD Providers.
KVC Health Systems/Camber Children's Mental Health Hospitals to extend authorization of services for children in crisis to ensure safe discharges and prevent inpatient readmissions. 105.e.ks23

Investing in New Technology

We will provide grants of $100,000 per year to help CCBHCs adopt tools to support measure-based care. 105.f.ks23

[redacted]

Care Coordination Staffing Model: Members in Foster Care

[redacted]

Our Foster Care model follows core tenets of safety and permanency, a trauma-responsive Provider network, family first/family preservation, linkage to BH services, management of medical needs, and a strong voice from children/youth. We understand the impact of trauma on the physical, behavioral, emotional, and social health and well-being of the children and youth we serve; through our trauma-informed assessment process, we identify the needs of

children/youth, stratify their risk, and connect them to appropriate services. Molina's whole-person integrated model reflects the intensity of services and supports that improve outcomes for children and youth in the child welfare system.

Care Coordination Staffing Model: Members with SDOH Needs

Molina's staffed Care Coordination Model identifies SDOH needs at the Member and community levels by leveraging data analytics and professional judgment and addresses unmet social needs through collaborative interventions, culturally appropriate solutions, and specialized SDOH staff and social programs. Care Coordination staff will be distributed throughout Kansas to connect Members to community resources and will build long-lasting community partnerships as well as accessing an extensive social network through our closed-loop SDOH platform.

Molina care coordinators will play a key leadership role in addressing SDOH needs, regardless of the Member's point of contact (TCM, community care coordinator, CCBHC, etc.). Our location and outreach strategies are timely, high-touch, and include field-based staff, like CHWs, who are supported by Housing Services and Supports Specialists, the Employment Services and Supports Coordinator, and the Workforce Development Manager. These staff work with partners throughout the State to assist Members and navigate their unique barriers to housing, food, transportation, and employment. Care Coordinators include needed community and social services on the Plan of Service/PCSP and coordinate with agencies (e.g., AAAs, WIC, Meals on Wheels), local school-based health centers, schools, homeless centers, youth service centers, family resource centers, public health departments, and faith-based organizations that support individuals who are experiencing SDOH needs.

Care Coordination Staffing Model: Perinatal Health Needs

[redacted]

Molina's maternal health program offers all pregnant Members entry into either our Healthy Moms, Healthy Babies Beginnings or into our High-risk OB programs, depending on Member stratification and need. Molina's program provides Members support from pregnancy through the 12-month stabilization period to ensure healthy and safe mothers and babies.

Initial engagement is completed by a Molina Maternal Care Coordinator to assess any need for high-risk maternal care coordination, to provide educational information for a healthy pregnancy, and to inform the Member about value-added benefits. [redacted]

Partnerships for Specialized Support
Maternity Care Coordinators can connect Members to virtual doulas through the **Mae Maternity Platform**, which reports consistently seeing a more than 30% reduction in C-section births and a 50% reduction in preterm births for women using any combination of their services, including their birth plan tool, weekly platform check-ins, and doula services. 105.h.ks23

Care Coordination Staffing Model: Members with Complex Conditions

[redacted]

[redacted]

Success with Complex Care Coordination

Our California affiliate's Complex Case Management program outcomes for 2021 included a **23% reduction in emergency department (ED) visits, 48% readmission reduction, and 13% increase in outpatient visits 6 months after enrollment**. Outcomes for black Members enrolled in the program included a 20% decrease in inpatient admissions. 105.i.ks23

d. Approach and Strategies to Effectively Engage Members, Particularly Those Who May Be More Challenging to Engage, to Participate in Care Coordination

Molina's approach for outreaching to and engaging Members in care coordination builds upon the use of culturally appropriate community strengths to involve Members in meaningful, targeted, and person-centered ways. We know Members may be reluctant to engage, particularly in care coordination, for myriad reasons. Members may have previously had a bad experience within the healthcare system or may be reluctant to discuss their situation openly with others. Whatever the reason, we approach Members from a "learner's stance," and we will try a multitude of strategies to build trust, spark engagement, and motivate Members to become drivers of their own health and wellness. We engage Members in full alignment with the requirements for Health Screening, HRA, and Needs Assessment completion by using intuitive techniques that consider Members' unique needs and personal preferences, meeting Members where they are regardless of condition, and nurturing community and Provider relationships. Our strategies, described below, help engage Members, ensuring each of them gets the right level of outreach and engagement and transitions to care coordination at the right time.

Strategy: Make It Relevant. Our focus is on empowering Members by making all Member materials and engagement relevant to their specific needs. As an example, our New Mexico affiliate—to accommodate Members with a diabetes diagnosis who prefer to interact through text messaging—developed a diabetes-focused text campaign with information about healthy eating for diabetes management and the importance of diabetic eye exams. Our strategy honors each Member's unique needs by tailoring engagement in care coordination to empower them to achieve their personal health goals.

Strategy: Make It Timely. Through Molina Insights and our continuous, data-driven approach to outreach, we ensure we meet all RFP requirements for outreach and engagement. We prioritize Member needs, and we waste no time in reaching out to Members experiencing a triggering event or supporting them to resolve immediate needs like hunger, housing, or transportation.

Addressing Health Disparities

Strategy: Make It Culturally Competent and Linguistically Appropriate. In collaboration with our Health Equity Director, our outreach and engagement strategies ensure equitable access for all Members, including

those with LEP, diverse cultural and ethnic backgrounds, or disabilities, regardless of gender or sexual orientation. We customize the delivery of services to each individual Member. Our field-based staff are hired from the communities they serve, as we know Members are often more likely to engage in care coordination when it comes from someone they trust in the community. For example, we deploy CHRs to help reduce barriers for American Indian Members to actively engage in their healthcare.

Strategy: Make It Convenient. We give Members a choice in how they interact with us and offer many modalities and opportunities to engage, including text, email, My Molina app, Member portal, Member services call center, community events and health fairs, face-to-face engagement at our Molina mobile units, or in-person engagement. When we are unable to connect with a Member using traditional approaches and strategies, we employ specific strategies to engage those who are hard to reach. [redacted]

In 2022, our Florida affiliate asked Best Foot Forward to locate more than 11,000 Members. Within 120 days, Best Foot Forward **engaged 51% of the Members and warm-transferred them to the health plan**. 105.j.ks23

e. Molina's Care Coordination Caseload Ratios

Molina's caseload ratios are the result of our affiliates' decades of experience delivering person- and family-centered, integrated, and comprehensive care coordination to 4.8 million Members receiving Medicaid in diverse geographic communities, settings, and circumstances. [redacted]

[redacted]

When developing caseloads, per RFP § 7.4.8, Molina considers the Member's population and individualized needs, engagement level, care setting, and geographic location; our model; and staff experience. This caseload framework is flexible to afford Molina Care Coordinators quality time to meet with Members, Providers, and other care coordinators in communities across Kansas to establish trusting relationships and break down barriers to community integration

while meeting the comprehensive, diverse needs of individual Members and families, populations served, and program requirements.

Frequency of Caseload Monitoring. Molina's Care Coordination leadership performs daily review and monitoring of caseload capacity during the level-of-care queue management and case assignment processes. We refresh caseload capacities nightly to see the most accurate depiction of a staffer's caseload percentages. Since Members' needs change and they shift among care coordination levels, we reassess Members' levels at least monthly, review caseload impacts, and adjust staffing as needed to ensure Members receive the frequency and types of support necessary to achieve improved health outcomes and quality of life. We will factor in the work completed by TCM, community care coordinators, CCBHC care coordinators, and Provider partners, along with our responsibilities, to ensure that work is completed appropriately and timely, when determining Molina Care Coordinator caseloads.

Caseload Monitoring Reports. We will aggregate and summarize our caseload data to get, at a minimum, a 12-month rolling picture of caseload shifts and trends over time, to inform our caseload ratios, staff forecasts, and recruiting and retention strategies. Our reports show the number of weighted Members assigned to each Care Coordinator to ensure that each Member's acuity is factored into caseload assignments and that the Care Coordinator will have the time they need to positively support the Member. We run these reports by waiver population and compare them against prior months' data to quickly identify trends that could indicate the need for additional staff. Molina leadership uses these reports as an oversight and monitoring tool to ensure appropriate caseloads and that Members are partnered with the most appropriately skilled Care Coordinator. We will generate reports quarterly and annually to observe long-term or seasonal capacity trends and make appropriate adjustments to program operations. The Care Coordinator Director will use these longitudinal views to evaluate the Care Coordinators' caseloads, project future needs, and proactively manage staffing levels.

f. Case Assignment Considerations and How Molina Will Monitor and Manage Vacancies to Ensure Members' Continuity of Care

Molina takes careful consideration when making case assignments and when monitoring vacancies to ensure continuity of care. Robust data analytics combined with Health Screening, HRA, and Needs Assessment(s) findings will help prioritize each Member's individualized health and psychosocial needs to properly match them with a Care Coordinator, and applicable delegated entity, who has the necessary skillset to appropriately meet those needs. We consider the following factors when assigning Care Coordinators to Members to achieve the best match possible: Member population and individualized needs; proximity; Care Coordinator skillset, qualifications, and expertise; culture and language; and caseload mix. Ultimately, Care Coordinators will be assigned to Members based on their primary care need.

Managing Care Coordinator Vacancies
Molina maintains an open recruiting pipeline to provide a pool of qualified candidates so we can quickly backfill when we experience a vacancy. We also offer a competitive salary and flexible work environment to maximize retention to provide continuity of care. **Our Texas affiliate—one of our largest MLTSS affiliates—has achieved an industry-leading five years' average tenure rate for Care Coordinators.** 105.k.ks23

Our goal is to minimize the number of situations in which a Member may need to be assigned to a new Care Coordinator. We make every effort to maintain the same Care Coordinator as the

Member's single point of continuous care. However, there are reasons why Molina may initiate a change in Care Coordinator: the Care Coordinator may no longer be employed by Molina; the Care Coordinator may be on temporary leave from employment; or the Care Coordinator's caseload may have to be adjusted due to its size or acuity. Additionally, we understand that at times a Member may request a change in their Care Coordinator. We recognize the importance of the relationship between the Member and their Care Coordinator to institute actionable change in the Member's health patterns for improved outcomes. We will work with each Member to fully understand their concerns and needs and will make a concerted effort to resolve any issues before they result in a request for change.

However, if it is not possible to avoid a change, no matter the reason for the change, our process will ensure continuity of care by using data and knowledge of the Member to place them with another Care Coordinator who can effectively meet their needs. We will warm-transfer the Member to a new Care Coordinator and ensure they are fully updated on the Member's physical health, BH, and psychosocial needs before the transfer is complete. When a Member's Care Coordinator will be unavailable on a short-term basis, the Member will receive backup care coordination from another person on the Care Coordination team in accordance with their plan of service or Plan of Service/PCSP and as discussed with the Member and their care team. In the event of a long-term change of Care Coordinator, Members are notified by phone or mail seven days before the change when we receive advance notice and contact information for their new Care Coordinator is shared within three business days of the change. We provide the Member and interdisciplinary team contact information for the primary and other Care Coordinators and backup contact per § 7.4.8, on the Member's Plan of Service or PCSP and in their EHR, all of which are accessible 24/7/365 through Molina's Care Coordination Portal.

g. How Molina's Care Coordination Program Identifies and Supports Members Who Are Not on an 1915(c) HCBS Waiver and Have a Need for Care Coordination

Identification: Varying groups of Members not on a 1915(c) HCBS Waiver are enrolled in Care Coordination, either based on their specific population type, condition or temporary or transitional need. As shown throughout subsection c above, we enroll Members into Care Coordination based on their specific circumstances. Children and Youth in Foster Care, for example, are identified on enrollment files and automatically enrolled into Care Coordination. Individuals with chronic or complex needs, including adults with SMI or children with SED not on a waiver, are identified through Health Screens, HRAs, Molina Insights risk stratification, through diagnoses codes on claims, or a combination of referrals and predictive analytics. Our Justice System Liaison will work with the Department of Corrections to identify adults being released from incarceration for care coordination. To identify pregnant women, we leverage an array of tools, including Lucina Analytics, which in some of our affiliates have more than doubled early identification of pregnancy through advanced algorithms, including leveraging lab results. We identify Members in need of transitional care coordination through ADT feeds, collaboration with the utilization management team and referrals from local discharge planners.

ADT Alerts Improve Outcomes
In our affiliates' Medicaid markets, HIE partners notify them as Members experience ED visits and inpatient admissions. Since 2022, these alerts have helped our Florida affiliate realize a **12% decrease in readmission rates, a 7% decrease in ED utilization,** an increase in discharges to the community, and an **82% improvement in maintaining accurate Member contact information**. 105.1.ks23

Support: Members not on a waiver receive care coordination supports based on their unique needs, acuity, conditions, and life circumstances. For example, a homeless Member with diabetes facing neuropathy and a potential loss of limb will register for higher levels of intensity from care coordination support than a stable diabetic managing their condition safely with their PCP at home. All Members enrolled in Care Coordination receive a full suite of assessments, and an appropriate Plan of Service for their condition, including back-up and crisis plans. All are supported to identify goals and needs and ongoing sources of care and services. Care Coordinators review medications and Provider guidance with Members, and support access to identified needed services, including help making appointments and arranging transportation. Members are educated and empowered to manage their own health and social needs using education and resource tools, including access to an SDOH closed-loop referral platform.

For non-1915(c) HCBS Members in transition, Care Coordinators reinforce discharge planning protocols, including medication reviews, to ensure Members have all the necessary resources post-discharge for continuity of care. Coordination begins when the Member is admitted and continues after the admission until the Member is safely and expeditiously transitioned home. The Care Coordinator implements a high-touch, timely, and appropriate transition plan in collaboration with the Member, their Providers, Transition of Care staff as well as UM nurse reviewers, hospital discharge planners, and social workers, as appropriate. The Care Coordinator takes the lead in coordinating connection to the full range of BH, physical health, and SDOH, like housing, food, and transportation, services available in the Member's community. Our dedicated team of Peer Support Specialists and Molina CHWs are instrumental in linking Members to vital community resources and fostering connections in advance of discharge, thus ensuring an effective discharge and mitigating the risk of hospital readmission. Quickly connecting Members to an ongoing source of care is our first focus when a Member is admitted to the hospital for an inpatient psychiatric or residential stay.

h. How Molina's Care Coordination Program Interfaces with its Disease Management Resources and Activities

The goal of our DM program is to help Members achieve wellness and autonomy through preventive care, health literacy, and adoption of healthy behaviors. DM is fully integrated into our care coordination process, and Molina's **17 evidence-based DM programs** are available to all Molina Members, depending on individualized need. Our DM programs are based on clinical practice guidelines from the MCG Chronic Care Guidelines or evidence-based guidelines (CDC, the American Diabetes Association, American Heart Association, the National Institutes of Health). We will also **partner with local organizations like NAMI Johnson County to expand our DM education and program offerings**.

Our DM Programs Make a Difference
A recent propensity match study found that **Medicaid Members enrolled in our Florida affiliate's DM program in 2022 had a 25% decrease in ED claims and an 8% decrease in inpatient admission claims**. Such disease management programs are a best-practice model for similar programs used in our affiliate plans in other states. 105.m.ks23

Identification of Members who may need DM begins early in the care coordination process. Enhanced data analytics, predictive modeling, and the Health Screen, HRA, and Needs Assessment(s) capture the broad DM needs of Members and inform Care Coordinators, community care coordinators, or TCM in identifying Members who would benefit from Molina's DM programs, wherever they may be across the spectrum of health. As a fully integrated part of

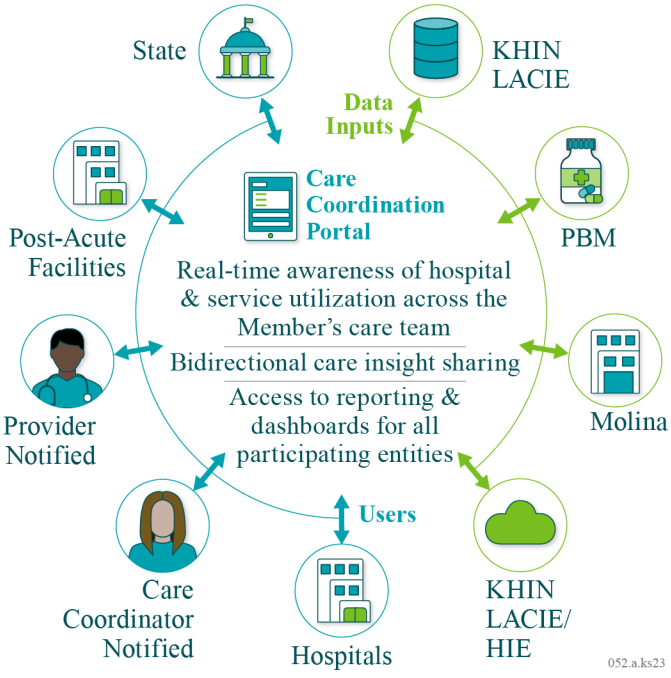
our care coordination process, we see any touchpoint with a Member—from our Care Coordinators to our in-home Care Connections staff—as a way to identify a Member for DM. Molina also integrates disease prevalence data and heat mapping into the design of our clinical programs, enabling us to target population health priorities at the community level to guide outreach and engagement strategies. After helping the Member select the DM solutions that meet their needs and preferences, the Care Coordinator will incorporate the DM program, goals, and interventions into the Member's Plan of Service or PCSP. Progress and outcomes are updated as part of the Member's engagement plan and adjusted as needed. For Members receiving TCM, CCC or CCBHC Care Coordination with Molina Care Coordination, we share our DM materials and protocols with the community care coordination partner and ensure it's integrated into their care coordination activities at every stage.

Molina's DM programs provide condition support for chronic conditions such as asthma, COPD, diabetes, hypertension, depression, and heart failure. Our healthy lifestyle programs support smoking cessation, weight management, and better nutrition. Care Coordination staff engage and send condition-specific information and educational materials to Members in their requested primary language, as available, by the modality of the Member's choosing, including through texting, portals, the My Molina app, telephonic outreach, by mail, and in person. Care Coordination staff provide education that will increase the Member's knowledge of their condition and early recognition of symptoms; aid in the development of a self-management plan with their Provider(s); and help establish strong Provider, FQHC, and medical home connections while fostering adherence to their PCSP and/or medications.

i. Molina's Processes and Systems Used to Share and Exchange Information with Those Involved in the Care and Treatment of the KanCare Member

The Care Coordination Portal, shown in **Exhibit 7-4**, allows for real-time bidirectional data sharing for secure access to current Member information. This platform aggregates information from Molina's electronic care management, claims, and other systems; social referral platforms; EVV; PointClickCare, the largest EHR provider for skilled nursing facilities; and Care Everywhere for practice management system data, and it will interface with third-party sources such as the State's KMMS, KHIN, and LACIE, ingesting all

Exhibit 7-4. Molina's Care Coordination Portal Integration.
Virtual care coordination establishes a dynamic support network.



ADT information electronically using multiple EHR integration sources and methods. The following are highlights of how our Care Coordination Portal effectively shares information and prompts action:

- **Reduces gaps in care.** Alerts pushed to Providers and care coordination partners so they can take action at the point of service when they engage the Member, such as testing A1C, ordering and scheduling a colonoscopy, or completing an EPSDT screening.
- **Facilitates follow-up care.** Alerts assigned to the Care Coordinator when the Member is admitted, discharged, or transferred to prompt engagement and follow-up actions more quickly than historical census reports and rounding. Alerts of missed visits from the EVV system prompt outreach to ensure Members' backup plans.
- **Addresses health risk and social needs.** Automatic notifications of new and emerging risk factors to prompt outreach and action with CBOs and other partners.

The Care Coordinator—whether a Molina employee, a community care coordinator, or a TCM—has a real-time, holistic view of the Member's health history, social needs, Provider relationships, and current situation, allowing the Care Coordinator to approach the Member with the most comprehensive, up-to-date information to offer valuable interventions and supports. Care Coordinators ensure every Plan of Service or PCSP is signed by the Member and shared either electronically or on paper with the Member and the Members' IDT, including Providers and caregivers as appropriate and in alignment with the Member's wishes and HIPAA and privacy rules. Providers have access to Member information through the Provider Availity™ Portal.

j. Molina's Approach to Monitoring and Ensuring KanCare Members Receive Necessary Services, Supports, and Resources to Improve Member and Population Outcomes

The Right Care at the Right Time
In our Virginia affiliate, Members in care coordination experienced a 35% decrease in inpatient utilization compared to those who did not participate. Members were also more likely to visit their PCP (12%) and BH Providers (19%). 105.n.ks23

Continuous accountability, quality improvement processes, advanced tools, and clinical judgment enable Care Coordination staff to track, monitor, and manage KanCare Members' receipt of necessary services, supports, and resources as well as the quality, effectiveness, and achieved outcomes at the system level, practice level, and the individual Member level. Molina Insights, our risk stratification and predictive modeling platform, identifies Members' risks and changing needs to best align care coordination efforts and interventions. Our Care Coordination staff understand Members through data and observation and are empowered to make clinical judgments about the most beneficial Member interventions.

Care Coordination leadership performs Aggregate Membership Reviews, Weekly Individual Member Reviews, Monthly Audits, and Molina's Case Activity Report**,** which tracks all Member and Provider outreach and outcomes, length of stay, and intensity of supports, to ensure all Care Coordinators, community care coordinators, and TCM are appropriately managing Member care. Supervisors look for activities outside the expected scope, duration, or frequency based on the Member's assigned risk level. We identify cases with inconsistencies or anomalies for more thorough case review. When a case is discovered with high Member contact frequency but lower risk composition, the supervisor audits the Member record for progress toward goals, interventions taken, and recent HRAs and Needs Assessment(s) results to determine appropriateness of risk level and case assignment. Supervisors audit Care Coordinators on three to five cases per month for appropriateness of risk level, interventions taken, and referrals made

and closed. They review progress and case notes, outreach activity, and assessment results. The staff is scored to determine their ability to appropriately manage or relevel cases. Staff must score 100% on regulatory compliance and 90% on Molina process. If staff fail to perform, actions are taken, up to and including retraining, progressive discipline, and termination.

To further determine Care Coordination program effectiveness, we monitor service utilization, review Member records as evidence of service provision, conduct random audits of Provider records, and track compliance with State requirements and applicable HEDIS and Molina metrics. Our Care Coordination Director generates lists of Members with open preventive care gaps to prioritize outreach and support quality initiatives for those Members and their Providers. We work collaboratively with Providers, distributing not only gaps-in-care lists that show compliance opportunities for Members, but also information about Members' SDOH needs, offering a variety of support tools to help ensure Members get appropriate services.

Improving Member Outcomes. We measure success within our Care Coordination Model through Member outcomes; for example, we measure success by the number of Members who remain in the community after leaving an institutional setting. However, we not only review Member data to understand the longitudinal progress and impacts of interventions and engagement, but importantly, we also listen to the Member to understand how they measure their own success. Our goal is to positively impact each Member's health trajectory, help them achieve their person-centered goals, and improve their quality of life.

Improving Population Outcomes. Our analytics tools, including our Quality Performance Dashboard, allow us to drill down on measures to evaluate specific populations based on race/ethnicity, gender, age, geographic location, and other factors. We monitor internal and external data inputs monthly and quarterly to evaluate population health outcomes and the effectiveness of our strategies and initiatives in meeting the goals and targets we set to achieve. We also look to the data to identify emerging trends that point to new challenges our membership and communities are facing. Specifically, we review overutilization and underutilization, SDOH needs, health disparities, and disease or condition, and drill down by county, zip code, or neighborhood. We monitor SDOH needs of the population twice monthly to confirm Members receive services and to allow us to address new or emerging SDOH needs in the populations we serve. We use nationally recognized processes to evaluate the effectiveness of our Care Coordination program to ensure we are making a positive impact on population health.

4.3.I.8 Community Health Workers and Community Health Representatives

8. Community Health Workers (CHWs) and Community Health Representatives (CHRs) offer a unique and important role in outreaching, educating, and connecting KanCare Members to health care Providers, social service systems, and their MCO. Describe the bidder's approach to:
   a. Utilizing and promoting the use of certified CHWs/CHRs as MCO staff and/or Providers located within local communities across Kansas.
   b. Identifying the roles and responsibilities of certified CHWs/CHRs and providing the training necessary to support certified CHWs/CHRs to successfully perform their roles and responsibilities.
   c. Measuring, monitoring, and evaluating whether certified CHWs/CHRs are effectively fulfilling their roles and responsibilities to improve Member care, individual outcomes, and population health.

The State's addition of community health workers (CHWs) as a Medicaid State Plan service enacts the first step in advancing the role and reach of CHWs across the State. Molina's commitment to and investment in Kansas extends beyond hiring CHWs as staff; we will work in partnership with community organizations, Providers, and the State to leverage existing infrastructure to certify, train, educate, and support the growth of CHWs. For example, as described later within this section, we have developed a relationship with the **Kansas Community Health Worker Coalition** to extend their training model. This collaboration allows Molina to become an approved education provider to certify and train CHWs, extending their reach, especially within rural and frontier communities. As an approved education provider, Molina is then enabled, through the **Kansas Department of Commerce's Apprenticeship Program**, to become a CHW Apprenticeship Intermediary, offering expertise to employers and healthcare organizations to successfully launch and promote CHW Registered Apprentices. By providing training and certification to CHWs who will serve and support any Kansas Member—not just Molina Members—and by providing a pipeline of qualified workers, we help address workforce challenges and create healthier communities throughout the State, long-term.

Bringing Long-term Success and Experience Leveraging and Promoting CHWs to Kansas

Since 2004, our parent company has invested in CHWs, understanding their critical and sustainable role in helping Members fulfill their individual needs and preferences within their trusted communities and in improving access to and awareness of community-based resources and services. **Molina Healthcare was the first MCO to embrace CHWs as an outreach and engagement component of the Care Coordination program in our New Mexico affiliate.** This program saw tremendous results; in 2011, a *Journal of Community Health* study about our CHW program in New Mexico found that, in only 18 months, our CHWs helped reduce emergency department (ED) use by 69%, inpatient stays by 83%, narcotic prescriptions by 62%, and non-narcotic prescriptions by 64%.[1] As a result of the program's success, all Molina Medicaid affiliates have implemented the CHW intervention nationally, continuing to deliver positive results. Now, across Molina's 18 affiliated Medicaid health plans, our Molina CHWs

[1] Johnson, Diane, et al., "Community Health Workers and Medicaid Managed Care in New Mexico," *Journal of Community Health*, September 28, 2011

assist Members in navigating their healthcare needs by connecting them to community organization resources, education, advocacy, and social supports.

Our Michigan affiliate is an example of our continued success in refining and deepening our approach to meet the evolving needs of Members. Similar to the model Kansas seeks to employ, our Michigan affiliate has CHWs deeply ingrained within the program, and their services through external agencies are billable. Our Michigan affiliate hires diverse CHWs and contracts with agencies that do the same to ensure Members receive culturally appropriate, quality care. Our national experience has informed our approach, including the importance of embedding CHWs within the community; covering certification costs instead of reimbursing later; and incentivizing and training CHWs to provide support—whether for Molina Members or not. Molina will bring this expertise to develop the critical role CHWs play in delivering person-centered support to KanCare Members.

Demonstrated CHW Success
Our Michigan affiliate's program realized a **25% reduction in ED visits and readmissions post-intervention** and a significant **decrease of $218 PMPM in total cost of care**.
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a. Utilizing and Promoting the Use of Certified CHWs/CHRs as MCO Staff or Providers

CHWs are frontline health workers who are trusted members of the community and are critical to facilitating linkages to needed services, following up to ensure services are meeting Members' needs, providing education and assistance in navigating benefits, and helping give Members a "voice" in their health and wellness journey. Many CHWs join their profession with valuable experiences that can be a lifeline for Members who are reluctant to engage with, or fearful of, the system of care. CHWs and Members may have similar health conditions or shared experiences, like experiencing homelessness or food insecurity. CHWs' knowledge of the barriers and challenges Members face position them to be strong advocates, navigators, and critical connectors to community services. Molina will use and promote the use of certified CHWs as Molina staff and in partnership with Kansas Providers.

Leveraging and Promoting Molina Certified CHWs/CHRs

Molina has elevated the CHW role to a fully integrated population health strategy by expanding the CHW role in community and Provider engagement, health education, and in support of SDOH interventions. Molina CHWs will be dispersed across Kansas to assist Members and will engage local CCBHCs, schools, homeless centers, youth service centers, family resource centers, prisons, public health departments, faith-based organizations, and other community-based organizations (CBOs) to best navigate Members' unique needs.

Expanding CHW Reach
Our Wisconsin affiliate is continually expanding their reach in the community with additional CBO partnerships to offer Molina CHWs. From 2021 to 2022, Molina CHW outreach increased by 11%.
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Leveraging and Promoting the Use of Molina CHWs Through Specialized CHW Staff. Our experience nationwide has highlighted the importance of and driven our approach to leveraging specialized CHWs, like Community Health Representatives (CHRs), as described below, to ensure culturally and linguistically appropriate care—helping to bridge the geographic and cultural divide, especially in rural and Provider-scarce communities where CHWs may be the closest resource for Member engagement.

CHRs will play a critical role in helping tribal Members address systemic barriers, such as transportation and housing, and access other resources. Our CHRs will support the tribes' and tribal organizations' capacity and ability to serve and support their Members, families, and communities to holistically improve health outcomes. The CHRs will connect Members with resources, perform wellness checks, provide transportation, deliver health education, and more. CHRs can assist with providing culturally competent education to tribal Members about chronic health conditions, such as diabetes and cancers, and behavioral health (BH) care through approaches that help bridge Western medicine with natural and indigenous medicines.

[redacted]

Leveraging the use of Molina CHWs to Find Difficult-to-Locate and/or Hard-to-Engage Members. CHWs assist in finding difficult-to-locate Members and in reaching out to Members who may have an identified risk or need. CHWs will be active in the field, visiting homeless shelters, food banks, clubhouses, places of worship, senior and community centers, and other areas to connect and engage Members. In some cases, CHWs go to the Member's last known address and talk to former neighbors, when available, or visit homeless shelters to look for the Member.

Our Washington affiliate's outreach and engagement strategies have **improved the rate of finding Members who are hard-to-reach by 12% and reduced the hard-to-reach rate by 24% after the first 3 months**.
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Leveraging and Promoting the Use of Certified CHWs as Providers Across Kansas

Providers and CBOs have long-standing relationships within their communities that enhance their ability to link those they serve to care, services, and resources, such as housing, nutrition, employment resources, clothing, postpartum care, utility assistance, and appointments. Molina fully envisions CHWs being embedded in local entities across Kansas, and we will wholly support the growth of the CHW position within Provider entities. Molina will also work to increase CHW certification among Promotoras, who can be key drivers of health promotion in Latino communities.

Molina's relationship with **KCHWC** is foundational to our approach to extending the CHW role and reach within Provider entities across Kansas, especially within rural and frontier communities. As a KCHWC-approved education Provider, we will be able to train and certify Provider entity staff—as well as any persons in Kansas interested in the role—as CHWs. Molina will cover the cost of training and certifying CHWs along with paying upfront, instead of through reimbursement. Molina will support KCHWC in educating communities about the value of utilizing CHWs for services, including Member outreach and engagement, translation services, health literacy education, transitions-of-care support, and other CHW responsibilities outside the scope of care coordination-specific activities. This approach to leveraging and promoting CHWs will help reduce the administrative burden for these Provider entities while adding benefit and value to their practice.

Molina CHW Success Story from Our South Carolina Affiliate

A Molina Member living in a hotel had two school-age children when she learned she was pregnant. The Member's food stamp benefit stopped in January 2023, and the Member had no food or transportation. Her household goods were in storage, but because she was unable to pay the storage fee, her belongings were sold. Along with getting evicted from the hotel, her biggest challenges included providing for her children and getting to medical appointments. As of March 2023, a Molina CHW was able to attain for the Member a new apartment with furniture. The CHW coordinated a donation of clothes from a local charity organization. She coordinated with the Member to re-apply for food stamps and arranged transportation for the Member and her children. Through our CHW program, the Member and her children now have a place to call home—one that is within the constraints of her budget—to ensure continued care for her and her children.

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Our approach promotes collaboration with the Provider community to bring CHWs into their practices. Molina will contract with Provider entities—including subcontracted community care coordination Providers, such as **Kansas Advocates for Better Care** as well as Area Agencies on Aging, CBOs, and CCBHCs—to hire, train, and certify staff as CHWs. CHWs will then be employed by and embedded within healthcare organizations. We will also collaborate with Provider entities/CBOs to train and certify existing staff to become CHWs. Our relationship with KCHWC will have a cascading impact on the expansion of the CHW role and increase the number of CHWs throughout Kansas. Below, we describe community organization collaboration.

- **Certifying community care coordinators as CHWs.** To ensure Molina Members receive holistic, community-driven care, Molina will also prioritize contracting with community care coordination Providers to train and certify willing community care coordinators to become CHWs. By training these coordinators to serve as CHWs, we will complement their existing skillset. We will enhance the benefit of this role by also training the community care coordinators to address SDOH needs of Members and help mitigate health disparities and barriers to appropriate, quality care.
- **Collaborating to certify existing staff or embed certified CHWs within CCBHCs.** Molina will work with CCBHCs to cross-train peers and individuals with lived experience to become certified CHWs. This additional education will augment the important roles they already play by giving them training on physical health and Member-specific education, specific skills for communicating with Members with SPMI/SUD, and how to share their personal stories of recovery. By becoming certified CHWs, CCBHCs will be able to bill for CHW services, expanding their capacity to complete activities through the lens of BH/SUD lived experience.

[redacted]

[redacted]

- **Collaborating to certify existing staff or embed certified CHWs within Centers for Independent Living (CILs).** Molina will partner with CILs, such as **Independence, Inc.**, to train and certify as CHWs those individuals with lived experience, which will provide unique supports both at home and in the workplace for Members with disabilities. These staff have a unique understanding of the complex challenges that affect Members. CHW education will augment the important roles of staff at CILs by providing training on engagement with Members with disabilities and how to share personal stories of disability, as appropriate. For those struggling to maintain employment or looking to enter the workforce, CHWs with disabilities themselves can provide much needed support in navigating the complexities of accessibility, workforce accommodations, and necessary assistive devices and DME that can facilitate independence and productivity. These staff are invaluable in advocating for Members with disabilities who are challenged with trying to achieve community inclusion, by connecting them to services, providing education, and serving as mentors.

> We are encouraged by Molina's dedication and community connectedness to improve culturally appropriate access to care. **Molina's experience and expertise in providing culturally sensitive, evidence-based programs and healthcare education will help improve health inequities** for all children and families in Kansas.
> *Lalo Muñoz*
> *Executive Director, El Centro of Topeka*
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In determining the locations to hire and embed potential CHWs within Provider and CBO offices, we will emphasize hiring to focus on health promotion in service deserts, areas of high Member isolation, frontier territories, communities impacted by the direct service workforce shortage, and communities with higher concentrations of refugee and immigrant populations. We will hire or contract with **local, highly qualified, culturally competent CHWs,** including through contracts with locally established, Kansas-based, independent peer/consumer and family-operated organizations. [redacted]

Incentivizing Providers/CBOs to Develop and/or Embed CHWs Within their Offices

Molina takes a multimodal approach to motivating and incentivizing Provider entities to embed CHWs in their offices or agree to certify existing staff as CHWs. We will actively work to reduce the administrative burden for these Provider entities by covering the cost of training and certification, establishing value-based arrangements, and supporting their workforce long-term through apprenticeships.

Molina Will Enroll with the Kansas Department of Commerce to Become a Healthcare Workforce Intermediary. The goal will be to support healthcare job seekers and employers to meet emerging workforce trends through **registered apprenticeship programs.** As an intermediary, Molina will be able to offer expertise to employers and healthcare organizations to

successfully launch and promote CHW registered apprentices. Molina will partner with educational institutions that will allow apprentices to complete the appropriate related instruction, either in person or virtually. Molina will promote CHWs, including CHRs, to become registered apprentices through this program. Any CHW—whether with Molina or a Provider entity, or any Kansas-based CHW who may be interested—can become a registered apprentice.

Working in parallel with on-the-job experience, CHWs will benefit from the technical instruction provided through the apprenticeship programs. Molina will partner with Provider entities to provide on-the-job learning, pay progressively higher wages as skills increase, and identify an experienced mentor to work with apprentices. Molina will offer grants to rural and frontier Providers to cover the costs of establishing a training program. Molina has identified this opportunity to increase the utilization of CHWs across the State through healthcare and healthcare-adjacent employers. Molina understands that apprenticeship sponsors provide distinct advantages to growing and diversifying healthcare-registered apprenticeships. With wage progression and nationally recognized, industry-specific credentials, Molina will support the creation of a pipeline of qualified workers for long-term success of the CHW program and the Provider.

Molina will also enter into **VBP arrangements with Provider entities** to promote the State's goals for expanding the use of CHWs throughout Member care delivery, encouraging and guiding Providers to utilize CHWs in their practices. Through VBP, we will also incentivize entities as they advance their CHW capabilities, including when their CHWs become a registered apprentice. Molina negotiates based on Provider type, documenting the percentage of the VBP payment to be paid directly to CHWs. We will engage in VBPs that include payment for activities such as Member outreach and engagement, translation services, health literacy education, transitions-of-care activities, and other reimbursable CHW responsibilities.

b. Identifying the Roles and Responsibilities of CHWs/CHRs and Providing Training

CHWs are **critical to our integrated population health approach**, connecting Members to the community, mentors, and health advocates. The CHWs facilitate access to services and improve the quality and cultural competence of service delivery. These individuals effectively assist Members in navigating the healthcare system, removing SDOH barriers, and providing health education to empower Members to self-direct their care. Our experience with CHWs has informed the development of our delineation of roles and responsibilities to include:

- **Being a valued part of the Member's care team.** Representing and advocating on behalf of Members and their concerns, CHWs are uniquely positioned to connect with Members and with their interdisciplinary teams to help them understand cultural, economic, social, and linguistic barriers.
- **Connecting Members with support for their individual health and wellness journeys.** Working in collaboration with Providers and CBOs to connect Members to services such as housing, nutrition, employment resources, transportation, clothing, utility assistance, and appointments; and to ensure access to prescription drugs and medical equipment.
- **Providing health promotion, wellness coaching, and self-management education.** Supporting Members in taking an active role in their healthcare and decision-making.
- **Person-centered planning.** Helping Members identify their goals and build their Plan of Service using methods such as "hope mapping."

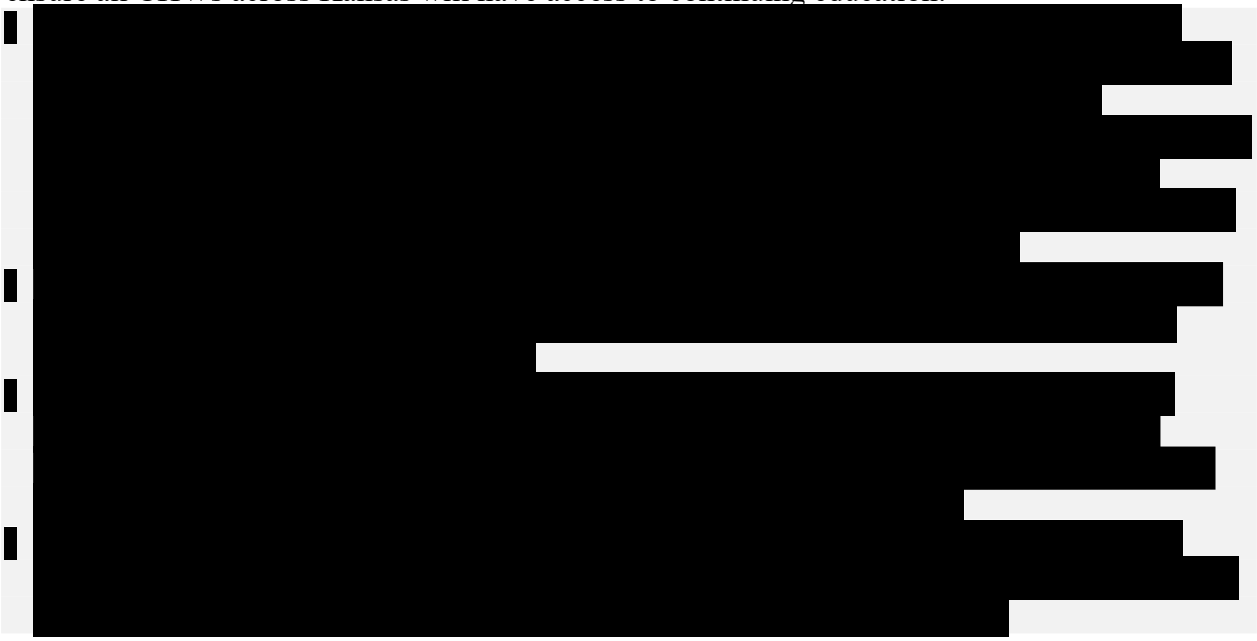
- **Supporting Members directly.** Performing initial screenings and educating Members on the benefits available to them, including value-added benefits, and on resources in their communities based on findings from assessments, including access to items such as prescription drugs and medical equipment.
- **Meeting non-responsive Members in person.** Meeting Members in person who may have an identified risk or need; working in shelters, detention centers, and EDs to support hard-to-reach Members; and providing wellness checks to ensure Member safety in rural areas.
- **Assisting Providers in finding unengaged patients.** Bridging the cultural gap to improve engagement between Providers and their patients to improve health outcomes.
- **Acting as trusted certified translators.** Helping immigrant and tribal Members communicate their medical history to Providers and translating information back to Members.
- **Following up with Members after care.** Supporting PCPs by following up with Members to ensure they are following through on their appointments, providing reminders for scheduled appointments, and conducting outreach to ensure adherence to treatments and medications.
- **Supporting Member transitions after a hospital stay.** Working in collaboration with the Molina Care Coordinator and delegated care coordinators, ensuring the Member has the necessary services and support to return safely to the community and avoid readmission.
- **Educating Providers.** Educating Providers about the health needs of the community and the cultural relevancy of interventions.
- **Advocating for Members.** Advocating for underserved individuals or communities to receive services and resources to address health needs.

Molina will promote and advance CHW presence both within clinical settings and in the community to support Member–Provider engagement and help reduce health disparities and systemic barriers, increase access to care, and bridge the gap between Members and Providers.

Certification, Training, and Growth Opportunities

Molina believes a successful CHW program starts with a solid infrastructure, which includes a training plan, a pathway for workforce and career development, community and Provider partnerships, and oversight and support for sustained engagement with Members. Our experience across our health plan affiliates has informed our evolving understanding of the infrastructure necessary to support effective CHW interventions. Molina's **CHW Training program** will offer comprehensive, ongoing training and continuing education, monitoring, and evaluation. Our program emphasizes outreach and engagement strategies, building on organizational skills, integration of primary and preventive healthcare, and a multidisciplinary approach to proactively address physical health, BH, SDOH, LTSS, and cultural barriers to care. Training includes topics such as cultural competency and awareness, SDOH, the **Nurtured Heart Approach**, and evidence-based practices. Our certified CHWs will be trained in the principles of trauma-informed care, person-centered thinking, strengths-based assessment and planning, cultural competency, and motivational interviewing. We believe strongly that CHWs should be skilled in communication, critical thinking, and problem-solving, especially when working with special populations. Molina will support CHWs with continued education, including annual continuing education requirements to maintain certification, ensuring frontline workers have the information, education, and tools needed to support their communities.

We partner closely with local Providers and organizations who know the barriers in their communities as well as the resources that provide high-quality services, to provide CHW training opportunities as well as to deepen our Molina Training Program for Kansas. This approach to training ensures CHWs are educated on community-level and population-specific needs and on systemic disparities, to best serve Members. For example, through conversations with partners such Catholic Charities, we heard the need for more education on health literacy and interventions for diabetes, vaping, and postpartum depression, and we see an opportunity to leverage CHWs for this community-level support. We will work across our Kansas Providers and national Molina affiliates and organizations to fund educational programs that address needs identified by our local CHWs. Below, we provide examples of community-level partnerships to ensure all CHWs across Kansas will have access to continuing education:



IT/Systems Training. Molina ensures all CHWs/CHRs have access and are connected to the **Care Coordination Portal** with role-based permissions that facilitate access to the full suite of Molina's care coordination solutions. This access includes training on the portal itself and how to use Molina's systems in support of Member health and wellness. We provide role-specific education for CHWs/CHRs, including how to make and track referrals via our established and fully operational **SDOH platform**, which is **already available to more than 23,000 CBOs nationwide.** The platform allows our staff to check the progress of referrals, input notes, and follow up with Members to make sure services are received or further assist if additional barriers are identified.

c. Measuring, Monitoring, and Evaluating Whether Certified CHWs/CHRs Are Effectively Fulfilling Their Roles and Responsibilities

Molina recognizes the importance of measuring, monitoring, and evaluating the performance and effectiveness of CHWs/CHRs, given the significant impact they have on Member care, Member outcomes, and population health. Our commitment to

Using CHWs, our Wisconsin affiliate health plan saw a **7% increase in the Timeliness of Prenatal Care HEDIS® measure, improving from the 25th to the 50th percentile.**

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continuous quality improvement is an **iterative process that evolves and adapts to the changing needs of the community.** Our evaluation helps us determine where and how CHWs/CHRs have the most impact in order for us to understand what is and isn't working well, consider replication of local models and skill sets to other areas of the State, or identify where small refinements are needed to continue to improve CHW/CHR effectiveness. Serving as the foundation for our evaluation, we clearly define goals, objectives, and outcomes, including what we intend to measure, define, and describe for the target populations and communities that are included in the evaluation; consider the priorities and interests of key stakeholders and how they can be engaged in the evaluation process; and only incorporate criteria and metrics that are measurable and capable of being tracked and monitored.

We engage both internal and external stakeholders to help inform our evaluation. **We also believe it is important to include CHWs/CHRs in the overall evaluation, including engagement in identifying the data to collect.** Due to the strong relationships CHWs/CHRs have in their communities, these individuals are important resources for the identification of data sources, bringing unique insights into the overall evaluation process. Molina uses community and Provider focus groups, Member and Provider advisory committees, delegation oversight reporting, and care coordination oversight reporting to monitor CHW/CHR program effectiveness. We continually incorporate feedback and responses from Providers, Members, and CBOs into our evaluation of CHWs/CHRs to address potential performance gaps. We will pose questions in our Member Advisory Committee meetings and in Provider surveys on CHW/CHR engagement, perceptions, and experiences.

Measuring and Evaluating Performance. We will measure and evaluate CHW/CHR performance using established metrics on process, utilization, cost, and quality, and Member-reported outcomes, to capture Member and Provider perspectives. We will complete an annual program evaluation to measure effectiveness and recommend improvements. **Table 8-1** shows examples of metrics we will use for evaluating CHWs/CHRs.

Table 8-1. Metrics for Evaluating CHWs/CHRs

Health Outcomes	• Gaps in care closed • Percentage of Members connected to PCP • Improvements in HEDIS scores (e.g., HbA1c improvements, hypertension controlled) • Medication adherence rates • Improvements in quality of life
Utilization Metrics	• Increase in outpatient primary care and BH services • Decrease in ED use • Decrease in hospital admissions/readmissions • Decreased length of stay • Appointment adherence rates
Cost Metrics	• Cost savings related to decreased readmissions or ED visits • Cost savings in reduction in lengths of hospital stays • Decrease in total cost of care
Process Metrics	• Number/percentage of assessments completed • Number/percentage of outreach visits completed

	• Number of Members who received education • Member engagement rates • Number of referrals made for SDOH needs • Number/percentage of closed SDOH referrals due to needs met • Number of Members housed or who gained meaningful employment • Number of children enrolled in after-school programs • Number of Members moving into stable housing
Satisfaction	• CHW satisfaction with their role and turnover rates for CHW positions • CHW satisfaction with training and onboarding • Member satisfaction with CHW/CHR services and level of engagement • Number of reported improvements in knowledge of health issues • Number of Members reporting more confidence in managing their health • Provider satisfaction with CHW effectiveness • Adherence to the Kansas CHW 12 Core Competencies

4.3.I.9 Three Strategies for Advancing Integrated, Whole-person Care for Members

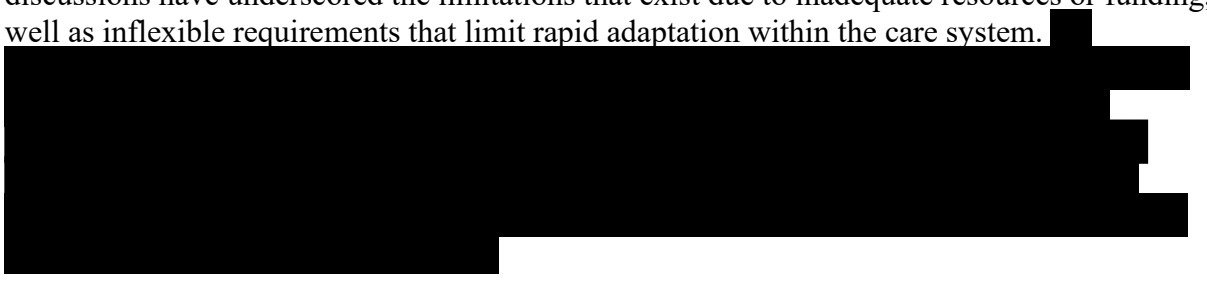
9. Describe the bidder's top three (3) strategies for advancing integrated, whole-person care for its KanCare Members and how the bidder will measure, monitor, and evaluate the effectiveness of the strategies.

Molina brings to Kansas a deep commitment to serving Medicaid populations and advancing integrated, whole-person care for KanCare Members. Molina upholds the highest standards in providing person-centered and integrated care coordination. We partner closely with Providers and community-based organizations (CBOs) to ensure expanded access across the State. We will build upon existing resources and the State's progress, leveraging momentum and successes, and will convene stakeholders to assess progress and jointly devise actionable solutions. Molina has already met with dozens of Kansas Providers and CBOs to co-develop impactful strategies to advance integrated, whole-person care. We will expand and enhance system capacity and capabilities with a focus on underserved geographic regions. We have designed our strategies and approaches based on the National Council for Mental Wellbeing's eight domains of integrated care, ensuring we are internally organized to reach the most advanced levels of integration at each domain of the framework.

Molina recognizes that our role in the system of care is to be actively engaged and physically present in the communities we serve, in order to enhance the healthcare experience. We will foster ongoing collaborative efforts to identify, define, and continuously implement programs to drive genuine system reform. Drawing invaluable insights from our affiliates, we have tailored our community-based approach to the unique needs of Kansas. Below, we detail our top three strategies, which include **advancing Provider infrastructure, enhancing care coordination through extenders, and addressing SDOH using a community-informed approach.**

Strategy #1—Supporting and Advancing Provider Infrastructure Through Practice Transformation, Contracting, and System Reform

Molina recognizes that to advance integrated, whole-person care for KanCare Members, we must address barriers that exist within the system of care, including operational and structural challenges to integration. For example, we know that most Provider practices are supported through fee-for-service billing and may be limited in terms of available billing codes to support care coordination and interdisciplinary team activities. Molina has created a support structure to meet Providers where they are—providing education, training, and sustainable reimbursement models tied to billing codes and offering incentives to move Providers across the integration continuum. As Providers make progress, Molina equips them with solutions, tools, and training to help them serve their patients in the most integrated way. Molina has facilitated discussions with Providers across Kansas, ranging from community organizations to large systems. These discussions have underscored the limitations that exist due to inadequate resources or funding, as well as inflexible requirements that limit rapid adaptation within the care system.



Advancing Provider Infrastructure Through Investment

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Value-based Contracting and Alternative Payment Arrangements

We recognize that providing incentives to Providers creates opportunities for program development and ensures workforce sustainability. A key component of our APMs includes alignment with Providers in selecting appropriate performance measures tied to integration. Smaller Providers may lack the necessary administrative infrastructure to succeed. However, Molina's APMs are flexible and built for incremental improvements. We support and assist Providers in building the necessary infrastructure and operations. Molina will enter unique contract arrangements with Providers, offering funding for specific capacity needs to support the transition, expansion, and development of integrated care models. We have already partnered with the following KanCare Providers to develop VBP arrangements.

[redacted]

[redacted]

[redacted]

[redacted]

Value-added Position

[redacted]

Strategy #2—Enhancing Access and Engagement to Care Coordination Through Extenders

Molina brings extensive experience in articulating the valued and critical role that care coordination extenders play in delivering person-centered care, both within Provider offices and throughout the community. We are committed to using extenders to deliver tailored services for Kansas that are not just more achievable and accessible but also more realistic. The information obtained from our extenders will provide valuable data that informs and evaluates priorities for improvement, for both Providers and care coordination. Below, we eagerly introduce two new types of extenders: Peer Support Specialists and CHWs/community health representatives (CHRs).

Peer Support Specialists. Molina provides an integrated, whole-person service delivery system that supports person-centered and self-directed care, leveraging skilled staff with lived BH experience. For example, our enhanced transition of care process incorporates peer support to ease the Member's transition back to their home and community after a hospitalization. Through the inclusion of peer support in the transition of care process, we ensure that appropriate community connections are established, setting the Member up for success.

Using Peer Support Specialists to Improve Member Engagement

In 2021, our Arizona affiliate's Peer Reach-in program resulted in the following successes:

- 39% decrease in BH hospitalizations
- 38% increase in outpatient BH services, such as counseling
- 41% increase in supportive BH services
- 39% increase in connections to PCPs

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The Molina peer support model is a fundamental differentiator for us. We employ additional staff members with lived experience to ensure that Member voice and choices are prioritized in all aspects of care. Upon Contract award, we will collaborate with CCBHCs and Community Run Organizations (CROs) to support and expand peer support, peer respite, and peer-led recovery center services. CCBHCs play a critical role in the system of care by incorporating lived experience and peer support within their service set and programs. When Members engage with CCBHCs, they will often be educated on and offered peer support as a part of their service plan. Under the overall care coordination approach, we will act as a support and resource to CCBHC peer support specialists, as invited and needed, as part of the Member's interdisciplinary team. These individuals teach and model self-advocacy, facilitate continued engagement with the CCBHC and their service plan, help the CCBHC to bust barriers to care across the continuum

when other coordinated recovery services are needed, and serve as a touchpoint during transitions of care. The Molina Peer Support Specialists work in lockstep with Molina Care Coordinators and CCBHC care coordinators, supporting Members in their journeys and sharing information with CCBHC peer support when needed.

CHWs/CHRs. CHW/CHR activities will strengthen integrated, whole-person care coordination by connecting Members with available healthcare services and social supports, addressing SDOH and improving access to community-based services. CHWs/CHRs are critical to facilitating linkages to essential services, ensuring services meet Members' needs, monitoring progress, providing education, assisting in navigating benefits, and empowering Members in their health and wellness journeys. Through our experience, we have gathered valuable insights and will implement best practices to support the CHW/CHR model and infrastructure across Kansas. We will invest in CHWs/CHRs because we know firsthand their ability to deliver cost-effective and sustainable services and supports and to achieve improved health outcomes and accessibility.

Demonstrated CHW Success
Since Molina first implemented a CHW program in 2004, the program has expanded to all 18 of our affiliated Medicaid health plans and has resulted in better health outcomes for Members, improved utilization patterns, and increased cost savings for states. For example, our Michigan affiliate's program realized a 25% reduction in ED visits and readmissions post-intervention and a significant decrease of $218 PMPM in total cost of care. 091.c.ks23

We incentivize entities to expand their relationships with CHWs/CHRs who are already in the community, enabling them to serve as care coordination extenders by:

- Functioning as key educators and facilitators in the areas of health promotion, evidence-based programs, and improved health literacy with cultural competency
- Supporting KS Community Health Worker Coalition activities aimed at increasing the availability of CHW training for community partners
- Assisting in bridging the geographic and cultural divide in rural, tribal, and Provider-scarce communities where CHWs/CHRs may be the closest resources for Member engagement
- Sitting on interdisciplinary teams alongside Members and Providers and serving as certified translators to speak in the preferred language of the Members, particularly in communities with high concentrations of immigrants and refugees
- Using Molina's Care Coordination Portal to support real-time updates about Member appointments and services
- Providing rural resources and wellness checks for Members to ensure safety

Strategy #3—Addressing SDOH from a Community-informed Approach

From our company's beginnings as a clinic built by Dr. C. David Molina to serve diverse and underserved individuals, we have had a deep understanding of how the social needs of Members affect their physical health and BH. Our affiliates' experience across these areas has informed our approach to collaborating with CBOs and Providers. We understand that advancing integrated, whole-person care will not result from a traditional, fragmented clinical approach.

Through our work on the ground and through conversations across all regions of Kansas, we have heard communities' concerns about their particular disparities. Whether these result from urban food deserts or historical disparities, especially in southeast Kansas, we will prioritize our community-level partnerships to assess specific community needs and available resources. We actively engage CBOs, Providers, and advocates to better develop our approach for connecting Members to existing services. We engage and invest in strategies to grow services to expand their reach and remove barriers when resources are difficult to obtain. Ongoing conversations help us pinpoint gaps in the current knowledge of MCO care coordination staff regarding MCO value-added benefits that target SDOH and highlight the need for better connections with care coordinators. Insights from Providers and partners stress the critical role of local champions for successful service or program expansion, regardless of funding.

MolinaCares Accord builds stronger communities through partnerships with community organizations. As part of our commitment to Kansas, Molina is proud to have invested in and worked with numerous diverse community partners, including:

- **El Centro of Wyandotte and Johnson County's Promotoras de Salud (Health Promotors) Program**
- **Kansas Children's Service League's Parent-Child Assistance Program (P-CAP)**
- **Catholic Charities of Southwest Kansas**
- **Greenbush Education Service Center**

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Our Care Coordination and Growth and Community Engagement teams will actively conduct community-level assessments to pinpoint successful partnerships and identify areas lacking resources. We'll gather feedback about why certain initiatives thrive in one community but fail in others and use this feedback to promote collaboration and problem-solving. Molina Care coordinators will refer Members to existing programs and promote Provider and community events through both Member and Provider newsletters. Growth and Community Engagement staff will connect at least quarterly with CBOs serving our communities to share insights, answer questions, and update contact details. To address SDOH from a community-informed approach, we will use various techniques, such as reinvestment commitment and SDOH platform integration, as described below.

Community Reinvestment Commitment. Our parent company has a proven track record of reinvestment in communities—specifically, with state partners in Medicaid programs in Arizona, California, Nevada, and Ohio—to enhance the capacity for key community partners and to benefit both Members and the broader community. Our affiliates have consistently been recognized for their community engagement approach, visible presence, and commitment to identifying and addressing SDOH needs for

Members and their families and communities. We will refine our approach for KanCare based on our successful strategies from our affiliated health plans nationwide, as well as our experiences in Kansas. [redacted]

Molina will collaborate with **Harvesters Community Food Network** to respond to the critical link between nutrition and health through the **Food is Medicine Program**. This initiative targets patients in the primary care safety net system who suffer from chronic conditions aggravated by inadequate nutrition. Harvesters effectively mobilizes the community to create equitable access to medically tailored groceries, nutritious food, meal ingredients, and cooking education opportunities. Patients can then—all with the purpose of helping patients better manage their chronic disease through improved nutrition.

SDOH Resource Platform Integration. Molina is committed to integrating with other SDOH platforms to create a comprehensive social care ecosystem. We will partner with all statewide social resource platforms, such as **Unite Us, the University of Kansas' IRIS, and our SDOH platform,** to provide the most robust referral system possible for Members. We understand that CBOs have established relationships that have invested in and integrated these platforms into their workflows. Molina partners with these organizations by providing access to resources with the least number of barriers, for a "no wrong door" approach. Molina is committed to being a leader by collaborating across stakeholders to tailor effective interventions, address disparities, target at-risk groups, and scale interventions to promote health equity.

How Molina Measures, Monitors, and Evaluates Strategy Effectiveness

Measuring, monitoring, and evaluating strategies for advancing integrated, whole-person care is crucial to ensuring effectiveness. As part of our continuous evaluation and improvement process, we will use traditional quality metrics as well as measurement-based care metrics. The process includes systematically assessing Members' changes in symptoms, functional abilities, and quality of life using quantifiable data. This data from our Providers, Care Coordination team, Practice Transformation and BH Practice Optimization Teams, and community extenders enables us to evaluate and tailor interventions based on the goals that were set by Molina, the State, Provider, and community stakeholders, and, most importantly, Members. Improvement is evidenced through repeated measurements and comparison against benchmarks and baselines that will be established at the start of the KanCare Contract and evaluated on an ongoing basis.

Our proven strategies for monitoring and evaluating healthcare quality using key metrics align with KanCare's quality strategy. These strategies include:

- Using data for monitoring, evaluating, and reporting based on root-cause analysis, Plan-Do-Study-Act, and using innovative tools and dashboards to inform our QAPI program
- Sharing scorecards, including gaps-in-care scorecards, with Providers to improve key quality-based care metrics while incentivizing Providers to use our portal, featuring APM monitoring
- Applying proactive data analysis via algorithms and machine learning and evaluating risk scores and identifying trends of preventable healthcare utilization for timely interventions that support better Member health overall

We use our analytics tools, including our Quality Performance Dashboard, to drill down on measures and evaluate results based on factors such as race/ethnicity, gender, age, and geographic location. We also evaluate community health and population-level data to identify emerging trends and new challenges facing both Members and communities. We review overutilization and underutilization data, SDOH needs, health disparities, and disease/condition trends using a public health lens. This analysis involves drill-downs by county, zip code, or neighborhood. Molina tracks and trends key metrics, such as:

- Quality measures, including HEDIS, National Quality Forum, and Agency for Healthcare Research and Quality
- Member experience and satisfaction and grievances and appeals
- Social needs measures, such as SDOH gaps resolved and closed
- Effectiveness of VBP arrangements compared to national benchmarks

We analyze utilization metrics to assess. We monitor service and resource utilization and analyze those metrics to assess the impact of integrated care strategies and to gain insights into the efficiency and accessibility of healthcare interventions. This data-driven method allows us to examine patterns and service utilizations to help us identify gaps, optimize resource allocation, and ensure that individuals receive timely and appropriate care. We proactively share this data at both the Provider and community levels to assist in program development and inform our approaches to clinical care.

Assessing success in advancing integrated, whole-person care involves actively reducing access barriers and improving Members' quality of life. Evaluation entails analyzing metrics such as timeliness of care intake, geographic coverage, and patient satisfaction to measure the effectiveness of strategies in overcoming access barriers. For example, to evaluate the impact of the care system, including care extenders, we integrate quality of life and functional assessments into our Care Coordination Model. We incentivize their use at the Provider level and collaborate to measure crucial performance indicators, such as length of tenancy for housing-first programs, sustained employment rates, community participation levels, and reduced criminal justice recidivism—aiming for a comprehensive evaluation and enhancement of our care strategies. Our goal is sustained improvement.

4.3.I.10 Methods to Identify, Track, and Address the Social Needs that Impact SDOH for KanCare Members, Members in Care Coordination, and Those Who Are Not

10. Describe the bidder's methods to identify, track, and address the social needs that impact Members' health Social Determinants of Health (SDOH) for its KanCare Members, for Members in Care Coordination, and those who are not. Include the following in the bidder's response:

a. The methods, strategies, and tools the bidder will use to identify and track KanCare Members' needs (e.g., Health Screens, Health Risk Assessments, and Z codes).
b. The individuals (e.g., MCO Care Coordination staff, care coordinators in other Care Coordination models) responsible for following up on identified SDOH needs, and the process for connecting KanCare Members to available resources.
c. The bidder's approach to making SDOH resource information available to its staff and Providers responsible for addressing Members' SDOH needs.
d. The methods and tools the bidder will use to track Member access to necessary resources (e.g., geographic information system [GIS], "closed loop referral" platform).
e. The bidder's efforts to engage, collaborate with, and support SDOH resource Providers.

Identifying and addressing SDOH needs is a critical element within our Care Coordination Model. We leverage cross-system collaboration to facilitate access to resources, aiming to enhance health outcomes and improve Member quality of life. Using insights from our initial SDOH hotspotting, over the past year Molina's Growth and Community Engagement team has nurtured relationships with more than 200 organizations across Kansas to comprehend community needs and available resources. These relationships are the backbone of our community engagement strategy at the system level and drive our care coordination strategy at the Member level. They enable us to establish deep relationships that ensure Members' needs are appropriately addressed when we refer them to local agencies. We are committed to investing in initiatives that promote wellness, improve health literacy, address food and housing insecurity, combat social isolation, and more.

At Molina, we use a data-driven, community-informed approach to identify, track, and address SDOH needs not only at the Member level but also at the broader population and community levels. We use comprehensive data, powerful analytics capabilities, and insights from community partners to identify specific geographical hot spots where concentrated needs exist within populations or subpopulations. This data empowers us to prioritize needs and opportunities for targeted investments aimed at alleviating barriers to health.

a. Methods, Strategies, and Tools to Identify and Track Member Needs

We will employ a multifaceted approach using technology and various tools to identify and track the social needs of KanCare Members. Proactively identifying individuals requiring services, we will collaborate with Providers, agencies, and stakeholders to connect these Members to the appropriate care. Employing diverse methods and strategies, we partner to complete the care loop for Member SDOH needs, and we do not close the referral loop until all Member needs are met, as outlined below in subsection d.

Making Member screening a consistent part of our approach is fundamental to who we are. We believe in understanding and addressing the unique needs of each Member. Our commitment to

tailoring care and support is embedded in our values, ensuring that each engagement mirrors our dedication to personalized attention. Through continuous information gathering and adaptation to changing needs, we remain steadfast in our mission to deliver customized solutions and elevate the overall Member experience.

Our outreach teams conduct Health Screens to help evaluate health risks and quality of life and determine who needs additional evaluation and link the Member to additional interventions (e.g., care coordination, community resources) that promote health and prevent disease. The initial screening process includes the PRAPARE® tool. We use this data to identify SDOH needs, conduct risk stratification, prioritize outreach efforts, and determine which staff can meet their unique requirements. This initial Health Screen is administered to all Members upon enrollment and annually thereafter. Upon identifying SDOH needs during these screenings, we are committed to connecting Members to the necessary resources and meticulously tracking any essential referrals through closed-loop SDOH referral platforms.

We use holistic, person-centered Health Risk Assessments (HRAs), which include all elements outlined in Appendix F, to determine the type of Needs Assessment warranted by the Member's health status and next steps to take in the process. Our Care Coordinators use a robust catalog of evidence-based and proprietary assessments for chronic behavioral health (BH) conditions, including SUD; health-related social needs; and informal supports. They also leverage data from our Molina Insights stratification and predictive analytics engine, risk scores, and Member's utilization claims. Certified community health workers (CHWs) who conduct HRAs can quickly identify appropriate Members and connect them with service coordination and specialty and social service needs, such as housing and transportation.

We encourage Providers to assess all Members for SDOH. Our Pay-for-Quality program will reward Providers for assessing Members for SDOH needs, documenting them through Z codes, connecting Members to community-based services, and confirming that Members successfully received services and the referral loop was closed.

Molina uses proprietary predictive analytics incorporating publicly available data, including the CDC's Social Vulnerability Index, with information from our centralized Data Lake, which hosts both internal and external quality data. We use these combined data sources to identify and stratify Members at risk for financial, food, transportation, and housing insecurities. This data is updated monthly and used in conjunction with individual screenings to prioritize Members at highest risk.

Through Molina Insights we can identify population and subpopulation SDOH needs. We identify geographic hotspots where specific needs such as food insecurity and housing instability are concentrated at the census tract, ZIP code, and neighborhood levels. By overlaying stratification and disparities information and filtering by factors such as race, ethnicity, age, and gender, we gain a granular understanding of SDOH needs within communities. For example, Molina has implemented a program to identify Members who are at risk of homelessness. We

developed a proprietary model using various data entry points to generate data. We compile these data points into our Data Lake, which includes returned mail, claims discharge codes, and Member addresses that imply a potential homeless situation. Our developed model generates a targeted at-risk list that can be readily shared with various stakeholders. These include our Providers, Care Coordinators, community care coordinators, and SDOH-specific partners, such as Kansas Coordinated Entry System representatives and other community-based organizations (CBOs) participating in the Kansas Statewide Homeless Coalition for focused interventions to address homelessness.

These activities are supported by our Molina Compass suite of sophisticated analytics tools, as shown in **Table 10-1**.

Table 10-1. Molina Compass Tools to Identify and Track Member Needs

Tools	Description
Molina Insights	Our proprietary risk stratification and predictive modeling platform aggregates data, community-based social risks, and consumer analytics. It identifies Member social risks and monitors changes in these risks over time.
SDOH Resource Platforms	SDOH resource platforms, such as the SDOH platform, UniteUs, and the University of Kansas' IRIS, all aid Members, Providers, and Molina employees in finding SDOH resources, screening for gaps, and identifying SDOH needs. These resource platforms assist with care coordination by enabling the completion, tracking, and closure of referrals.
Molina Rural Index Vulnerability Indicator	Our strategic, web-based tool identifies community-level and rural gaps in access to care, pinpointing areas for targeted community-based interventions and resources.
Socially Determined	A data platform that quantifies and visualizes SDOH risk exposure to determine social risk factors for individuals and communities.

[redacted]

b. Molina Care Coordination Staff Responsible for Supporting Members' SDOH Needs

We assess every Member at every interaction to identify any new or ongoing needs for SDOH support. We collaborate with community organizations across all touchpoints, ensuring a "no wrong door" approach to accessing services. This includes empowering Members to engage with their Molina Care Coordinator or community care coordinator, CHWs, Providers, or other community partners.

All our staff, regardless of their location (e.g., community, office, or remote), have access to the Molina SDOH resource platform. This platform is used to find resources for identified social needs, make referrals, and track referrals until the Member's needs are met.

> Within a week of talking to [my Care Coordinator] for the first time, she had home health care in here. I found out that I had transportation if I needed it. [My Care Coordinator] takes time and she has become my lifesaver. My next foot will be a moveable ankle and I will drive again. They care about their clients, and I am so thankful for them. It's the support system that I need to get to the point that I can take care of me. I can call any one of these people in Molina and they remind me where I was and where I've come to and where I'm going.
>
> *Diane, an Ohio Member living with obesity, diabetes, and amputation speaking on her relationship with Molina Care Coordinator*
>
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Our in-house Care Coordinators take the lead in coordinating care for Members and assessing their SDOH needs, such as housing, food, and transportation. Care Coordinators prioritize community outreach to engage, screen, and make referrals that connect Members to appropriate services and supports. They coordinate follow-up with Members to ensure the service was received and that the closed-loop referrals are included and tracked in the Member's Person-Centered Service Plan and shared with their PCP. We have found that the use of Peer Support Specialists with lived experience are integral to our Care Coordination teams, ensuring that Members' voice and choices are prioritized in all aspects. [redacted], Health Equity staff, and Molina CHWs, who have expertise in public health, extend our care coordination services by personally connecting Members directly to community supports. These individuals excel as highly trained communicators and subject matter experts, stepping in when Care Coordinators are not required and when a Member's needs pertain solely to SDOH.

Value-added Position

Community Care Coordinators, positioned within the heart of the community, are not just knowledgeable but deeply committed to finding local services that meet the unique needs of Members in addressing SDOH. These individuals undergo rigorous, specialized training and will be encouraged to become certified CHWs to ensure the highest quality care for our most vulnerable populations. They serve as the primary and unwavering points of contact for Members, providing a dedicated and reliable source of support. Our Growth and Community Engagement staff have developed partnerships and invested in CBOs to expand capacity in organizations that are often under resourced, under the weight of growing referrals. In addition, our certified CHWs can initiate a reassessment of Health Screens to identify and connect Members with service coordination and social service needs, such as housing and transportation. Because CHWs are members of the communities they serve, they can help Providers and service coordinators connect Members to services between established touchpoints and identify cultural, economic, social, and linguistic barriers that inhibit the Member from being successful.

Successful Housing Agency Partnership

Our Wisconsin Affiliate also partnered with county agencies to provide a **Housing Navigator program, which resulted in a 48% reduction in ED admissions**.

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Our Housing Services and Supports Specialist operates within the Housing First model, honoring and prioritizing Member choice. They will collaborate with Kansas housing agencies and programs to facilitate access to affordable housing services for BH and LTSS-receiving Members. The specialist educates and assists Care Coordinators in connecting KanCare Members with affordable housing services. They will serve as a liaison with

KDADS housing coordinators and CMHC-based housing specialists, contributing to Kansas' broader housing strategies and initiatives. The specialist will collaborate with KDADS to ensure community Providers are trained and maintain fidelity in evidence-based practices.

We take an employment-first approach by prioritizing competitive employment within integrated community settings for Members. This approach involves encouraging Members to integrate their education, job training, and employment goals into personalized service plans. Our full-time Employment Services and Supports Coordinator collaborates closely with the interdisciplinary team to identify appropriate employment supports for each Member, ensuring a comprehensive approach to addressing their specific needs. The coordinator also assists Members with exploring various employment services and Providers, while the interdisciplinary team focuses on skill development to support competitive employment.

Continuous monitoring and support are provided to ensure Members receive necessary assistance, actively promoting integration in community settings. We recognize that one of SAMHSA's Eight Dimensions of Wellness for BH recovery is occupational, and that CCBHC model criteria includes care coordination services and community partnerships for employment services. Our Employment Services and Supports Coordinator will partner with the Association of Community Mental Health Centers of Kansas (ACMHCK) to support CCBHCs to build upon successful employment programs, such as the Johnson County Mental Health Center program, and identify and collaborate on initiatives that will work best in each community.

c. Molina's Approach to Making SDOH Resource Information Available to Staff and Providers

Molina promotes the accessibility of SDOH resource information for staff, Providers, and other stakeholders through diverse and accessible channels. SDOH resource platforms host a wide array of resources spanning housing, job opportunities, and more. To facilitate staff access, direct links to our digital 24/7/365 SDOH platform are seamlessly integrated and easily accessible through single sign-on across our Provider portal and internal applications. Additionally, Members have direct access to these resources through various entry points, including our dedicated Member portal, allowing them to explore and leverage the available SDOH information to meet their needs. This accessibility ensures that a range of stakeholders can tap into these resources to address SDOH concerns effectively.

Our staff complete comprehensive initial and annual refresher training on covered services and resources. Ongoing training ensures that staff remain current on State and federal guidelines, best practices, utilization trends, and the latest SDOH tools and programs.

Molina affiliates have successfully incentivized Providers to use CHWs to help Members identify insecurities, barriers to healthcare, and physiological or safety needs and to then use SDOH resource platforms for real-time referrals before the Member leaves their appointment. This collaboration aims to enhance Members' access to essential resources and support systems.

Our Provider Relations team actively engages with Providers and their office staff, educating them on addressing Members' SDOH needs when deploying whole-person care. Molina's Provider Representatives educate them during new Provider orientations and disseminate information via our Provider Manual and toolkits, the Provider portal, and quarterly newsletters.

Provider Representatives also educate Provider practices about MolinaU, a comprehensive and versatile learning experience that includes virtual sessions, instructor-led training, and self-paced curricula on a range of topics that enhance support for SDOH.

Staff Participation in Community Events
Molina encourages staff participation in community-based resource events ensuring they stay updated on current SDOH resources. Our staff in an affiliated health plan participated in HomelessConnect, serving 1,200 homeless or at risk of homelessness and 90 service Providers, many who offer SDOH resources. 078.d.ks23

We offer technical assistance to Providers, and their staff are offered technical assistance when needed. Our Practice Transformation Team will provide coaching and empower Providers and frontline staff to connect Members to services. We educate Providers to ensure they document all referrals and follow up on them as part of their VBPs and other quality metrics.

d. Molina's Methods and Tools to Track Member Access to Resources via Closed-loop Referrals

We use a data-driven approach to identify areas of greatest need and tailor our efforts accordingly. Our SDOH closed-loop referral system offers comprehensive community resource information. Accessible to all Member-facing staff, Providers, and CBOs across Kansas, our system streamlines access to various resources, including housing, food, employment, home repair, financial support, legal services, and more. Resources within the SDOH platform undergo regular updates for accuracy, allowing the ad hoc addition of new CBOs. This system enables real-time tracking of referrals to ensure that Members receive necessary community support, trackable by Molina staff, Providers, CBOs, and Members.

We offer a platform-agnostic approach to assisting care coordination staff and Providers with finding the care Members need. Molina will partner with established Kansas referral platforms such as Unite Us and the University of Kansas' IRIS to create a social care ecosystem that addresses Kansas' needs. Molina will continue to work within these systems to identify Members and will follow up on referrals that have been made and closed through these programs. Molina's goal is to work with all organizations that support Members, meet Members where they are, and identify opportunities to share this data across platforms.

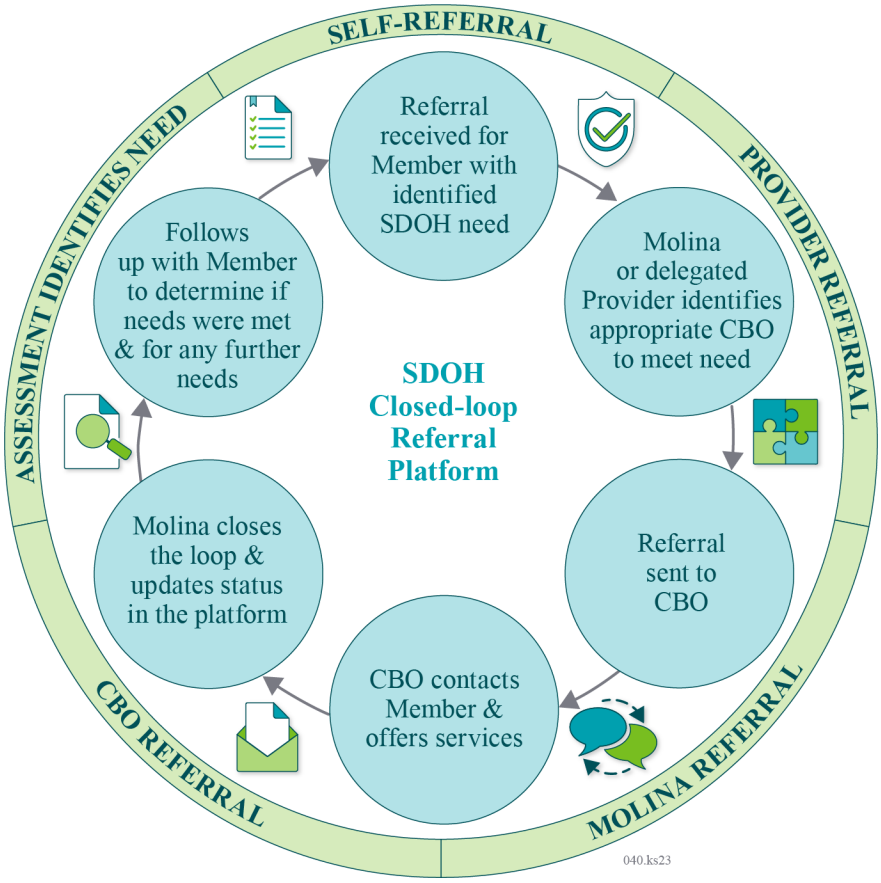
Given our intense focus on Member SDOH, Molina is eager to work with KanCare and other MCOs, as well as key stakeholders, on continuing to enhance the capture of SDOH data in a closed-loop referral process.

We incorporate referral system data into our Molina Insights platform to determine system effectiveness, track capacity or timeliness issues to address with CBO partners and identify resource gaps. Our Health Equity team will stratify outcomes in their assigned geographies to identify disparity reduction opportunities. We use this information in our quality improvement interventions, such as enhancing staff training, modifying workflows, and identifying priorities for community investment.

Exhibit 8-1 illustrates the seamless flow of data exchanged among all parties to impact Member care and close referral loops.

Our MIS integrates data to provide insight into Member SDOH needs from a wide range of sources, such as the State enrollment file; Member screenings and assessments, including the PRAPARE tool; Z codes from claims; and a variety of public sources. We integrate this data with claims, encounters, and other data—including lab and pharmacy data, data pulled from Provider EHRs, and all Kansas HIEs —into our Data Lake platform. [redacted]

Exhibit 8-1. Closed-loop Referral Platform. We successfully link Members to curated local supports to meet their SDOH needs.



[redacted]

e. Molina's Efforts to Engage, Collaborate with, and Support SDOH Resource Providers

We understand that CBOs have been flooded with requests that far exceed their resources and infrastructure and funding is often unstable and inadequate. Recognizing the important role that CBOs play in the community, we engage with CBOs to foster long-term relationships through which we provide not only financial support, but also assistance with developing infrastructure, including technology, data analytics, and data sharing; building coalitions; and implementing long-term community strategies that address SDOH through sustainable programs and build community trust. Molina values our collaborations with CBOs and is honored to lead system improvements through participation in the convening of advocates, Providers, and stakeholders, such as the Kansas Center for Rural Health's inaugural Rural Maternal Health Symposium and the Kansas Mobile Integrated Health/Community Paramedicine Summit.

Coordinating with CBOs. We will align with the State's vision and goals to educate, engage, and empower Kansans by aligning with local community agencies that are dedicated to connecting resources that support the health and social needs of the community. We partner with faith-based organizations, advocacy groups, and other CBOs to support current efforts and

develop and deploy new grassroots strategies aimed at addressing SDOH across urban and rural communities. [redacted]

We coordinate with communities throughout the State to help eliminate homelessness. A proud member of the **Kansas Statewide Homeless Coalition (KSHC)**, Molina will collaborate with the coalition to enhance coordination among agencies. Molina aims to improve programs and projects, ensuring better service and systems planning for housing resource allocation. We will use a trauma-informed, holistic approach and engage and empower individuals with lived experience in all aspects of care coordination. We will promote KSHC education and training for the community and bring meaningful programs and projects that focus on building systems to address rural-urban disparities and racial inequality, working to address gaps alongside community partners, such as Built for Zero, that create equitable systems of care. [redacted]

One of our initiatives is through transition-age youth educational workshops, which support prevention efforts by providing education for youth and young adults transitioning into adulthood. These workshops are designed to engage the community, including parents, caregivers, and pregnant or parenting youth, and cover risk and protective factors related to homelessness. Topics include mental health, SUD, and experiences in foster care and juvenile corrections, alongside other critical areas such as financial insecurity, education, and employment. The workshops also cover topics related to the most vulnerable of populations, including individuals who are black, indigenous, people of color, or LGBTQ.

Our Housing Services and Supports Specialist will collaborate with and support KDADS housing coordinators and housing specialists on Kansas' broader housing strategy and initiatives. They will work with KDADS to ensure that community Providers are trained and achieve fidelity in keeping with evidence-based practices, such as the Housing First model, and will provide ongoing advocacy, training, education, and support. The Housing Services and Supports Specialist will support the privacy of all individuals and work under the Housing First model, honoring Member choice and helping to expand resources and connect individuals to safe and sustainable housing. Molina will help eliminate barriers by supporting the new Kansas Balance of State CoC assessment, which is used to determine potential housing and support needs for

people experiencing homelessness. The assessment will prioritize referrals across all agencies and the community to provide housing support quickly and successfully and support appropriate interventions based on vulnerability and severity of need.

[redacted]

Targeted Outreach. Molina's Texas affiliate has actively engaged and led events throughout the state, fostering partnerships with CBOs in the counties served to educate mothers on children's health and wellness. We intend to replicate these successful efforts in Kansas. To achieve this, comprehensive research is underway to understand the unique health needs of mothers and children in targeted Kansas counties. Molina is proactively engaging with local CBOs and stakeholders to collaborate on tailored educational events. The aim is to adapt messaging to the local culture, leverage diverse communication channels, and measure impact through established metrics. Throughout this process, Molina prioritizes compliance with local regulations, fostering long-term sustainability in its commitment to improving children's health in Kansas communities.

Collaborating with CBOs to Close the Loop. We will provide training and support to CBOs to enhance their ability and remove barriers to using Molina Help Finder and other State-sanctioned social resource platform tools. [redacted] We engage and collaborate with CBOs to understand their specific needs and develop partnerships that are tailored for the CBO and the community they serve.

4.3.I.11 Approach to Identifying and Addressing Health Disparities for KanCare Members

11. Describe the bidder's approach to identifying and addressing health disparities for KanCare Members. Include the following in the bidder's response:
a. The bidder's definition of health disparities.
b. The bidder's approach to monitoring for unintended bias in Utilization Management and service delivery in KanCare. Additionally, provide an example of an identified concern in a program similar to KanCare and the actions that were taken in response.
c. An example of a specific health disparity in KanCare, the bidder's proposed approach to addressing the disparity, and the anticipated impact on KanCare Members.

Molina Affiliates Have Achieved NCQA Health Equity Accreditation
Eleven Molina affiliates have achieved NCQA's Health Equity Accreditation, which recognizes their focus on improving CLAS and their efforts to reduce healthcare disparities.
Our California affiliate was 1 of 9 health plans selected to earn NCQA's Health Equity Accreditation Plus.
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More than 40 years ago, our parent company grew out of a community clinic with the primary focus of removing barriers to quality healthcare for immigrants in an underserved community. Since our inception, addressing health disparities has been the foundation of our mission of improving the health and lives of Members through integrated, accessible, and value-driven healthcare. By investing in community wellness initiatives, advocating for culturally competent health education, and supporting programs and policies aimed at bridging gaps in health inequality, we help foster inclusive, appropriate, and accessible healthcare for all Members. Within the remainder of this section, we first detail our approach to identifying and addressing health disparities and then respond to the subparts of the section (a, b, c).

Approach to Identifying and Addressing Health Disparities for KanCare Members

Molina leverages our affiliates' extensive experience identifying, addressing, and mitigating racial and ethnic disparities in Medicaid populations across 18 states. This experience informs our approach to reducing the impact of barriers to care, whether they be cultural, linguistic, physical, and/or age-, gender-, or race/ethnicity-based biases. Our experience reflects the importance of leveraging data to produce results, developing culturally relevant interventions, and collaborating across the health and social services continuum to identify, address, and mitigate disparities. Our affiliates test, refine, and share successful strategies, incorporating lessons learned and customizing to complement the service delivery system and available community-level programs. Our success reflects our understanding that improving Member health outcomes requires reducing disparities and improving health equity. We can deploy strategies in Kansas to deliver similar results.

Molina's designated and qualified Health Equity Director will be accountable for monitoring health disparities and championing integration efforts organization-wide to ensure health equity-driven care. Working with our Care Coordination, Quality, and Data Analytics teams—as well as community-based field staff—the Health Equity Director will identify and address health disparities while ensuring covered services are delivered in a culturally competent manner to all Members. The Health Equity Director will oversee the development, maintenance, and refinement of Molina's Health Equity and Cultural Competency Plan for Kansas.

Highlight of Success: Disparities Identified and Addressed by Our Florida Affiliate

Our Florida affiliate implemented a population health strategy focused on reducing health disparities and increasing cultural competency. This approach resulted in a **significant reduction in C-section rates among Latino (23%) and black (17%) Members** in care management. The program also led to improvements in birth outcome measures year over year, **reducing preterm deliveries by 33% from 2021 to 2022.** 080.b.ks23

Nationwide best practices; data and population health analytics; as well as conversations with Providers, Members, and other stakeholders across Kansas (such as Area Agencies on Aging and CCBHCs) form the base of plan development and implementation. Through our discussions, we heard of the inequities surrounding diabetes, asthma, and rates of tobacco use. We learned about the disparities rural and frontier Members face in accessing care. Stakeholders discussed the need for better education from the health plan and better connection with health plan services, including value-added benefits and opportunities to receive care in a setting where Members feel safe from stigma and judgment. We also discovered the need for greater health literacy education, as its impact typically creates better adherence to prescribed healthcare interventions, including screenings, vaccinations, and engagement in disease management programs.

Addressing Health Disparities

Because we recognize that reducing disparities requires all system partners to integrate their efforts, our Health Equity Director will initiate partnerships with local health and social services organizations across Kansas communities. We will collaborate with a wide range of organizations that serve Kansas Medicaid Members. This effort will include leveraging our partnership with [redacted]

Molina will methodically use data and feedback to inform our approach to identifying and addressing disparities through targeted interventions, solutions, and innovations. To measure success, we will use qualitative feedback from Members, Providers, and community-based organizations (CBOs). We will also use quantitative data, such as HEDIS and HEDIS-like metrics; utilization metrics, including emergency department (ED) visits and admissions; care coordination engagement metrics; CAHPS data; the percentage of Members connected to SDOH resources; and the percentage of referred Members who access services. In addition, we will use Member and Provider committees to regularly review and improve upon our approach. This will be complemented by a formalized evaluation process using our Health Equity Dashboard, described later in this section, and monthly and annual rapid-cycle performance improvement analyses.

The goal of our data-driven, community-based health equity approach is to create an environment for Members in which the attainment of optimal health through high-quality, effective care is achieved for all people as the rule, not the exception—irrespective of a Member's cultural background, language proficiency, socioeconomic status, or other identity.

Data-driven Approach to Identifying Health Disparities

Molina recognizes that health disparities exist in the Medicaid population. Our enhanced data-mining and analytics capabilities allow us to drill down on subgroups within our overall population and identify disparities in health outcomes, such as those regarding race, gender, and

age. [redacted]

[redacted]

Highlight of Success: Disparities Identified and Addressed by Our California Affiliate

Our California affiliate partnered with Black Infant Health and Mamás y Bebés to help pregnant women of color develop their health-promotion skills, such as mobilizing social supports, applying self-efficacy, and using positive coping skills. **The initiative resulted in increased rates of well-child visits (at 15 to 30 months) in all counties, ranging from 5.35% to 33.42% year over year.**

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KanCare Population Analysis. A key component of our Health Equity and Cultural Competency Plan is Molina's population and community needs analysis, which will help us to understand the differences in health outcomes among different Kansas populations. We will analyze Member and community-based data to identify themes and areas that may represent potential health disparities. Data collected includes Member-identified race, ethnicity, language, disability, and SDOH, among other factors. This comprehensive analysis allows us to pinpoint disparities in healthcare access, services, and outcomes. We then stratify our analysis by population most affected by health inequities to infer potential unintended biases causing disparities in utilization, approval, and denial rates. Leveraging CDC's Social Vulnerability Index (which ranks social factors such as minority status, poverty level, and disability), we can visualize data through geographic information systems software, mapping areas of high and low vulnerability to aid in risk stratification and care management for Members.

SDOH

By leveraging data from the Social Vulnerability Index and combining it with information from individual screenings, we aim to better address SDOH barriers, particularly in maternal health. We will target resource allocation based on vulnerability, creating a data-driven epidemiological report to track and analyze key maternal health indicators, such as prenatal and postpartum care, birth outcomes, and maternal mortality. This will help identify at-risk communities and populations, allowing us to direct interventions and outreach effectively. The report will also help us identify where there are disparate outcomes, and this information informs our initiatives and programming. If disparities are found, we investigate whether unintended bias contributed to these differences.

We will develop an annual Health Equity Report Card that includes stratified performance measures. Each quarter, we will evaluate the trends we identified in the annual report to

determine if new issues have arisen. We will use this data to continually improve our Care Management, Utilization Management (UM), and QAPI programs and implement innovative strategies and interventions that effectively close gaps in care for all Members, including those who may be disproportionately impacted by SDOH. The report card, including quarterly updates and progress reports, will be posted on the Molina website; we will develop and implement strategies to address identified disparities and evaluate the impact of those strategies. We will work with the State to determine the content and format of the Health Equity Report Card and quarterly updates/progress reports.

Approach to Addressing Health Disparities for KanCare Members

Once we identify a disparity and its root causes, we use the nationally recognized Institute for Healthcare Improvement's Model for Improvement and the Plan-Do-Study-Act cycle to develop, implement, evaluate, and, as needed, modify strategies addressing disparities. Molina's Health Equity and Cultural Competency Plan will include a description of programs, strategies, and interventions (including Provider and community partner involvement) to identify and address needs. For example, Molina will help to address geographic health disparities by delivering care and services in an equitable and culturally competent manner in rural areas of the State via telehealth strategies. Molina will work to address SDOH and health disparities through the early identification of needs and interventions to connect Members to the right CBO partner.

As part of our root-cause analysis, and as recommended by the organization Advancing Health Equity, we research and consult with community partners to understand and effectively address health system barriers. We identify system partners, such as Providers and CBOs, who can work with us to design programs. We also look for staff who will implement and oversee interventions. We seek Provider and CBO guidance on how best to address disparities in each community and collaborate on goals and interventions. [redacted] Molina's Health Equity Director will work with Care Coordination, Quality, and Community Engagement teams to design action plans with specific goals, interventions, metrics, and monitoring and evaluation time frames. Once we implement the action plan, we monitor progress frequently and make rapid-cycle improvements as needed to ensure we are on track to achieve the stated goals.

Molina's Commitment to Being Culturally Competent and Reducing Health Disparities

Eleven Molina affiliates **have achieved NCQA's Health Equity Accreditation,** which recognizes their focus on improving culturally and linguistically appropriate services and their efforts to reduce healthcare disparities. NCQA's standards provide a rigor with which we can demonstrate how well we assess and manage population health. As a best practice, Molina mitigates disparities using National CLAS Standards and integrating equity strategies into existing systems, rather than creating a separate program. Our Health Equity Director will support an integrated approach. We will hire staff who live in the Kansas counties where Members live to ensure an understanding of local needs and resources.

We provide training to ensure a **culture of equity**; all employees and Member-facing Subcontractors complete training on health equity and cultural competency upon hire and

annually thereafter. Our training includes the following two modules: **Part 1: Introduction to Cultural Competency**, which focuses on cultural awareness and the celebration of diversity at Molina, and **Part 2: Health Disparities, Health Equity, and SDOH**, which focuses on disparate health outcomes and unconscious biases. Molina educates staff to understand the linguistic, economic, and social barriers that Members may experience, as well as related cultural nuances (e.g., regarding beliefs, mistrust, values), so Molina staff can engage with Members in a culturally appropriate way to help reduce health disparities. Molina requires, all governance, leadership, and workforce personnel to train on culturally and linguistically appropriate policies and practices on an ongoing basis, and we monitor adherence.

Our parent company provides an internal Health Equity SharePoint site to support integrating health equity and cultural competency across our organization. Staff can obtain up-to-date, relevant articles and information on upcoming webinars from national organizations such as CMS, NCQA, and the National Institutes of Health. Molina continuously improves cultural competency training to focus on trends and critical concepts. Molina recently expanded its training to include a focus on the framework and connection among health equity, cultural competency, and Diversity, Equity, and Inclusion (DEI), in alignment with National CLAS Standards. This focus includes exploration of the root causes related to structural and systemic racism, discrimination, and bias; dedicated learning modules on LGBTQ cultural competency, disability awareness, and accessibility; and leadership training on strategies to implement DEI within the workplace.

a. Definition of Health Disparities

Molina's definition of health disparities follows aligns with a shared understanding that of the HHS Healthy People 2030 framework: health disparity definition. We define a health disparity as a preventable or avoidable difference in health that is closely linked with economic, social, or environmental disadvantage. Adversely affected groups include those who have systematically experienced greater social or economic obstacles to health based on their gender, age, sexual orientation, gender identity, racial or ethnic group, geographic location (e.g., rural), preferred language, disability, or other characteristics historically linked to discrimination or exclusion.

b. Approach to Monitoring for Unintended Bias in UM and Service Delivery

Our approach to monitoring for unintended bias within our utilization management (UM) and service delivery processes is grounded in data-driven UM methodologies, data analysis, and monitoring; active involvement of Providers in clinical policy review, adoption, and monitoring; and proactive coordination with Providers on UM decision-making to gain timely feedback.

Data-driven UM Methodologies to Avoid Unintended Bias in Utilization Management

Molina recognizes that automated, data-driven processes are subject to bias, which can exacerbate disparities; however, we never deny prior authorization (PA) requests based on the use of artificial intelligence. We use our automation to approve requests and expedite the process, but all denials require a Medical Director's review.

Molina staff regularly analyze and monitor utilization data to identify and report on health disparities. We closely monitor utilization rates, approval and denial rates, and service delivery metrics across various demographic groups, regularly benchmarking our performance against national standards and HEDIS measures. Through our integrated UM platform, we target specific

health conditions and use key identified characteristics for stratification, including race, ethnicity, gender, and lower-income status for neighborhoods or geographic areas. Our selection of measures aims to mitigate health disparities for priority areas and by Provider types. This approach provides valuable insight into variations in UM and service delivery, highlighting potential areas where we should investigate unintended bias as the root cause. The approach also enables us to address the distinct health needs of our diverse Member populations, to achieve equitable health outcomes.

Our UM platform enables end-to-end reporting and comprehensive analysis by risk group of medical utilization trends, including inpatient, outpatient, professional, therapies, and DME. This analysis allows us to identify and address over- or underutilization of services, including by drilling down to identify this information by race and ethnicity. We leverage the data analytics platform to identify utilization trends driven by access issues or health disparities, supporting clinical guideline development and monitoring changes in authorization request volumes. We will use this platform to generate monthly PA reports to KanCare in the specified format, to ensure compliance with reporting requirements.

UM leadership will use UM dashboards to monitor our performance, with a lens on health disparities using HEDIS and other key performance indicators. This process allows us to remain agile in mitigating any negative trends. We monitor Member utilization across all settings, including admissions and discharges. We use available data to promote effective and equitable service delivery, including transition planning or connecting Members to information and supports to avoid high ED utilization.

Involvement of Providers in Policy Review, Adoption, and Monitoring. Molina recognizes the importance of capturing Provider feedback to addressing potential health disparities in UM and service delivery. We involve Providers in the development, revision, and adoption of—as well as the monitoring of adherence to—guidelines through our Provider Advisory Committee and UM Committee. Our Provider Advisory Committee and UM Committee are key mechanisms used to ensure we are responsive to and aligned with our Providers. In Kansas, Molina will benefit from the expertise of locally based physicians and other clinicians with varying specialties who are familiar with and can provide context regarding population health needs and disparate trends and outcomes. This feedback supports Molina's equitable application of its policies and criteria.

Proactive Coordination with Providers on UM Decision-making. Our Medical Directors will engage in peer-to-peer consultations as a proactive measure against discriminatory denials. Our Illinois affiliate, for example, facilitates peer-to-peer consultations through a pilot program using an online consultation platform. Providers and Medical Directors use the platform to discuss Members' unique circumstances for the purpose of clinical decision-making. Our affiliate's Medical Directors can share clinical and nonclinical data with Providers via the platform's real-time clinical profile tool. This collaborative dialogue has resulted in a reduction in denials and the administrative burden associated with Provider appeals.

Monitoring for Unintended Bias in Service Delivery

Our Health Equity Director plays an active role in monitoring for unintended bias in service delivery, engaging with Members and Providers to gather valuable input and ensuring access to

culturally and linguistically appropriate services. We believe that Members should always have access to quality healthcare, regardless of their cultural and ethnic backgrounds, physical or cognitive disabilities, personal characteristics, identities, or traits.

Molina recognizes that unintended bias exists, and this can result in Members receiving inaccurate diagnoses or treatment or experiencing delays in services. For example, our experience supporting Members with disabilities includes an understanding that ableism exists broadly across the service delivery system. Unintentionally, this may result in a lower quality of care. For example, a Member may have limited access due to the lack of ramps in buildings or failure to have available translation or accessible communication.

By leveraging advanced analytics, we identify trends and patterns that signal potential bias in service delivery. For example, we will track and report health outcomes by race, ethnicity, disability status, language, gender, geography, and SDOH; identify differences in utilization and results; monitor expected utilization and identify when services have not been received; and intervene through Provider education to increase awareness and Member outreach.

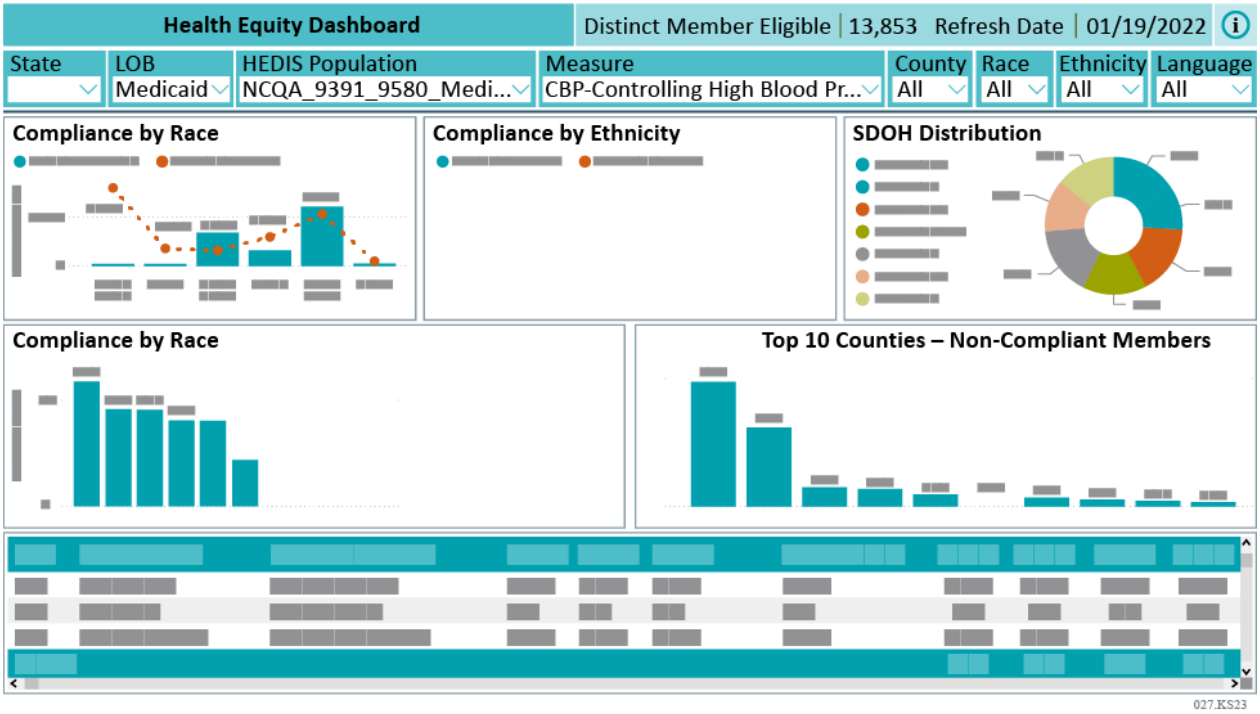
Molina's Health Equity Dashboard Tool for Monitoring Unintended Bias. Molina uses its integrated suite of performance dashboards and reports for tracking and monitoring UM and service delivery. Our Health Equity Director and Quality, Clinical, and Health Equity teams use tools like our Health Equity Dashboard to track performance over time and evaluate against our goals and prior-year performance. Tracked items include the utilization of physical health and behavioral health (BH) services at the State and county levels. The dashboard pulls data from our integrated Data Lake to deliver insights at the Member, Provider, and clinical program levels. It also benchmarks performance against standards such as HEDIS and State performance goals, while identifying Members for prioritized outreach. Our tool's filtering capability provides insights into health equity trends by filtering for important attributes—such as race, ethnicity, language spoken, gender, age, sexual orientation, population, disability status, SDOH, and other characteristics—to help us develop needed interventions.

Highlight of Success: Disparities Identified and Addressed by Our South Carolina Affiliate

Using data gathered from the Health Equity Dashboard, our South Carolina affiliate identified elevated preterm births among black Members. They implemented strategies that **reduced preterm births by 50%.** 080.d.ks23

Our Health Equity Dashboard **(Exhibit 11-1)** allows our teams to develop population health programs and strategies and assess, measure, and report on their success to reduce disparities and improve care outcomes and quality. This sample dashboard image from our affiliate plan reflects Members with high blood pressure and provides insights on the extent to which an SDOH impacts this population. In this instance, their dashboard relays that employment, health services, and food insecurity are the highest SDOH factors. This information allows our affiliate to develop targeted interventions to address these barriers and work toward good health outcomes.

Exhibit 11-1. Health Equity Dashboard. We developed our proprietary tool to implement interventions and monitor their impact in efforts to achieve health equity.



Using Stakeholder Feedback to Monitor Utilization Management and Service Delivery

Stakeholder feedback is integral to our monitoring approach, and consequently, we incorporated it into our Healthy Equity and Cultural Competency Plan. Because Member experience is a continuous process, we gather, analyze, and monitor feedback about UM and service delivery throughout the year. We listen to a variety of sources (including Members, Providers, and CBOs) to continuously assess trends and outcomes, and learn where health education is needed. We refine our approaches to ensure they remain equitable and culturally and linguistically appropriate. We also have processes to monitor and follow up on all complaints and grievances; all perceived or actual instances of discriminatory practices are swiftly and effectively addressed. We bring a summary of health equity activities to the Member Advisory Committee to gather feedback and input.

Member Satisfaction Surveys. Member satisfaction is the responsibility of every employee, Provider, and Subcontractor. Our Quality Committee monitors Member survey data at least annually—and grievances and appeals data quarterly—assigning corrective action plans when issues are identified. The Quality Committee monitors action plans for compliance and measures them against subsequent survey information to ensure improvement in identified measures. We use various survey methods to assess Members' experiences with care management services and to ensure Care Coordinators are providing unbiased, patient-centered care. For example, Care Coordinators should help Members find services and information, listen to concerns, help with problems, and treat Members with respect. We share survey results with Provider and Member committees, engaging participants in discussion to ensure cultural competency.

Grievances and Appeals Data. Our integrated grievance and appeals platform supports the collection, storage, tracking, reporting, and analysis of—and access to—Member grievances and appeals data, maintaining a complete picture of the Member experience. Our Grievances and Appeals team monitors and reviews Member and Provider grievances and appeals data monthly, **using guidelines and benchmarks to look for biases and ensure that decisions are made fairly and equitably.** We monitor trends for the potential of inappropriate care or quality-of-care concerns. This monitoring may include examining the rate of successful appeals for Members of different demographic groups or analyzing the types of complaints that are being filed. We take steps to address any patterns of bias and ensure fair treatment. Our grievances and appeals procedures are transparent, accessible, and consistently applied to achieve these goals. Areas of concern are flagged for review and discussed with our Health Equity Director, Medical Director (Chief Medical Officer), BH-CMO, Dental Director, or Quality Management Director.

Call Center Oversight. The Member and Provider services call centers record and track all calls, to help identify unresolved or continued issues related to health disparities or bias. Call center representatives promptly document and report these issues to call center leadership through the Service Quality Assurance instant intervention process. Any identified deficiencies must be reviewed and corrected by the Call Center Leadership team within 24 hours. The Member services call center provides training to employees, empowering them to understand health equity's significance and how disparities impact health and wellness. This training focuses on recognizing and addressing a Member's experience of health inequity, specifically, the disparities experienced by Kansans. The training provided to employees will equip them with comprehensive tools, techniques, and resources aimed at fostering cultural competency and recognizing implicit biases that Members might encounter. The primary objective is to ensure that every interaction is sensitive to Members' diverse needs while proactively addressing any health inequities they may encounter.

Example of an Identified and Addressed Concern in a Similar Program

Success Improving Blood Pressure Control Among Black Members. Through regular HEDIS monitoring, our Ohio affiliate discovered that across measurement periods, black Members had controlled blood pressure rates 10%–30% lower than the overall membership. Our affiliate's Care Coordinators conducted an outreach campaign to black Members with high blood pressure. They completed a hypertension assessment, assessed and educated about medication use, scheduled PCP visits, and provided home blood pressure monitors. Members who received a monitor received in-home outreach from a Molina Community Health Worker (Molina CHW) to ensure they understood how to use it correctly and report readings to their doctor. The affiliate modified educational materials on how to check blood pressure at home and use the monitor based on Member feedback. Due to these interventions, **controlled blood pressure rates increased among black Members by 32.7%** (from 54.6%–72.5%) from 2018 to 2020. The affiliate surpassed their initial goal of 65.5%.

c. Example of a KanCare Health Disparity and the Anticipated Impact of Our Approach

Molina is dedicated to addressing the impact of diabetes in Kansas, considering the substantial costs highlighted by both the CDC and the American Diabetes Association®. In Kansas, we'll concentrate on the specific disparities evident among black and Latino Members, in both adults and children dealing with diabetes. Our commitment will help alleviate the significant burden on families, communities, and the economy, as well as the health implications.

Molina aims to blend ongoing support with innovative strategies, actively working alongside various stakeholders to address these pressing health concerns in Kansas. To address issues in Kansas regarding diabetes, smoking cessation, and nutrition, Molina plans to introduce innovative interventions that will complement and will not duplicate existing programs, [redacted]

Experience Improving Performance Measures

Our California affiliate identified a disparity among Latino Members in completing diabetic eye exams. The affiliate conducted a root-cause analysis and developed and implemented a call campaign. They also developed and implemented a targeted cultural competency training for Providers. Our affiliate saw a **55.5% increase to 61.1% between 2018 and 2020** in completion of diabetic eye exams for the target population.

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To address health disparities in Kansas, we will use data, such as prevalence, cost, utilization, trends, care coordination engagement, and the number of comorbidities across 70+ physical and BH conditions defined by CMS' Chronic Conditions Data Warehouse. We will stratify this data by race, ethnicity, age, and SDOH needs. We will also stratify data by Provider and geography, and we will collaborate with Providers and Members to identify root causes of disparities (e.g., access, language, and cultural competency barriers) to develop targeted solutions across the spectrum of the condition. These solutions include prevention (e.g., regarding prediabetes) and disease management to eliminate or slow disease progression and its sequelae. We will implement stratified care coordination interventions, with a focus on outreach and engagement of identified Members, tailoring our approach based on risk levels. Individuals classified as high risk will receive personalized attention, while those at lower risk levels will benefit from more interactive support. This interactive support includes nutritionist consultations, customized meal options, promotions for physical activity through apps, group support, and access to health club memberships.

[redacted]

Molina will measure success in reducing disparities for black and Latino Members with diabetes by using the HEDIS measures for HbA1c control <8 and eye exams. We expect to reduce disparities for these two measures for black and Latino Members with diabetes (compared to the white population) by 2%–5% after the baseline measurement year (Contract Year 1). If we meet this goal earlier, we will readjust this evaluation criteria.

Utilization Management and Services (Tab 7d)

MOLINA HEALTHCARE

4.3.I.12 Ensuring Appropriate Utilization of Services While Reducing Provider Administrative Burdens

12. Describe the bidder's strategies and approaches to ensuring appropriate utilization of services while reducing Provider administrative burdens.

Molina's comprehensive integrated utilization management (UM) program that we will bring to the KanCare program encompasses all covered services and care settings and fully complies with NCQA accreditation requirements, health equity standards, and Federal and State laws and regulations. Our UM program is flexible and adaptable to meet the State's standards and goals and comply with RFP § 7.8, Utilization Management.

Under the direct oversight of our Kansas Health Services Director with complete oversight by our Chief Medical Officer (CMO), Molina's UM program for the KanCare program builds on our successful national experience.

Our affiliates operate Medicaid health plans in 18 states and complete nearly **1.5 million UM reviews annually** through the use of well-trained staff, transparent UM processes, easy-to-use Provider tools and resources, effective Provider education, and evidence-based criteria and guidelines.

Our UM Program Approach for KanCare

We've taken the best practices and innovative strategies from our affiliated Medicaid health plans' UM programs and adapted them to meet the specific needs of KanCare Providers and the State's vision and goals.

Demonstrating Congruence with KanCare's Vision and Goals
From application of evidence-based practices to reducing Provider administrative burden, **our UM approach aligns with the State's vision and goals.**
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For example, we heard from Providers in Kansas that they desire open and transparent communications with MCOs that we address through our Provider portal, user-friendly tools, and collaborative approach to authorization requests.

Central to our approach is **providing Members with timely access to quality, cost-effective, and medically appropriate care while reducing Provider administrative burden**. Our comprehensive, data-driven UM program encompasses the spectrum of authorization types, including necessary acute services, services identified through service coordination, and concurrent inpatient reviews.

As UM is essential to helping Members receive the most appropriate level of services and ensuring the long-term sustainability of the KanCare program, we ensure resources are spent on the most clinically appropriate, cost-effective services.

We balance our role as a steward of taxpayer dollars with our responsibility to promote high-quality care. Guided by a written UM program description that includes the requirements contained in RFP § 7.8.1.A, our **UM approach aligns with and supports key State goals**, including:

Delivering integrated healthcare. We go beyond traditional UM and integrate with our quality, care coordination, and population health strategies, looking holistically across functional areas, the full range of Member needs, and the system of care to promote and ensure timely access to appropriate services.

This approach includes **weekly integrated clinical rounds** by our physical health, behavioral health (BH), and LTSS Medical Directors, Pharmaceutical Director, and Care Coordination and UM leadership for Members with complex needs, high utilization, or significant SDOH needs. Our systems are fully integrated, and **we provide BH and pharmacy UM in-house**, streamlining decision-making, reducing Provider administrative burden, and setting Molina apart from MCOs that use a third-party or affiliate to perform BH services.

Providing whole-person healthcare. Taking the next step when a request doesn't meet criteria to proactively determine what the Member needs is key to helping them achieve optimal health and wellness. For example, one of our Medicaid affiliates approved incontinence wash and wipes that weren't a covered benefit in the state for an adult Member who had developmental delays and suffered from intractable seizures—demonstrating a commitment to doing the right thing for Members.

Applying evidence-based practices. Evidence-based medical necessity and appropriateness criteria and guidelines, including MCG care guidelines (with prior written approval by the State) for physical health and mental health, ASAM Criteria® for SUD services, and Kansas' medical necessity and appropriateness criteria for pharmaceuticals will guide our UM decision- making.

Addressing SDOH. We consider how SDOH impacts Member health and well-being. Our Clinical Reviewers are trained to recognize Member SDOH needs and refer them for care coordination, as appropriate. For example, we will coordinate a hotel stay for an unhoused Member requiring post-discharge care or a pregnant Member who lives in an area without appropriate Providers and has to travel for outpatient monitoring for a high-risk condition.

Reducing health disparities. Applying advanced analytics and data from our Health Equity Dashboard, we evaluate utilization and other data to identify disparities by race, ethnicity, disability, age, and other factors. We then use findings as a springboard for action. For example, our South Carolina affiliate used UM data from the Health Equity Dashboard to identify elevated preterm births among black Members and implemented strategies that reduced preterm births within this Member cohort by 50%.

Educating, engaging, and empowering Members. We authorize appropriate and necessary HCBS services while promoting services that increase Member self-management and encourage empowerment. For example, we may approve hours for an attendant care worker to engage with a Member in a community activity, such as attending a Wichita Wind Surge baseball game with the Member who needs personal care assistance at the game, to address the Member's functional needs and promote community access.

Improving the Provider experience. We collaborate with Providers to streamline our UM processes and make it easy to deliver timely, appropriate care. For example, Providers can use

our online peer-to-peer platform to schedule a consultation at a time that best meets their schedule.

We also include network Providers in our UM Committee and incorporate Provider satisfaction as a key metric in our annual UM program evaluation. In our Kentucky affiliate's most recent Provider satisfaction survey, 81% of respondents stated the rate of procedures for obtaining pre-certification/referral/authorization information was well above or somewhat above average.

Increasing efficiency and reducing Provider administrative burden. Using our HIPAA-compliant, web-based Provider portal, Providers can submit prior authorization (PA) requests electronically and receive an expedited, often immediate response with our automated check of UM criteria; upload supporting documentation; track and check the status of requests; view determinations; and receive authorizations, reducing the time and cost inherent in fax and telephone interactions.

We will continue our work to standardize and streamline UM processes, including forms, to improve efficiency and reduce Provider burden through a range of activities including collaborating with other KanCare MCOs, the State, and Providers.

Through rigorous ongoing monitoring activities, we also validate that our UM policies, medical necessity criteria, and Provider network participation, reimbursement policies, and adequacy standards comply with MHPAEA.

Strategies to Ensure Timely, Appropriate, and Consistent UM Decision-making

Our board-certified, licensed, and Kansas-based CMO will collaborate with our LTSS Clinical Officer/Medical Director, BH Medical Officer/Medical Director, and Pharmaceutical Director in the development and implementation of our UM policies and procedures and their compliance with State and Federal requirements.

Our Kansas-based clinical leadership will play a vital role in this process, ensuring that Molina does not arbitrarily deny or reduce in amount, duration, or scope of a required service solely for cost savings or because of the diagnosis, type of illness, or condition, in compliance with State, Federal, and NCQA requirements.

We do not structure compensation to our UM staff so as to provide incentives for them to deny, limit, or discontinue medically necessary services or services for an assessed need to any Member. We **assign UM Clinical Reviewers to specific facilities** to provide a consistent point of contact and regular collaboration on UM-related concerns.

Reducing Provider Burden
We employ a range of activities to minimize Provider administrative burden, including:

- Soliciting **Provider feedback** through vehicles such as our Provider Advisory Committee, Provider Representatives, and Joint Operating Committee meetings
- Providing **in-house BH and pharmacy decision-making** for PA requests
- Offering Providers an **online platform to schedule a peer-to-peer consultation** at a time that best meets their schedule
- Allowing Providers to **electronically submit PA requests** through our Provider portal
- Offering Providers access to our **Criteria Transparency tool** to boost approval of PA requests
- Providing expedited response to requests through our **AutoAuth** process

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Supporting Members Who Have Extraordinary Service Needs

Our processes will ensure timely and appropriate extraordinary funding decisions, payment, and reporting to support Members with IDD who have extraordinary service needs. We'll engage our Provider Advisory Committee and our IDD Provider Advisory Group who serve adults with IDD to fully understand their concerns and to solicit feedback on our policies and procedures so they reflect the needs of Providers and support the health and well-being of the covered population.

Our solutions will include **reducing the frequency with which Providers must submit PA requests and extending authorization periods**. Molina will also collaborate with our state partners, other MCOs, and Providers to identify opportunities to streamline this process to ensure Providers are well-informed of the required documentation needed for these requests and that concerns we have heard in the market, including change of documentation requirements or medical records, are not inhibiting this process.

Delivering Timely Authorizations

Timely response to PA requests expedites Member access to care and drive Provider satisfaction. Molina's UM leadership will monitor our performance in real time relative to the State's timeliness expectations and Contract requirements, tracking requests to quickly identify any potential delays in the end-to-end workflow. They will monitor turnaround times and productivity for each Clinical Reviewer to identify and address emerging trends that could adversely affect turnround times.

Our systems are configured to comply with all CMS rules on timeliness, including authorization of hospital observation stays, and we will continue to adhere to all CMS rules.

Ensuring Appropriate Care and Services

Our UM staff apply evidence-based criteria and guidelines to confirm appropriate care and services for Members. In the absence of State Medicaid medical necessity and appropriateness criteria and with written approval from the State, Molina will apply MCG care guidelines for physical health and mental health.

We will use ASAM criteria for inpatient and outpatient SUD treatment and Kansas' medical necessity and appropriateness criteria for pharmaceuticals to make objective determinations about medical necessity and the appropriateness of covered services. Criteria are based on current evidence in widely used treatment guidelines or clinical literature. We **review clinical criteria at least annually** to ensure they are accurate, up-to-date, evidence-based, and peer-reviewed.

Molina's Medical Directors conduct peer-to-peer consults with Providers, as indicated, to ensure we consider the Member's circumstances and all available clinical data in the decision-making process. During these consultations, Medical Directors review clinical criteria, diagnoses, and preliminary decision rationale to help Providers identify next steps.

Providers can also call our UM team to schedule a peer-to-peer consultation or use our **online peer-to-peer platform to schedule one at a time that best meets their schedule**.

Because the platform supports secure data sharing, Providers can participate in the consultation through the platform where our Medical Director will share a clinical profile of the Member that includes all of the data we will use to make the service decision, **providing a transparent and collaborative environment with the Provider**. We will offer a peer-to-peer consultation within a mutually agreed-upon time within 24 hours of a Provider's request for a peer-to-peer consultation.

We make every effort to obtain all necessary clinical information and **leverage EHR connectivity to engage and gather the supporting clinical information** for PA requests from Providers, streamlining the UM process. When information is missing, we contact Providers to obtain the supporting details rather than issue a denial.

Molina **makes medical necessity decisions only after we receive adequate supporting clinical documentation**. In all situations, whether a requested service is approved or denied, we focus on connecting Members to the right services to achieve optimal health and wellness.

Any decision to deny a PA request or to authorize a service in an amount, duration, or scope that is less than requested, will be made by a Kansas-licensed physician or pharmacist who has appropriate expertise in addressing the Member's physical health, BH, or LTSS needs.

Applying Consistent Decision-making

Molina develops and trains experienced UM staff with appropriate clinical experience and expertise to interpret and apply Molina's policies and UM criteria and practice guidelines to authorization requests.

We ensure consistent application of review criteria for authorization decisions, compatible with Member needs, through continuous auditing of staff and **quarterly inter-rater reliability reviews**.

Our monthly auditing procedures and annual inter-rater reliability assessment is based on industry standards and best practices to ensure uniform application of criteria to the Member's specific needs. UM staff, including Medical Directors, must pass a 90% threshold for annual inter-rater reliability assessments.

We provide additional training to any staff who do not achieve the target until performance competency is established. The 2023 inter-rater reliability review evaluated 208 Medical Directors and 806 Clinical Reviewers who achieved an **average inter-rater reliability score of 99%**.

Providing Integrated Services

Our UM staff, processes, and systems are not just aligned but truly integrated with every functional area across Molina—integration occurs among staff, processes, and systems. For example, UM staff work with Care Coordinators for all Members receiving HCBS and living in nursing facilities.

Molina operates as a **single, integrated clinical system**—our data, processes, workflow, staff, and systems operate as one. This single system combines all services (physical health, BH, dental, vision, and pharmacy) across all functions (UM, claims, call center, and care coordination), ensuring a collaborative approach that addresses Members' holistic needs.

Integrated Technology Drives Quality and Efficiency
Our UM platform will leverage the technical ability to **directly integrate with Kansas Provider EHRs and KHIN**, the State HIE. Our experience indicates this technology reduces Provider burden by removing the extra step of submitting additional clinical documentation and expedites the review process.
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Each Member record is one record, housed in one documentation system. The system supports **both automated and manual authorization determinations and responses**.

Our Medicaid health plan affiliates have established direct connections with 20 state HIEs along with 3 national ADT vendors that cover close to 95% of our affiliates' membership across the country. This enhanced level of communication helps reduce hospital readmissions, facilitate smooth post-discharge transitions, and improve Provider-to-Provider communication.

Streamlining Processes and Activities

Streamlining processes and driving efficiency, **authorizations automatically connect to our claims processing system,** where they are used as one of the components reviewed in our claims adjudication process to verify the validity of all claims submitted and ensure consistent and timely Provider payment.

[redacted]

Molina also takes measures to ensure our processes do not place unnecessary burdens on Providers, and we offer various tools and resources to enhance their experience. For example, we have an "incomplete authorization" process that gives Providers additional time to submit the necessary documentation to substantiate a request for service.

We will work with other MCOs, the State, and Providers to develop a standardized PA form/submission elements for PA requests that we will implement no later than the beginning of the second Contract year. Approximately **25% of our affiliates nationwide use standardized PA forms**. We will draw upon their best practices and lessons learned to deliver a streamlined, standardized solution for KanCare.

We reduce Provider burden for pharmacy PA reviews by streamlining activities because we perform BH and pharmacy PA in-house and we have a high level of data integration. For example, **pharmacy PA reviews are completed using the clinical information available in our system,** eliminating the need for Providers to submit a PA request or additional clinical documentation.

Reducing Provider Burden and Fostering Transparency
Molina's online PA look-up tool **improves transparency and efficiency, and eases Provider administrative burden**. Providers can quickly query if a procedure requires PA, verify that it is a covered benefit, and review required supporting clinical information.
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Our AutoAuth tool uses available clinical documentation to determine medical necessity without additional intervention by the Provider or reviewer. It applies Member information from eligibility, claims, and/or medical records to **automatically pre-qualify a Member for authorization** through automatic coding. If the data elements do not meet the pre-specified criteria, we conduct a manual clinical review.

Molina's Provider Portal

Providers can **easily submit PA requests and appeals through our HIPAA-compliant, web-based Availity® Provider portal 24/7/365 and view the status of the request in real time**, reducing burden. We also recognize that not all Providers are ready for portal-based processes, so we accept these communications in other ways, including our toll-free fax line.

Provider Experience

Providers can access our **PA look-up tool**, empowering them to quickly determine what services require PA and facilitating timeliness. Our Provider portal accepts specific procedure and diagnosis codes to be authorized through an **AutoAuth-expedited workflow for more timely approvals**.

The system automatically performs the clinical review for the requested procedure and approves authorizations that meet clinical criteria. If a PA submission meets criteria, the **Provider receives immediate notification of approval**—there is no waiting period; if the request does not meet criteria, it is automatically routed for nurse review. For authorization requests that do not meet criteria, an automated process transmits them, along with supporting documentation, for review and faster decision-making.

[redacted]

Employing Tools to Expedite Reviews and Reduce Burden

Reducing Provider burden, we offer Providers access to our **Clinical Transparency tool, a trusted, evidence-based, physician-authored clinical decision support tool** that promotes service request approvals and submission of appropriate clinical documentation.

Providers use the tool to view condition-specific clinical practice recommendations, including the use of conservative treatments. Providers also use the Clinical Transparency tool to identify the supporting clinical information that is necessary for authorization.

Demonstrating Timely Reviews
We bring a track record of quick responses to PA requests. For example, our:

- Mississippi affiliate's turnaround time for standard requests averaged 1.4 days in the most recent 12 months
- Ohio affiliate's average turnaround time for expedited requests was 1 day in the most recent 12 months
- Virginia affiliate has met turnaround times for 99.92% of all pharmacy requests, with a final approval or denial decision made within 24 hours of receipt for 85% of all requests since January 2022

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Molina offers Providers easy and flexible access to the clinical criteria our UM staff use when determining medical necessity. These criteria include **MCG Cite for Guideline Transparency,** which operates as a secure extension of our existing Provider portal and offers transparency for care delivery, including access to MCG clinical evidence that Molina uses to support Member care decisions.

Streamlining Authorization of LTSS Services and Addressing HCBS Waiver Populations

Care Coordination

Molina has a tightly managed process for authorizing LTSS services that ensures continuity of care and stability for Members and Providers. Our **Care Coordinators are empowered to authorize services to ensure initiation of needed services, including HCBS, and remove unnecessary delays and duplication**.

Our interoperable UM and care coordination systems allow Care Coordinators to complete assessments on a tablet while in the home or community setting with the Member. During the

person-centered planning process, Care Coordinators document the Member's formal and informal services and supports and ensure there is no duplication of service across payers or community-based organizations (CBOs).

We **automatically authorize needed LTSS services based on the Member's PCSP** to ensure we connect the Member with services as quickly as possible. Services are only modified when there is a change in condition or a need for additional support, which is identified and discussed with the Member, interdisciplinary team, and Provider during the reassessment and PCSP update processes.

Care Coordinators **facilitate the authorization process for Providers** by ensuring they are submitting their service requests timely and providing additional clinical information, if needed. Care Coordinators also understand coordination of benefits, such as with Medicare and between State Plan and waiver benefits, and assist Providers with authorization requests to the appropriate source.

Additionally, our process is designed to meet Members' needs and deliver services and supports in accordance with their preferences. We take into consideration the whole person when working with Members during service planning and consider whether the denial of equipment, supplies, or services would inhibit their community access or the progression of their PCSP to ensure they receive authorized services.

Timely HCBS Initial Authorization Decisions
Our process **automatically authorizes** necessary LTSS services based on the Member's signed PCSP. **Providers are immediately notified** of the decision through our Provider portal, allowing Molina to easily meet the Contract requirement to notify Providers at least 14 business days prior to the first date of service delivery. 050.f.ks23

Care Coordinators will complete the PCSP and HCBS Needs Assessment within 14 calendar days of the establishment of HCBS Waiver eligibility. To ensure Members who are enrolled in an HCBS Waiver receive services according to their PCSP, our UM and Quality teams will review active HCBS authorization data and compare it to our utilization, claims, and encounter data to identify Members who have an authorization without a claim to confirm they received the service.

Our Care Coordinator will reach out to the Member and verify that services and supports have started as planned and that the Member is satisfied, and address any barriers to facilitate access to HCBS.

DME, Assistive Services, and Home Modifications

Integrated Whole-person Care

Molina looks forward to collaborating with other KanCare MCOs, the State, Providers [redacted] and Members to standardize, streamline, and increase transparency for the process of accessing DME, assistive services, and home modifications. We'll bring best practices and lessons learned from our affiliates to develop clear, standardized, and streamlined processes and forms, and provide clear and consistent information to Providers and Members.

Molina employs various activities to ensure Members have timely access to DME, assistive services, and home modifications while minimizing administrative burden for both Members and Providers.

Our **Care Coordinators work one-on-one with Members to navigate the process for obtaining services**, including in lieu of services that do not require PA. When PA is required, our UM staff apply evidence-based criteria and guidelines to confirm appropriateness of services.

To guide decision-making, we share available criteria, such as the MCG Ambulatory Care guidelines, with Providers and Members (upon request) to ensure transparency. We also engage Periscope, whose physical and occupational therapists perform **in-home assessments** to support authorization of DME, assistive services, and home modifications for Members with complex needs, such as a non-standard power wheelchair. To ensure appropriateness and cost efficiency of home modifications, we require multiple bids and homeowner approval for authorization.

Identifying Services for PA and Providers That No Longer Require PA

Our Kansas-based UM Committee will meet quarterly to **monitor the ongoing effectiveness of our PA requirements to ensure they are being appropriately employed**. Annually, the committee will review procedures that have been eliminated from the national code set and removed from the PA list, and evaluate new codes for effectiveness, potential for abuse, and expected utilization.

Waiving Requirements Based on Data-driven Analysis

During their regular review of dental services requiring PA, our Massachusetts affiliate noted that more than 20% of the codes were approved 100% of the time upon review. Our affiliate implemented an initiative to improve Provider satisfaction and **reduced pre-payment review requirements** for 46 CDT codes.

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This comprehensive analysis of utilization appropriateness, the overall number of PA requests, and the rates of approval and denial based on medical necessity criteria is done to identify services, procedures, surgeries, devices, supplies, or drugs that have the potential for overutilization or are high-cost/high-risk treatments.

We look for trends indicating an opportunity for improvement, including PA requirements that receive almost 100% approvals, may be creating an unnecessary barrier to care, are not effective or valuable in managing utilization, and may have a real risk of causing significant Member harm if not medically necessary.

For example, our Texas affiliate's data analysis indicated a high approval rate for continuous glucose monitoring supplies after medical necessity was met for the initial continuous glucose monitor. Consequently, our affiliate removed the PA requirement to eliminate any barriers to the Member receiving monthly supplies to monitor their blood sugar levels.

We will also waive PA requirements for Providers that have demonstrated **high reliability practices**, such as meeting Molina's defined thresholds for PA approval rates or by utilizing a clinical decision support functionality that has rendered the use of PA as a management tool unnecessary. One way we identify these Providers is by **employing machine learning algorithms** to identify Providers who consistently make proper utilization control decisions using Molina's Provider portal.

Including Provider Feedback and Involvement in UM and Services Requiring PA

We use ongoing formal and informal Provider interactions to inform PA requirements. Practicing clinicians with active licensures, including board certifications, are involved in the development and adoption of criteria specific to their area of expertise. Our Kansas-based Provider Advisory Committee will give us an opportunity to request input and listen to a diverse group of Providers.

At least once a year, we will **proactively solicit feedback from Providers** that participate in our Provider Advisory Committee and collaborate on strategies to optimize and improve Member care, including elimination or addition of PA requirements.

We will also engage our Pharmaceutical, LTSS, and BH Provider Representatives for insight and feedback on Provider views and concerns related to PAs.

We also review feedback received during regularly scheduled Joint Operating Committee meetings with health systems and large Provider groups where we discuss elements of proper UM, including topics such as utilization trends and care gap reports.

Other sources for feedback include Provider satisfaction survey results, insight from Provider Representative contacts with network Providers, Providers participating in our Quality Committee, Provider association meetings that our Chief Executive Officer, CMO, and Provider Relations Director will attend, appeals data analyses, and PA clinical discussions with requesting Providers.

We will use this compiled feedback to adapt or modify our policies and procedures to improve program performance and mitigate Provider concerns and/or burden.

Delivering Live Support to Providers

Along with our **Provider services call center that will be available from 7:00 a.m. to 6:00 p.m. Central Time, exceeding Contract requirements**, Molina will have UM Helpline staff available after-hours and on weekends to discuss post-stabilization authorizations with live UM clinicians who can provide immediate authorizations (s).

UM Helpline staff will be well-versed on KanCare program requirements. Staff will provide the appropriate level of service to resolve service requests promptly and appropriately. For example, when emergency department (ED) Providers want to admit a Member into the hospital, they can contact Molina to discuss relevant clinical information and service authorization. In addition to our UM Helpline,

Promptly Responding to Provider Calls

In the most recent quarter (July through September 2023), our UM Helpline's performance included:

- Average speed of answer: **7 seconds**
- Abandonment rate: **0.37%**
- Calls answered within 30 seconds: **96%**

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Providers can submit PA requests and view the status of the request 24/7/365 through our Provider portal or send an email to our escalation resolution box and receive a response from the UM team or Provider Relations team within one business day.

Retrospective Activities to Ensure Appropriate Utilization

Molina's KanCare UM program will have policies, procedures, and systems in place to evaluate efficiency and appropriateness of service delivery and to identify instances of over- and underutilization of healthcare services, aberrant Provider practice patterns (especially related to ED, inpatient services, and drug utilization), and critical quality-of-care issues.

Molina's UM and Quality teams **monitor monthly, quarterly, and annual utilization trends through a variety of standard dashboards and reports**—they will report identified trends to Molina's Kansas-based Quality Committee for development of potential improvement programs and interventions.

Identifying Over- and Underutilization of Healthcare Services

Our UM and Quality staff conduct **periodic analyses of utilization data in comparison to established thresholds,** such as HEDIS® and unplanned readmissions, to identify over- or underutilization, which includes, for example, analysis of ED utilization. We identify Members who are high utilizers of EDs and reach out to them to offer our ED Diversion program or care coordination services to help them stabilize, prevent emergent problems, and receive care in a more appropriate setting.

Our UM and Quality teams also review active authorization data for Members receiving HCBS and compare it to our utilization, claims, and encounter data to identify over- and underutilization. Molina's UM, Quality Management, and Provider Network teams meet monthly to share pertinent findings using utilization reports and EVV Aggregator data to determine the root cause and develop remediation strategies.

Once we identify and confirm instances of over- and underutilization, we deploy a range of specialized activities and interventions, such as Provider education or Care Coordinator outreach to assess changes in the Member's level of need or a deep dive into factors that relate to underutilization, such as dissatisfaction with a Provider or potential abuse, neglect, and exploitation concerns.

We also monitor pharmacy data to identify improvement opportunities. Our CMO, BH Medical Director, Care Coordinators, and Pharmacy staff also review records of child Members with three or more BH medications prescribed (e.g., antidepressants, antipsychotics) and recommend interventions.

We reach out to the prescriber and discuss findings and remediation. During this engagement, we solicit input on ways to improve our processes to better reflect Provider practice patterns and factors, such as housing instability, which may have led the Member to use different pharmacies.

Improving Appropriate Utilization and Decreasing Costs
Preliminary 6-month outcomes of our affiliate's DUR initiative on children's BH polypharmacy include decreases of 31% in total medical cost, 48% in ED visits, 58% in inpatient visits, and 30% in pharmacy costs.
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For instance, to reduce psychotropic polypharmacy in children and ensure safe, evidence-based, trauma-informed treatment, we monitor concomitant and increased psychotropic prescribing, particularly for youth in foster care. **We flag excessive doses and prescriptions for targeted Member and prescriber outreach and develop individualized action plans**.

ED Protocol and Emergency and Post-stabilization Services

Based on **nationally recognized evidence-based guidelines,** Molina's ED Diversion program aims to reduce unnecessary ED visits and promote integrated services. The program assesses Member physical health, BH, and SDOH needs and responds with individualized Member Plans of Service, completed within one day of assessment, which address their needs and assure integrated services for their BH and physical health needs.

When a Member is identified as an overutilizer of ED services and contact is made, a Care Coordinator will conduct an ED diversion assessment to determine if the Member is an appropriate candidate for ED diversion. Upon confirmation, the Care Coordinator will identify the reason for ED use; assess the Member's health status, health behaviors, and social support system; and identify goals that drive their Plan of Service.

Members can also decline participation in the program. Members are supported by an interdisciplinary team that includes Molina Medical Directors, registered nurses, licensed vocational nurses, licensed clinical social workers, BH professionals, Peer Specialists, and Molina Community Health Workers, as well as non-clinical support staff such as our Employment Services and Support Coordinator and Housing Services and Supports Specialist.

Promptly Responding to Provider Calls
Our Texas affiliate saw a **21% reduction in ED utilization** for their CHIP Members within 6 months of their enrollment in the ED Diversion program between 2019 and 2022. During this same time frame, ED utilization decreased by 14% for their STAR (Medicaid) Members enrolled in the program.
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Once enrolled in our ED Diversion program, our Care Coordinators further educate and support Members to increase their health literacy and connect them to appropriate resources, including our 24/7/365 Nurse Advice Line, Member Crisis Line, telehealth services, urgent care, and retail clinic options.

[redacted]

Molina will not deny payment for treatment obtained when a Member has an emergency medical condition, and we will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. We will comply with all of the provisions contained in RFP § 7.8.3.2, Emergency and Post-Stabilization Services.

Administrative Lock-in

We will leverage the experience of our 18 affiliated Medicaid health plans that operate lock-in programs, including 13 that have multiple lock-in types, such as prescriber, pharmacy, and ED. A key differentiator in our approach, and best practice of our affiliates, is that our **Lock-in program is part of our Care Coordination program**, not solely a claims edit.

This approach reflects how we weave together the benefits of care coordination, which directly impacts healthy behaviors and lifestyles while reducing inappropriate utilization, with service restrictions for Members with extreme needs.

When we identify a Member who appears to meet one of the situations for administrative lock-in noted in RFP § 7.8.3.3, we will evaluate claims, medical information, assessment results, Member conduct, and other applicable information to gain a better understanding of the situation. We will also confer with individuals who can provide additional insight, such as a treating Provider or Molina staff member.

We focus on **addressing the Member's behavior to avoid placing them in administrative lock-in** using person-centered principles, recognizing the daily challenges Members face, and understanding their unique health circumstances. All information, including attempts to educate and change the Member's behavior, will be documented in the Member's record, the interdisciplinary team worksheet, and progress notes.

If Member education is inappropriate or ineffective in addressing the Member's behavior, our Care Coordinator will ensure a physician, pharmacist, or nurse confirms the appropriateness of the Member's enrollment in administrative lock-in.

If the interdisciplinary team sees signs of potential fraud, waste, or abuse, the Care Coordinator will refer the case to our Kansas-based Program Integrity Manager for review. Our lock-in system is consistent with State and Federal regulations, and we will notify Members via certified mail of their opportunity for a State Fair Hearing before placement in lock-in as well as their right to appeal placement.

UM Program Evaluation

To keep our UM program current and appropriate, Molina will **monitor and evaluate the appropriateness of care and services on an ongoing basis.** Following approval by our UM and Quality Committees, our Compliance Officer will submit our UM plan and evaluation results at least annually to the State. As we discussed under the subheading, Identifying Over- and Underutilization of Healthcare Services," our UM and Quality staff conduct periodic analyses of health plan data compared to established thresholds to identify over- or underutilization.

Under the subheading, "Identifying Services for PA and Providers No Longer Requiring Review for Medical Necessity," we discussed how our Kansas-based UM Committee meets quarterly and monitors the ongoing effectiveness of our PA requirements. We will include the rationale and evidence to support Molina's decision to apply PA to certain services in our KanCare UM program evaluation.

Molina maintains clear procedures for monitoring for and demonstrating MHPAEA compliance, including procedures to monitor for and ensure parity in the application of QTLs and NQTLs for physical health and BH services.

We will **conduct a thorough parity analysis any time there is a change to the mental health and SUD benefits offered in the KanCare program,** and we will include an analysis validating compliance with MHPAEA in our UM program evaluation.

4.3.I.13 Mental Health Parity and Addiction Equity Act (MHPAEA)

13. Describe the bidder's approach to developing and monitoring its Utilization Management program, in writing (e.g., policy, guidelines) and in operation, to ensure compliance with Mental Health Parity and Addiction Equity Act (MHPAEA).

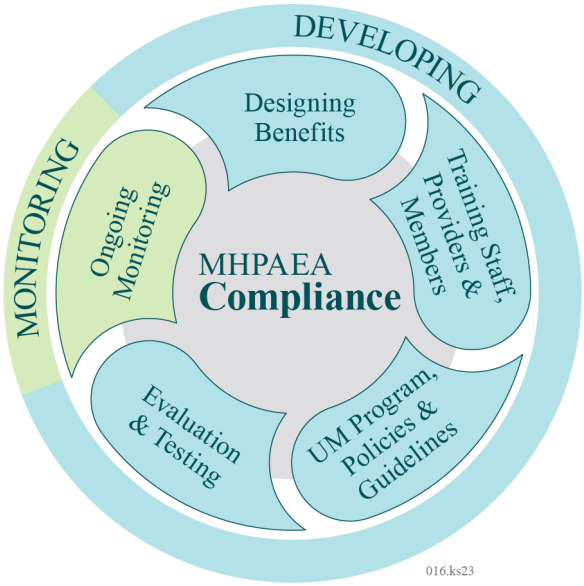
Molina's approach to developing and monitoring our utilization management (UM) program to ensure compliance with MHPAEA draws upon the experience and best practices of our 18 affiliated Medicaid health plans and solid record of ensuring behavioral health (BH) services are provided in the same equitable manner as physical health services. Our affiliated Medicaid health plans have **never been cited for imposing more stringent financial requirements and treatment limitations on mental health/SUD benefits than on medical/surgical benefits.**

We will continue to comply with all Federal laws, rules, and regulations for parity, including 42 CFR part 438, subpart K. Molina will also provide documentation and reporting to establish and demonstrate compliance with 42 CFR Part 438, Subpart K in a format and frequency as specified by the State. We have carefully reviewed RFP § 7.1.6, Mental Health Parity and Addiction Equity Act, and can confirm we have the policies, processes, tools, and guidelines in place to comply fully in our role as a KanCare MCO.

Our operational model is in place and includes a cross-functional BH team that ensures MHPAEA compliance by:

- Reviewing benefit coverage at least two times per month or more often when there are significant material changes to the benefit structure
- Conducting quarterly reviews of all benefit updates impacting service coverage and determinations
- Performing an annual internal review that uses the identified factors in the most recent version of the US Department of Labor's Self-Compliance Tool

Exhibit 13-1 Developing and Monitoring MHPAEA. We use a range of activities to ensure MHPAEA compliance.



This process includes confirming Molina's processes, strategies, evidentiary standards, and other factors in determining access to nonparticipating Providers for mental health and SUD benefits are comparable to and applied no more stringently than for nonparticipating Providers for medical/surgical benefits in the same classification.

We will also **conduct an annual review of our administrative, clinical, and UM practices** to assess their compliance with the MHPAEA under the KanCare Contract.

Using established written policies and procedures and in compliance with Contract requirements, we will ensure Members have equitable access to all benefits through rigorous development and monitoring activities (see **Exhibit 13-1)** that we describe in the remainder of this response.

Developing Molina's UM Program to Comply with MHPAEA

Written policies and procedures, guidelines, and tools guide the development of our UM and MHPAEA program activities for the KanCare program. All of Molina's UM and medical policy committees include BH Provider representation to ensure MHPAEA compliance and equitable access to services for Members. As part of this process, BH Providers give input on clinical policies, medical necessity criteria, and clinical criteria and guidelines before they are approved for use.

Developing a Compliant Program
Written policies, procedures, guidelines, and tools, such as our Mental Health Parity Checklist, direct Molina's operations to ensure parity. **We conduct a thorough parity analysis of mental health and SUD benefits any time there is a benefit change.**
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Molina operates our BH services internally and does not subcontract them out. This capability affords Molina an **increased level of accountability and transparency** that is not available to health plans that rely on BH Subcontractors or separate corporate entities.

Our approach to integrating BH services also gives us direct control over Provider training on covered benefits and prior authorization (PA) requirements and processes, and allows us to offer a broad network of BH Providers, which limits referrals to nonparticipating Providers.

[redacted]

Designing Benefits That Ensure Member Access to BH Services

Molina will provide mental health and SUD services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same benefit/service specified in the State's Medicaid Provider manuals and Contract.

Molina's Members will be able to access BH services from a network Provider **without having to get a referral**. To ensure timely Member access to BH services, **Molina does not require PA for most outpatient BH services**, including assessments and screenings, therapy, peer support, psychosocial evaluation, office-based opioid treatment services, emergency services, and treatment for a BH crisis. Moreover, in the spirit of true Provider collaboration and to ensure Member continuity of care, [redacted]

We will not impose quantitative treatment limitations (QTLs) or non-quantitative treatment limitations (NQTLs) on mental health and SUD benefits, such as visit limits or day limits, unless mandated by the State. **Molina does not limit payment for BH services** or apply lifetime payment limits or annual dollar obligations.

Training Molina Staff, Providers, and Members

We train Molina staff to remove barriers to care and facilitate integrated, whole-person care for Members, so they can access all the services they need to optimize health and wellness. Molina's key personnel for our KanCare program will undergo **annual parity training** to ensure they fully understand the law and the implications of unfairly limiting Members' access to necessary mental health or SUD services.

Because parity has local nuances, our Kansas-based BH Provider Representatives and BH Practice Optimization Team will provide additional staff training at the local level to ensure compliance.

Educating Providers on UM Criteria and Guidelines

We educate Providers on medical necessity criteria and how they can **easily submit PA requests and appeals through our HIPAA-compliant, web-based Availity® Provider portal 24/7/365** and view the status of the request in real time, reducing Provider burden. Providers can also access our **PA lookup tool**, empowering them to quickly determine what services require PA to facilitate timeliness.

Collaborating with BH Providers
Our specialized BH Practice Optimization Team will collaborate with Kansas BH Providers to support MHPAEA compliance and delivery system reform, monitor utilization trends, develop new clinical program interventions, bring clinical teams together to examine care coordination workflows, analyze and exchange population data, connect to evidence-based practices, and provide guidance for Molina's claims and operational systems.
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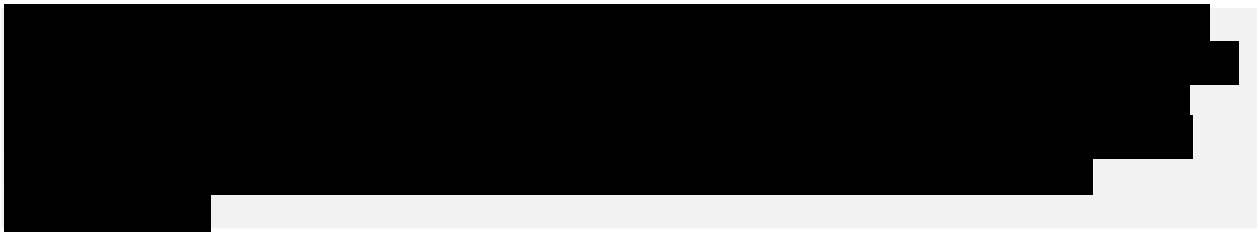
Clinical criteria are integrated in the portal and authorization engine to provide actionable intelligence to guide clinical decision-making at the time of PA submission, reducing the likelihood of denials. Providers can also request the UM clinician's PA documentation to review medical necessity determination elements.

Our **BH Toolkit**, available to all Providers, includes diagnostic criteria, clinical guidelines, screening tools, and links to additional clinical resources, including evidence-based practices.

For example, the clinical guidelines for Members with moderate risk of clinical depression that are included in the toolkit promote medication review, evaluation of social supports, referral to our Care Coordination team, referral to a Provider, assistance with locating a local Provider and scheduling an appointment, and coordination with the Provider.

Educating Members on Parity and How to Access BH Benefits

Educating, engaging, and empowering Members on their parity rights and timely access to BH services is key to ensuring parity. Trained in active listening and covered BH benefits (including value-added benefits and ILOS), our Member Services Call Center Representatives, Molina Community Health Workers, Community Health Resources (Molina CHW/CHRs), and Care Coordinators explain available BH treatment options to Members during their interactions. As appropriate, they refer Members to services and offer to arrange appointments.



Molina's KanCare Members will be able to access **value-added benefits that promote healthy behaviors, close gaps in care, and encourage them to play an active role in their own health and wellness**, including BH. For example, our Healthy Rewards program rewards Members for completing a follow-up visit with a BH Provider within seven days of an inpatient hospitalization for mental illness.

Elderly Members receiving LTSS will be able to receive a screening for depression, anxiety, and SDOH needs to address potential social isolation and connect with a support center representative over the phone.

We also educate Members on how to file a grievance or appeal, and we **routinely review Member grievances and appeals for trends that may suggest a MHPAEA compliance issue**. Our Kansas-based Grievances and Appeals team will flag areas of concern for review with our Chief Medical Officer (CMO) and BH-CMO in coordination with our Quality Committee.

Developing a Compliant UM Program in Policies, Guidelines, and Operations

MHPAEA is integrated into our UM program and operations. We understand PA requirements cannot be so restrictive that their application results in inappropriate denial, reduction, or termination of medically necessary services or used to strictly manage costs.

Molina reviews benefits that require PAs annually for cost, clinical efficacy, approval rate, and safety concerns to determine which benefits will continue to require authorization. We identify and address trends, as appropriate, that indicate an opportunity for improvement, including PA requirements that receive almost 100% approval.

Molina recognizes these types of PAs may be creating an unnecessary barrier to care, are not effective or valuable in managing utilization, and may have a risk of causing significant Member harm if not medically necessary, and as such, need to be continually monitored and adjusted to ensure better Member care and reduced Provider burden.

Clearly defined activities ensure our UM program, operations, and processes comply with MHPAEA, including:

- Applying evidence-based medical necessity and appropriateness criteria.
- Reviewing UM clinical criteria and guidelines at least annually to ensure they are accurate, up-to-date, evidence-based, and peer-reviewed.
- Conducting ongoing audits and annual inter-rater reliability testing to ensure consistent application of medical necessity criteria.
- Ensuring Members can access adequate, timely, and medically necessary covered services from a nonparticipating Provider if Molina's network is unable to provide adequate and timely services.
- Providing Member information on our medical necessity criteria, upon request and free of charge.
- Educating Providers on medical necessity criteria.
- Providing peer-to-peer consultations with a Provider who has expertise in treating the Member's condition and are in the same specialty/subspecialty as the requesting/ordering Provider. Providers can either call our UM Helpline or use our online peer-to-peer platform to schedule a consultation at a time that best meets their schedule.
- Including BH Providers in our Kansas-based Quality Committee that will provide input on our UM policies and procedures.
- Evaluating UM policies and procedures annually.
- Using a standardized format for PA requests for physical health and BH services.
- Monitoring UM denial rates for mental health and SUD services to make sure they do not exceed denial rates for physical health services across various levels of care.
- Monitoring utilization trends by level of care followed by a deep dive into diagnosis and Provider practice type.

All UM coverage determinations are made by Molina staff, which includes a dedicated team of psychiatrists, licensed professional counselors, registered nurses, licensed vocational nurses, and ABA Providers who have backgrounds in providing psychiatric care.

In making determinations for BH services, **we will apply evidence-based medical necessity and appropriateness criteria**, including MCG care guidelines (with prior approval by the State in writing) for mental health and ASAM Criteria® for SUD services. We ensure consistent application of review criteria for all authorization decisions, including BH, that are compatible with Member needs, through continuous auditing of staff and quarterly inter-rater reliability reviews.

Our monthly auditing procedures and annual inter-rater reliability assessment is based on industry standards and best practices to ensure uniform application of criteria to the Member's specific needs.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by an individual who has appropriate expertise in addressing the Member's medical, BH, or LTSS needs.

If a BH service is denied, we will send a Notice of Adverse Benefit Determination to the Member in accordance with Kansas statutes and Federal regulations. The written notice will

explain the reason for the determination and the Member's right to reasonable access to and copies of all documents, records, and other information relevant to the Adverse Benefit Determination, including the medical necessity criteria used.

Evaluation and Testing Activities to Ensure Parity

We evaluate and test mental health and SUD parity for all applicable medical/surgical, mental health, and SUD benefit allocations, including value-added benefits and ILOS.

We will conduct a **thorough parity analysis of BH benefits at least annually**, any time there is a change to the BH benefits we offer for the KanCare program, and upon request of the State. Our analysis will include a review of clinical, operational, and financial considerations.

We also use the Department of Labor's Self-Compliance Tool that integrates the most recent MHPAEA guidance and helps us evaluate potential parity concerns. It also provides a chart that serves as a framework for comparing reimbursement rates for certain mental health, SUD, and medical/surgical services based on CPT® codes.

Upon completion, our national BH team submits the tool and any associated documents to our parent company's BH Operations and Clinical Policy Oversight teams for review and identification of any potential concerns.

If any risk is detected, our BH team will work in collaboration with our Kansas-based team to revise policies, processes, or strategies to mitigate any potential issues. Our BH team evaluates the benefit following Department of Labor guidance to ensure benefit applications and administrations are equitable with those for medical/surgical benefits.

In addition to the Self-Compliance Tool, we employ other specialized tools and processes to evaluate and test compliance with the MHPAEA, as shown in the **Table 13-1**.

Table 13-1. Parity Compliance Tools

Specialized Tool/Process	Description
Parity Crosswalk	This internal crosswalk guides evaluation of assigned classifications using comparable methodology across both medical/surgical and BH benefits. The tool includes side-by-side comparisons between BH and medical/surgical benefits for PA/concurrent review requirements and processes and evidentiary standards (using level-of-care guidelines and clinical policy for reviews).
Parity Checklists	Our internally developed and maintained parity checklists provide a detailed, consistent approach that we will use to assess our compliance with MHPAEA and identify areas to strengthen compliance for our KanCare program. The checklists offer line-item assessment of QTLs for each level of benefit classification and NQTLs relating to medical management and network standards for BH and medical/surgical benefits.
Parity Decision Language Tool	We use this specialized tool to confirm parity and remove any language on fail-first requirements or limits that are more stringent than those for physical health.
Data-driven Tools	We conduct means testing of variance and standard deviations of NQTLs applied to both medical/surgical and BH benefits.

Ongoing Monitoring of Our Program to Ensure Continued Compliance

Our national BH team provides oversight to ensure MHPAEA compliance, which involves a wide range of monitoring activities that include reviewing:

- Molina's UM program
- Physical health and BH policies
- Benefits configuration
- Claims data
- Grievances and appeals data
- Medical necessity criteria and guidelines
- Physical health and BH network adequacy
- Percentage of nonparticipating Provider BH claims
- Reimbursement rates and policies

The BH team also **monitors benefit updates/potential changes biweekly** to ensure they have no impact on parity.

We have been enhancing our monitoring capabilities of NQTLs through a **new MHPAEA Dashboard that will align with updated Federal mental health parity regulations**. Currently under development with implementation planned before the Contract effective date, the MHPAEA Dashboard will include key elements such as authorization decisioning, network credentialing, and Provider reimbursement for both medical/surgical and BH benefits. Our BH team and Kansas-based Compliance Officer, BH Medical Directors, and BH leadership will use this dashboard to monitor compliance at least quarterly.

Although Medicaid programs are not subject to the Consolidated Appropriations Act of 2021, **Molina will bring our experience and best practices applying these rules and regulations for our Marketplace plans to our KanCare program**.

These best practices include approaches to Provider network composition, adequacy, and reimbursement. For example, we will examine differences in utilization of network vs. nonparticipating BH Providers in comparison to physical health Providers.

We will also tap into the knowledge and insights of Providers and stakeholders to monitor our program and ensure optimal compliance. We have already met with several CMHCs such as **Bert Nash, Pawnee Mental Health Services, and Valeo Behavioral Health, as well as the Association of Community Mental Health Centers of Kansas (ACMHCK), NAMI Kansas, and the Kansas Mental Health Coalition,** and discussed parity issues, access to BH, and effectiveness of treatment on an individual basis. We will meet quarterly with these organizations throughout the term of our KanCare Contract to solicit input and other feedback on Molina's BH services, including compliance with MHPAEA.

Soliciting Member and Provider Feedback to Ensure Compliance and Access to BH Care

We use both formal and informal Member and Provider interactions to gain feedback on MHPAEA compliance and Member access to BH services.

At least once a year, we will **proactively solicit feedback from our KanCare Member Advisory Committee and Provider Advisory Committee**, which will represent a diverse group of Providers and include one or more BH Providers, on strategies to optimize and improve Member access to BH services, PA requirements for BH services, and our compliance with MHPAEA.

Proactively Soliciting Feedback
Our Arizona affiliate solicited feedback from their Member Advisory Committee on the lack of knowledge of BH benefits by Members who were adoptive parents. The feedback led to a partnership with the Arizona Association for Foster and Adoptive Parents that brought our affiliate's outreach team together with a trusted BH Provider to educate members of the Arizona Association for Foster and Adoptive Parents on the BH system, Medicaid covered services, and rights within that system. 051.d.ks23

We will also engage our BH, LTSS, and Pharmaceutical Provider Representatives for insight and feedback on parity as well as concerns relating to PA and network availability.

Molina's record of MHPAEA compliance translates to improved Member access to BH services. We do not impose any barriers to service access or limitations on medically necessary BH care, demonstrating Molina's commitment to interdisciplinary whole-person care for Members.

4.3.I.14 Ability and Approach to Collaborating with the State to Design, Implement, and Evaluate Pharmaceutical Initiatives and Best Practices

14. Describe the bidder's ability and approach to collaborating with the State to design, implement, and evaluate pharmaceutical initiatives and best practices. In addition, describe in detail at least one data driven, innovative clinical initiative that the bidder implemented within the past thirty-six (36) months that led to improvement in clinical care, including how improvement was measured, for a population comparable to the ones described in the RFP.

Molina's adept ability and skillful approach to collaboration with the State is built on the extensive experience, best practices, and lessons learned from our staff, parent company, Medicaid affiliates across the country, and input from key partners.

Molina Brings Extensive Pharmaceutical Experience to the KanCare Program

Molina's Plan President and CEO, Aaron Dunkel, brings valuable experience designing and implementing pharmaceutical initiatives and best practices. For example, in his previous role as the Executive Director of the Kansas Pharmacists Association, he led several efforts in the State to allow pharmacists to practice at the top of their license, supporting better patient and population health outcomes.

Mr. Dunkel was also instrumental in coordinating the community pharmacy response to COVID-19 and the development of CPESN® in the State, a clinically integrated network of pharmacies that are dedicated to providing advanced clinical pharmaceutical services for better care for patients.

Collaborating with Other MCOs
One of our affiliates collaborated with other Medicaid MCOs to achieve:

- **Standardized processes.** Retrospective DUR programs and related reporting are standardized across all MCOs for polypharmacy, antipsychotics for children, ADHD stimulants for children less than 6 years old, COPD, and medication adherence.
- **Administrative simplification.** Providers receive communications from a single MCO, as all MCOs take turns sending out routine communications to an all-MCO Provider list.
- **Improved communications.** MCO pharmacy directors create letter templates, with all MCOs sending the same message to Members and Providers.

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Our parent company **successfully administers pharmacy benefits for nearly 3.5 million Medicaid Members in 17 states** where the outpatient pharmacy benefit is carved into MCO contracts. Complementing the experience with integrated pharmacy benefits, our affiliates have long-standing experience successfully collaborating with their state partners in designing, implementing, and evaluating pharmaceutical initiatives and best practices. In Kansas, we will subcontract with CVS Caremark as our PBM of choice due to demonstrated capabilities and ability to partner with Molina Healthcare to deliver state-of-the-art pharmacy benefits.

Molina also brings extensive experience working with uniform PDLs that will enhance our ability to collaborate with the State and to follow the PDL, including prior authorization (PA), step edit, and utilization edit criteria. Our parent company has **more than 15 years of experience loading a uniform PDL, UM edits, and authorization requirements** of state-determined PDLs in 14 states and administers more than 1,800 unique medication authorization and UM criteria.

Our process can accurately receive, test, and load the State's PDL updates in as few as two business days, which exceeds the requirement in RFP § 2.7.2.2 to implement drug-related State file updates within three business days. Thorough testing will validate appropriate system configuration of the State's PDL. Our Medicaid health plan affiliates have implemented pharmacy programs designed to meet the requirements outlined in the **SUPPORT Act**.

These programs aim to address the opioid epidemic and improve clinical care for Medicaid beneficiaries with SUD and opioid use disorder. As required by the SUPPORT Act, our retrospective DUR program includes review of concurrent use of opiates and benzodiazepines/antipsychotics, and review of the appropriateness of antipsychotic agents in children and adolescents.

In line with the SUPPORT Act requirements, antipsychotic agents prescribed to Members who are 18 years of age and under are reviewed. These reviews ensure that antipsychotic medications are prescribed based on approved indications and clinical guidelines, promoting safe and appropriate use.

In the last 6 months of 2022, more than 6,600 educational letters were mailed to Providers who prescribed antipsychotic medications for Molina affiliate child and adolescent Members but did not conduct metabolic testing. Follow-up analyses indicated that **20% of the identified Providers adjusted their prescribing pattern.** Implementing these SUPPORT Act initiatives demonstrates our commitment to addressing the opioid epidemic, improving clinical care for Members with SUDs, and aligning our pharmacy programs with state and Federal requirements.

Our Ability and Approach to Designing, Implementing, and Evaluating Pharmaceutical Initiatives and Best Practices

We will employ a **hands-on, transparent approach** for the KanCare program that includes a Pharmaceutical Director who will be a licensed pharmacist physically based in Kansas and an **in-house team of pharmacy experts** who will perform utilization management (UM) activities instead of delegating these high-touch Provider and Member interactions to the PBM.

Our **Pharmaceutical Director will serve as the single point of contact with the State** for pharmaceutical initiatives. They will leverage our integrated data and reporting systems to help the State identify metrics, operational processes, and best practices for the KanCare program.

Our in-house Pharmacy team performs PAs; grievances and appeals management; pharmacy Provider line support; PDL management, including DUR with support from an independent Pharmacy and Therapeutics Committee; reporting; and PBM monitoring and oversight. Our proven organizational experience, in-house pharmacy management, and stringent PBM oversight position us to exceed the State's requirements for pharmacy benefits.

We **integrate all available pharmacy data into our clinical system**, including data provided by Molina's PBM, data collected during the Health Risk Assessment and transitions of care processes, and data related to physician-administered drugs and implantable drug systems that we will manage.

This integration allows us easy access to data to support the design, including establishing baseline data, and evaluation of clinical initiatives that we can share with State.

Our UM team, Care Coordination team, Quality team, and pharmacists will use this data to analyze prescriber and pharmacy utilization patterns to identify opportunities for improvement and innovative clinical initiatives.

Molina **analyzes and uses all available pharmacy utilization data** in our physical health and behavioral health (BH) PA processes, population health strategies, and Care Coordination program to drive improvement. Our systems ingest industry-standard and proprietary files (including pharmacy claims and authorizations from our subcontracted PBM) to perform advanced analytics to identify favorable and unfavorable trends.

This capability allows us to tailor strategies and initiatives to particular populations, such as youth in foster care, and conditions, such as co-occurring BH disorders and IDD, to improve Member health outcomes.

Collaborating with the State

Our health plan affiliates have extensive experience successfully collaborating with Medicaid state customers. From identifying retrospective DUR interventions to designing innovative PIPs, we will tap into the extensive experience, best practices, and lessons learned our Medicaid health plan affiliates bring to collaborate with the State of Kansas.

Molina will develop **collaborative, transparent partnerships with the State, KDADS, KDHE, and other relevant agencies** to advance the State's goals and priorities. We will leverage the expertise, experience, innovative strategies, approach, and capabilities of our in-house Pharmacy team and affiliated Medicaid health plans. Our Pharmaceutical Director and staff from our Pharmacy and Quality teams will collaborate with the State to:

- Identify trends in utilization, health outcomes, and prescriber patterns
- Design and implement targeted pharmaceutical interventions, including baseline metrics and quality measures to evaluate performance
- Monitor performance and outcomes
- Modify and/or expand the initiative, as indicated

As requested by the State, **we will share our experience, best practices, and lessons learned on design, implementation, and evaluation**. Moreover, we will make any changes necessary to our policies, procedures, and systems that affect our pharmaceutical program, including our operations and the services we provide, to align with the needs of KanCare Members, Providers, and the overall program.

We will **engage our proven, standardized change process** to implement pharmaceutical initiatives,

Supporting State Efforts to Control Costs

Our Pharmacy team will identify drug classes and medications to reduce spending, presenting results to Molina's State customers to support policy changes. For example, in May 2023, our affiliate's team recommended off-label use of glucagon-like peptide 1 (GLP-1) agonists (a diabetes drug) for weight loss to the Virginia Department of Medical Assistance Services (DMAS). On July 1, 2023, DMAS implemented a service authorization that required a diabetes diagnosis for this drug, which **decreased spending by 25%**.

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identifying the staff and resources necessary to facilitate implementation and identify any impact it may have on both Members and Providers.

We will also develop a **comprehensive work plan that identifies the time frames and key milestone checkpoints** along with the project scope, resources, tasks, deliverables, critical paths, and dependencies.

Quality controls will be established to ensure any changes to system configurations are in place and thoroughly tested before go-live, and we will continuously monitor each change after go-live to confirm success and ensure quality of care and access to services for Members. Because we manage our pharmacy PA and medical necessity review process in-house instead of delegating this function to a PBM, Molina can see firsthand the impact of various initiatives and suggest adjustments as indicated.

To **enhance collaboration between our Pharmacy department and the State**, we will implement targeted strategies to optimize communication, knowledge sharing, and the design, implementation, and evaluation of pharmaceutical initiatives and best practices. We will foster this collaborative approach through:

Onsite meetings. We will participate in regular meetings with pharmacy stakeholders, including representatives from the State and relevant healthcare Provider organizations such as the Kansas Pharmacists Association, Kansas Association of Chain Drug Stores, Kansas Hospital Association, Kansas Dental Association, and the Kansas Medical Society.

These meetings will serve as a forum for discussing policy changes, addressing concerns, and aligning design and implementation strategies that reflect emerging pharmaceutical trends and industry best practices. This proactive approach will also ensure that our DUR processes are aligned with the latest developments.

Interagency drug criteria workshops. We will conduct workshops that bring together pharmacy professionals from Molina and the State. These workshops will focus on sharing insights on drug updates, formulary changes, and evolving clinical criteria. This direct interaction will promote a mutual understanding of priorities and challenges and influence the design of future pharmaceutical initiatives.

Shared information platforms. We will implement shared information platforms or databases to facilitate real-time exchange of relevant data. This approach will ensure that Molina and the State have access to the latest information on medication utilization, adherence patterns, and outcomes, promoting evidence-based decision-making.

Supporting Public Health Initiatives

Molina will closely collaborate with the State, the Kansas Association of Local Health Departments, and local health departments to address specific public health concerns, such as vaccination campaigns, opioid epidemic management, and infectious disease control. Leveraging community pharmacies across Kansas to administer vaccines, conduct health screenings, and offer preventive services to Medicaid beneficiaries can significantly impact public health outcomes.

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Our affiliates have operationalized shared platforms in some states, such as the integrated Microsoft Teams and SharePoint site our affiliate uses with the Mississippi Division of Medicaid.

Regular reporting mechanisms. We will institute a structured reporting system for updates on pharmacy-related activities that we will use to evaluate pharmaceutical initiatives for the KanCare program. This system will include routine reports on medication utilization trends, cost analyses, and Member outcomes.

Current reports include Top 100 Drug Cost and Utilization, PA Denial Rates, and Top 50 High-Cost Members. Transparent reporting will promote accountability and facilitate data-driven discussions with the State.

Collaborative working sessions. We will help organize and actively participate in sessions to align pharmacy policies with broader State health initiatives and address specific issues such as formulary management, cost containment, and patient outcomes, fostering collaboration on targeted initiatives such as smoking cessation and transition-of-care drug management.

This collaborative approach will ensure that pharmacy services are in sync with the State's KanCare vision and goals and regulatory requirements, including providing integrated, whole-person healthcare and supporting population health outcomes.

We look forward to collaborating with the State and bringing innovative strategies to the KanCare program that will improve health outcomes and the service delivery system. For example, **Molina proposes to collaborate with the State and Kansas-based pharmacists to expand on in-place pharmaceutical interventions**, such as medication synchronization, immunizations, and chronic disease management.

We also propose advocating for reimbursement models that recognize the value of and incentivize pharmacist-provided services, such as flu, strep, and uncomplicated UTI testing and initiation of therapy; immunization administration; adherence packaging; and patient counseling.

Data-driven, Innovative Clinical Initiatives

Molina will draw upon the experience of our Medicaid affiliated health plans to help the State design and implement data-driven, innovative clinical initiatives for the KanCare program. In our experience, the best **data-driven approaches include continually evaluating clinical and nonclinical data**, such as quality indicators, Member characteristics, satisfaction survey results, utilization patterns, and network adequacy, to help drive continuous improvement.

Below, we describe two data-driven, innovative clinical initiatives that led to improvement in care for comparable populations, including how improvement was measured.

Initiative 1: Long-acting Injectable (LAI) Antipsychotics

How the Initiative Was Identified. An issue with LAIs was identified by our Texas affiliate that operates an LTSS program through their regular analysis of pharmacy claims data to identify patterns and trends related to Members who are prescribed LAIs.

Educating and Empowering Members

Molina will offer the Health Tags program, which educates and empowers Members to track and manage their health information and medication regimens. When Members pick up their prescription at a participating pharmacy, they will receive a reminder to obtain certain services, such as a flu shot or A1C screening. 061.e.ks23

Adherence to LAIs was closely monitored, including gaps in prescription refills and potential interruptions in medication regimens. Utilization patterns, including emergency department (ED) visits and hospital admissions, were analyzed to identify any potential correlations with nonadherence to LAIs. Quarterly pharmacy claims reports also helped to pinpoint Members with adherence gaps and those at risk of potentially avoidable events due to LAI nonadherence.

Improvement Strategies. In March 2021, a pilot program was designed for Members who were prescribed LAIs and had adherence gaps that could result in preventable ED services. Our affiliate analyzed pharmacy claims data and identified Members at risk of nonadherence.

They sent educational letters to the Members and their Providers about filling prescriptions on time and informing them that medication can be administered at network pharmacies. The program aimed to increase Members' medication adherence, improve their quality of life, and decrease preventable ED utilization and hospital admissions. The pilot was expanded in October 2021 to add Members with on-time prescription fills of LAIs and remind them that the medication can be administered at the dispensing pharmacy.

In September 2022, the program was expanded again to include Members receiving oral antipsychotics who had adherence issues to convert them to LAI use that requires less frequent dosing/administration. This program continues today. **Exhibit 14-1** shows a timeline of the strategies.

Measurable Outcomes. An analysis of pharmacy claims data showed a **24% reduction in inpatient BH utilization**, indicating a positive outcome of the initiatives. Concurrently, there was a **13% increase in specialty prescription medication utilization for LAIs**.

These findings reflect the tangible impact of the strategies and interventions that have been put into action.

Initiative 2: Adherence to Controller Medications for Respiratory Conditions

How the Initiative Was Identified. Our Mississippi Medicaid health plan affiliate identified an issue with adherence to controller medications for respiratory conditions based on an analysis of data for the HEDIS Asthma Medication Ratio in alignment with their ongoing initiatives to improve HEDIS quality measure performance.

Through their analysis of pharmacy data and claims, our affiliate pinpointed a significant trend among Members with persistent asthma who use a rescue inhaler more that 50% of the time during a calendar year.

Improvement Strategies. Implemented in January 2022, the initiative aimed to improve adherence levels, ensuring Members were effectively using prescribed controller medications for optimal respiratory health. Specific strategies included Adherence Intervention, Closing Gaps in Medication Therapy, and MTM programs. The Adherence Intervention program identifies Member-specific opportunities to improve health outcomes and reduce costs.

When a Member is late in refilling a prescription or ceases therapy, the prescriber is contacted by fax or through an IVR system and notified of the Member's nonadherence to the pharmaceutical regimen.

Through the Closing Gaps in Medication Therapy program, Pharmacy advisors from our affiliate's PBM work closely with Providers to address identified gaps in medication therapy for Members with prevalent chronic conditions, such as asthma, diabetes, osteoporosis, ischemic heart disease, and rheumatoid arthritis.

Gaps are identified through a daily review of pharmacy claims for targeted Members who have prevalent chronic conditions.

Measurable Outcomes. The adherence rate for controller medications increased by 12.7% from February 2022 to June 2022; this initiative continues today.

4.3.I.15 Ensuring KanCare Members Receive Non-emergency Medical Transportation (NEMT) Services

15. Describe the bidder's approach to ensuring KanCare Members, including Members residing in Rural and frontier areas of the State, receive non-emergency medical transportation (NEMT) services in accordance with the Access standards in Section 7.5.5.5 of the RFP.

Because Members may have limited or varying access to personal vehicles and public transportation systems are inadequate in many Kansas communities (particularly in frontier and rural areas), NEMT is a critical service for getting to healthcare appointments, including dialysis and prenatal care. Molina's approach to coordination and provision of NEMT includes delivering superior service while emphasizing a personalized experience for each Member.

Approach to Ensuring Members Receive NEMT Services

Molina employs multiple measures to ensure Member access to timely transportation services, including maintaining a robust transportation provider network, preserving accurate Member data, and implementing innovative tracking technology. In an effort to further reduce barriers to access, we will only require advance notice of two business days (48 hours) for NEMT trip requests.

Exceeding Timeliness Standards
In Ohio, Iowa and Mississippi, where provider timeliness standards align with KDHE's definition of arrival within 15 minutes of the scheduled pickup time, **Molina's affiliates contract requirements with 96% or better pickup timeliness. These affiliates also have a complaint-free rate of 99.9%.**
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We will ensure our NEMT vendor complies with as well as exceeds Contract requirements in RFP § 7.5.5.5. Our Molina affiliates serving Members in urban, frontier, and rural areas of Ohio, Iowa, and Mississippi are experienced in meeting on-time performance standards similar to KanCare, including driver arrival at pick-up locations no later than 15 minutes after the scheduled pick-up time and wait times of one hour or less for trips after appointments that do not have a pre-arranged pick-up time.

To provide appropriate transportation to all members, including those residing in rural and frontier areas, our NEMT provider network will include mileage reimbursement, ambulatory services, wheelchair vans, stretcher vans, bariatric wheelchair and stretcher transport, non-emergent basic life support, and non-emergent advanced life support services to all 105 counties in Kansas. We will also monitor network adequacy and NEMT performance to identify gaps and address them.

Addressing Health Disparities

Our Member Advisory Committee will include representation from rural/frontier and tribal Members and Providers who can provide valuable insight into transportation challenges in these areas, which will inform our NEMT strategies. MTM, Inc., our NEMT Subcontractor, is committed to managing quality transit services to Members who, without reliable transportation, may be unable to take advantage of employment opportunities, get to the doctor, and access other community resources.

[redacted]

[redacted]

Member Feedback Leads to Improvement of NEMT Services

Participants in our Ohio affiliate's Member Advisory Committee revealed challenges with their value-added NEMT service, such as benefit exclusions for trips to pharmacies and grocery stores. Participants also suggested that it would be helpful to know the location of the NEMT provider in real-time.

In response to the committee's feedback, our Ohio affiliate expanded the benefit to include trips to pharmacies, grocery stores, and food banks, as well as development of the Transportation Trip Management app, which enabled Members to see vehicle location in real time via GPS mapping.

Following implementation of these changes, our Ohio affiliate reported **99.96% complaint-free transports with 91% of Members surveyed reporting being satisfied with Molina's NEMT benefit**—a 5% increase over the prior period. 046.e.ks23

Incentivizing Performance. We have developed an incentive program that will provide increased reimbursement to our transportation vendor for exceeding established quality and timeliness standards, including on-time pickups, low complaint rates, and high satisfaction survey scores.

Providing Easy Scheduling Options. Molina creates a seamless experience for Members who need transportation services. Our **scheduling approach will let Members choose how they want to schedule and manage their trips.** Molina's "no wrong door" approach ensures that Members will be connected to the support they need no matter how they reach out to us.

To ensure continuity of care and reduce Member abrasion, our transportation vendor will schedule standing transportation orders for Members with routine trips to the same treatment location. Standing order trips will reoccur for a minimum of six months, with allowances for shorter or longer periods dependent on the Member's Plan of Service.

Members and Member representatives can schedule NEMT through multiple access points:

- **Toll-free transportation number.** Members can schedule NEMT through our toll-free transportation number, which connects callers to transportation assistance representatives at our vendor's call center. All of the transportation assistance representatives are thoroughly trained in Kansas' requirements, geography, and prevalent cultural needs. They are also trained in screening for specialized needs, such as the need for a wheelchair-accessible vehicle,

and cultural preferences, including preference for a Spanish-speaking driver. These preferences will be recorded so they are available for future trips.

- [redacted]
- **Care Coordination team.** Our Care Coordination team will assist Members, their families, and caregivers with scheduling transportation as needed. We will coordinate with our transportation vendor to extend or reduce the length of standing order transportation to reflect adjustments to the Member's Plan of Service.

Preserving Accurate Member Data. Molina understands the important part that Member data plays in providing timely transportation services. Inaccurate address data can cause delayed arrivals or missed appointments. Our transportation vendor's call center staff verifies the Member's pick-up address for every scheduled appointment. If the designated pick-up address is not the address of record, we will ask the Member whether the new address should be added to their personal health record or whether it is just a one-time pick-up location.

The Transportation Trip Management app will prompt Members making an online transportation reservation to designate or confirm the pick-up location and give them the ability to modify their preferred location information for future reservations. Members will receive one-way text messages and/or app push notifications with trip updates. To support ongoing care-related outreach and scheduling, Molina receives and manages our Member address and telephone updates within our internal systems.

Maintaining a Robust Provider Network. Molina's selected transportation vendor currently operates in the State. We will ensure our transportation vendor has an adequate, statewide transportation network to fulfill all covered transportation requests and consistently achieve timely pickup and drop-off metrics for Members accessing NEMT services. To address known NEMT access issues, including workforce shortages and drivers' lack of familiarity with rural roads, we will employ multiple modes of transportation, innovative technology, and oversight to meet the needs of KanCare Members, especially those in rural and frontier communities.

Monitoring Provider Capacity. Our transportation vendor's wholly owned dispatching and scheduling tool, **Reveal**, manages the NEMT provider network and gauges capacity and availability for purposes of network adequacy. Reveal is the same software that KDOT has contracted for years to provide to

Mobile Integrated Health Team
Our transportation vendor's Mobile Integrated Health team coordinates resources among EMS, healthcare Providers, in-home services, virtual care platforms, and the health plan. This team will target high emergency department (ED) utilizers and vulnerable populations, such as those who reside in known Provider deserts. We will deploy the Mobile Integrated Health team strategically across Kansas' rural and frontier geographies to serve as a dedicated resource for both prescheduled and on-demand service needs. The Mobile Integrated Health team sends community care Providers, such as paramedics and other clinicians, to the Member's home in coordination with Molina Care Coordinators to conduct regular health and vital sign screenings, checkups to help close care gaps in HEDIS® measures, and health education programs to help individuals and communities maintain their health and prevent the development of chronic conditions. 046.c.ks23

Kansas' public transit agencies statewide. Similarly, all NEMT providers have access to the same technology, at no cost, to improve efficiencies, increase capacity, and reduce administrative and logistical planning ensuring that drivers utilize the most time efficient and cost-effective routes.

The transportation software stores all NEMT provider information, inclusive of service area, coverage capabilities, and specifications for pick-up and drop-off locations, to determine network capacity in each local region. Capacity against demand is continuously monitored to establish fleet needs. Our transportation vendor pools like Members in urban as well as rural areas to determine utilization patterns. Part of the algorithm includes a buffer in volume assumptions to ensure coverage in the event of utilization spikes or on-demand needs, which is then compared to observed trend components.

Gas mileage reimbursement and public transit utilization are intentionally omitted to further build an adequacy buffer. This process provides valuable and broad data points, enabling accuracy in the network adequacy evaluation process. As a result of this process, Molina and our transportation vendor can pinpoint where to best allocate resources to provide an effective NEMT provider network.

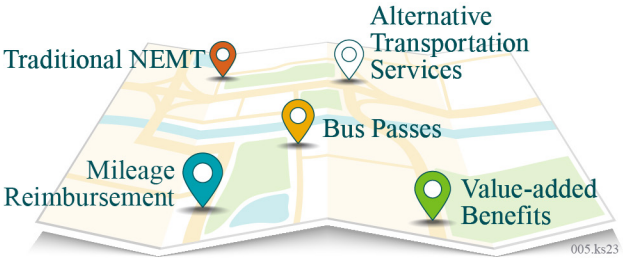
Responsible Vendor Oversight
An NEMT Subcontractor of our Florida affiliate identified a partner that was not picking up Members at agreed-upon pick-up locations, resulting in missed appointments. The Subcontractor placed the partner on a CAP for noncompliance with contract requirements and redirected transportation appointments to other partners. After two months of unsuccessful remediation efforts, our affiliate terminated the contract with the noncompliant downstream partner. 046.d.ks23

Maintaining the Needs of Critical Populations. Our transportation vendor will provide real-time trip monitoring and escalation for appointments to critical care therapies, such as chemotherapy; radiation; dialysis; surgery, including pre-op and post-op visits; high-risk pregnancy-related appointments; and urgent care. As part of our NEMT solution, we will use Envoy America to provide compassionate, dependable, and cost-effective companionship, assistance, and transportation. [redacted] **will provide individuals with IDD, LTSS, and higher risk** with specialty transportation through their assigned companions, which will improve the overall Member experience and add to available driver resources for individuals with special needs.

Transportation Vendor Oversight. Molina maintains a robust monitoring program for compliance and performance of subcontracted transportation vendors and their downstream providers. This process includes pre-implementation, post-go-live, and ongoing activities, as well as a formal Delegation Oversight program that follows established policies and processes, commits to review performance regularly as a core component, audits subcontracted functions, and ensures accountability through close communication with our transportation vendor, KDHE, and other stakeholders. **Due to our discipline in delegation oversight of subcontracted transportation vendors, Molina affiliates with similar transportation programs achieved missed trip and complaint thresholds of less than 0.5% in 2022.**

Flexible NEMT and Other Transportation Options

Molina will offer an array of transportation options to meet Members' individual transportation needs, including the following services.



Traditional NEMT. Through our transportation vendor, we will provide traditional NEMT transport for all Members, including those with specialized needs. Our transportation vendor will contract with area agencies on aging, community-based organizations, and FQHCs that offer transportation services to support access to care and social services.

Value-added Service

[redacted]

Mileage Reimbursement. We will offer mileage reimbursement when transportation is provided by a friend or family member, or when Members drive themselves to covered Medicaid services. By offering mileage reimbursement, we aim to reduce barriers and facilitate consistent access to healthcare services, especially for Members residing in rural and frontier communities. From publicly available reporting, we understand that mileage reimbursement is a preferred option for individuals living in rural and frontier communities with limited transportation options.

Bus Passes. Bus passes enable Members to combine trips, such as picking up a prescription on their way home. Bus passes may offer Members the freedom to travel to a broad variety of locations, improving access to places such as the food bank or workplace or to obtain other social services.

Access to Care & Services

Integrated Service Delivery. While NEMT is a critical benefit for many to access healthcare, NEMT programs are often overlooked and not leveraged as part of an integrated service delivery model. Should Members be unable to secure an in-person appointment with their healthcare Provider, **our transportation vendor can deliver communication devices to Members for telehealth appointments**. In addition, once there, should the Member need to visit urgent care or the ED, our transportation vendor can take them. Leveraging our expertise in coordination and healthcare, our comprehensive solution delivers medical care and support when Members want it—right away.

Independent Driver Provider Program. Our Independent Driver Provider program, which is comprised of individually contracted drivers, tackles common issues that Members face in rural and frontier areas such as service delays, rescheduling needs, and other demand-response scenarios due to broadened NEMT provider network capacity.

Our transportation vendor can broadcast specific needs for additional drivers in targeted areas well as use financial incentives to encourage additional individually contracted drivers to log on or adjust their locations within the service area based on demand.

While all Members have access to our Independent Driver Provider program, Members in rural or frontier areas will especially benefit from this approach as it integrates traditional transportation providers with individually contracted drivers to create a responsive and reliable network that operates in real time.

Key features of our Independent Driver Provider program include:
Real-time tracking. All vehicles, both traditional and individually contracted, are tracked in real time. This enables us to have a comprehensive view of the transportation network and respond swiftly to changing demands.

Flexible and responsive network. The Independent Driver Provider program allows for immediate adaptation to changing circumstances. By notifying individually contracted drivers of trip opportunities in their vicinity, we ensure a flexible and responsive transportation network.

Proactive problem-solving. Our model enables us to identify and address potential issues before they escalate. This proactive approach results in improved on-time rates and a more efficient response to unexpected transportation needs.

Our individually contracted drivers achieve 98.4% on-time performance for urgent, on-demand transportation requests, with an average response time of just 14 minutes—more than 2 times faster than traditional NEMT providers. We achieve these fast response times while maintaining a 4.8 out of 5 quality rating from Members and 3 times fewer safety/driver complaints than traditional providers.

Community connectivity. Integrating individually contracted drivers into the transportation network fosters community connectivity. Drivers become essential contributors to addressing the unique transportation needs of rural and frontier areas.

Trained individually contracted drivers. Drivers are fully trained and credentialed according to all State, federal, and client requirements, including in first aid, CPR, HIPAA, ADA, patient sensitivity, and hand-to-hand service.

4.3.I.16 Behavioral Health (BH) Crisis Services, Interface with 988, and Other Crisis Resources

16. Describe the bidder's proposed array of Behavioral Health crisis services and how those services will interface with 988 and other crisis resources within Kansas. Include the following in the bidder's response:

a. The bidder's approach to collaborating with its Behavioral Health crisis Providers, first responders, and other crisis resources to create a comprehensive, well-coordinated, Behavioral Health crisis continuum for all Members.
b. The bidder's approach to collecting data, measuring, and evaluating the effectiveness of its Behavioral Health crisis services, and implementing improvements based on its evaluation findings.
c. The bidder's plan for evaluating and meeting network adequacy with Behavioral Health crisis services, like mobile crisis services and crisis stabilization services.
d. The bidder's plan for promoting awareness of 988 and how to access local crisis services to Members.

Molina's Proposed Array of BH Crisis Services and Interface with Kansas Crisis Resources

Investments in the Kansas BH Continuum
Molina **is contributing more than $1 million to the Kansas BH continuum**, including crisis support services, through investments in organizations such as Roya Health and Benchmark Human Services. 055.d.ks23

Molina's fundamental philosophy revolves around viewing each Member from a holistic perspective. Understanding that a person's mental health is intrinsic to their overall wellness, we naturally incorporate a fully integrated BH approach into our services. Our BH crisis supports are individualized because we recognize that crises are different for different populations: a BH crisis for a child with IDD needs in western Kansas, for example, would need a different approach than one for a homeless woman with schizoaffective disorder in Kansas City.

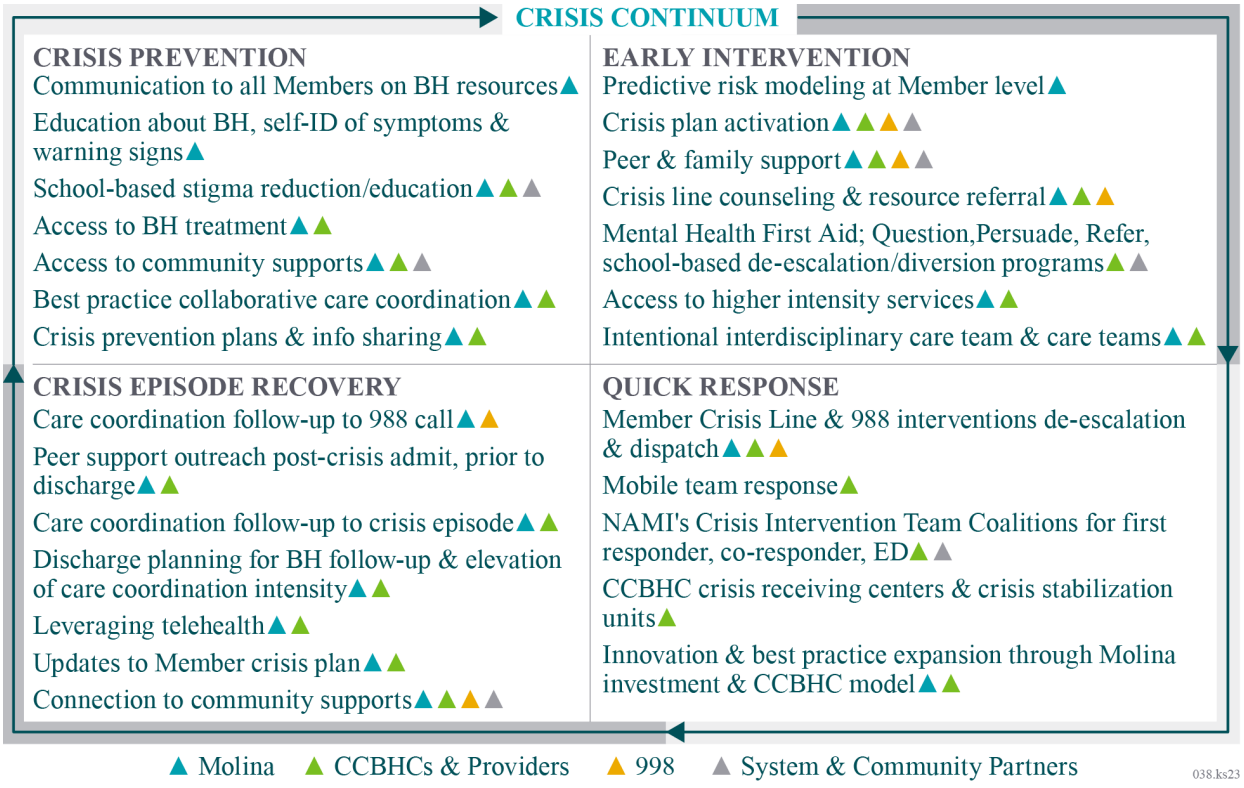
Regardless of the situation, Members facing a BH crisis require a network of resources and support systems to navigate the situation effectively. **Exhibit 16-1** shows our proposed array of BH crisis services and how they interface with Kansas crisis resources. At each step of the process, our crisis services interface with Kansas' community crisis resources to address crisis events in as near real time as possible through direct staff-to-staff connections and tools and technology to share Member and community-level data and information. Our multilayered, person-centered BH crisis services include:

- Comprehensive training for Member- and Provider-facing staff in trauma-informed care
- A care coordination model approach for the prevention, monitoring of, and responding to BH crises
- Molina Member Crisis Line, available 24/7/365
- Peer and family supports, including our Peer Support Specialists
- [redacted]

We use safe, supportive, local resources to provide Members with **someone to talk to, someone to come to them, and somewhere safe to go** in alignment with SAMHSA's vision of the ideal

crisis response system. These guidelines prioritize fundamental components necessary for managing mental health crises.

Exhibit 16-1. Comprehensive BH Crisis Continuum. Our coordinated system of crisis resources delivers person-centered care at the right time in the right setting.



We will leverage best practices from our affiliated health plans' nationwide experience in delivering integrated, whole-person healthcare services to Medicaid Members for almost 30 years. These lessons learned have shaped our community-based approach, which considers the specific needs of Kansas and builds on the momentum and successes of existing crisis resources and the progress the State has already made. We will drive change by implementing our evidence-based care model and robust Provider Engagement program.

We will continue to invest in partners that model best practices included in the comprehensive BH crisis continuum, including using recovery-oriented, trauma-informed approaches; incorporation of peers; zero suicide/safer care approaches; and partnerships with law enforcement in rural and frontier communities.

Most importantly, we will convene stakeholders to collaborate and develop actionable solutions that expand the crisis continuum in capacity and capability and into underserved geographies.

a. Approach to Collaborating to Create a Comprehensive, Well-coordinated BH Crisis Continuum

Our approach to creating a comprehensive BH crisis continuum starts with truly understanding Kansas' existing crisis system, how it functions, and where gaps present opportunities. We have begun our community-level assessment of the Kansas crisis continuum, evaluating local access

to a crisis line, mobile crisis units, stabilization services, and crisis receiving centers and how these entities are linked (or not linked) by data, processes, and people.

Through our assessment, we found that Kansas has emerged as a pioneer and leader in the nationwide effort to embrace the 988 crisis response system and the CCBHC model as part of a comprehensive crisis response system.

Molina strongly believes that Kansas' steadfast commitment to CCBHCs is a transformative force, benefiting not only Members but the State as a whole. In line with their vision, we are committed to fully incorporating the CCBHC model into our BH approach to care.

This commitment offers a promising pathway for expanding the adoption of crisis mobile teams and regional crisis stabilization units, two best practices that have emerged as a direct result of Kansas' unwavering support for local Providers, innovative solutions, and community-based

interventions. These resources will help to expand crisis services, particularly in areas where they may be limited, such as rural or frontier counties.

Approaches Specific to Each Point on the BH Crisis Continuum

Our BH staff are out in Kansas communities, engaging with BH crisis Providers, first responders, and other crisis resources. Our processes ensure that no Member in crisis deals with their situation alone. Below, we describe how we bring together internal Molina staff, Providers, processes, and tools during each stage of the crisis continuum (prevention, early intervention, response, and recovery) to create a comprehensive and well-coordinated BH crisis continuum.

Crisis Prevention

For all Members, our preventive approach to BH crises begins with our Welcome Calls and initial Member outreach efforts. We use these avenues to educate Members on their rights and opportunities to access BH services and Providers in the same way as for physical health, and to familiarize Members with crucial BH support services, including our Member Crisis Line, 988, Nurse Advice Line, and warm lines from community organizations such as NAMI Kansas, Mental Health America, and community recovery organizations.

We include BH screening questions in our first contact with all Members through our Welcome Packet and subsequent follow-up for their Health Screen. For Members who are actively engaged in care coordination, our approach includes repeatedly evaluating risk factors through screening tools such as the PHQ-9, Columbia Suicide Severity Rating Scale, and ASAM Criteria®, ensuring a continuous assessment of Members' vulnerability to BH crises.

Our approach also involves personalized education on available resources. Through person-centered care planning, we collaborate with individuals, particularly those managing serious and chronic mental illness, to develop crisis prevention and response plans.

Our team, comprising Care Coordinators and Peer Support Specialists, engages Members in identifying triggers and determining their preferred contributors to the crisis prevention and response plan. We will educate Members about potential crisis situations that may arise specific to their diagnoses and include in the crisis prevention plan how they can best respond to those situations.

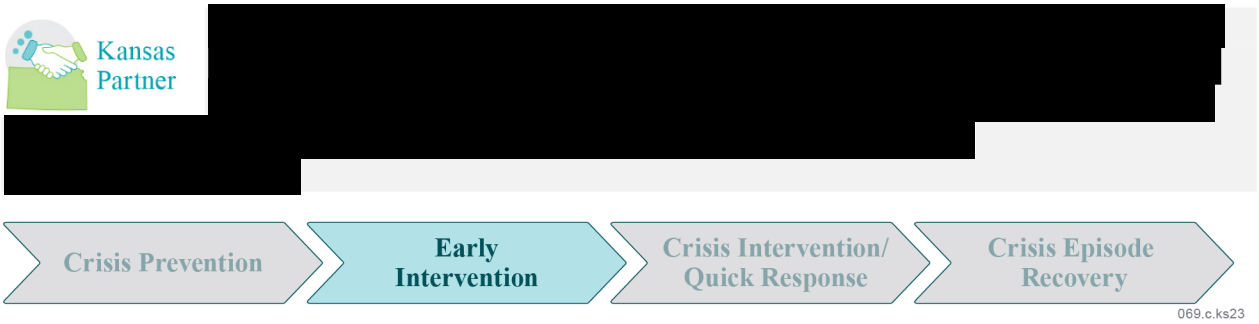
Collaboration forms a cornerstone of our preventive efforts, entailing cross-training initiatives and coordination with CCBHC care coordinators. This collaboration aims to align processes and implement best practices in crisis prevention and stigma reduction education.

We provide ongoing support and resources to CCBHC care coordinators and other Providers on the Member's interdisciplinary team, sharing Member crisis plans with explicit Member consent through secure platforms like our Care Coordination Portal and interdisciplinary team meetings.

We will also leverage partnerships with organizations like NAMI Kansas, Mental Health America, and **Confluence HRKC**. These alliances allow us to extend peer and family education

services within the community, focusing on capacity building and crisis prevention. Through these concerted efforts, we aim to address the diverse needs of our Members and promote a proactive approach to mental health and wellness.

We also acknowledge the importance of supportive communities such as Oxford Houses and Clubhouses such as the **Breakthrough House Clubhouse** in Topeka and **Breakthrough House Clubhouse** in Wichita, fostering environments conducive to recovery and offering critical peer support networks.



Early Intervention

For our early intervention phase, we focus on individuals experiencing challenging thoughts or emotions or suicidal ideation. As part of our service planning process, Care Coordinators work with Members and their interdisciplinary teams to develop a **crisis plan**. The crisis plan identifies triggers and outlines steps that Members and their support systems can take to avoid a crisis before it occurs, including using their own cognitive, self-care, and natural support tools identified by the Member. It also includes important contact information for their BH Provider; our Member Crisis Line and Nurse Advice Line; peer supports; Molina Care Coordinator; and CCBHC care coordinator, for the right type of support to meet their needs.

Molina's Bilingual 24/7/365 Member Crisis Line. Our Member Crisis Line, available in English and Spanish, is a first-line intervention that can often ease the Member's distress, and most calls do not require immediate dispatch for an in-person evaluation. Our Member Crisis Line is answered live by clinically trained professionals who triage calls and ensure timely, emergent, and urgent access to appropriate Providers, such as direct dispatch to a mobile crisis unit, 988, or EMS in life-threatening situations. The clinician assesses the Member's immediate needs, level of distress, imminent danger of self-injury or homicide, SUD or psychiatric medication utilization, domestic abuse, safety, and suicidality.

If Members contact our Nurse Advice Line or Member Crisis Line, we can divert them from the ED to more appropriate care settings, minimizing unnecessary high-cost care. The Member Crisis Line is a resource for keeping Members safe in time in between a crisis and an in-person visit with their Provider. Our Care Coordinators continuously monitor Members' progress toward their goals, assess their changing needs, and update their Plan of Service as needed.

Our proactive approach includes collaboration with CCBHCs, ensuring that Members receive comprehensive services and care coordination. We facilitate the sharing of crisis plans with CCBHCs and provide robust support for peer support initiatives like Wellness Recovery Action Plan (WRAP®) and Whole Health Action Management, designed to identify triggers and activate

wellness tools when needed. By leveraging interdisciplinary teams and collaborating closely with CCBHC care coordinators, we identify and implement interventions such as cognitive behavioral therapy and peer support, aiming to intervene before crises escalate.

Recognizing the critical role of effective collaboration and communication with community crisis resources, we engage in cross-training initiatives with organizations such as **Kansas Suicide Prevention HQ (KSPHQ)** and their 988 counselors. Through this training, we educate counselors on Molina's care coordination contacts and processes, empowering them with language and talking points to guide discussions about KanCare and available BH services.

We use community events, Provider partnerships, and Member-facing staff to disseminate information about the multifaceted role of 988, emphasizing that it is not solely for crises but also for general inquiries regarding BH treatment and support.

Our proprietary BH predictive modeling platform, Molina Insights, identifies Members at risk of a BH event. Our BH Event Risk Model uses medical, behavioral, pharmacy (including medication adherence), utilization, and SDOH data to predict the likelihood of a Member having a BH event within the next 12 months. Recent suicide attempts and use of crisis services are imported into a dashboard that delivers Member-level insights that aid interdisciplinary teams in prioritizing outreach and determining intervention strategies.

Our BH care management programs, as a whole, have led to a 16% reduction in inpatient stays, a 12% increase in PCP visits, and a 34% increase in outpatient mental healthcare.

Molina Care Coordinators, CCBHC care coordinators, and Peer Support Specialists will use daily reports on opioid-related ED visits, inpatient admissions, and Nurse Advice Line and Member Crisis Line contacts to rapidly identify Members in real time and prioritize outreach. Our Utilization Management Care Review Clinicians review authorizations for BH services and make referrals to care management and peer support teams.

We actively support school-based mental health programs and crisis diversion alternatives through various training programs for students, teachers, and parents, such as Mental Health First Aid; Applied Suicide Intervention Skills Training; Question, Persuade, and Refer; and Multi-Tiered System of Supports for teachers and school administrators.

Using the skills from these trainings, participants can identify and stratify students into tiers and identify needed interventions as part of an overall approach to crisis and juvenile justice diversion.

Our goal in collaborating with 988, CCBHCs, and other community-based supports is to facilitate timely recognition of mental health issues and provide appropriate interventions to address them effectively.

Crisis Intervention/Quick Response

Molina will offer Members immediate support through accessible channels like the Nurse Advice Line, Member Crisis Line, and 988. These avenues ensure that individuals in crisis have easy access to BH clinicians, enabling screenings for urgent intervention needs—prioritizing individuals who pose a danger to themselves or others. Our Care Coordinators undergo specialized training in trauma-informed care, de-escalation skills, and crisis protocols, ensuring a supportive and responsive approach to crisis situations.

We prioritize continuity of care by enabling warm transfers from our Member Crisis Line to 988 when appropriate, ensuring that individuals maintain contact with clinicians and crisis counselors, which eliminates the feeling of being alone in a crisis situation. Collaborating within local BH crisis systems, we facilitate dispatching 911 or crisis mobile teams when necessary.

We actively support NAMI's Crisis Intervention Team programs to help train law enforcement on de-escalation techniques and jail diversion programs. These training programs focus on reshaping law enforcement responses, advocating for treatment over incarceration, and ensuring appropriate follow-up care after ED visits.

Crisis Intervention Teams represent a cutting-edge approach to first response in crisis situations, integrating law enforcement with community, healthcare, and advocacy collaborations. They offer specialized crisis intervention training for law enforcement personnel to effectively assist individuals dealing with mental health challenges. This initiative enhances the safety of both patrol officers and the broader community, benefiting Members and their families.

Molina will be a participant in local Crisis Intervention Team coalitions, supporting them by identifying funding streams, as a training and convening partner, and by integrating local processes for referral and intervention into our care coordination workflows. Our efforts aim to alleviate the burden on law enforcement and reduce the criminalization of mental health challenges.

Crisis Episode Recovery

Molina coordinates follow-up with crisis Providers to ensure that Members have access to community stabilization services, peer support, and wraparound services to prevent recurrence of crises. Molina Care Coordinators and community care coordinators conduct outreach and offer face-to-face meetings post-crisis to update crisis and care plans.

In addition, after a Member calls our Member Crisis Line, it is documented in our Crisis Call Dashboard. The Molina Care Coordinator and CCBHC care coordinator will follow up with the Member within 24–48 hours of the crisis call to assess the Member's needs post-crisis, connect them to services and supports, develop a safety plan, and update the comprehensive care plan, as appropriate. We will also work with 988 to identify opportunities to share data, including with other MCOs, to integrate into our own crisis dashboards. If the Member has not previously been engaged with BH services, and, as a result, has not been connected with a CCBHC previously, the Molina Care Coordinator will connect the Member with the appropriate CCBHC.

Our Peer Support Specialists conduct outreach upon receiving notification of an ED visit or admission due to crisis, overdose, or other urgent conditions. Once identified, our Peer Support Specialists contact Members to connect them to timely follow-up services. Molina Members with SPMI/SED who received peer support experienced improved outcomes, including **a 53% reduction in inpatient utilization and a 14% reduction in ED usage.**

BH Providers can continue to support Members who identify telehealth as their preferred treatment modality. We will work with our national partners who can support the existing ecosystem with a virtual suite of services to connect Members to a BH Provider before, or immediately upon, a BH-related discharge or crisis. Providing access to virtual services helps to ensure needs are met and follow-up appointments are promptly scheduled and attended, which reduces avoidable ED visits and readmissions.

For Members in regions with limited broadband access, we provide transportation to places where Members can access telehealth, for example at community-based organizations like [redacted] As a result of telehealth adoption, **we achieved a 5% improvement in the timely initiation of treatment and follow-up visits after ED and inpatient events.**

b. Approach to Collecting Data and Measuring and Evaluating Effectiveness of BH Crisis Services

Our strategy to drive continuous improvement in the Kansas crisis continuum reflects our commitment to accountability, transparency, innovation, and system transformation (see **Exhibit 16-2**). Molina measures crisis system metrics at the system, region, Provider, and Member levels, then incorporates these metrics into our quality improvement (QI) plans. We use a variety of feedback mechanisms to gather meaningful, actionable data that is crucial to understanding where the system effectively meets Member needs.

We will collaborate on data collection methods, performance metrics, and data sharing across the continuum. We will build on the synergy of existing committees and workgroups, including the Quality, Member Advisory, and Provider Advisory Committees and for our crisis continuum efforts, the 988 workgroups.

In Arizona, our affiliate helps Providers develop metrics that they can monitor in their patient panels, such as calls to crisis lines, tracking of involuntary detention, and validating PCP seven-day follow-up post-crisis. In Kansas, we will seek input to identify other primary care HEDIS measures relevant to crisis metrics, identify opportunities to leverage pharmacy data to analyze prescriptions and refills for long-acting injectables, and opportunities to work with school-based

health centers and school districts to track crisis episodes and impact on child well-being. Key performance indicators for each crisis continuum component may include:

Call center. The number of mobile teams dispatched, number of individuals connected to crisis resources or hospital beds, and number of first responder-initiated calls connected to care

Crisis mobile services. The number served by eight-hour shift, percentage of calls responded to within a specified time frame, and percentage of mobile crisis responses resolved in the community

Crisis receiving and stabilization services. The number served, percentage of referrals accepted, percentage of referrals from law enforcement and drop-off time, average length of stay, percentage discharged to community, readmission rate, service satisfaction, and percentage of individuals reporting improved ability to manage a future crisis

Exhibit 16-2. BH Continuum QI Strategy. The BH crisis system performance will be measured through a proven QI strategy.

To ensure the crisis continuum operates effectively, we combine internal data with Member and Provider feedback to understand strengths and identify opportunities. For example, we will monitor metrics related to crisis utilization, Member Crisis Line calls, post-crisis Member outreach, and timeliness of follow-up care and conduct random audits to confirm adherence to established standards.

We will track data on BH-related ED visits, wait times for psychiatric bed transfer (ED boarding), BH diagnoses and overdose/opioid use disorder-related diagnoses, HEDIS rates on ED follow-up, and law enforcement activity. We will overlay demographic data at the neighborhood level to identify disparities in crisis resource access and target interventions like suicide prevention initiatives.

Should we identify an area for improvement, we will use this data to divert resources to remedy the issue. For example, if we see an increase in ED utilization for BH events in a certain community, our BH Member Advocates, BH Provider Representatives, and Health Equity Director, along with our Quality and Network teams, will perform an analysis of that community from the viewpoint of the crisis system.

They will collaborate with local Providers, other MCOs, and KDADS, as appropriate, to solve the issue, for example by leveraging community reinvestment funds to support the expansion of crisis services.

During Member and Provider contacts, we will solicit input on the responsiveness and quality of crisis services. The qualitative and quantitative data we collect will inform our improvement activities. Our BH Practice Optimization team will share best practices and provide technical assistance to any Providers with performance outliers.

As part of our QI process, we will convene a Quality Review Panel that includes our BH leadership, crisis Providers, and stakeholders to provide an ongoing review of the crisis system. Participants will review data and Member and Provider input and work together to develop mutually agreed upon process improvements, notifications, and warm handoffs.

c. Plan for Evaluating and Meeting Network Adequacy with BH Crisis Services

We have been on the ground in Kansas and have learned about the myriad challenges in access that Kansans face today, including specific gaps in access to a complete continuum of BH services and other specialty Providers. Molina fully integrates all BH services, so we do not rely on external or internal vendors to build, service, or maintain a network of BH Providers.

By having services fully integrated in our network build, we connect the BH needs of all Members across the full continuum of mental health and addiction medicine care, regardless of severity of need.

Establishing a Comprehensive Provider Network for Integrated Crisis Services

Member supports must be built on a foundation that includes a robust Provider network with the capability and capacity to provide crisis services, data sharing arrangements to build connections among all crisis stakeholders, and investments in and leveraging of existing community-level Providers.

We are building a Provider network that includes all available mental health and SUD levels of care—specifically those defined by the ASAM—to support the continuum of care delivery, including crisis prevention, stabilization, and postvention and follow-up.

Our network approach ensures that we meet diverse Member needs and the requirements of a connected, statewide crisis system, which include Mobile Crisis teams, Mobile Crisis Response teams for children, Mobile Crisis team follow-up, stabilization services for children and families, and on-call BH crisis receiving centers.

Community and Stakeholder Evaluation. Molina will be a full partner and convener with CCBHCs; FQHCs and primary care practices; hospitals; system partners like law enforcement, juvenile justice, child welfare, and schools; and community-based organizations meeting key SDOH needs like housing. We will use these meetings to take steps to evaluate individual community needs for crisis system services and resources.

Molina will leverage and share our own data and bring together partners to identify and gather other data, including population size, length of stays in inpatient levels of care (including tracking of psychiatric boarding in EDs), readmission rates, and incarceration for lower-level and misdemeanor offenses, to measure crisis resource needs using best practices from SAMHSA and other states for calculation and assessment.

Building a Provider Network to Support the Crisis Continuum

We use a multipart strategy to support the comprehensive BH system of care, including:

- Practice transformation
- Comprehensive VBP
- Training and toolkits for Providers, such as Psych Hub™, Collaborative Assessment and Management of Suicidality (CAMS), and Mental Health First Aid
- Community reinvestment, including workforce development initiatives

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Molina will share results, identify creative solutions, and use our capacity for crisis system enhancement by supporting the CCBHC model and prospective payment system (PPS) rate. We will also bring new Providers into the network, enhancing payment through VBP and outcomes-based programs, presenting solutions for reduced administrative burden and efficient claims submission and payment, reinvesting in communities, and expanding evidence-based practices.

Mobile Crisis Response. Mobile crisis response is a crucial gap in many areas of Kansas and is often the best and fastest service for reaching Members with emergent needs. Mobile Crisis team services are a critical part of the crisis system blueprint. In Kansas, CMHCs and CCBHCs statewide have implemented mobile crisis services for youth and adults as a part of the State's coordinated crisis system.

These teams include licensed clinicians, case managers, and peer support specialists who can de-escalate, triage for additional need, assess, and connect to BH services. Some CMHCs in Kansas, like Johnson County, also operate co-responder models in which a BH clinician responds with law enforcement to an emergency scene where BH is a factor.

Leveraging CCBHC Rollout. As stated, we highly support the State's plan to build a network of CCBHCs. As the State moves forward with the CCBHC model, we are investing practice transformation resources into supporting Provider movement to CCBHCs. The CCBHC transformation will provide a foundation for expansion of crisis services to the State's rural, frontier, and urban communities.

Crisis Stabilization Units. Person-centered, recovery-informed crisis receiving centers provide safe and supportive local places to help with detox, psychiatric beds, and other settings to help stabilize individuals in crisis**.**

New Crisis Stabilization Units and receiving centers are now operational in Kansas through Providers like the Bert Nash Center, The Guidance Center, Wyandot Center, Compass Behavioral Health, Pawnee Mental Health Services, Family Service and Guidance Center, and others offering a "no wrong door" approach and Crisis Stabilization Units focused on adults and youth. Molina has also heard how not enough crisis beds in counties like Ellis have created a concern in the community.

Molina understands how to help Members access crisis centers, build them into Members' crisis safety plans, disseminate information about this level of care in Kansas communities, and follow up with Providers post-crisis. Molina will support the Kansas rate structure that makes new crisis capabilities possible by offering supplemental payments for CCBHCs that are building out innovative practices for Members with SUD and IDD.

Expanding BH Telehealth Services, including in Rural Areas. Telehealth services can increase timely access to BH services and act as a gateway to in-person services when wait times are long. Telehealth encourages Members to continue their treatment with convenient options even in areas that are underserved by specialists. For follow-up after a crisis, BH Providers can continue to support Members who identify telehealth as their preferred continued treatment modality.

Molina Community Health Workers (Molina CHWs) will also support Members when they apply for the Affordable Connectivity Program, which allows households greater access to Wi-Fi in their homes. Molina will also work with community-based organizations and physical health Providers to create opportunities for Members in areas with slow or unstable Internet access to use exam rooms or office space to participate in telehealth services.

Post-crisis Follow-up. A highly functioning crisis system involves partnering for best practices for prevention and postvention, not just response. We are investing in State and local strategies to ensure warm handoffs and Member engagement with multidisciplinary teams highly specialized in peer support and wraparound services, for example.

These and other services, such as assertive community treatment and multisystemic therapy, bring care coordination teams together to support Members at critical times, especially during recovery from a crisis episode.

d. Plan for Promoting Awareness of 988 and How to Access Local Crisis Services

We promote awareness of 988 and provide information on local crisis services beginning with our Welcome Calls and initial Member outreach efforts. These touchpoints, along with information presented in our Member Handbook, on our Member portal, at community events, and through community reinvestment partnerships, serve as gateways to inform and educate individuals about available BH resources.

We use these avenues to familiarize Members with crucial BH support services, including our Member Crisis Line, 988, our Nurse Advice Line, and warm lines from community organizations such as NAMI, Mental Health America, and community recovery organizations.

We emphasize disseminating information about BH symptoms and warning signs and how to access services. By providing contact information for these resources and information on CCBHCs, we ensure that Members recognize where they can seek assistance during challenging emotional periods or when in urgent need of BH care.

As part of our approach to promoting awareness, we will work closely with **KSPHQ** to educate the public about how and when to use 988 to mitigate potential crisis situations and its role as a public health and resource referral tool for everyone, not just people in crises or who experience suicidal thoughts.

Should an individual access 988 and disclose that they are a Molina Member, 988 crisis counselors will document that and offer to connect them to our Care Coordination program as appropriate and needed, with their consent. In these cases, our Care Coordinators will diligently follow up, ensuring continued support.

We will support new capabilities for KSPHQ to respond to teen crises using trained peers and training for 911 dispatch centers on 911 diversion through warm transfers to 988 for crisis counseling or mobile dispatch.

In addition, we will ensure our Member Services Call Center Representatives, Care Coordinators, and Member-facing staff are fully trained and well-versed in the availability and importance of providing Members with information on how to access these critical services.

> We will work closely to expand the Resilience Program to bring suicide awareness into middle school populations and local community agencies. Through Molina's coordinated case management, we will ensure adolescents and their families are provided a closed-loop referral system to improve physical, behavioral, and social supports.
>
> *Alicia Walker*
> *CEO, Helping Empower Adolescents Reject Thoughts of Suicide (HEART)*
>
> 055.a.ks23

This includes addressing any concerns or misconceptions Members may have and guiding them on how to access these services when needed.

We will provide Members with comprehensive information about how 988 operates, its range of services, and the crucial role it plays in ensuring the well-being of our Members.

We are committed to training our community partners on 988 and crisis services so they can effectively share this information with Members to enhance the reach and impact of these critical resources.

This training will emphasize the importance of clear and compassionate communication when discussing 988 with Members. Our educational initiatives will emphasize that 988 is not only a resource for immediate crisis intervention, but also serves as a powerful preventive measure and education tool in reducing stigma.

We will also conduct comprehensive training sessions with Providers to ensure they can efficiently connect Members back to Molina in a timely manner.

By empowering our frontline staff with this vital knowledge, we aim to ensure our Members receive accurate and timely information about 988, ultimately enhancing their ability to seek help during times of crisis.

4.3.I.17 Approach to Increasing the Provision of Screening and Tobacco Cessation Services

17. Describe the bidder's approach to increasing the provision of screening and tobacco cessation services to KanCare Members disproportionately affected by smoking and tobacco use. Include an example of a similar approach the bidder has taken with similar populations that was successful, the measurable impact achieved, and why the bidder anticipates the approach will result in improvements in KanCare.

Smoking remains a persistent public health challenge, and its impact on the well-being of Medicaid beneficiaries cannot be overstated. Nationally, adults enrolled in Medicaid are twice as likely to smoke cigarettes than other insured adults. This demographic often faces unique barriers to tobacco cessation, including socioeconomic disparities and difficulty navigating access to treatment and supports.

To address the critical issue of tobacco use within the KanCare population and increase the provision of screening and cessation services, we will focus our efforts on those individuals who are most disproportionately affected by issues related to tobacco use.

We will offer a suite of solutions and programs tailored to meet the specific needs of pregnant women, individuals with IDD, and individuals with chronic health conditions. As KanCare Members are, by definition, individuals with low income, they are less likely to be able to afford specialized resources, such as tobacco cessation treatment.

By offering smoking cessation tools and incentives, we can reduce the financial burden that smoking places on Members.

Approach to Increasing the Provision of Screening and Tobacco Cessation Services

We are committed to supporting Members on their journey toward a healthier, tobacco-free life. We know that most smokers want to quit, and many try to quit several times before succeeding. We also recognize that each individual's path to cessation is unique.

To that end, we have developed a diverse array of resources, with the Molina My Health Tobacco Cessation Program, described below, as the foundation. In addition to this evidence-based program, we have established solutions that are designed to incentivize and educate Members and Providers and increase the likelihood of success.

Molina's My Health Tobacco Cessation Program

Our healthy lifestyle programs, including Molina's Tobacco Cessation program, support Members wanting to make a change. Molina's My Health suite of condition support programs educate and empower Members with chronic conditions including tobacco dependence, asthma, COPD, diabetes, hypertension, and heart failure to effectively manage and coordinate their care.

Molina's My Health programs are based on nationally recognized clinical practice guidelines and evidence-based guidelines, including guidelines from the CDC, American Lung Association, and the National Institutes of Health, which are reviewed and adopted annually by the Quality Committee.

Molina's My Health Tobacco Cessation program has been created to support Members who are ready to quit tobacco and nontobacco products, such as vaping e-cigarettes, cigarettes/cigarillos,

and smokeless tobacco, by providing them with smoking cessation medications, health education, and care coordination.

Our **Tobacco Cessation program is administered entirely by registered nurses who have undergone specialized training to achieve certification as Tobacco Treatment Specialists and who we refer to as clinical health educators**.

Our primary focus is on intervention and prevention. Identification, outreach, and engagement of Members begins early with the Health Screen, Health Risk Assessment (HRA), condition specific assessments including OB, and conversations between the Member and their Care Coordinator, Member Services Call Center Representatives, or referrals from Providers.

Once Members have indicated a desire to quit smoking, they are referred to Molina's My Health clinical health educator, who connects with the Member by telephone to begin an assessment to understand a Member's readiness to quit smoking and current tobacco utilization.

A key part of helping Members choose healthier lifestyles is encouraging change through motivational interviewing. Motivational interviewing improves self-efficacy and personal control for behavior change, empowering Members through a collaborative process of identifying the short- and long-term costs and benefits associated with making this lifestyle change.

Our clinical health educators are skilled in helping Members identify and complete small steps to build confidence, which leads to meeting personal goals.

Members receive personalized and ongoing education on stress management, coping techniques, tips for dealing with addiction and psychological dependency, and new habits for a healthier lifestyle. Members work with their clinical health educator to prepare for their quit day, having established a realistic plan for maintenance through the individualized Plan of Service/Person Centered Service Plan.

Throughout this journey, clinical health educators emphasize the importance of connecting with the PCP as soon as the decision to quit has been made, especially if the Member is interested in smoking cessation medication, at least several weeks before the quit day. The PCP will help to determine the appropriate pharmacological aid.

[redacted]

Additional Tobacco Cessation Initiatives

In addition to the My Health Healthy Lifestyle Tobacco Cessation Program, and through lessons learned from Molina's Medicaid affiliates, we will offer the additional solutions and strategies outlined below to support Members who decide to quit.

Value-added Benefits. As secondhand smoke can worsen asthma symptoms in children and pose risks to those needing caregiver support, our value-added tobacco cessation benefit for adult Members aims to prioritize the well-being of high-needs individuals by supporting smoke-free environments.

[redacted]

Provider Collaboration. [redacted] We will educate Providers on how to use the Smoking and Tobacco Use Cessation Counseling CPT codes. We can track the use of the codes by Provider, quarter over quarter, year over year, to measure program effectiveness and inform additional targeted Provider outreach and training.

We will train Providers on available smoking cessation resources, including Molina's My Health Tobacco Cessation program. We will include smoking and tobacco use cessation counseling into Provider incentive programs and will support and encourage Providers in their use of SBIRT, which includes components for identifying the unhealthy use of tobacco and readiness to quit, to ensure early identification and interventions for tobacco cessation.

We will leverage the collaboration opportunity involving community pharmacies, including CPESN members, to support medication adherence for Members who have made the decision to quit.

Partnership with the National Council for Mental Wellbeing. According to the National Council for Mental Wellbeing, "Individuals with mental health and substance use challenges who

smoke have less access to tobacco cessation treatment than the general population and experience delayed screening and treatment for tobacco use."[1]

We will use our Joint Operating Committee meetings with CCBHCs as a forum to ensure they are aware of available national training resources, such as the ones provided by the National Council for Mental Wellbeing.

Additional Partnerships. We will collaborate with schools in counties with the highest rates of youth smoking to provide anti-tobacco educational programs and events and to support and promote the work KDHE is doing as part of their Vape-Free Schools initiative.

Additionally, we will leverage the work Molina Community Health Workers (Molina CHWs) do in the field to identify opportunities for partnership with school systems and engagement with workgroups to promote education and advocacy for tobacco cessation.

Molina CHWs will also be trained on KDHE's Kansas Tobacco Cessation Help course to help them support Members who want or need help quitting.

Example of Similar Approach That Was Successful

To help Members quit smoking and using tobacco, our affiliate health plan in Michigan uses an evidence-based tobacco cessation program provided by the nonprofit, National Jewish Health (QuitLogix). National Jewish Health's personalized coaching and online resources have some of the highest success rates in the country, with 40% of participating individuals quitting and a 90% satisfaction rate.

Using tobacco use screening questions in the HRA, our affiliate identifies Members interested in quitting their tobacco use. Members can also self-refer or be referred through the Care Management team to the QuitLogix program.

Like our My Health Tobacco Cessation program, QuitLogix tobacco cessation coaches are trained in the behavioral change model for smoking cessation.

Highest Among All MCOs
Molina's Michigan affiliate was the **only MCO to receive a 5-star rating** for the following measures: Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, and Exploring Cessation Strategies. **They achieved scores of 82.45%, 62.11%, and 55.38%, respectively—the highest among all MCOs in Michigan.** 030.ks23

They provide customized, culturally appropriate, compassionate support and guidance for Members. Culturally appropriate information developed for multiple audiences include African Americans, Asian Americans, American Indians, and teens/teens who vape.

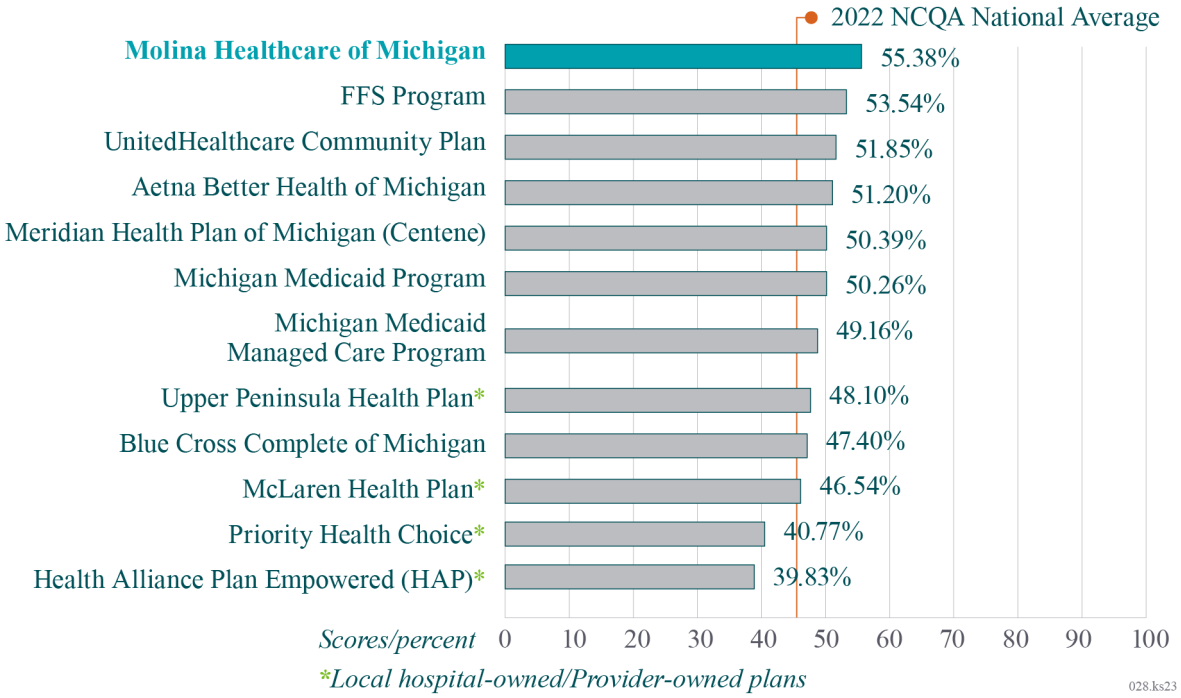
Throughout the program, our affiliate's care managers remain connected to Members to ensure access to additional needed services and supports, including connecting Members with their providers.

[1] National Council for Mental Wellbeing, Our Work/Focus Areas/Public Health: "Tobacco," 2023.

Measurable Impact Achieved

As described in Exhibit 17-1, Molina's Michigan affiliate achieved the highest CAHPS® score among all Michigan Medicaid health plans for the Advising Smokers and Tobacco Users to Quit measure in 2023. Molina Healthcare of Michigan has demonstrated exceptional performance supporting individuals toward tobacco cessation receiving **– the highest among all MCOs in Michigan.**

Exhibit 17-1. Advising Smokers and Tobacco Users to Quit Measure. Molina's affiliate health plan in Michigan scored highest among all MCOs in 2023.



Why Molina's Approach will Result in Improvements in KanCare

Helping KanCare Members, particularly those disproportionately affected by smoking and tobacco use, is an effective population health strategy to reduce disease burden, costs, and mortality caused by smoking.

Access to evidence-based tobacco cessation programs, pharmacological interventions, and BH supports, such as care coordination, have proven to be successful. Molina will leverage best practices and lessons learned through our affiliates' experience, tailoring our approach to complement, but not duplicate, services already available to KanCare Members.

Our "no wrong door" approach to identifying and referring Members for tobacco cessation services will include self-referrals through text, Member portal, or our My Molina app, and referrals from Care Coordination staff, Providers, pharmacies, caregivers, and community-based organizations (CBOs).

We will incorporate questions from the HRA within Molina Insights to triage and trigger referrals to our Molina My Health Tobacco Cessation program, facilitating direct referrals to Molina's clinical health educators. These Certified Tobacco Treatment Specialists will educate Members about these resources available through Molina, the State, nationally or through CBOs.

We will augment our support with value-added benefits that empower Members to access tobacco cessation products at no charge. We will "close the loop" and incorporate provider incentives, training, and referral protocols to help identify and encourage tobacco cessation.

Our Care Coordination staff and clinical health educators are essential to our tobacco cessation approach. We know from experience that most people quit smoking or using tobacco when personally affected, such as a death of a loved one.

Our staff take the time to build meaningful relationships with Members—listening to their stories and understanding their unique struggles and motivations—so they can develop individualized approaches to quitting smoking or using tobacco that resonate with the Member.

They celebrate big and small milestones to foster a sense of accomplishment and encouragement for the Member. This support, in concert with community-based resources and pharmacological interventions, provides Members with a personalized and compassionate experience, ultimately leading to better outcomes and improved overall health.

4.3.I.18 Value-added Benefits

18. Describe in detail the proposed value-added benefits the bidder intends to offer KanCare Members, including the scope of each benefit (including any limitations), the target population, and the anticipated benefit to KanCare Members. Include the bidder's approach to assessing the impact and value of the value-added benefits to Members.

Molina Healthcare Inc.'s (Molina Healthcare's) experience delivering value-added benefits to approximately 4.8 million Members across 18 subsidiary Medicaid health plans informs our approach to creating a suite of innovative solutions tailored to meet the unique needs of Kansans. Using best practices and lessons learned from almost 30 years of serving Medicaid Members, we will design and implement effective value-added benefits to address the whole-person needs of KanCare program Members.

Molina Healthcare uses value-added benefits as a key strategy to reduce health disparities and address SDOH needs, creating significant cost savings through reduced emergency department (ED) and inpatient admissions/readmissions and prevention of worsening conditions. Enterprise wide, our affiliates' value-added benefit offerings realized Medicaid program savings of $1.79 billion in 2019 and $1.8 billion in 2020—an increase in savings of approximately $74 million, even during the COVID-19 pandemic. As a result of value-added benefits, Members experience improved health, and communities benefit from healthier residents. For example, our Mississippi affiliate saw a 54% increase in the HEDIS rate for Well-Child Visits in the First 15 Months with Member incentives as part of their approach.

Our carefully curated suite of statewide value-added benefits aligns with our population health approach and the State's goals for improved health outcomes to:

- **Improve Member experience and satisfaction** by incentivizing Members to complete preventive care visits and offering benefits that encourage Members to play an active role in their own health
- **Reduce health disparities** by removing barriers to care, including SDOH, to improve access to and quality of care for Members
- **Improve health outcomes and promote independence** by offering person-centered services and supports to help Members live independently, including those residing in a LTC facility

To ensure our value-added benefits are appropriately utilized, tracked, and communicated, we are implementing the Molina Health Tracker. With this tool, Members will be able to easily see which value-added benefits are available to them and how to access them. Our staff will be able to use the tool as an advanced utilization tracker, which will help us both identify underutilized benefits and devise improved strategies to promote their utilization. Molina Health Tracker will also help our staff refine benefit strategies to raise utilization, satisfaction levels, and targeted health outcomes.

Proposed Value-added Benefits

Molina has a portfolio of value-added benefits that are proven effective in our health plans nationwide. We use a data-driven approach to continually monitor and evaluate our value-added benefits to verify alignment with our integrated, whole-person care approach and the State's

goals. We will ensure the State approves all proposed value-added benefits prior to them becoming part of our scope of services for the duration of the Contract term.

We provide information about our value-added benefits in various Member materials, including Member Welcome Packets, flyers at community events, and on our website and My Molina app. We also train Providers on the value-added benefits we offer during orientation and on an ongoing basis, so they can make recommendations based on an identified health condition or SDOH need. Our call center representatives also receive comprehensive training on value-added benefits and how to connect Members to these offerings, which they can do during any Member call.

Below, we have organized our value-added benefits into the following categories: Dental and Vision, Maternal and Child Health, Healthy Rewards, Health Equity and SDOH, Special Populations (LTSS/IDD, Physical Disability Waiver), and Special Populations (Foster Care). For each category, we have provided information on the scope of each benefit, the target population, and the anticipated benefit to KanCare Members.

Dental and Vision

Dental and vision benefits are integral components of Members' holistic wellness, significantly impacting an individual's quality of life. Offering additional benefits to access dental and vision benefits promotes preventive care and empowers Members to access vital services that contribute to their overall health.

Dental and Vision **Additional benefits to dental and vision to engage and improve overall health offerings to Members. Molina will measure the effectiveness of these value-added benefits through Member utilization and outcomes, and completion of timely interventions to prevent escalation of services in acute settings.**			
Value-added Benefit	**Scope of Benefit/ Limitations**	**Target Population**	**Anticipated Benefit to KanCare Members**
Adult dental care. Recognizing the direct correlation between good dental health and a healthy lifestyle, Molina will offer preventive, restorative, and periodontal care, including periodontal root planing and scaling, dental exams/cleanings twice per year, annual bitewing X-rays, fillings and extractions, root	[redacted] for dental services	Members 21 and older and pregnant Members	Providing dental services to adult Members will help emphasize preventive care. Regular dental check-ups and early intervention for dental problems can help Members avoid more serious and costly dental procedures later. Proper periodontal care can prevent gum disease and

Dental and Vision **Additional benefits to dental and vision to engage and improve overall health offerings to Members. Molina will measure the effectiveness of these value-added benefits through Member utilization and outcomes, and completion of timely interventions to prevent escalation of services in acute settings.**			
canals, and fluoride treatments.			help maintain healthy teeth and gums.*
Vision. Members can choose one pair of ZENNI® eyeglasses every two years. Members will have more than 50 styles to choose from, with virtual try-on and recommendations based on face shape. As part of this benefit, Members can choose hydrophobic antireflective coatings (ARC) lenses. A clamshell case, lens cloth, and bifocal or progressive lenses based on Member preference.	[redacted]	Members age 21 and older	Providing eyeglasses to Members helps reduce the risk of eye-related chronic health conditions, deaths, falls, and injuries. Eyeglasses can also help improve vision for Members and reduce overall health costs through early identification of health concerns, such as diabetic retinopathy.
Vision replacement. Members in foster care often transition from placement to placement, causing an increased chance of losing or misplacing eyewear. Molina will support Members in foster care by adding a replacement pair of eyeglasses.	[redacted]	Members in foster care	Providing eyeglasses for children in foster care accounts for their potentially frequent relocations and helps mitigate the challenges associated with losing or misplacing them during transitions. Providing eyeglasses helps ensure continuity in vision care, even among frequent moves.

* Aligned with Contract

Maternal and Child Health

Molina has committed to improving maternal health by extending services not only for mothers' well-being, but also to support the healthy development of their children and the stability of families. Our California affiliate received the state's first Health Equity Plus Accreditation award in 2018 for their innovative program to reduce disparities among black women receiving postpartum care. We anticipate being able to support similar outcomes for KanCare Members.

Maternal and Child Health **Our value-added benefits provide reward incentives to improve maternal health and reduce infant mortality rates. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, monitoring Member utilization, and completion of timely prenatal and postpartum visits by race and ethnicity.**			
Value-added Benefit	**Scope of Benefit/Limitations**	**Target Population**	**Anticipated Benefit to KanCare Members**
Postpartum visits—Molina Care Connections program. It is important for women who have had a baby to receive a postpartum exam within eight weeks of delivery. Molina Care Connections nurse practitioners offer evidence-based, in-home postpartum care to remove barriers to care.	[redacted]	New moms	Providing an evidence-based maternal home visiting model provides personalized care and support to new mothers in the comfort of their home. Healthcare professionals conducting home visits can identify postpartum complications or issues early, enabling timely interventions and preventing potential health problems.
Doula services. Pregnant Members have access to doula assistance g for prenatal visits, postpartum visits, and delivery assistance to provide emotional and physical support to the laboring mother and her family.	[redacted]	Pregnant Members meeting high-risk criteria	Studies have shown that doula support is associated with reduced rates of medical interventions during childbirth, especially for marginalized populations. This can help mitigate disparities in healthcare outcomes, such as lower rates of C-sections and other medical interventions that might

Maternal and Child Health **Our value-added benefits provide reward incentives to improve maternal health and reduce infant mortality rates. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, monitoring Member utilization, and completion of timely prenatal and postpartum visits by race and ethnicity.**			
			disproportionately affect certain groups.*
Lactation support. Access to lactation support for expecting mothers.	[redacted]	Pregnant Members	Lactation support can significantly improve the health outcomes for mothers and infants. Breastfeeding has numerous health benefits, including reducing the risk of certain illnesses for infants and aiding in postpartum recovery for mothers.*
Pregnancy rewards—safe sleep. Provide rewards to expectant mothers for a crib along with safe sleep education to promote infant safety.	[redacted]	Pregnant Members who complete their first prenatal exam within the first trimester (first 60 days of plan enrollment)	Providing education on safe sleep practices and cribs can contribute to reducing the risk of sleep-related infant mortality, promote healthy behaviors, and empower families to provide a safe sleep environment.*
Additional transportation. Additional transportation for pregnant and new mothers to pregnancy and postpartum value-added benefits and support groups. As an added benefit, Members may bring children/family members to their	Provides transportation to food banks, WIC, domestic violence agencies, housing authorities, and job interviews or trainings. Members need to request and receive approval through their Case Manager; only two additional family members.	All Members	Transportation services can help pregnant Members and new mothers easily access maternal support groups, which can provide emotional, informational, and social support. By adding a transportation benefit that extends to

Maternal and Child Health **Our value-added benefits provide reward incentives to improve maternal health and reduce infant mortality rates. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, monitoring Member utilization, and completion of timely prenatal and postpartum visits by race and ethnicity.**			
maternal medical visits and postpartum visits.			children and family members, we ensure Members do not have to find childcare and/or can bring emotional support with them as they access maternal health and support services.*
Transition meals for high-risk pregnant Members. Members may request home-delivered groceries that can support their nutritional needs during pregnancy, including high-risk pregnancies and gestational diabetes, and when breastfeeding, such as low birthweight babies.	[redacted]	Pregnant high-risk OB Members or through the first year postpartum	Molina's transitional meals program supports high-risk pregnant Members with chronic conditions and newly delivered moms by addressing food insecurity, a critical SDOH need that impacts post-discharge health outcomes. **Using data across our Medicaid affiliated health plans, we found that providing transitional meals reduced Member inpatient utilization by 70% and average medical costs by 39% over a 9-month period.***
Transition meals for pregnant or postpartum Members. Members may request home-delivered meals that can support their	[redacted]	Pregnant Members or through the first year postpartum	Molina's transitional meals program supports high-risk pregnant Members with chronic conditions and newly

Maternal and Child Health **Our value-added benefits provide reward incentives to improve maternal health and reduce infant mortality rates. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, monitoring Member utilization, and completion of timely prenatal and postpartum visits by race and ethnicity.**			
nutritional needs during pregnancy and when breastfeeding, e.g., for high-risk pregnancies, such as having gestational diabetes.			delivered moms by addressing food insecurity, a critical SDOH need that impacts health outcomes post-discharge.*
NICU support package. NICU support kits include educational materials on breastfeeding, a breastfeeding starter kit for moms, as well as a supply of diapers. Sample contents may include newborn clothing and essentials (e.g., baby onesie, socks, bibs, baby wipes, suction pump, pacifier, and thermometer), and delivery/postpartum educational materials such as safe sleep practices.	[redacted]	New moms with a baby in the NICU	Access to proper clothing, diapers, and essentials can contribute to the overall well-being of premature or ill infants.
Pacify box. Members who sign up for Pacify are eligible to receive a box that contains a burp cloth and guide card.	[redacted]	KanCare-eligible moms	Access to proper clothing, diapers, and essentials can contribute to the overall well-being of premature or ill infants.
Healthy Baby Text Education program. Text4baby™ helps prepare Members for motherhood by sending appointment reminders;	Free app for all pregnant Members	Pregnant Members and Members with children	Providing timely and easily accessible reminders and educational materials helps improve adherence to

Maternal and Child Health Our value-added benefits provide reward incentives to improve maternal health and reduce infant mortality rates. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, monitoring Member utilization, and completion of timely prenatal and postpartum visits by race and ethnicity.			
personalized information on prenatal care, baby's development, signs of labor, breastfeeding, and nutrition directly to Members' phones at no cost.		under one year old	healthcare appointments and improve healthcare outcomes.

* Aligned with Contract

Healthy Rewards

At Molina, we aim to foster a culture of proactive health management. Providing value-added benefits aimed at promoting healthy behaviors and preventive care arms Members with the tools and resources necessary to take charge of their health and well-being. Accessing preventive care and exercising healthy behaviors can help Members preempt health issues before they escalate, improving overall health outcomes and reducing the incidence of chronic conditions.

Healthy Rewards Reward incentives to promote healthy behaviors, close gaps in preventive care, and encourage Members to play an active role in their own health. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and monitoring Member utilization.			
Value-added Benefit	**Scope of Benefit/Limitations**	**Target Population**	**Anticipated Benefit to KanCare Members**
Smoking cessation. This benefit provides a [redacted] gift card for qualified Members, direct caregivers of Members, and close relatives of children with asthma when they sign up for the KanQuit program and an additional $30 upon completion of the program. In addition, we will provide a $30 Provider incentive for	[redacted]	Adult Members	Helping Members quit smoking can increase healthy eating, control weight, and lower cholesterol. Quitting smoking can also help improve diabetes management for diabetics. Decrease ED visits and readmissions.

Healthy Rewards **Reward incentives to promote healthy behaviors, close gaps in preventive care, and encourage Members to play an active role in their own health. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and monitoring Member utilization.**			
facilitating Member sign-up to the KanQuit program. We will also offer qualified Members, close relatives living with children with asthma, and direct caregivers of Members [redacted] for over-the-counter tobacco cessation products that are not covered by the KanQuit program.			As secondhand smoke can worsen asthma symptoms in children and pose risks to those needing caregiver support, this value-added benefit aims to prioritize the well-being of vulnerable individuals by supporting smoke-free environments.*
Follow-up after high-intensity care for SUD. 7-day follow-up after high-intensity care for SUD.	[redacted]	Only rewarded if diagnosis applicable	Incentivizing compliance with post-ED follow-up visits can be associated with a reduction in substance use, future ED use, and hospital admissions.
ADHD follow-up: 10 months. ADHD—follow-up visits within 10 months; visits within 10 months of initial prescription.	[redacted]	Only rewarded if diagnosis applicable	Promoting adherence to ADHD follow-up visits helps review medication use and effects to confirm right dosage and compliance, and for Members with ADHD to learn more about the how to manage their condition.
ADHD follow-up: 30 days. ADHD—follow-up visits within 30 days of initial prescription.	[redacted]	Only rewarded if diagnosis applicable	Promoting adherence to ADHD follow-up visits helps review medication use and effects to confirm right dosage and

Healthy Rewards **Reward incentives to promote healthy behaviors, close gaps in preventive care, and encourage Members to play an active role in their own health. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and monitoring Member utilization.**			
			compliance, and for Members with ADHD to learn more about how to manage their condition.
Diabetic eye exam. Receive annual diabetic retinal eye exam and complete HbA1c lab work.	[redacted]	Members ages 18–75 who have been diagnosed with diabetes	Improved vision for Members and reduced overall health costs through early identification of health concerns such as diabetic retinopathy. Improved compliance with Members with HEDIS diabetic eye exam measure.
Well-Child Visits: <15 months. Complete up to 6 well-child visits on time within a 15-month period.	[redacted]	Members from birth through 15 months old	Promoting adherence to well-child visits ensures children are hitting their developmental milestones and receiving any scheduling immunizations. This helps identify any potential issues, increasing overall wellness and reducing medical costs.
Well-Child Visits: 15–30 months. Complete 2 or more well-child visits when the child is between 15–30 months old.	[redacted]	Members ages 15–30 months old	Promoting adherence to well-child visits ensures children are hitting their developmental milestones and

Healthy Rewards **Reward incentives to promote healthy behaviors, close gaps in preventive care, and encourage Members to play an active role in their own health. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and monitoring Member utilization.**			
			receiving any scheduling immunizations. This helps identify any potential issues, increasing overall wellness and reducing medical costs.
Well-Child Visits: >3 years old. Complete a well-child visit annually.	[redacted]	Members ages 3–21	Promoting adherence to well-child visits ensures children are hitting their developmental milestones and receiving scheduled immunizations. This helps identify any potential issues, increasing overall wellness, and reducing medical costs.
BH inpatient follow-up visit. Complete a follow-up visit with a BH Provider within seven days of an inpatient hospitalization for mental illness (includes telehealth).	[redacted]	All Members	Follow-up visits post-BH inpatient stays contribute to after-care compliance and helps prevent readmission by reinforcing the treatment plan and evaluating the medication regimen.
Post-ED follow-up: mental illness. 7-day follow-up post-ED visit for mental illness.	[redacted]	All Members	Incentivizing compliance with post-ED follow-up visits can help improve health

Healthy Rewards **Reward incentives to promote healthy behaviors, close gaps in preventive care, and encourage Members to play an active role in their own health. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and monitoring Member utilization.**			
			outcomes and prevent readmissions.
Post-ED follow-up: substance abuse. 7-day follow-up post-ED visit for substance abuse.	[redacted]	All Members	Incentivizing compliance with post-ED follow-up visits can be associated with a reduction in substance use, future ED use, and hospital admissions.
PCP follow-up visit. Complete a follow-up PCP visit within seven days of an inpatient hospitalization or BH stay; unlimited (includes telehealth).	[redacted]	All Members	Incentivizing compliance with follow-up visits with PCPs post-ED or BH stays can improve Member outcomes and decrease the likelihood of re-hospitalization.
Adult preventive screening. Complete annual adult preventive screening visit (limited to one per year).	[redacted]	18 years and older	Compliance with adult preventive screenings can help mitigate health issues before they become chronic illnesses or conditions. They also help reduce the risk for diseases and disabilities.
HRA completion. Complete initial HRA, limited to one per enrollment period	[redacted]	All Members	HRAs can help mitigate health issues at an early stage, allowing for timely interventions and preventive measures.
Handle on Health: Bike and Helmet. Molina Members turning 8, 9, or 10	[redacted]	Members turning 8, 9,	Supporting compliance with well-child visits

Healthy Rewards **Reward incentives to promote healthy behaviors, close gaps in preventive care, and encourage Members to play an active role in their own health. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and monitoring Member utilization.**			
years old will get a gift card to use on their choice of bike and/or helmet, if they complete their well-child visit. They must complete the well-child visit as a Molina Member; once in lifetime reward.		or 10 years old	improves the overall health outcomes of Members and helps early identification of potential issues.
WW® (Weight Watchers). Members who receive prior authorization (PA) from the health plan can receive up to [redacted] of Weight Watchers services; they can be referred by Providers, internal departments (Care Coordinators and more), or by self-referral.	[redacted]	All Members	Increased healthy eating, weight control, and lower cholesterol. Improved diabetes management for diabetics. Support for postpartum nutritional needs. Increased food security for Members in food deserts. Decreased ED visits and readmissions. Improved CAHPS® scores and retention.
Mammogram. Complete an annual mammogram screening; [redacted]	[redacted]	Female Members ages 40–74	Compliance with adult preventive screenings can help mitigate health issues and detect cancer early. They also help reduce the risk for diseases and disabilities.
Cervical cancer screening. Complete an office visit for cervical cancer screening (pap test).	[redacted]	Female Members ages 21–64	Compliance with adult preventive screenings can help mitigate health issues and detect cancer early. They also help reduce the risk for

Healthy Rewards **Reward incentives to promote healthy behaviors, close gaps in preventive care, and encourage Members to play an active role in their own health. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and monitoring Member utilization.**			
			diseases and disabilities.
Chlamydia screening. Complete an annual chlamydia/gonorrhea screening.	[redacted]	All Members	Compliance with adult preventive screenings can help mitigate health issues and detect cancer early. They also help reduce the risk for diseases and disabilities.

* Aligned with Contract

Health Equity and SDOH

We offer value-added benefits specifically aimed at addressing SDOH and promoting health equity. We design these benefits to tackle barriers that hinder access to healthcare, such as transportation or food insecurity. By focusing on these supplementary benefits, we aim to provide practical support that directly addresses root causes of health disparities among our Members, creating more equitable health outcomes.

Health Equity and SDOH **These value-added benefits provide programs and services to reduce the impact of SDOH, such as food insecurities, lack of transportation, and limited education. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and Member utilization rates for the ED, PCP visits, and pharmacy refills.**			
Value-added Benefit	**Scope of Benefit/Limitations**	**Target Population**	**Anticipated Benefit to KanCare Members**
SDOH platform. Provides Members on-demand, 24/7/365 access from our website and mobile application access to thousands of community resources across the State in the	Free—no cost for Members	All Members	By providing free access to community resources, Members can gain access to needed services such as food pantries, cash assistance programs, and housing assistance.

Health Equity and SDOH These value-added benefits provide programs and services to reduce the impact of SDOH, such as food insecurities, lack of transportation, and limited education. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and Member utilization rates for the ED, PCP visits, and pharmacy refills.			
areas of health, financial support, education, emergency resources, legal support, housing, employment opportunities, transportation, and food security.			
Additional transportation. Additional transportation including family members. Members may receive transportation to certain medical and SDOH resources (community-based organizations, job counseling, job interviews) and may have their children/family attend Provider visits.	Provides transportation to food banks, WIC, domestic violence agencies, housing authorities, and job interviews or training; only two additional family members	All Members	Transportation services can help Members access the services they need, mitigating SDOH challenges. Also, providing this benefit for up to two family members helps eliminate the need for childcare.*
Free phone with apps. We will partner with TruConnect to provide Members with access to a new smart mobile device (with unlimited mobile data, voice, and text) that will be preloaded with Molina care coordination apps, including telehealth,	[redacted]	Members who qualify for the federal Lifeline program	This partnership will allow us to bridge the gap of multiple platforms by providing Members with a single use resource with live customer service for ongoing education and engagement.

Health Equity and SDOH These value-added benefits provide programs and services to reduce the impact of SDOH, such as food insecurities, lack of transportation, and limited education. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and Member utilization rates for the ED, PCP visits, and pharmacy refills.			
and organized in a user-friendly way. Customer support includes digital literacy, such as how to keep information secure; download and log on to apps, portals, and websites; and how to use the apps. If the Member already owns a device, TruConnect will load the apps for them and offer the same level of customer service.			
Asthma remediation program. Provide remediation and home assessment for asthma triggers in the home environment such as: mattress and/or pillow covers, air purifier, carpet shampooing as needed to manage triggers.	All Members in the Asthma Disease Management program	Up to [redacted] of supplies to help mitigate environmental triggers in the home	Asthma remediation items can help reduce asthma symptoms and improve asthma management, which in turn will lead to reduced ED visits, hospitalizations, and the need for urgent medical care.
Member care grant. Care Coordinators will be empowered to meet identified Member needs in real-time using care grants. Members may use funds for things such as emergency utility assistance, pest	[redacted]	Members in care management meeting the criteria	Financial assistance to help Members pay for necessities can address basic needs, promote stability, and foster better health outcomes, allowing Members to focus

Health Equity and SDOH **These value-added benefits provide programs and services to reduce the impact of SDOH, such as food insecurities, lack of transportation, and limited education. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and Member utilization rates for the ED, PCP visits, and pharmacy refills.**			
control, baby formula, and diapers.			on their health and well-being.
YMCA. Members can participate in activities/classes at a local YMCA. **YMCA360.** Platform that offers live or on-demand group exercise classes with favorite instructors, nutrition classes, youth enrichment, fitness options, and more. Focuses on Members with diabetes and obesity.	[redacted]	We will provide organization membership dues to the YMCA360 program for qualified Members under the age of 20	Member access to all levels of physical exercise supports greater health and wellness.
Healthy Foods program. Members experiencing food insecurity and a high-risk condition such as diabetes or high-risk pregnancy can receive membership or fresh funds accounts for food choices.	[redacted]	For high-risk Members with chronic conditions requiring access to food services	Access to affordable, healthy food is especially important for individuals with chronic conditions or who are pregnant. Nutrient dense food choices can lower the risk factors associated with these conditions, potentially preventing avoidable hospitalizations.
GED testing. Vouchers to take GED test for free at	[redacted]	Members age 18 and older	Helping Members receive their GED helps open doors for better job

Health Equity and SDOH These value-added benefits provide programs and services to reduce the impact of SDOH, such as food insecurities, lack of transportation, and limited education. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and Member utilization rates for the ED, PCP visits, and pharmacy refills.			
authorized testing centers.			placement, promotes personal development, and plays a role in fostering healthier, more empowered communities.
GED testing. Gift card for passing GED exam.	[redacted]	Members age 18 and older	Helping Members receive their GED helps open doors for better job placement, promotes personal development, and plays a role in fostering healthier, more empowered communities.
My Molina app. The My Molina app provides Members with a variety of resources, including information about their Molina benefits, Member ID card, list of medications, and Plan of Service. Our My Molina app delivers push messages with information about how to close an identified care gap, e.g., reminders that it's time for a preventive visit. With the touch of the screen, Members can	Free—no cost for Members	Members actively enrolled and participating in Molina programs that have communication access barriers	Using the My Molina app will help Members take control of their healthcare. They are more empowered to reach out to their interdisciplinary team easily, make sure that they are meeting their preventive care visit schedule, and access their health records easily.

Health Equity and SDOH These value-added benefits provide programs and services to reduce the impact of SDOH, such as food insecurities, lack of transportation, and limited education. Molina will measure the effectiveness of these value-added benefits through Member outcomes, including year-over-year HEDIS rates, and Member utilization rates for the ED, PCP visits, and pharmacy refills.			
connect with their interdisciplinary team.			
Criminal record expungement. Members can have a nonviolent criminal record expunged at Molina's expense through our record expungement service.	[redacted]	Members age 18 or older who meet the guidelines for expungement	Helping Members receive legal and administrative support to expunge their criminal record.

Special Populations—LTSS, IDD, and Physical Disability Waiver

Molina uses effective Member engagement strategies and creative solutions, such as enhanced services, to support community integration. Use of these best practices in our affiliate health plans has increased the annual transition rate from 2% to 9%. Nationally, 93% of Molina Members receiving MLTSS are living in community settings.

Special Populations—LTSS, IDD, Physical Disability Waiver These value-added benefits provide programs and services to empower persons with disabilities to make decisions about the services they receive and the individuals who provide them, including having choice and control over the type of support services they receive and the who, what, and where of service delivery.			
Value-added Benefit	**Scope of Benefit/Limitations**	**Target Population**	**Anticipated Benefit to KanCare Members**
Transition assistance. Nursing Facility to Community Setting Community transition waiver. This will assist with deposits for housing or utilities, household items (e.g., furniture, microwave), health and safety items and moving expenses.	[redacted]	LTSS Members age 60 and older	Transition assistance supports individuals' preferences, promotes better quality of life, encourages social integration and facilitates independent living.*

Special Populations—LTSS, IDD, Physical Disability Waiver These value-added benefits provide programs and services to empower persons with disabilities to make decisions about the services they receive and the individuals who provide them, including having choice and control over the type of support services they receive and the who, what, and where of service delivery.			
Caregiver assessment and training. Incentive to Member upon primary caregiver completion of an HRA. Caregivers assessed with moderate- to high-risk for burnout receive care planning and management to address identified risks.	[redacted]	Caregivers age 18 and older	Helping caregivers prevent burnout ensures better quality of care, enhances safety, empowers and supports caregivers, reduces healthcare costs, and promotes the ability of individuals to remain in their homes.
Additional transportation. Additional transportation for Frail Elderly and Physical Disability Waiver Members to certain medical and SDOH resources and may have their children/family attend Provider visits.	[redacted]	Members eligible for IDD, SED or Autism Waivers	Transportation services can help Members access the services they need, mitigating SDOH challenges. Also, providing this benefit for up to two family members helps eliminate the need for childcare.
Care for caregivers. Assessment and free, clinically validated training for caregivers to enhance their skills and confidence to support Members and access to peer support groups.	[redacted]	Caregivers age 18 and older	Helping caregivers ensures better quality of care, enhances safety, empowers and supports caregivers, reduces healthcare costs, and promotes the ability of individuals to remain in their homes.
Decision support. We pay for an independent occupational therapist expert to provide options/recommendations for services to better meet their needs.	Initially upon request by Member or care team and as needed in conjunction with assessment.	Members receiving HCBS or on HCBS wait list.	Decision support upholds individuals' preferences, promotes better quality of life, encourages social integration and

Special Populations—LTSS, IDD, Physical Disability Waiver These value-added benefits provide programs and services to empower persons with disabilities to make decisions about the services they receive and the individuals who provide them, including having choice and control over the type of support services they receive and the who, what, and where of service delivery.			
Promotes choice and addresses critical workforce shortages.			facilitates independent living.
Fall prevention incentive. Incentive for completing fall reduction program. This program is offered virtually with community partnerships to reduce likelihood of falls that may lead to institutionalization or prevent transition.	[redacted]	LTSS Members age 60 and older	Providing incentives for fall reduction education promotes proactive measures to reduce fall risks, leading to a healthier, more independent lifestyle.
Social isolation. Provides screens for depression, anxiety, and SDOH needs. Allows for Members to connect with a support center over the phone.	Members with a lack of social contact or support	LTSS Members age 60 and older	Screening for social isolation risk factors facilitates early intervention and promotes mental and physical well-being.
Weighted blankets. Members who are on the IDD, Autism or SED Waivers will be given a weighted blanket.	[redacted]	Members eligible for IDD, SED or Autism Waivers	Weighted blankets will help support improved sleep quality, reduce anxiety and stress, assist in sensory regulation, and alleviate certain types of pain.
BH caregiver therapy. Individual therapy sessions for caregivers.	[redacted]	Caregivers age 18 and older	BH therapy can help give caregivers coping strategies to help manage and reduce stress and provide them with healthy problem-coping strategies. In turn, this can help

Special Populations—LTSS, IDD, Physical Disability Waiver These value-added benefits provide programs and services to empower persons with disabilities to make decisions about the services they receive and the individuals who provide them, including having choice and control over the type of support services they receive and the who, what, and where of service delivery.			
			health outcomes for Members.
Caregiver transportation. Caregiver transportation for LTSS-eligible caregivers who need transportation to see loved ones in an assisted living facility.	[redacted]	Caregivers age 18 and older	Helping to coordinate transportation for caregivers to see loved ones helps reduce barriers to providing care, giving caregivers the ability to focus on their loved ones' needs.
Meals reimbursement for day trips. Members age 60 and over can get reimbursed for meals during travel days for medical visit	[redacted]	LTSS Members age 60 and older	Providing meal reimbursement during medical visits helps Members, especially those living far from medical care, supports nutritional needs, reduces financial stress, enhances the overall experience during medical visits, and promotes equitable access to healthcare resources.
Respite care. Molina provides respite care to Member caregivers to allow self-care time to recharge and rejuvenate.	[redacted]	Caregivers age 18 and older	Providing respite care to caregivers reduces burnout and allows caregivers time to recharge, which in turn, helps them better care for Members.
Legal services—guardianship. Provides	[redacted]	LTSS Members age	Providing legal assistance for

Special Populations—LTSS, IDD, Physical Disability Waiver These value-added benefits provide programs and services to empower persons with disabilities to make decisions about the services they receive and the individuals who provide them, including having choice and control over the type of support services they receive and the who, what, and where of service delivery.			
legal assistance to the individual who wants to file a petition for guardianship, ensures individuals are given notice and opportunity to be heard prior to appointment of a guardian.	[redacted]	60 and older; Members needing guardianship to transition into healthcare setting or home	guardianship will help Members' health, safety, and general welfare by having someone make important decisions on their behalf. Guardians can provide emotional and practical support to Members, helping them live a full, more independent life.

* Aligned with Contract

Special Populations—Foster Care

Children in foster care have unique challenges and diverse needs—we aim to provide comprehensive and tailored support beyond standard healthcare coverage by offering specific foster care value-added benefits. For aging-out youth, we offer transition to adulthood planning built on best practices in other states, such as our Texas affiliate's partnership with the state's Preparation for Adult Living program to address needs related to health, safety, job readiness, fiscal management, life decisions, and relationships.

Special Populations—Foster Care Molina focuses on supporting Members in Foster Care achieve success at home, in school, and ultimately in the workforce with programs and services to promote independence and economic self-sufficiency, from success within life skills to aging out in transition to adulthood.			
Value-added Benefit	**Scope of Benefit/ Limitations**	**Target Population**	**Anticipated Benefit to KanCare Members**
Age-out transition assistance. Up to $500 in one-time assistance for young adults transitioning out of foster care at age 18 or extended foster care at age 21.	[redacted]	Members in foster care age 18 and older	Youth transitioning out of foster care often need financial assistance with things like rent, utilities, and insurance payments. Providing a financial

Special Populations—Foster Care **Molina focuses on supporting Members in Foster Care achieve success at home, in school, and ultimately in the workforce with programs and services to promote independence and economic self-sufficiency, from success within life skills to aging out in transition to adulthood.**			
			benefit helps ease stress.*
Transition legal support. [redacted] for legal services for guardianship and other transition support for youth age 16 and older.	[redacted]	Members in foster care age 16 and older	Offering transition legal support empowers Members in foster care as they navigate complex legal aspects of aging out of the foster care system. It facilitates a smoother transition to adulthood and ensures understanding of rights and legal matters.
Vocational training. For Members pursuing vocational school/ certificate program (e.g., welding program, dental assistant certification), we will provide up to [redacted]	[redacted]	Members in foster care	Providing financial assistance for vocational training promotes independence and help Members in foster care gain the skills they need for careers.
Driver education. Fee for the behind-the-wheel course required to obtain State driver's license.	[redacted]	Members in foster care	Helping Members in foster care attain their driver's license enhances independence, expands opportunities, promotes responsibility, and supports their transition into adulthood.
Transitional life skills. Financial management and	[redacted]	Members in foster care	Helping Members in foster care with transitional life skills

Special Populations—Foster Care **Molina focuses on supporting Members in Foster Care achieve success at home, in school, and ultimately in the workforce with programs and services to promote independence and economic self-sufficiency, from success within life skills to aging out in transition to adulthood.**			
soft skills to promote independence.			equips them with practical tools as they transition into adulthood. It also builds their confidence, resilience, and ability to navigate adulthood.
Calming comfort. Aromatherapy, light therapy, and sound machines to address BH needs.	[redacted]	Members in foster care	Calming comfort can help reduce stress, improve sleep and enhance overall well-being.
College supplies. Sponsorship for essential supplies (e.g., bedding, towels, school supplies) for current and former foster youth attending college.	[redacted]	Members in foster care	By helping Members in foster care with supplies supports academic success, promotes stability, and reduces financial stress.
Clothing stipend. [redacted] to purchase needed clothing.	[redacted]	Members in foster care	Often, children in foster care have challenges accessing proper clothing. Offering a clothing stipend supports their dignity, self-expression, and well-being by providing access to suitable clothing.
Backpacks/duffle bags. Backpack or duffle for transition-age youth to transport belongings.	[redacted]	Members in foster care	By providing backpack/duffle bags to children in foster care, we help provide them with a place to keep their belongings, and support their sense of dignity (i.e., being able to use a duffle bag

Special Populations—Foster Care **Molina focuses on supporting Members in Foster Care achieve success at home, in school, and ultimately in the workforce with programs and services to promote independence and economic self-sufficiency, from success within life skills to aging out in transition to adulthood.**			
			versus a trash bag), organization, and emotional well-being.
Transportation. NEMT to participate in job-related or extracurricular activities.	No limit on number of rides	Members in foster care	Transportation services can help Members in foster care access the services they need, mitigating SDOH challenges.
Care grants. Care Coordinators will be empowered to meet identified Member needs in real-time using care grants. Members may use the funds for services and supplies for social or physical activities, such as a gym membership, sports equipment, and art supply application fees for post-high school education.	[redacted]	Members in foster care	Care grants provide Members in foster care resources that support their holistic development, mental health, social integration, and skill acquisition
Life skills. Education for children age 12 and older with developmental disabilities to help them keep, learn, or improve skills and functioning for daily living.	[redacted]	Members in foster care age 12 and older	Providing life skills to Members in foster care with developmental disabilities helps them develop vital skills for future independence.
Companion support. Molina Community Health Workers (Molina CHWs) accompany transition-age youth to their first adult PCP appointment to support self-advocacy skills and confidence.	[redacted]	Members in foster care	CHWs can provide Members in foster care with emotional support as they visit their PCP. They can also assist with communication and advocacy skills.

Special Populations—Foster Care **Molina focuses on supporting Members in Foster Care achieve success at home, in school, and ultimately in the workforce with programs and services to promote independence and economic self-sufficiency, from success within life skills to aging out in transition to adulthood.**			
Extra orthodontic services. We will provide additional orthodontic services to Members in foster care.	All Members in foster care are eligible for extra orthodontic care if they meet the following criteria: • The benefit covers braces up to [redacted]. • Deep impinging overbite greater than 70% that shows palatal impingement of lower incisors. • True anterior open bite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted.) • Anterior crossbite and posterior crossbite involving more than one tooth. • Impacted incisors or canines or blocked out teeth that will not erupt into the arches without orthodontic or surgical intervention.	All Members in foster care	Providing additional orthodontic services to Members in foster care not only supports their dental health and overall well-being, but also assists in building their self-esteem and confidence, addresses potential speech issues, and prevents future dental complications.

Special Populations—Foster Care Molina focuses on supporting Members in Foster Care achieve success at home, in school, and ultimately in the workforce with programs and services to promote independence and economic self-sufficiency, from success within life skills to aging out in transition to adulthood.			
	• Overjet more than nine millimeters. • Class III occlusion. • Excessive spacing or crowding greater than 10 millimeters when teeth are fully in occlusion. • Cleft lip/palate deformities and other significant craniofacial anomalies. • Malocclusions requiring a combination orthodontic and orthognathic surgery for correction. Members may visit a contracted dental Provider to utilize this value-added benefit for approved braces.		

* Aligned with Contract

Approach to Assessing the Impact and Value of the Value-added Benefits to Members

We understand that value-added benefits can be under-communicated or underutilized, rendering them ineffective. At Molina, we are not only committed to ensuring Members are aware of the benefits they are eligible for, but also to conducting ongoing analyses to make sure our benefits are relevant to Members. Through this commitment, we will leverage new tools, technologies, and systems that will improve the quality, accessibility, and effectiveness of our value-added benefits, quality incentives, and SDOH solutions.

To that end, we are developing a unique, proprietary platform, Molina Health Tracker, to streamline the management, oversight, and reporting of these benefits. Molina Health Tracker will equip Molina staff, including call center representatives, and Care Coordinators with detailed and rapid insights on which benefits Members are eligible for and what Members need to do to access benefits. Our health plan staff will use the benefit-specific Member outcomes, demographic, claims, encounters, and SDOH data analyzed by Molina Health Tracker to proactively identify benefits that are underutilized by Members, design effective engagement strategies, and improve the types of benefits we offer. Members can access the Molina Health Tracker via the Member portal and My Molina app. They will be able to use the platform to receive detailed information on each of the value-added benefits and see which value-added benefits they are eligible to receive.

In addition, while some health plans may focus on performance measures to validate the effectiveness of their value-added benefits, Molina believes it is far more impactful to measure how we have improved our Members' overall health and well-being, addressing Members' physical health, BH, LTSS, and SDOH needs.

In addition to year-over-year HEDIS rates, we also monitor key performance indicators (e.g., utilization rates by population streams, Member satisfaction results, reductions in acute care costs) to assess the impact and value of value-added benefits. We are developing mechanisms to capture value-added benefit utilization regarding clinical benefit and health outcomes. We will compare the clinical benefit with the financial cost of providing these services.

We will implement a cross-functional Value-added Benefits Committee dedicated to improving the Member experience and developing and implementing methodology to capture and measure Members' improved health outcomes related to our value-added benefits offerings. The committee, which will include staff across our organization, including Community Engagement, Provider Engagement, Quality, and Care Coordination leaders, will also regularly review reports to monitor trends and identify opportunities for improvement.

The team will study the data to identify key drivers and design and test solutions to increase Member awareness, monitoring subsequent utilization changes. We will analyze the expected utilization and outcomes and conduct financial forecasting to determine if we should be offering or expanding value-added benefits to different populations. When we determine that a value-added benefit is not achieving the desired outcome, we may refine it or discontinue it to allow investment in another value-added benefit that offers Members greater opportunity for success.

Quality Assurance (Tab 7e)

MOLINA HEALTHCARE

4.3.I.19 Quality Program and Approach to Implementing a Quality Program for KanCare That Drives a Program-wide Culture of Continuous Quality Improvement (CQI)

19. Describe the bidder's quality program and the bidder's approach to implementing a quality program for KanCare that drives a program-wide culture of continuous quality improvement. Include the following in the bidder's response:

a. The structure, composition, and responsibilities of the bidder's quality-focused committees and how the bidder will use its quality structures to promote changes in plan and Provider practices and operations.
b. The bidder's capabilities to collect and examine quantitative and qualitative data and information to evaluate clinical and LTSS quality, including health outcomes and Member experience, and effective health care operations. Include the bidder's approach to utilizing data, information, and analytics to drive continuous performance improvement.
c. The bidder's approach to regularly providing information available to the public about the bidder's program performance in KanCare, including the information the bidder proposes to publicly share and how the information will be shared.

Drawing from nearly 30 years of experience across our affiliates nationwide, our well-established QAPI program incorporates invaluable lessons learned to enhance Member quality of care. The QAPI structure and policies of our 18 Medicaid affiliated health plans support the integrated, holistic needs of approximately 4.8 million Members. We take a comprehensive approach to address the distinct needs of Members. The approach encompasses not only physical health but also behavioral health (BH), dental care, pharmacy services, and socioeconomic supports. This holistic strategy ensures we attend to all facets of the Members' well-being. Our affiliates implement a localized, comprehensive strategy tailored to address each state's unique Medicaid program needs; we will take the same approach for the KanCare program. Our parent company ensures that quality improvement (QI) and health equity are deeply entrenched throughout our organization, so no Molina Medicaid affiliates delegate QI or health equity.

Molina's Approach to Implementing a Culture of CQI

Quality begins at the top, which is why our overarching QAPI program will be overseen by Kansas Plan President and Chief Executive Officer (CEO) Aaron Dunkel and our Medical Director (CMO) and will permeate everything we do. The cornerstone of our QAPI program is our leadership's fundamental commitment to a data-driven and proactive approach. All members of our organization—from Mr. Dunkel through Molina employees at all levels—will be involved in continually identifying improvement opportunities through formal and informal interactions with Members, Providers, and community organizations. We will systematically address these improvement opportunities through data-driven and -informed interventions that reflect the perspectives of those we serve, with the goal of improving the health, well-being, and experience of those enrolled with Molina. Our QAPI approach, including as described later in subsections a, b, and c, can be differentiated from those of other MCOs in several ways:

We Are Built Specifically for Medicaid. Unlike other MCOs, which use commercial quality programs, key performance indicators, and infrastructure as a foundation for their Medicaid quality programs, Molina is wholly dedicated to serving individuals in government-sponsored programs and understands from this experience that improving quality for individuals who receive Medicaid benefits requires a completely different approach. We understand that engaging

individuals enrolled in Medicaid programs is different, Member needs are more extensive and multifaceted, State goals are foundational, and improvement opportunities must be approached differently and often in collaboration with other MCOs, Providers, and community organizations.

We Collaborate with Providers and Stakeholders. We know that healthcare is local and understand that it's with local Providers and in local communities where quality care happens. We offer real partnerships by meaningfully including stakeholders in policy and program development and evaluation, efforts that include flexible and quality-driven and -supported VBP and community reinvestment programs. In the process of becoming a KanCare MCO, we designed our KanCare MCO based on feedback from hundreds of meetings with stakeholders in every corner of the State. We also relied on Mr. Dunkel's deep experience in Medicaid and healthcare. We offer adaptable intervention strategies to meet the needs of unique populations. These strategies include an investment in automated appointment scheduling to help Members schedule their preventive and chronic healthcare visits or mobile visits with in-house nurse practitioners. This solution also reaches people in rural and frontier areas.

We Weave Health Equity Throughout Our Organization. Rather than treating health equity as a separate program, all quality activities—including data analytics, intervention design and implementation, value-based payment models and performance improvement plan activities—incorporate a health equity lens, because we understand that improving population outcomes requires intervening at each population group level to reduce disparities.

We Achieve Results. Molina affiliates across the country achieve outcomes regarding their states' priorities that are often better than those of our peer health plans. Generally, across all states that withhold a portion of payments for quality outcomes, Molina affiliates gain back more than 84% of dollars withheld because they reach quality and operational targets. Additionally, various affiliate health plans achieve top ratings in their states. Our Florida affiliate, for example, is the only plan in Florida to achieve a 4-star rating for three years in a row, according to NCQA's Health Plan Ratings for Medicaid.

Advancing Kansas' Quality Strategy Goals Through Molina's Quality Solutions

Molina's QAPI program and approach align with KanCare priorities, goals, and objectives. Our objectives include improving quality of care and health outcomes for Members, and we emphasize Member and representative choice, rights, access, safety, dignity, independence and community inclusion, and productivity. Below, we highlight examples of specific quality programs and strategies to support KanCare.

KanCare Goal: Improve Member Experience/Health Outcomes While Recognizing SDOH

Molina's locally based Care Coordination team—comprising Care Coordinators, CHWs/community health representatives (CHRs), Peer Support Specialists, and specialized SDOH-focused staff—collaborates closely with Providers, stakeholders, and agencies to frequently engage in high-touch care to address SDOH and improve health outcomes. For example, to expand access to community-based supports, [redacted]

Kansas Partner

[redacted] Our approach to supporting community care coordination, targeted case management (TCM), and CCBHC care coordination models further demonstrates our commitment to improving the Member experience and seamlessly addressing SDOH needs.

Removing SDOH Barriers to Improve Access to Care. We are leveraging a variety of identification tools and screeners to quickly identify and address Members' SDOH needs and connect Members with appropriate SDOH Providers. Our commitment includes investing in the sustainability of the SDOH infrastructure and ensuring continued follow-up for successful outcomes. We will implement closed-loop referral monitoring tools that can interface with a variety of platforms—including Unite Us, our SDOH platform, and KU IRIS—to measure SDOH impact and to ensure Members receive needed services.

KanCare Goal: Reduce Healthcare Disparities

Using our advanced analytical tools, we slice quality and outcomes data by various cohorts (e.g., race, ethnicity, gender, and geography), so every planned intervention is targeted and considers disparities. Our Health Equity team will analyze outcomes in various geographies to identify opportunities to reduce disparity in the Member experience within the healthcare and community care ecosystem. We will use this information in our QI interventions, for example, enhancing staff training, modifying workflows, and prioritizing community investments.

Addressing Disparate Birth Outcomes. Given the known disparities in maternal health outcomes, we've invested specifically in this area in a variety of ways. For example, we know doula services are a proven method of enhancing early engagement in prenatal care. Therefore, we're committing to the following program enhancements, which we expect to drive improved maternal health outcomes, particularly in areas that have higher rates of disparate outcomes:

[redacted]

KanCare Goal: Improve the Provider Experience/Expand Provider Network Capacity

Molina's strategy to improve outcomes begins by expanding access to existing Provider networks, which are vital to implementing a strong Medicaid program. We will focus on local investments through VBP arrangements, incentive programs, technical and financial program support, and differential rate adjustments for evidence-based high-quality care. We have reached out to Kansas Providers to establish a foundation for partnering and to develop collaborative approaches that extend beyond letters of agreement. [redacted] We will continue to expand upon these solid first steps and commit to holding quarterly Provider Forums to solicit feedback in the first two years, exceeding contractual requirements.

[redacted]

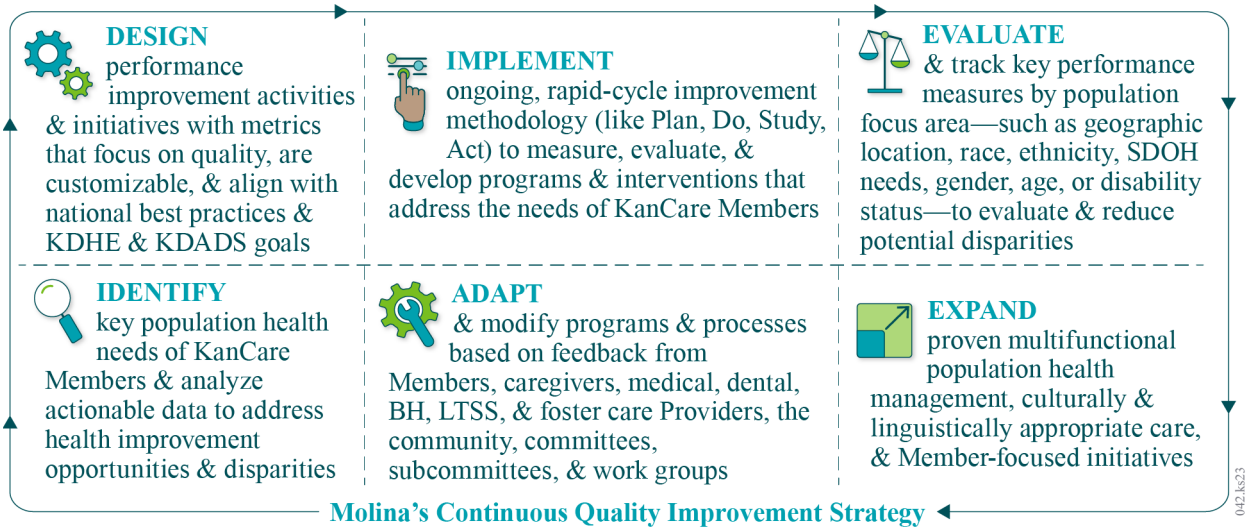
KanCare Goal: Increase Use of Cost-Effective Strategies to Improve Health Outcomes

We partner with Providers to close care gaps and prevent inappropriate use/overutilization of services. We aggregate the screening, assessment, and service needs of Members and their families, identifying needs that require timely follow-up and providing relevant information to Providers. Through our integrated Provider Notify program, participating Provider practices receive automatic care gap alerts. We partner with community care coordinators and external CHWs to conduct Member outreach regarding care gaps and educate Members on incentives for preventive screenings.

Molina's Commitment and Approach to Implementing a Quality Program Drives CQI

Molina fosters a culture of CQI, innovation, and service excellence at all levels of QAPI program design. Our commitment to CQI includes integration of quality principles, such as the Institute for Healthcare Improvement's Quintuple Aim, and the systemic exploration of CQI opportunities through cross-departmental collaboration. We deploy the Institute for Healthcare Improvement QI Essentials Toolkit across all departments to better apply industry best practices, such as Plan-Do-Study-Act (PDSA) rapid-cycle testing. **Exhibit 19-1** shows Molina's QAPI program's comprehensive approach to CQI.

Exhibit 19-1. Molina QAPI Program's CQI. Our QAPI Program unites teams to transform system performance and elevate service quality across our organization.



At the core of our QAPI program are experienced staff, who have deep subject matter expertise; and our infrastructure, which includes key oversight and accountability across critical internal functional areas, an integrated local committee structure, advanced data and analytics capabilities, innovative Member strategies, and collaboration with Members, Providers, and stakeholders. Molina's leadership—with support from subject matter experts across our larger organization who have experience in HEDIS operations, advanced analytics, intervention innovation, Provider collaboration, and NCQA accreditation—will create and foster an ongoing and dynamic culture of innovation, CQI, and healthcare excellence. This culture encompasses our entire organization and includes continually responding to the evolving and holistic needs of Members, Providers, regulators, and other program stakeholders, in alignment with nationally recognized standards. We will do so through our QAPI program, which will be tailored to Kansas' demographics, health and service priorities, and Contract requirements.

Molina's Commitment to Improving Quality in KanCare

Molina's focus on making a positive impact on the KanCare program can be seen through our tangible commitments. After studying the program, analyzing current results, and reviewing what affiliated health plans with similar populations have achieved, we are making the following commitments to improving quality in the KanCare program:

- Ensure all Quality staff and key health plan leaders take Institute for Healthcare Improvement QI courses in the first year and use QI tools routinely.
- [redacted] mechanisms that include monthly and quarterly meetings, collaborative events, and QI activities, as well as documented feedback loops tracking how the feedback was received and how the response to input was completed.

Success from Molina Workgroups
During a regional Provider workgroup, a network BH nurse practitioner stressed the importance of system interoperability in coordinating care. She stated that in the emergency department (ED), if a patient is from a different state and they are in an interoperable EHR system, medical staff can see information about the patient and put in referrals to the local health system. This feedback helps drive Molina to restate the importance of this electronic connection across health systems and physicians.
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- **Conduct targeted surveys** that focus on Member and Provider experiences and quality of life. The surveys should be designed to promote generalizability to the overall population based on statistically significant survey response rates. [redacted]

a. Molina Structure and Composition, Responsibilities of Quality-focused Committees, and Use of Our Quality Structure to Promote Changes in Plan and Provider Practices and Operations

Our QAPI program governance structure, as shown in **Exhibit 19-2**, will support the continuous collection of feedback on and evaluation of the quality and clinical appropriateness of care furnished to Members and all other relevant variables of Molina's Medicaid operations. This includes how we address the needs of specific populations, such as Members with LTSS needs, Members who have IDD or SPMI, and foster care children and teens. Our quality-focused committees will facilitate transparent and collaborative environments for Members, Providers, and other stakeholders to promote quality healthcare service delivery. **Our committee approach goes beyond State and NCQA requirements by adding additional workgroups, such as nursing facility (NF) and HCBS advisory workgroups.** Our affiliates recently instituted an approach using workgroups across contiguous states that afforded them the opportunity to receive input from Providers, identify best practices, and collect feedback that may apply to more than one health plan. The conversations on the first workgroup topic (continuity and coordination of care) provided valuable feedback about integrated physical and BH interventions.

[redacted]

Molina's Board of Directors will have ultimate accountability for our QAPI program and provide strategic direction on all QAPI activities, including data collection and analysis, evaluation, improvement, and identification and remediation of issues affecting performance, and compliance with KanCare's Quality Strategy. Our Board will ensure quality of care and service excellence are instilled system-wide and that we have the resources and support necessary for a highly effective QAPI program, including a robust health information system. Our Board will also ensure Member, caregiver, Provider, and CBO voices are elevated through formal governance and reflected in our QAPI activities, policies, and performance. Our Board will entrust our overarching Quality Committee to handle the day-to-day responsibilities of our QAPI program, including monitoring and evaluating outcomes, ensuring the overall effectiveness of the QAPI program, and initiating CAPs. Our Quality Committee is responsible for the implementation, oversight, and ongoing monitoring of the QAPI program and reports directly to the Board of Directors.

Committee Composition and Responsibilities

The committee and subcommittees will conduct functionally aligned quality and health equity improvement activities while strengthening inter-committee linkages and coordination, enhancing communication, and engaging stakeholders. Our Quality committees are directly accountable to the Board of Directors and will each possess a clearly outlined charter defining their roles, responsibilities, membership, and meeting frequency.

Our **Quality Committee**, chaired by both the Medical Director (CMO) and Quality Management (QM) Director, is responsible for all aspects of our QAPI program, including reviewing and approving policies and procedures that direct QAPI program activities; analyzing and evaluating results of our QAPI program and health equity activities; reviewing performance measurement results, utilization data, and Member and Provider satisfaction data; acting to address deficiencies and following up to ensure deficiencies are addressed in a timely manner. QAPI program descriptions, work plans, and evaluations will be reviewed at least annually before Board review and approval. Work plan deliverables will be monitored quarterly. Molina participants will include our Plan President and CEO, Mr. Dunkel; the BH Medical Officer/Medical Director (BH-CMO); Chief Operating Officer; Program Integrity Manager; Compliance Officer; Pharmaceutical Director; Member Services Director, Provider Relations Director, and leadership from the QAPI, Utilization Management (UM), Care Coordination, Network, and Community Engagement teams. Because our Quality Committee will perform administrative and clinical governance, committee membership will include external network Providers, including PCPs, specialists, and LTSS Providers.

Our **Compliance Committee** will be chaired by Molina's Compliance Officer and will meet quarterly to review and approve Compliance program documents, policies, and procedures. The committee is responsible for overseeing the Compliance program and compliance with federal and State rules and regulations. Committee membership includes leadership from the QI, Care Coordination, UM, Member and Provider services, Pharmaceutical, and Community Engagement teams.

Our **Healthcare Services Committee**, chaired by our Medical Director (CMO) and VP, Healthcare Services, meets quarterly to review and approve program documents, policies and procedures, protocols, guidelines, and criteria used to review UM and Care Coordination programs. Its responsibilities include analyzing outcomes data, identifying trends, monitoring under- and overutilization across selected diagnoses and practice types, and evaluating and recommending new actions, with a focus on physical health, BH, SDOH, and LTSS and performing all activities through a lens of health equity. The committee also works to enhance Member and Provider satisfaction and ensure consistency in decision-making. This committee will work closely with the Delegation Oversight Committee, described below, to monitor shared care coordination models—including TCM, community care coordination, and CCBHC care coordination with the MCO Care Coordination Model—to ensure they are working as intended, meeting Member needs, and adhering to regulatory, operational, and clinical guidelines. Committee membership includes the Medical Director (CMO), LTSS Clinical Officer, Health Equity Director, Oral Health Director, BH-CMO, Network Management and Contracting Director, EPSDT Coordinator, Care Coordination Director, Pharmaceutical Director, QM Director, Foster Care Coordinator, and Grievances and Appeals Manager.

Chaired by our Subcontractor Oversight Manager, our **Delegation Oversight Committee** meets quarterly to review Subcontractor performance. This involves assessing pre-contractual and annual results, ensuring compliance with regulations, and approving policies for effective healthcare operations. Membership includes the Medical Director (CMO), Compliance Officer, and managers from the UM, Member and Provider services, Quality, and Delegation Oversight teams.

Our **Member Advisory Committee**, chaired by a member of our Growth and Community Engagement team, meets quarterly to ensure Molina tailors services and programs to meet Members' cultural and linguistic needs. It establishes education and outreach priorities, reviews communication plans, and identifies community resources, gaps in service, and unmet health needs. The committee explores quality activities by monitoring and evaluating programs, specifically addressing the diverse needs of special populations, such as children, teens, adults, Members with chronic conditions such as diabetes and asthma, LTSS recipients, and Members who have BH needs or IDD. Committee membership includes Members, Providers, Member Advocates, caregivers, leadership, and staff from the Quality, Care Management, Health Equity, Grievances and Appeals, Compliance, Network, and Member services teams.

Our **Provider Advisory Committee**, chaired by our Medical Director (CMO) and Network Management and Contracting Director, meets quarterly to gather Provider insights and suggestions beneficial for plan programs and processes. The committee focuses on identifying potential barriers and actionable interventions. It includes the QM Director, LTSS Clinical Officer, Health Services Director, Pharmaceutical Director, and representatives from major Provider organizations in Kansas. Network practitioner participants will include Providers of physical health, BH, dental health, and LTSS; pharmacists; and representatives from foster care organizations. Network Provider recruitment for this committee includes specialists in primary care, pediatrics, and adult medicine; LTSS Providers; dental care Providers for children and adults; and BH and SUD practitioners, including psychiatrists, psychologists, therapists, and specialists focusing on the needs of individuals with IDD or SPMI and foster care populations.

Our **Professional Review Committee**, chaired by the Medical Director (CMO) and LTSS Clinical Officer, meets monthly to oversee credentialing (including Provider credentialing and recredentialing) and our structure, protocols, and peer review process (which we use to evaluate the quality, appropriateness, and cost-effectiveness of care delivered). It also reviews cases of potential ineffective quality of care and reviews participating Provider performance, when appropriate. The Medical Director (CMO) or a physician designee will chair the Professional Review Committee and oversee all decisions made by the Professional Review Committee. To ensure that decisions cannot be overturned by a separate credentialing or other committee, our Professional Review Committee includes a review of both credentialing and peer review activities. Membership includes physical health, BH, and LTSS Providers; pharmacists; specialized medical directors; and staff from the Credentialing and Quality teams.

Molina's Use of Quality Structure to Promote Change

Molina's committees will be forums for Members, caregivers, Providers, and other stakeholders to share their perspectives on improving quality of care for KanCare Members. Our quality program structure enables us to collect and integrate experience-of-care and satisfaction data from Members, caregivers, Providers, and other network partners into the QAPI program. The

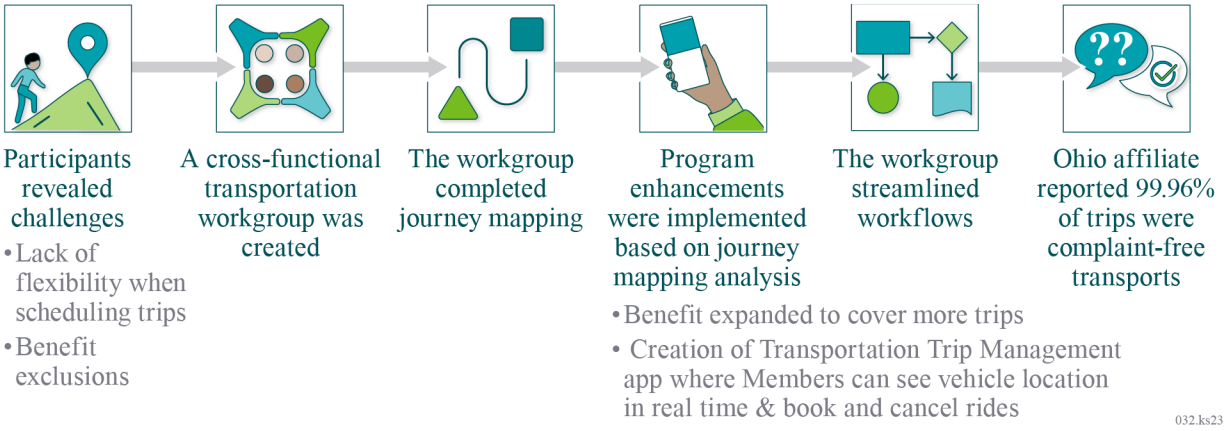
role of the bodies in our quality structure will be to advise Molina on various aspects of our QAPI program to promote change in Molina's practices and operations, as well as in our Provider practices and operations. Through this interaction, we will partner to deliver focused solutions and interventions that support KanCare's goals. These solutions include targeted PIPs, the introduction or expansion of value-added benefits or Member incentives, the implementation of Provider incentives and VBP models, and the design of strategies to expand access to care and improve Member and Provider experiences through innovative and collaborative community approaches.

Promoting Changes in Plan Practices and Operations

We will invite committee, subcommittee, and workgroup participants to share their experiences about the healthcare delivery system as well as their experiences with Molina. We will elicit information about differences in care, barriers, and gaps. When paired with our extensive quantitative data (as described in subsection b.), this feedback will help us develop and implement targeted programs, services, and interventions and help us modify processes to best serve KanCare Members**.** We will engage committees in discussing our value-added benefits, such as our Aging Out program, Lead Remediation program, and No-Cost Glucometers program.

In an example of this collaboration, our Ohio affiliate hosts quarterly advisory committee meetings across key cities: Cleveland, Cincinnati, and Columbus. These meetings provided them with insights into Member issues concerning the value-added NEMT benefit. Our workgroup intervention led to **91% of Members surveyed reporting they were satisfied with Molina's NEMT benefit, representing a 5% improvement over the prior period**. **Exhibit 19-3** shows the process as they engaged in learning, resolution, and analysis of outcomes.

Exhibit 19-3. Member Feedback Resulting in Plan Practice Changes for Our Ohio Affiliate.
Involving Members in the process cultivates a sense of ownership and loyalty, driving deeper engagement.



QAPI and Quality Activities. We will engage committee, subcommittee, and workgroup participants in reviewing Member satisfaction survey results, other Member-experience-related measures, and performance measures such as HEDIS, non-HEDIS, and other Medicaid adult and core set measures. Committee participants will assist us in developing Quality program projects and interventions to improve the quality of care provided to Members. For example, we will discuss our Healthy Rewards program, which provides Members with gift cards for completing

recommended services, such as annual eye exams and HbA1c tests for Members with diabetes or doula services and home-delivered meals for Members who are pregnant or postpartum.

Program Monitoring and Evaluation. Committee, subcommittee, and workgroup participants will provide feedback to support qualitative analyses, which will be essential for us in interpreting the results of our monitoring and evaluation efforts. Given the KanCare-identified priority of access to healthcare services, we will engage our committees in discussing factors affecting the delivery of healthcare and interventions we can implement to address these causal factors. For example, we could use the information to home in our reinvestment strategy on a particular area of need regarding access improvement, such as the expansion of dentists to serve Members who have IDD or additional services for children with SED.

Member ID Cards and PCP Information
Through QAPI program feedback, our Wisconsin affiliate received questions from Members and Providers about whether care was limited to the PCP listed on their ID card. They reviewed how they could assist Members in identifying their PCP without confusing them or limiting their access to care. Members liked having an ID card, but the PCP information on the card did not add value. Our affiliate removed the PCP information from ID cards and continued to educate Members and Providers on the fact that Members can seek care from any network Provider. The number of questions received from Members decreased once this change was made. 103.b.ks23

Member, Family, and Provider Education. We will engage committee and workgroup participants to serve as a sounding board regarding our education-related efforts. For example, we will invite participants to review educational materials and processes to ensure these programs are culturally competent, understandable, and accessible and they address the needs and concerns of Members, caregivers, Providers, and key stakeholders**.** For example, we will share our plan for communicating QAPI information with Members and Providers and request feedback about our QAPI Scorecard, quality booklets, and newsletter content.

Community Collaboration. We will invite committee participants to share input and feedback on identifying community service gaps, exploring potential partnerships, and suggesting community-based solutions to address SDOH-related needs. [redacted]

Promoting Changes in Provider Practices and Operations

Value-based Purchasing

One of the critical ways we promote change in Provider practices and operations based on CQI feedback is by tailoring our Provider incentive and VBP programs to support high-quality care. We have customized our models for the KanCare program to increase Member choice of Provider and setting, create long-term sustainability in the KanCare program, and help support Providers

Successful VBP Incentives in Illinois
Our Illinois affiliate implemented the nursing-facility-focused quality program in January 2022. In less than one year, they realized a **$45 PMPM reduction in inpatient spend and a $4 PMPM reduction in ED spend**. 103.c.ks23

as Members successfully transition to the community.

Collaborating with our Provider partners, including those serving on our NF and HCBS workgroups, we will explore additional models and measures, such as offering more dental services, transitions-of-care support, obesity and weight counseling, and SDOH screenings. Additionally, building on our organization's experience in other states, we have established additional APMs for HCBS Providers. One example being implemented by our Texas and Illinois affiliates involves personal attendant Providers. They incentivize direct care workers who assist Members with daily living needs to document and notify Molina when there is a change in the Member's condition.

We also maximize feedback to promote change in Provider practices and operations related to integrated care and a seamless Member experience. We use feedback to shape our comprehensive Provider training program. For example, our affiliates have continued to enhance training around SDOH impacts on health behaviors and educate Providers on identification of Member SDOH needs, the use of Z codes, use of our SDOH platform, and our closed-loop SDOH referral system. [redacted]

b. Molina's Capability to Collect and Examine Quantitative and Qualitative Data and Other Information to Evaluate Clinical and LTSS Quality

We design our QAPI program to achieve continuous year-over-year quantitative and qualitative improvements. The basis of Molina's QAPI program is our fundamental commitment to collecting and using timely, accurate, holistic data to make informed decisions and achieve the highest level of quality performance. Through our experienced and knowledgeable staff, resources, and data collection methods, we analyze data, make information actionable, implement interventions, and gauge improvement in results. Our Quality staff use the definitions outlined in **Table 19-1** to ensure all aspects of analysis are incorporated into our Quality projects. This structural framework enables us to develop and promote an organizational culture of CQI.

Table 19-1. Quantitative vs. Qualitative Data Analysis

Quantitative Data Analysis	Qualitative Data Analysis
Includes defining the goals of an activity based on baseline, benchmarks, and intervention success, and drawing a conclusion from data	Includes who conducted the analysis and a description of what is or may be driving results
Requires comparison of results, with a goal set by Molina or the State, and addresses the desired level of performance or benchmark (e.g., measuring against a minimum threshold for performance and flagging the need for intervention)	Prompts us, through analysis, to ask what drove this improvement, if any barriers were in the way of achieving the goal, why the performance was what it was, and what drove the performance

Quantitative Data Analysis	Qualitative Data Analysis
Requires the need to evaluate if anything has changed the outcome, how results compare to previous results, whether we are improving, if we have reached our goal, and if the change is statistically significant	Addresses barriers focused on systems, processes, people (e.g., staff, Providers, Members, caregivers, and community organizations), and systems or technology

Staff and Resources to Support Quantitative and Qualitative Data Collection

Molina's dedicated full-time staff play a crucial role in facilitating quantitative and qualitative data collection and reporting. They ensure that frontline staff have immediate access to information necessary for developing real-time, holistic interventions for Members. Molina staff are experienced in and knowledgeable about Medicaid, and we invest in our staff's development through relevant ongoing training, education, and mentorship. Guided by an experienced QM Director (who will be a registered nurse or have a master's degree or Certified Professional in Healthcare Quality certification), this team includes dedicated IT programmers, data and reporting analysts, Quality program managers, medical record experts, Abstractors and Overread teams, Compliance staff, and Kansas-based Quality and Reporting teams who are supported by their respective leaders. This staff will also include a full-time Chief Data Analytics Coordinator who has a minimum of three years' experience aggregating disparate datasets and analyzing data to identify trends and opportunities for improvement. These professionals have expertise in managing Kansas-specific data at every level of collection, analysis, and reporting. They will work closely with the QM Director to use data-driven insights and best practices for informed Quality activities.

Our Robust Infrastructure Supports Reporting-related Activities. Reflecting the importance we place on performance measurement and reporting, Molina performs all activities internally. This infrastructure enables us to report in the most efficient, effective, and compliant way possible. The core of our reporting infrastructure includes secure, HIPAA-compliant data management with data storage and exchange capabilities. Our integrated IT platforms fully support standard and ad hoc data collection, advanced analytics, and performance reporting regarding clinical information, quality of care, population health, and SDOH. Our reporting environment is scalable so we can meet any new or revised requirements.

Technology and Other Methods for Collecting Data

Our disciplined approach to tracking measures that matter uses the power of data and stakeholder input to examine causes and barriers, identify needed program changes, and share best practices—all to affect Members' healthcare status in a positive way. Our key performance indicators include nationally recognized measures:

- Structural measures (e.g., access and availability)
- Process measures (e.g., immunization rates)
- Experience measures (e.g., Provider satisfaction)
- Outcome measures (e.g., control of diabetes)

Quantitative Data Collection Methods

The Molina Data Lake, which resides in our IT cloud platform, serves as our central repository for data on Members, caregivers, and Providers and on services furnished. Data includes claims,

reference data, and supplemental information; capitated physical health, BH, dental health, vision, and prescription encounters; and encounter-like data, SDOH, and social vulnerability indicators, including demographic data essential to identifying and mitigating trends in disparities. The data lake also serves as a quality data repository where we manage and prepare data from all internal and external sources and make it consumable for our NCQA-certified HEDIS Engine.

Molina's HEDIS Engine supports our reporting and analytics platform, enabling us to monitor various medical record reviews to ensure that we capture the most accurate and timely Member data to drive real-time quality initiatives. We feed administrative data, such as claims/encounters and labs, and supplemental data into our reporting system, and we refresh the data monthly. We can then report population-specific HEDIS measures (e.g., Comprehensive Diabetes Care rates for all Members, and information on Members who are IDD, have SPMI, or receive LTSS and HCBS) and stratify measures by Member demographics (e.g., race, ethnicity, language, disability status, and geography).

To create Population and Community Health Needs Assessments, we will integrate stakeholder and community-level feedback and data with Member population-level data, including clinical outcomes (e.g., HEDIS), SDOH (e.g., Z codes and CBO referrals), and satisfaction data (e.g., CAHPS). We will assess the combined data against rates and trends in performance and compare it to statewide and national benchmarks to identify areas for improvement.

Our QI tool, part of our Molina Compass suite of analytic tools, enables our Quality and Clinical teams to review, track, and show trends in Member gaps in care to identify targeted interventions. This tool integrates data from our data lake platform to deliver insights at the Member, Provider, and assigned Care Coordinator levels, and it benchmarks performance against national standards, such as NCQA's HEDIS quality measures, State performance goals, and other State initiatives.

Our Quality and Clinical teams use our Health Equity Dashboard to review health outcomes and disparities related to race, ethnicity, language, disability status, and geography. Teams also use this dashboard to develop and implement interventions and monitor impact towards achieving health equity.

Critical to Molina's approach to quantitative data are our deep understanding and experience working with complex populations like those served in the KanCare program. HCBS Waivers and varying levels of care require quality programs to be adaptable to account for different, yet critical, metrics. We can collect and analyze data using LTSS measures to assess the experience of Members enrolled in LTSS and HCBS programs. Through review of care management records, vital records, and registries—and via claims and encounters—we collect QI measures data for LTSS assessment, care planning, and rebalancing. This flexibility also allows us to work with other high-needs populations, such as youth who are in foster care or involved in the juvenile justice system, or individuals recently released from incarceration. In these instances, non-HEDIS quantitative data points (e.g., permanency or recidivism) may be just as important in understanding the outcomes of our programs and interventions.

Qualitative Data Collection System or Method and Description of Data Collected

While performance measure data and Provider survey results are critical elements of our QAPI program and important sources of information about our program and Members' health statuses, they alone are not enough to drive improvements and positive change. We also use other data sources and feedback mechanisms to help drive improvement and positive outcomes, such as:

- Member and Provider Advisory Committees (described in subsection a.)
- Provider and CBO discussions
- Care coordination engagement
- Member focus groups
- Results from Member services contacts
- Molina QI town hall discussions

We integrate these data sources with quantitative performance measures and Provider and Member satisfaction survey results to develop a holistic understanding of Members' and Providers' needs. We can then effectively evaluate programs and policies and implement changes to better support Providers in caring for their patients. This approach also helps Members and their families improve their health and well-being. Our Plan President and CEO, Mr. Dunkel, will also directly engage with State agencies and stakeholders, such as legislators and advocates, on a regular basis to get feedback on our program to inform program design and interventions.

We use complaints, grievances and appeals, and reports of quality-of-care issues to monitor and evaluate the quality of clinical and LTSS care. Molina routinely evaluates grievances and appeals data for trends that may suggest inappropriate care or potential quality-of-care concerns. Grievances and Appeals staff monitor and evaluate data and flag areas of concern for review by our Medical Director (CMO), QM Director, LTSS Clinical Officer, Pharmaceutical Director, and others, as needed.

Holding stakeholder listening sessions is another way we conduct extensive outreach and engagement with diverse Members, beneficiaries, advocates, and stakeholders. We uncover what's working and what needs improvement, document the discussion, implement action steps, and follow up with our stakeholders. We have begun building relationships and attending listening sessions with stakeholders, such as the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight. We have also attended KanCare stakeholder listening sessions, the InterHab conference, the Kansas Health Care Association conference, and LeadingAge events. Private listening sessions attended include those with the KanCare Advocates Network; COF Training Services; Starkey; Johnson County Developmental Supports; Big Lakes; TARC; Minds Matter, LLC; Independence, Inc.; and Kansas Advocates for Better Care. We want to make sure our partners know their experience matters to us and helps shapes our program.

Our Member Advisory Committee provides an opportunity for Member involvement in our Quality initiatives. Member representatives who are from the KanCare program and come from a diverse set of KanCare populations will participate and provide formal feedback about the Member experience and the QAPI program. We will supplement information from our committees with feedback collected at focused workgroups, such as the NF and HCBS advisory workgroups. Participants will provide feedback to support our qualitative data, and this will be essential for us to interpret the results of our monitoring and evaluation efforts. We also use

stakeholder community forums and focus groups to gather feedback and recommendations on certain topics. We then incorporate those insights into our QI activities. During Joint Operating Committee meetings with health systems and large Provider groups, we discuss operational, claims, and utilization to enhance Provider collaboration; review detailed reports on quality, claims, and prior authorization (PA); and discuss results to improve success with VBP engagement.

Collaboration with our fellow MCOs is also an important way to glean stakeholder feedback. Collaborative efforts produce recommendations on quality of care, policies, procedures, and system performance. These efforts also enable the managed care system to align on improvement solutions, share best practices, and synchronize messaging—which leads to more positive Provider, Subcontractor, and Member experiences. Our affiliates have had multiple experiences leading peer MCOs on issues found through qualitative data analysis. For example, in Nevada, there was no formal exchange of Member data among MCOs until our affiliate led a workgroup to solve the issue, promoting a more seamless transition for Members who switch plans.

Approach to Using Data, Information, and Analytics to Drive CQI

Because of our continuous QAPI PDSA (or reference cycles per instruction) cycle, we are experienced in collecting and using data to design solutions (plan), implementing interventions (do), evaluating (study) program effectiveness, and (act) reporting data on a wide range of topics, taking action where appropriate. This method helps to identify, analyze, and resolve operational inefficiency quickly to improve Member and Provider experience and quality of care. Using data from various sources, we identify potential gaps and areas for improvement, design and conduct our clinical and nonclinical PIPs, carry out QI interventions, and evaluate the efficacy and effectiveness of our QAPI program.

Example: Enhancing Member Materials. Our Michigan affiliate's review of HEDIS 2021 data revealed the rate of cervical cancer screening among white women was 57.54%, significantly less than that for black women, at 60.15%. Our affiliate then hosted a community forum with United Outstanding Physicians to collect qualitative feedback about available educational materials for members of the Arab American/Chaldean community who identify as white according to Michigan Medicaid enrollment data. United Outstanding Physicians' feedback led to enhancements in Member educational materials. Based on United Outstanding Physicians' recommendations, our affiliate updated the layout of the materials to make some topics more prominent. Once the revised materials were translated into Arabic, our affiliate engaged United Outstanding Physicians in content review to ensure the translation was correct and culturally appropriate. We would implement similar approaches to developing culturally relevant materials in Kansas, especially in areas with high diversity indices, such as Wyandotte, Kiowa, Elk, and Thomas Counties.

Using Data to Design, Implement, and Evaluate Our QAPI Program

Stratifying measures by demographic and geographic characteristics to identify disparities and target improvement activities for specific populations is invaluable. For example, we report HEDIS measures stratified by race, ethnicity, gender, disability status, and geography. Data sources used to design, implement, and evaluate program effectiveness could include claims and encounters data; LTSS quality measures (e.g., measures relating to quality of life, rebalancing, and community integration activities); Child and Adult Core Sets measures; time to HCBS

service; CAHPS HCBS (e.g., quality of life, customer experience); NCI-AD; NOMS; NCI; utilization trends, including PA data; and Fair Hearing trends and outcomes.

The quality measures we track span the entire healthcare continuum. Such tracking will enable us to direct our resources to Kansas key areas of focus. We present data and reports to our Quality Committee, and at these presentations, we begin the PDSA process based on Member outcomes and service usage. Committees and senior leadership then develop a course of action based on those recommendations. We use fishbone and key driver diagrams to consider the barriers faced by Members in obtaining services and achieving ideal health outcomes and use the same to consider interventions to address those barriers.

Modifications to plans that address performance gaps may include development or modification of or updates to policies and procedures; changes to staffing patterns, personnel, or training; changes in network Providers or scope of services, materials, and systems that support Providers and address Member needs; and deployment of new or modified systems. We will also communicate results and update internal staff and external Providers.

While performance measure data is critical to our QAPI program, performance measures alone are not enough to drive CQI and positive change. Molina's affiliates use multiple data sources for performance measurement and other previously mentioned feedback mechanisms to help drive improvement and positive outcomes. By integrating these data sources, we develop a holistic understanding of Members' and Providers' needs and can thus effectively evaluate clinical and LTSS programs and policies and implement changes. The examples shown in **Table 19-2**—from our Ohio, Virginia, Michigan, Texas, and California affiliates—illustrate our approach and how we will use a variety of feedback collection methods, as described above, for KanCare.

Table 19-2. Improvements Derived from Stakeholder Feedback.

Identified Need	Feedback, Recommendations, and Outcomes
After identifying disparities in HEDIS postpartum results for black Members, Molina's California affiliate conducted Member outreach to assess barriers to care.	Member feedback revealed black Members experienced far more SDOH barriers to care, including lack of transportation and childcare, and poor alignment of Member schedules with Provider office hours. They brought services to postpartum Members with Molina Care Connections nurse practitioners and **reduced the disparity among black Members by 37%.**
One affiliate realized that a large Provider (serving 60% of their enrolled population in a particular county) was performing below the 50th percentile for selected quality measures, including well-child visits and adolescent well visits. Our affiliate's Clinical, Network, and Quality teams met with the Provider's clinic leadership during	Provider feedback revealed the need for financial support to expand appointment availability and a need for actionable care gap reporting and strategies for patient and family engagement. The Provider group and our affiliate participated in months-long clinical collaboration. They implemented numerous interventions, including upfront supportive payments to the Provider to enable extended clinic hours and availability for patient calls. In four months, the

Identified Need	Feedback, Recommendations, and Outcomes
Joint Operating Committee meetings to discuss performance.	Provider increased their adherence with **well-child visits by 33% and adolescent well visits by 25%.**
When an affiliate's population health analysis indicated a low well-child visit rate in a specific region, they drilled down into the data and identified a gap for infants 0–12 months. A root-cause analysis identified the need for additional engagement for expectant and new moms to raise awareness of the importance of well-child visits and help them to access care.	Recognizing the importance of postpartum engagement in improving maternal and child health outcomes, our affiliate used postpartum care gap data to target telephone outreach. They focused on completion of postpartum visits, postpartum depression screening, and newborn and well-child visits, and assisted Members in scheduling appointments, as needed. They also developed a postpartum incentive for OB/GYN Providers to improve quality and access. These efforts, in addition to their baby showers and other maternity engagement strategies, resulted in a **17% improvement in well-child visits in 2023 and a 25% improvement in well-child visits overall**.
Daily facility discharge reports from an HIE helped identify Members who are IDD and need follow-up post-hospital stays for BH conditions. The affiliates' Care Coordinators who had experience supporting Members with IDD and their complex needs helped these Members, their caregivers, and Providers navigate the complex system of supports.	From September 2022 to September 2023, the Follow-Up Within 7 Days of ED Visit for mental illness rate for Members who have IDD **increased by nearly 7 percentage** points, and the 30-day follow-up rate increased by over 25 percentage points. During the same period, the Follow-Up Within 7 Days Post-Discharge after a hospitalization for mental illness rate for Members who have IDD **improved by over 1 percentage point, and the 30-day follow-up rate increased by nearly 4%.**
Using data analytics, our affiliate identified Members living in the community with an increased risk of long-term stays. The affiliate's Care Coordinator scheduled a visit to verify changes in circumstances and assess Members' HCBS needs.	**Ninety-two percent of Members remained in the community**—the preferred setting for those individuals—resulting in a **29% reduction in medical costs and approximately $1 million annual savings** by using HCBS in lieu of institutional services.

Using Member and Provider Survey Feedback Across Affiliates. All Molina affiliates conduct and analyze the results of Member and Provider satisfaction surveys using a key driver analysis to identify drivers of key results, opportunities for improvement, and interventions taken because of feedback. They then use these analyses to monitor actions taken and review the results of the next year's survey to determine whether improvement occurred. With our unique structure involving affiliates in adjoining states, we can receive critical feedback from our network practitioners on unique barriers in one state and glean whether there are additional issues from other states that could be addressed. For example, we held a regional workgroup with

representatives from Nevada, California, and Arizona to discuss physical health and BH care coordination. This workgroup allowed PCPs and BH practitioners to discuss critical issues surrounding this topic and next steps to take action.

Identifying Over- and Underutilization of Healthcare Services. Our UM and Quality staff conduct periodic analyses of utilization data and compare it to established thresholds, such as HEDIS and unplanned readmissions, to identify over- or underutilization. These analyses include reviews of, for example, ED utilization data. We identify Members prone to frequent ED visits and offer our ED Diversion program or care coordination services to help them stabilize their health, prevent problems, and ensure they receive care in a more appropriate setting.

c. Molina's Approach to Regularly Providing Information About KanCare Performance

Transparency is crucial for building trust with our State partners, Members, and Providers. To maintain this transparency, we commit to sharing our program's performance information at least annually and publicly, through multiple channels. Molina actively gathers necessary information from various sources—including QAPI committees, internal teams, external partners, organizations, and stakeholders—ensuring we meet their informational needs. This process allows Molina to deliver essential details driving CQI.

QAPI Program Information to Be Provided to KanCare and Other Kansas Organizations

Molina will share QAPI program information (e.g., Annual Core Measures Report, Annual QAPI program description, collaborative annual PIP) in required quarterly legislative and quality meetings with the State. All health plans are required to present quality issues in front of the legislature multiple times a year, and we will use this opportunity to share any pertinent and needed program performance information. Additionally, we will provide updates on our PIP interventions, performance, and additional quality activities on an ongoing basis—at least quarterly—to Members and Providers during Quality Committee meetings and through the website. This information will be presented in easily usable formats. We will also provide information upon the State's request to show QAPI program progress.

We schedule these meetings regularly, typically quarterly or every six months, and the frequency can be adjusted at the organizations' request. In addition, we will commit to meeting with any of the above groups or other representative groups, as requested, throughout the term of the Contract. We will also keep an internal Issues Log containing feedback (e.g., basic resolution or claims issues based on specific factors) from all groups we meet with, which we will share with

the State. Any item on the Issues Log that requires action will be brought back to the Quality Committee at the earliest meeting date available, so we can discuss it and create action items.

QAPI Program Information to Be Provided to Members

Molina will provide Members with information about our QAPI program using a variety of ongoing targeted and broad communications:

- Molina's Member Handbook will feature information about elements of our QAPI program, such as studies to be performed, Member surveys, preventive health guidelines and recommended screenings, and diagnostic and immunization schedules. We will also use other methods, such as our Member portal, to convey this information.
- Our annually mailed Grow & Stay Healthy guide and Guide to Getting Quality Health Care will provide Members with helpful information about QAPI programs, including HEDIS, CAHPS, preventive health guidelines, and population health programs. We notify Members of these guides through mailings, and they are available at any time on our website.
- We will use direct mail, calls, and our biannual Member Newsletter to communicate information about QAPI program key elements, including annually reported HEDIS and CAHPS results, PIP studies being performed, and preventive health recommendations and programs. PIP updates will be reported quarterly via our website.
- Members serving on our Member Advisory Committee will receive quarterly information about our QAPI PIPs, performance measurement results, Member and Provider satisfaction survey results, and accreditation status.
- The Molina website, Member portal, and My Molina app provide essential QAPI program details and information and offers 24/7/365 Member reminders for upcoming services, such as preventive services, condition management, and available services and programs.

Annual Reporting of Progress Against Goals

As part of our ongoing Member communication regarding our QAPI program, we will report progress against goals at least annually using our QAPI Scorecard, organized into four areas. Upon KDHE and KDADS' approval, we will publish the scorecard to the QAPI section of our website. Printed copies will be available for those with limited Internet access and those who prefer hard copy formats. The Internet-based version of the QAPI Scorecard will feature:

- Summarized (at least quarterly), up-to-date PIP information, focused on clinical and nonclinical issues and emphasizing prevention and care of acute and chronic conditions, high-risk populations, high-volume and high-risk services, continuity and coordination of care, LTC, EPSDT screening, and community outreach. We pay special attention when CMS 416 rates are below 85%, including KDHE- and KDADS-approved results.
- Performance results compared to the prior year's performance, where applicable, and our performance goals and external benchmarks, as they are available. We will include dental and non-dental care HEDIS measures and performance measurement information. The latter will be updated at least annually—and quarterly, as needed—to show potential disparities related to performance measurement results.
- Provider and Member satisfaction surveys results, displayed with our prior year's performance, where applicable, and performance goals. Filtering will allow the display of dental/non-dental care Member satisfaction results for both adult and child surveys. Posting will be annual, and intervention status will be provided at least quarterly.
- Summarized, up-to-date information about our NCQA accreditation status.

QAPI Program Information Available to Providers

During Providers' onboarding, they will receive information about our QAPI program through the New Provider Orientation, and ongoing QAPI-related information will be available through MolinaU, our Provider training program. Beyond being provided at the initial and ongoing Provider training, QAPI program updates will be available via various channels:

- Molina's annually revised Provider Manual, available in hard copy and digital formats, will include information about performance measures and PIPs.
- [redacted]

[redacted]

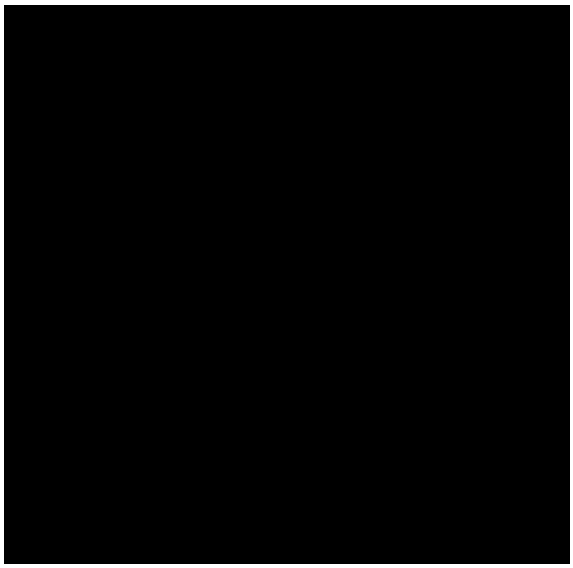
- Providers serving on our committees and participating in workgroups will review our QAPI program descriptions, work plans, PIPs, and analysis of operational activities. This review encompasses examinations of call center reporting, grievances and appeals reporting, Provider credentialing and recredentialing, delegation oversight, and clinical performance information related to our QI activities. Providers will also review our progress against goals as they review our annual evaluations and Member and Provider survey results prior to KDHE and KDADS submission. Details will be provided at least quarterly during committee and workgroup meetings.
- Our Provider website features HEDIS and CAHPS reporting information, presenting detailed results, medical record documentation standards, and guidelines for clinical practice and preventive care. The website provides tailored educational materials and videos for prospective network practitioners. These materials cover our credentialing and contracting processes and provide designated points of contact.
- We'll also offer online cultural competency videos, quarterly refreshed Health Equity Report Cards, and quarterly updated Health Home quality measures. This website provides monthly refreshed information on current/future workforce capacity and capabilities. Our secure environment, requiring login and password credentials, provides access to user-friendly tools for accessing QAPI-related information, clinical practice guidelines, and a venue for task management. The website includes Member-level information on screenings, immunizations, and overdue services, and we update that data at least monthly, to reflect the latest HEDIS rates and for ongoing monitoring.

Sharing Data with Providers. We share real-time MTM results with Providers and pharmacists to optimize therapy and resolve side effects. In 2022, our affiliate in Virginia communicated to Providers about at least one drug-related issue for 52% of the affiliate's Members in the commonwealth who met MTM criteria. This education had a lasting population health impact, as Providers can apply new knowledge to others with similar issues within their patient panel. **Since 2018, nationally, our affiliate's MTM program has provided more than 171,700 interventions to improve medication use and reduce adverse events, saving more than $20 million.**

4.3.I.20 HEDIS®

20. Describe the bidder's experience and approach to improving performance for the following two (2) Healthcare Effectiveness Data and Information Set (HEDIS®) measures in programs similar to KanCare. Include the actions the bidder will take to improve performance on these measures in KanCare and the anticipated improvement for KanCare.

a. Timeliness of postpartum care
b. Lead screening



Molina's nationwide affiliates have nearly 30 years of experience using HEDIS to measure performance in health outcomes and service delivery. As a quality-driven organization, Molina's integrated, organization-wide approach to quality is informed by our mission statement to improve the health and lives of Members by ensuring delivery of high-quality healthcare. HEDIS is the backbone of our approach, providing industry-accepted measures and performance quartiles that allow Molina to compare quality results across plans, geographies, races and ethnicities, ages, and genders. Molina prioritizes HEDIS measures as one of our key performance tools, comparing expected and actual performance against benchmarks and other MCOs to identify care gaps, design interventions, and enhance service delivery.

We have engaged with Kansas Providers, stakeholders, and community agencies to understand the challenges and barriers facing KanCare Members, including women and children. We discussed highlighted disparities, such as the infant mortality rate among black women, which is double that among white women, as well as the significant challenges that Latino mothers face. These conversations have helped us to gain invaluable insights into the community's lived experiences to create culturally relevant interventions and address specific root causes for the target populations.

Molina leverages our affiliates' extensive experience using HEDIS data in the design, implementation, and evaluation of performance improvements. HEDIS data is used to monitor population health, providing performance measurements from which we will develop culturally relevant interventions and collaborate with partners across the health and social services continuum to identify, address, and mitigate disparities. Our affiliates test, refine, and share successful strategies, incorporating lessons learned and customizing to complement the service delivery system and available community-level programs. Our affiliates' success reflects an understanding that improving Member health outcomes requires reducing disparities and improving health equity, and we can deploy proven strategies in Kansas to deliver similar results. Our approach and experience in improving postpartum care and lead screening measures is demonstrated throughout this response.

a. Molina's Experience, Approach, and Actions to Support Improvement in Timeliness of Postpartum Care

Molina's experience with and approach to improving the timeliness of postpartum care addresses women's healthcare in its entirety before, during, and after pregnancy. Actions include designing and aligning our [redacted] implementing interventions and developing relationships with Providers and community-based organizations (CBOs); investing in programs and Providers that expand access to evidence-based interventions; and evaluating the effectiveness of our interventions using HEDIS measures. Since local CBOs, State agencies, and other stakeholders are most in tune with the needs of their communities, we have met with a variety of these groups to discuss and learn about KanCare Member health disparities and poor birth outcomes experienced by women of color. Molina supported the Kansas Center for Rural Health's Inaugural Rural Maternal Health Symposium, where Providers and advocates discussed mental well-being during the prenatal and postpartum periods and the statistics showing twice the infant mortality rate among black infants compared to white infants. Additionally, in conversations with members of the Kansas Fourth Trimester Initiative, we learned that the Latino population faces considerable disparities in timely access to care compared to white Members. These conversations help to inform our design of meaningful, complementary interventions and solutions that are culturally relevant. Molina will bring this knowledge, along with the experience and lessons learned across our affiliates, to KanCare Members.

Improving Postpartum Care
Our Virginia affiliate saw postpartum care HEDIS rates improve nearly 4 percentage points from measurement year (MY) 2021 to MY 2022.
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Access to Care & Services

Examples of Molina Affiliates' Experience Improving Timeliness of Postpartum Care

We created programs and processes to improve the timeliness of postpartum care and sustain continuous improvement, drawing from the best practices of our affiliates, specifically in Virginia and Wisconsin, highlighted below.

Our Wisconsin Affiliate's Molina CHW Intervention Outcomes
- Members had a 22% scheduling and appointment completion rate.
- Molina CHWs surpassed the goal of 125 Members, with 199 Members having scheduled and attended appointments.
- Intervention targeted 32% more Members compared to the previous year.
- Members who worked with a Molina CHW had a compliance rate of 83%.

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Embracing Lessons from Virginia. Using HEDIS measures, our Virginia affiliate found an opportunity to improve their postpartum care measure as well as the well-child visit measure in the state's Central region. They used postpartum care gap data to target their telephone outreach with a focus on postpartum visits, postpartum depression screening, and newborn and well-child visits and assisted Members in scheduling appointments. They also developed a postpartum incentive for OB/GYN Providers to engage them in improving quality and access. These efforts, in addition to engagement strategies such as baby showers, resulted in **an improvement in the Postpartum Care HEDIS measures of more than over 4% from 2020 to 2022**.

Embracing Lessons from Wisconsin. Our Wisconsin affiliate's Molina Community Health Workers (Molina CHWs) serve as community-based Member advocates, leveraging their personal knowledge to engage and assist vulnerable Members in managing their postpartum health needs. Contacting Members prior to discharge ensured they could discuss barriers to care

and receive the support they needed. Molina CHWs helped to schedule postpartum appointments, arranged transportation, and followed up with Members after appointments. Our affiliate assigned Molina CHWs to hospitals and revamped the outreach process. With a goal of improving the postpartum measures, Molina CHWs increased outreach to six attempts within seven days and expanded outreach to all Members, not only those from high-volume hospitals. This focused approach showed positive results in MY 2022 HEDIS measures. For Members who received an intervention, the Postpartum HEDIS rate for these Members was 83%, nearly 3 percentage points higher than the general population.

Building on this experience, in 2022 our Wisconsin affiliate implemented an intervention using Molina's Care Connections program to improve postpartum care. The intervention targeted Members facing transportation barriers and missing scheduled appointments. Molina nurse practitioners conducted home visits, providing comprehensive assessments, including postpartum depression screening, health education, and referrals to community resources such as WIC and mental health services. In addition, Care Connections helped to schedule the appointment and transportation that best fit the Members' availability, reducing no-show rates.

Wisconsin Care Connections Outcomes
In Wisconsin, 308 appointments were completed in 2022, versus 68 in 2021, **which was a 353% increase**. Additionally, our affiliate's postpartum care rate in NCQA's Medicaid Health Plan Ratings increased from 2 to 3 stars from 2022 to 2023 because of this initiative. 090.d.ks23

Approach to Support Timeliness of Postpartum Care

[redacted]

Care Coordination

Trained in trauma-informed and culturally competent care principles, Molina Care Coordinators **reach out to 100% of newly identified pregnant or postpartum Members to ensure they receive the care they need**. Care Coordinators assist with scheduling prenatal and postpartum appointments and educate Members about available benefits, such as extended Medicaid coverage for up to 12 months after delivery, and postpartum Member benefits, such as the NEMT benefit that allows Members to take their children with them to appointments. For added convenience and to bridge the crucial first postpartum visit care gap, especially in rural and frontier areas when there are barriers to timely access to care, Molina's **Care Connections nurse practitioners** will be available to conduct the first postpartum visit in the Member's home. During these postpartum visits, we provide education on topics such as family planning, postpartum depression, breastfeeding, immunizations, baby safety practices, and smoking cessation. Care Coordinators ensure Members have selected a pediatrician and scheduled PCP visits following delivery. They provide support in selecting pediatricians and scheduling appointments when one has not been chosen.

Commitment to Reducing Disparities

Using HEDIS metrics and conducting in-depth data analysis to identify racial and ethnic groups with disparities, our California affiliate's Care Connections team conducted more than 150 prenatal and postpartum visits to black mothers as part of our efforts that reduced the disparity of black women engaged by 37%, setting the stage for a lifetime of health. 090.e.ks23

Through our Maternity Dashboard, HEDIS metrics and utilization measures support the identification of trends across populations, geographies, and Providers to facilitate the design of real-time interventions at the Member, Provider, and community levels. To further support timeliness of care, Care Coordination staff use the Maternity Dashboard to track outreach status for each Member so we can effectively coordinate with Providers for postpartum care and well-child visits. We ensure that Providers have ready access to data and information to support their efforts and prioritize Member interventions through our easy-to-use Provider portal. In addition to their individualized performance data, Providers can view Member lists for closing HEDIS care gaps.

We have identified and created maternal health Provider incentive programs aligned with evidence-based practices from the Alliance for Innovation on Maternal Health. These incentives include HEDIS measures such as timeliness of prenatal and postpartum care, postpartum depression screening, and controlling high blood pressure and diabetes. Molina's P4P programs include an Improving Women's Health program that encourages PCPs to meet HEDIS measures for various screenings and control levels; a Family Planning program that incentivizes Providers to support Member-centric family planning; and a targeted incentive program for PCPs or OB/GYNs to become MAT Providers, all aimed at improving postpartum health outcomes. Additionally, in Kansas, Molina will partner with CCNK members and Upstream USA, which provide technical assistance and training to improve patient-centered family planning services. Molina, CCNK, and Upstream USA will partner to create a P4P program that supports the CMS Core Measure on family planning.

Actions to Support Timeliness of Postpartum Care for KanCare Members

To augment our Healthy Moms, Healthy Babies program, we have designed a suite of solutions and interventions to bring postpartum care to KanCare Members. One key element of our strategy is building strong relationships with Providers and CBOs to promote these solutions and

support timeliness of postpartum care. Our approach encompasses addressing SDOH, behavioral health (BH), and access to care needs.

Commitment to Mothers Needing MAT/SUD Support
Our affiliate partnered with Kansas Children's Service League to expand capacity for the Parent-Child Assistance Program, which supports mothers in obtaining MAT/SUD treatment and staying in recovery throughout their postpartum period and future pregnancies. 090.f.ks23

Actions Addressing SDOH. Through our closed-loop SDOH platform, we connect Members with necessary resources, working to remove barriers related to basic living conditions, housing, and nutritional needs. Care Coordinators and Molina CHWs remove SDOH barrier and connect Members to essential resources such as WIC and child support. They address nonclinical needs such as nutrition and baby supplies through partnerships with organizations including Kansas Head Start Association, Greenbush Education Service Center, Kansas Breastfeeding Coalition, and El Centro. Members can access the SDOH platform directly to identify options to meet their nonclinical needs. Molina will provide both NEMT and value-added transportation benefits to Members to increase access to SDOH resources, including WIC appointments, pharmacies, maternal medical visits, and grocery stores, among others. Members can use the additional passenger value-added benefit to have their children or other family members accompany them to postpartum care and other healthcare visits arranged through their Care Coordinator. Through EPSDT relay text messaging, Molina sends texts to the birth parents before a baby is born, encouraging the mother to prioritize self-care and prepare for scheduling a postpartum appointment.

Actions Addressing BH. Molina facilitates connections for Members with SUD to appropriate support systems throughout pregnancy and the postpartum period, which may encompass access to postpartum detoxification programs or MAT as part of their comprehensive care. Molina will collaborate with Kansas Connecting Communities to educate local BH Providers and CCBHCs about perinatal BH resources. This education will help them provide interventions for positive screens, integrate quality referral options into care plans, and provide evidence-based treatment recommendations. Molina will educate Providers who oversee care of a prenatal patient in a maternity care desert about the Kansas Perinatal Provider Consultation Line for Behavioral Health. This resource supports Providers in addressing the mental health and SUD needs of their perinatal patients.

Actions Addressing Access to Care. [redacted]

[redacted]

Anticipated Improvement in Timeliness of Postpartum Care Rates

Molina looks forward to bringing our experience and innovative strategies to KanCare. In the 2023 Postpartum Care HEDIS rates, 2 out of 3 health plans in Kansas scored 2 out of 5 stars in NCQA's Medicaid Health Plan Ratings, highlighting opportunities for improvement. To align with Molina's commitment to quality in Kansas, our goal is to improve the Postpartum Care HEDIS rate by **5% annually until Molina reaches at least the 75th percentile**. Following this achievement, we will aim for 2% improvement each year thereafter.

b. Molina's Experience, Approach, and Actions to Support Improvement in Lead Screening

Molina understands the significant impact of lead exposure on children's development and future health. In the 2023 Health of Women and Children Report, Kansas ranked 35th out of 50 states in the rate of housing with lead risk, reaching nearly 21% as compared to the US average of nearly 17%. Maintaining lead-free homes and conducting proper lead screening can significantly reduce the number of children exposed to lead. To address this issue, we will collaborate with local FQHCs, such as CHC/SEK and the Salina Family Healthcare Center, to help improve the lead screening rate in Kansas. Informed by our affiliates' experience, we will monitor the effectiveness of our approach and actions using the HEDIS Lead Screening measure.

Examples of Molina Affiliates' Experience Improving Lead Screening Rates

To improve lead screening rates in Kansas, we will build on the success of our affiliates in Michigan, Kentucky, and California as demonstrated below.

Embracing Lessons from Michigan. Our Michigan affiliate led a PIP to improve the HEDIS Lead Screening measure with interventions designed to connect and engage Members and their families through alternative solutions to address access issues. Leveraging HEDIS gaps in care, both upcoming and overdue, the affiliate conducted a multimodal education campaign using mailers and reminder letters to notify parents/guardians about their child/children's care gaps in blood lead screening. Through additional outreach, our affiliate provided at-home lead testing kits, delivered through the mail, along with instructions for conducting the test and returning the kit for results. Our affiliate also offered a $25 gift card to incentivize completion. They created an alert within the Care Coordination Portal to notify staff of the HEDIS care gaps and screening requirement. They also conducted targeted outreach to educate new mothers about the importance of blood lead screening. **In 2020, our affiliate exceeded the 50th percentile in the HEDIS Lead Screening.**

Our Michigan affiliate's Provider Relations team supplemented these Member-level interventions with monthly virtual visits to Providers, offering a list of Members who were due or overdue for a blood lead screening and educating Providers on how to directly refer Members to the Blood Lead Care Coordinator. Providers were reminded to conduct tests for children 24–72 months of age without a previous history of a lead test. The Provider Relations team

discussed with Provider offices the use of appropriate billing codes to capture all components of the well-child visit. The Provider Representative made on-site visits to ensure Providers were registered with the Childhood Lead Poisoning Prevention Program (CLPPP) to receive credit for completed blood lead screenings.

Embracing Lessons from Kentucky. Our Kentucky affiliate created a Lead Project Coordinator role to help improve HEDIS Lead Screening rates. Monthly reports from the Quality team are received by the Lead Project Coordinator to identify pediatric Members with a blood lead level of 3.5 or greater. They contact newly identified Members and provide education on reducing lead levels, the importance of PCP follow-up, and the availability of our affiliate's Care Coordination program. Additionally, they make referrals to the local county health department for continued follow-up. The Lead Project Coordinator initiates three outreach attempts by telephone, and if they are unable reach the Member, they send an "unable-to-contact" letter containing the Lead Project Coordinator's contact information. They use Kentucky's immunization registry to determine if levels are increasing, decreasing, or remain the same from the last reported result. Upon identification of Members with increased levels and meeting internal thresholds set by clinical leadership, the Lead Project Coordinator makes a referral to the Pediatric Care Coordination team. **This intervention has resulted in our Kentucky affiliate reaching a 70% HEDIS Lead Screening rate for 2023.**

Our Kentucky affiliate's EPSDT Coordinator also actively engages in efforts to improve lead screening rates through participation in various Metro United Way workgroups, including a subgroup dedicated to reducing lead toxicity in Louisville. By participating, Providers, and other community partners have enabled the state to comprehend the challenges surrounding lead screening and the subsequent follow-up procedures for positive blood lead testing. Our Kentucky affiliate also collaborated with a pediatric Provider to perform a soft trial referral by the practice to a certified Molina CHW they had trained in lead screening and toxicity prevention when a Member with elevated blood lead levels was identified as unable to contact for follow-up. Our affiliate also approached the Louisville Metro Department of Public Health and Wellness' CLPPP, the centralized referral point for all elevated blood lead screens in the county, to expand the offering. They provided education on how to contact the Lead Project Coordinator using a pre-populated standard referral form and how to follow up for children who they had referred.

Embracing Lessons from California. Our California affiliate designed specific processes and programs to address barriers to care and improve health equity outcomes in HEDIS Lead Screening rates. Using data exchange protocols to automate reporting, they leverage various data sources such as monthly reports, lab data feeds, and HIE data to identify Members with blood lead exposure. Using HEDIS gaps in care measures and applying geographic and health equity factors, they also identify children at high risk for lead exposure who have not undergone lead screening. A dedicated Lead Care Coordinator experienced in California's lead program conducts outreach, educates the Member's parents or guardians, performs a comprehensive Health Risk Assessment, and coordinates with the Member's Providers and health department blood lead coordinator. The Care Coordinator partners with the child's county public health nurse and local resources to assist with locating new housing, if necessary, and engages in consistent follow-up with Members and their families. For example, in December 2021, they conducted an outreach campaign targeting California families of 24,100 Members aged 2 and under, as well as more than 10,500 pregnant Members, by mailing a lead screening brochure in the Members' preferred

languages. Due to these interventions, the HEDIS Lead Screening measure **in California increased by five percentage points from MY 2021 to MY 2022**.

Our affiliate's Provider Relations team complemented these actions with Provider interventions. Their Blood Lead Screening **Quality Learning Award Program**, designed to recognize and reward Providers for improving blood lead screening rates for Members, issues an award of up to $25,000 to participating Providers for meeting requirements that include improving their blood lead screening rates by up to 30% over approximately 14 months. The program currently covers an average of 10% of our California affiliate's pediatric membership in each county, with a goal to expand to cover 50% of pediatric membership by 2024.

Approach to Support Lead Screening

The only way to know that a child has lead poisoning is through testing. Our approach to supporting improved lead screening rates will include leveraging the experience described above with specialized staff, processes, and tools developed specifically for the KanCare program.

Lead Screening Program Oversight. We will designate a **Lead Program Coordinator role** in Kansas and collaborate with the CLPPP team to increase awareness, share successful prevention strategies, and identify opportunities for systemic improvement. We will also partner with the CLPPP team to provide educational and outreach materials, make in-person presentations, and speak at local events. For example, the Lead Program Coordinator will promote **Hunter and Scout's Lead Poisoning Prevention Program for children preschool age to elementary age**. **We will bring this program to FQHCs, schools, and daycare centers in Kansas**. Molina CHWs will collaborate with FQHCs and Head Start programs to ensure each location has a copy of the Happy, Healthy, Lead-Free Me! book available.

Effective and Impactful Member Education. In addition to ensuring materials are developed at the appropriate reading level, we go above and beyond by developing materials tailored to be culturally appropriate to different populations. For example, the CDC reports the prevalence of elevated blood lead levels among refugee children compared with children born in the United States. To help address this, one of our Medicaid affiliates is developing educational materials with best practices on management of blood lead screening specifically for refugee Members within the required reading level.

Comprehensive Provider Education. Our KanCare education efforts will extend beyond Members and their families. The scope of our Provider Education program is comprehensive and supports the full array of information on blood lead levels. We outline the expectations for comprehensive assessments that must be completed at each well-child visit and the steps Providers should take for missed appointment referrals. We will conduct comprehensive training sessions for Providers and their staff to ensure they are informed about the Member incentive for lead screening and how a Member can receive it. Molina knows that sharing this information along with the referral for testing can increase test completion rates.

Proactive Identification Using Advanced Analytics. Members whose clinical conditions or social risk factors place them at increased risk, and therefore at a higher level of care management services, are primarily identified using our risk stratification and predictive modeling solution, Molina Insights. This solution collects multiple types of data, including

screening and assessment results, medical and pharmacy claims, lab results, and data from referrals and Providers' EHRs. Molina Insights applies analytics to the comprehensive data integrated into our enterprise data warehouse, along with KanCare-specific rules, to generate clinical risk score, impactable opportunities, the SDOH composite score, and gaps in care. Advanced analytics determine prioritization for outreach, the intensity of interventions, and frequency of follow-up, as well as assigning Members to a Care Coordinator who best suits their primary concern or diagnosis, including social risk factors, such as homelessness, interpersonal violence, isolation, or living in the frontier.

Actions to Support Lead Screening

We have carefully designed our actions specifically for KanCare. Our Member-focused strategies will include targeted Member outreach and educational campaigns to clinics and CBOs in high-risk areas. We will partner with CBOs and stakeholders to create informed, culturally competent child health promotion mailings. We will reach out to WIC to offer partnership and collaboration through in-person presentations and convening with early childhood organizations. These efforts have proven successful for our affiliates, and we will bring the same methods to KanCare Members. To reach even more Members in an efficient manner, Molina will roll out a new **text messaging campaign** to Members, families, and caretakers to educate them on lead screenings and prevention. The text will state: "Blood samples are taken to make sure your child is healthy, including lead screenings. Make sure to ask your child's doctor about blood lead testing if your house or daycare was built before 1978." We will also provide family-focused Member materials that include information on the importance of lead screening, explanations of what the results mean at specific scores (e.g., 0–4 means that the child's lead result is average), and helpful tips and tools to protect children from lead poisoning (e.g., wash toys, stuffed animals, pacifiers, and bottles with soap and water often). We will educate CHWs through the Molina CHW Training program on the importance of lead screenings, requesting screening at well-child visits, and incentives available through all KanCare MCOs.

Improving Access to Care Through Molina Care Coordination Staff. In Kansas, our Care Connection program's nurse practitioners will conduct blood draws for lead screenings at Members' homes in areas with elevated blood lead levels (e.g., Ellis County) to streamline the lead screening process. We will also train community-based care coordinators on lead-detection sprays to use during visits to Members in their homes.

Increasing Access to Lead Screening in Communities. Molina also relies on our strong community partnerships to further our goal of reaching more Members. We will partner with local schools and childcare facilities that perform lead testing in their centers, and they can refer Members with elevated blood levels to us or we can refer Members to them to be tested.

Anticipated Improvement in Lead Screening Rates

KanCare HEDIS Lead Screening rates demonstrate a continuing opportunity for improvement. Rates for all 3 MCOs in Kansas remained at the 25th percentile as reported in 2023, whereas 10 out of our 13 Molina affiliates achieved above the 25th percentile. To align with Molina's commitment to quality in Kansas, our goal is to improve the Lead Screening for Children HEDIS rate [redacted]

4.3.I.21 Approach to Identifying and Addressing HCBS Service Gaps for KanCare Members Enrolled in an HCBS Waiver

21. In practice, MCOs have experienced challenges in providing necessary HCBS Waiver services, including those that have been authorized for a Member, creating service gaps. Describe the bidder's approach to identifying and addressing HCBS service gaps to ensure needed services are provided to KanCare Members who are enrolled in an HCBS Waiver and what the bidder will do when Providers/direct care workers are not available to deliver an authorized HCBS Waiver service.

Molina's approach to identifying and addressing HCBS gaps is multifaceted, with a focus on Member choice, access, safety, independence, and community inclusion that aligns fully with the State's goals for delivery of HCBS Waiver services while also addressing long-term risks and solutions. Molina Care Coordinators are responsible for ensuring Members receive HCBS Waiver services in a timely manner. Our Care Coordination and QAPI programs use Member and Provider feedback and data to monitor those services and inform continuous quality improvement activities related to HCBS Waiver services.

Molina's strategies to deliver authorized HCBS Waiver services are grounded in the feedback we have obtained from KanCare stakeholders and our affiliates' extensive experience in providing HCBS services. As discussed throughout this response, we have the appropriate expertise, tools, resources, and partnerships to administer HCBS Waiver services in a manner that Members, Providers, and other KanCare stakeholders can trust and depend on.

Identifying and Addressing HCBS Service Gaps

Molina has participated in multiple meetings, conferences, and listening events in Kansas to learn about gaps in services for in-home workers, therapies, and alternatives to ongoing, person-delivered care (e.g., complex DME and home modifications). Our interactions have included:

- Public hearings and private Provider association events, such as the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight meetings, KanCare stakeholder listening sessions, the InterHab conference, the Kansas Health Care Association conference, and LeadingAge events
- Private listening sessions with KanCare Advocates Network; COF Training Services, Inc.; Starkey; Johnson County Developmental Supports; Big Lakes Developmental Center; TARC; Minds Matter, LLC; Independence, Inc.; Cerebral Palsy Research Foundation of Kansas; and Kansas Advocates for Better Care

In addition to gathering information from stakeholders, we have reviewed wait list information and service denial data; evaluated current managed care practices; and reviewed our affiliates' best practices for successfully closing HCBS service gaps, including in rural areas. Insights from those activities have helped us identify three primary challenges in providing HCBS Waiver services:

- Lack of Providers to deliver these services
- An administratively burdensome authorization process for HCBS Waiver services
- Providers' reluctance to accept Members with complex needs who require HCBS Waiver services

Below, we offer our solutions to each of the three challenges, including what we will do when Providers or direct care workers are not available to deliver authorized HCBS Waiver services.

Solutions to Challenge #1: Lack of Providers to Deliver HCBS Waiver Services

Lack of Providers to deliver services may be the result of a workforce capacity issue (e.g., no Provider is available) or unforeseen circumstances (e.g., a direct care worker doesn't show up for work). Our solutions include multitier backup plans, supports that enhance the Member's ability to self-serve, caregiver self-direction support, and Provider incentives.

Developing Multitier Backup Plans

A multitier backup plan is critical to getting people help with daily activities when their primary HCBS solutions are unavailable. Care Coordinators will help Members plan for the unexpected, document that plan, and train the Member and Care Coordination team to activate it. For each service, particularly those that are human delivered, the Member's backup plan will include primary, secondary, and tertiary options that the Member and their Care Coordination team can activate as needed. Solutions include:

- Informal supports provided by family, friends, and community volunteers (includes securing commitments from those individuals)
- Backup agencies to provide services (includes authorizing those services)
- Alternative services, such as day programs, respite care, and access to shelf-stable meals

Closing Service Gaps Through Value-added Benefits

To ensure Members receive the help they need when their primary HCBS solutions are unavailable, we will offer value-added benefits, such as providing the informal caregiver with transportation to and from the Member's home.

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For alternative services, our Care Coordinators are empowered to proactively authorize emergency meals and day services or set up a respite care authorization that may be used for backup whenever needed. We will also design value-added benefits—for example, providing informal caregivers with transportation to and from the Member's home—to help eliminate barriers to Members receiving care.

The Care Coordinator—or, for self-directed Members, the financial management services provider—will confirm with the designated backup individuals or organizations that they are willing and able to provide care. That confirmation will be documented in the Member's file. The Care Coordinator will update and verify the backup plan at least quarterly or when there is a change in services. When alerted to a missed service, the Care Coordinator will follow up with the Member to confirm that the backup plan is activated.

Offering Supports That Enhance the Member's Self-serve Ability

To promote independence, we offer Members access to HCBS Waiver services that meet their needs and do not rely on ongoing human delivery. As part of our person-centered planning process, Care Coordinators may leverage an occupational therapist to help identify services such as home-delivered meals, DME lift chairs, home modifications, therapies, or assistive technology. Three examples of assistive technology are described below.

[redacted]

[redacted]

Smart Tablets. For those Members receiving HCBS Waiver services who are at high risk of institutionalization, Molina will provide tablet devices and a 24/7/365 expert support team of nurse practitioners, doctors, therapists, and social workers to help triage immediate needs. The Member can simply press the "Help" button on their tablet to contact the support team.

Offering Caregiver Self-direction Support

[redacted]

Offering Provider Incentives

[redacted]

Solutions to Challenge #2: An Administratively Burdensome Authorization Process for HCBS Waiver Services

Streamlining Authorizations
Molina will convene an HCBS Waiver Services Workgroup, which will include KDHE, KDADS, other MCOs, and other stakeholders, to collaborate on standardizing and streamlining authorization processes and practices.
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Because burdensome authorization processes can create a fundamental barrier to administering HCBS Waiver services, Molina has created innovative solutions that make it easier for Providers to be paid accurately and on time while simultaneously making it easier for Members to access alternative services. Described below are three strategies that have been successful in our affiliates' health plans and that we will customize for KanCare. And, to continue to simplify the HCBS Waiver Services authorization process, we will also convene a work group that includes KDHE, KDADS, other MCOs, and other stakeholders to collaborate on standardizing and streamlining authorization processes and practices.

Authorizing an Extraordinary Funding Rate

We learned from KanCare Providers and stakeholders (e.g., KETCH, Lakemary Center, and Mosaic) that Providers have difficulty in getting authorization for super-tier funding related to access-to-care issues. Currently, they receive short-term authorization for super-tier funding, typically after a denial and multiple delays. Molina has created a solution to this problem: If a Member meets the criteria based on an assessment, we will authorize (on request) a super-tier for a complex-needs Member for the entirety of their Person-Centered Service Plan (PCSP). The authorization will be completed during the Care Coordination team meeting and will become part of the annual PCSP process. Care Coordinators will have the ability to authorize the super-tier rate for 12 months through our streamlined extraordinary funding process.

Streamlining DME Authorizations

Provider Experience

In listening sessions with the CPRF of Kansas (a leader in the development of rehabilitation engineering) and others, we learned that the HCBS DME authorization process is lengthy and does not include the appropriate type of clinician to review the case. In addition, we heard from advocates and KanCare Members that, although DME equipment is covered under State plan benefits, challenges with accessing wheelchair customization and modification affect Members' ability to access services and be fully integrated into their community. For example, there is an artificially created limitation on accessing new wheelchairs as children grow and need new/modified equipment or when adults are discharged from institutional care and need a wheelchair that will function well in their new home and in their community. To streamline DME authorizations as part of the PCSP, Molina's DME approval process will include occupational therapists and other specialized Providers. Involving the appropriate type of clinical review in the planning process will create a better experience for Members and the Providers who serve them.

Streamlining Home Modification Authorizations

Delays in completing authorized home modifications can occur due to differences in authorization processes and lack of qualified contractors (e.g., in areas such as central and western Kansas). LifewiseCHM has been recognized by the community and Providers for overcoming contracting shortage issues by providing timely modifications statewide, as authorized and as agreed upon by the PCSP. Molina, LifewiseCHM, and our HCBS Provider Advisory Committee will work together to co-develop a streamlined service for the home modification authorization process. Molina will invite other MCOs and home modification Providers to join us in standardizing processes to benefit KanCare Members.

Solutions to Challenge #3: Providers' Reluctance to Accept Members with Complex Needs Who Require Services

We learned during our listening sessions that HCBS Providers are reluctant to accept new Members with complex needs (e.g., individuals with brain injuries or IDD) due to a lack of access to needed supports and uncertainty about the level of payment needed to provide the required services effectively. This hesitation to provide services causes avoidable HCBS access gaps. Our solutions to this issue include negotiating an enhanced rate and offering targeted technical assistance, as described below.

Negotiating an Enhanced Rate

When we determine during the person-centered planning process that a Member with complex needs lacks access to HCBS, we will engage our specially trained LTSS Provider Representatives to negotiate an enhanced Provider rate that includes a higher level of staff to provide the HCBS needed. We will honor the enhanced rate throughout the annual PCSP, adjusting it at the annual reassessment (if needed) or upon a significant change in condition.

Offering Technical Assistance

Identifying Missed HCBS Waiver Services

If Molina learns about an HCBS service gap, we will take immediate action to help the Member get what they need**.** Options include facilitating self-direction (e.g., determining if the Member can hire a family member); identifying natural supports to help deliver services; and working with HCBS Providers to help them recruit additional workers. If the issue is in real time, we will activate the Member's backup plan, as discussed earlier in this response. Across our affiliate health plans, the occurrence of missed HCBS Waiver services is extremely rare. For example, our Texas affiliate's **successful HCBS service initiation rate was 98.84%** (as of November 2023).

As described below, Molina uses three methods to identify missed community-based services: Member outreach, service alerts, and Member reporting.

Member Outreach

Following the scheduled initiation of services as identified in the PCSP, a Care Coordination team member will contact the Member within five business days to confirm that services are being satisfactorily provided. For Members transitioning to the community from a facility, the Care Coordinator will follow up no later than two days from discharge—and, for ongoing services, at least monthly or more often in accordance with their PCSP.

If the Member states that services have not been rendered, or have not been rendered as authorized, the Care Coordinator will follow up with the Provider and support the resolution. If the Member is dissatisfied, the Care Coordinator will work to remediate the issue. We will also monitor service timeliness to ensure the time from assessment to initial services aligns with the Member's needs per their PCSP.

Service Alerts

For services subject to EVV and in accordance with Molina policies and procedures, system alerts will identify late or missed visits and trigger Member outreach. Although each Member is empowered to invoke their multitiered backup plan if a service is missed, we will respond the same day to address potential gaps in care. We will also run reports to alert the Care Coordination team when there is no claim for an authorized service. This retrospective review will help identify individual missed service trends beyond those subject to EVV.

Effectiveness of Service Alerts

Our affiliate health plans consistently deliver more than 99% of HCBS subject to EVV. Less than 1% of Members experience missed visits.

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Member Reporting

As part of the person-centered planning process, Members and their interdisciplinary teams are informed about the importance of timely HCBS service delivery in supporting the Member to achieve their community living goals. They are also informed about how to report a missed service. Members or their Care Coordination team will report missed or late services to their primary Care Coordinator, who helps the Member get the help they need. In the Member's health record, the Care Coordinator will document how they became aware of the missed service, details of the missed service, and the resolution.

If we discover a trend of missed visits by a Provider, their designated Provider Representative will work with the Provider to identify the root cause, offer education, and ensure improved performance. If the Member reports they are unhappy with the Provider, the Care Coordinator will work with the Member to identify another Provider. Leveraging best practices used by other Molina-affiliated health plans, we will finalize the detailed process and protocol according to Kansas standards and will describe the process in full in the submitted Policies and Procedure Manual.

Provider Network (Tab 7f)

MOLINA HEALTHCARE

4.3.I.22 Approach to Developing, Managing, and Monitoring an Adequate, Qualified Provider network for the KanCare program

22. Describe the bidder's approach (including methodology, data used to assess network adequacy, timeline, and use of selective contracting) to developing, managing, and monitoring an adequate, qualified Provider network for the KanCare program. Describe anticipated challenges, network gaps, and how the bidder will address those challenges, including the use of telehealth and other technologies.

Molina is well underway in building a robust Provider network that will fully meet the State's network adequacy requirements at the time of readiness review and in advance of KanCare Members' open enrollment. Our approach to network development, management, and monitoring draws on the experience of Molina's 18 affiliated Medicaid health plans, which for almost 30 years have been delivering comprehensive, high-quality, Medicaid-specific networks not just for TANF and CHIP programs but also for complex waiver populations identical to those in KanCare. **Affiliate health plans that were new market entrants in Nevada and Iowa recently launched adequate, qualified networks that were ready on Day 1 of go-live.** A significant factor in our affiliates' success was establishing a high-touch, transparent engagement approach that earned Providers' trust. We will leverage their best practices, as well as insights gained from hundreds of conversations with Kansas Providers, to deliver a fully compliant KanCare network that gives Members the care they need when and where they need it.

[redacted]

Over the past year, our team has engaged with well over 200 Provider and community groups to learn about their unique needs and pain points working with KanCare's current MCOs. We have met with large health systems, small Provider groups, FQHCs, CCBHCs, maternal health experts, safety net clinics, HCBS Waiver service Providers, behavioral health (BH) and LTSS Providers, personal/direct service advocates, community-based organizations, and professional associations. Our willingness to listen and be flexible has helped us secure letters of intent (LOIs) from organizations and associations, representing Providers of all types, including the Association of Community Mental Health Centers of Kansas (ACMHCK); Children's Mercy Hospital; Community Care Network of Kansas (CCNK); Community Health Center of Southeast Kansas (CHC/SEK); GraceMed; Health Partnership Clinic; Hunter Health; Minds Matter, LLC; Diversicare of Council Grove Healthcare & Rehabilitation Center; Diversicare of Chanute; Diversicare of Haysville; Diversicare of Hutchinson; Diversicare of Larned; Pratt Health and Rehab; Rock Creek of Ottawa; New Hope Services; and InterHab members such as Arrowhead West Inc., Big Lakes Development Center, Inc., Journey Homecare Services, and Karis Inc. Our engagement and recruitment activities are ongoing.

Molina's Plan President and Chief Executive Officer (CEO), Aaron Dunkel, will provide executive oversight of all network development, management, and monitoring activities, including hiring a Network Management and Contracting Director with deep Kansas roots. Mr. Dunkel, who brings 20 years of Kansas public health experience to this Contract, has made

transparency, trust-based relationships, problem-solving, and the expansion of evidence-based programming pillars of his career. Under his expert leadership, we will:

- Use proven methodologies to identify, recruit, contract and credential, train, retain, and support Providers
- Ensure network adequacy, accessibility, and compliance with time/distance standards through ongoing network analysis/monitoring using analytics software and data from claims, accessibility audits, and other appropriate sources
- Adhere to timelines for critical tasks (e.g., recruitment, contracting and credentialing, training, soliciting feedback on our performance, and submitting reports to the State)
- Offer contracts to all willing, qualified Providers of all types, which means **we will not selectively contract among Providers** when building our KanCare network.

We will document these activities in our detailed Network Development and Management Plan, which we will submit annually to the State for review and approval. Below, we highlight the key points of that plan, beginning with our three-step outreach and recruitment process, network development timeline, and examples of confirmed partnerships and initiatives with Kansas Providers and other stakeholders to better serve KanCare Members. We summarize the core components of our approach, including experienced staff, targeted Provider training and education, and ongoing communication with Providers to ensure they have the tools, supports, and resources they need to be successful. We then present our network monitoring approach, which is grounded in ongoing review/analysis of quantitative and qualitative data to address care gaps and improve Members' choice of Providers and services. Finally, we discuss anticipated challenges to delivering a compliant KanCare network, including examples of proposed strategies and solutions based on our knowledge of the Kansas Medicaid landscape and our affiliates' experience working with Medicaid across the country.

Developing a Qualified Provider Network for the KanCare Program

Our Network Development and Management Plan for KanCare is designed to give Members true and unwavering access to care that not only meets their physical health, BH, and LTSS needs, but also their cultural, ethnicity, language, health disparity, and SDOH needs. We take a methodical approach to network outreach and recruitment using the three-step process summarized below.

Going the Extra Mile to Meet Members' Complex Needs

For children with severe or rare conditions who are unable to receive treatment in-state due to a lack of Providers who render those specialty services, we have identified two out-of-state Providers—Children's Nebraska and the Children's Hospital Colorado—as recruitment targets to fill those service gaps.

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Step 1—Identify Network Targets

Our first step is to identify network targets based on an assessment of Members' covered benefits and service needs compared to currently licensed and practicing Providers. We look for Providers who understand local health and social issues, as well as strong partners who may not currently serve the Medicaid population. While our network will be built to be Kansas-centric, we will recruit out-of-state Providers if needed for services and Provider types that are unavailable anywhere in Kansas.

When identifying targets, Molina considers:

- Anticipated Member enrollment
- Expected utilization of services

- Provider types (e.g., specialty) required to furnish the contracted services
- Numbers of Providers who are not accepting new Members
- Proximity to public transportation and/or reliance on NEMT
- Geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and the location's physical and programmatic access for Members with disabilities
- Ability to offer HIPAA-secure virtual/telehealth services, as appropriate

To identify potential targets, we also review national networks and adequacy using industry-recognized sources, the National Plan and Provider Enumeration System database, and other MCO competitors' Provider networks.

Step 2—Conduct Recruitment

After thoroughly analyzing the data, we create a tiered list of unique Providers to target for recruitment. We focus initially on Providers who currently render KanCare services, followed by Providers in specialty areas where there are access gaps. Our target list is tiered to deliver partners capable of supporting the needs of complex, and usually higher-risk, Members. For example, our methods for identifying/securing BH, IDD, HCBS, and SUD Providers will include recruiting qualified BH professionals and CCBHCs who serve as BH and SUD care extenders.

We use a strategic array of tools to identify, track, and report network development activities, including analytical software to assess network adequacy, identify gaps, and verify compliance with State standards; customer relationship management systems; and core IT management systems. To encourage network participation, we facilitate monthly "Join Our Network" recruitment meetings (both virtual and in person) to answer Providers' questions about contracting, rates, quality programs, or other topics that may affect their decision to join our network. We also call prospective Providers directly to solicit their participation.

Step 3—Process and Execute Provider Agreements

Our Kansas-based Network and Contracting staff will seamlessly and simultaneously manage Provider contracting and credentialing activities. Our proven approach includes:

- **Assigning each Provider a single point of contact at Molina.** A designated Network and Contracting staff member who has experience and knowledge about the Provider type's unique needs and circumstances will function as their single point of contact throughout the contracting/credentialing process.
- [redacted]
- **Giving Providers access to our Provider portal.** Through Molina's Provider portal, Providers will have access to self-service contracting/credentialing capabilities, such as submitting their network application, tracking its status, and updating their demographics profile. (They will receive full access to the portal's range of Provider support features upon being credentialed.)

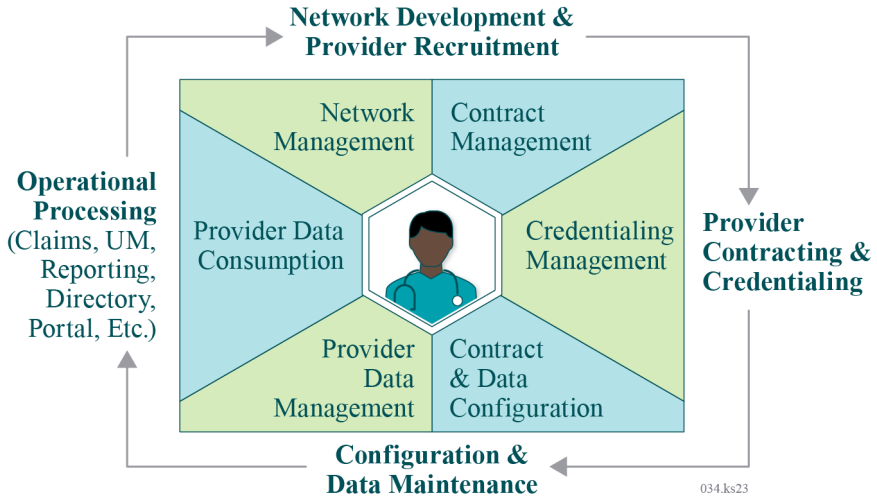
- **Offering Providers flexible contracting arrangements.** As part of contract negotiations, we will offer VBP arrangements to willing, qualified Providers to incentivize them to deliver value-based care that advances the State's goals for improved Member outcomes. We will also negotiate FFS rates with Provider types as required in RFP § 7.5.2.G.

VBPs with PCPs
We will offer 100% of PCPs a VBP arrangement from Day 1 that aligns with key KDHE quality goals. 096.c.ks23

- **Configuring Provider data for KanCare.** Providers' data will be configured into our system within 14 calendar days of credentialing. For key Providers such as new BH and LTSS Providers, a Provider Representative may conduct a network integrity site visit prior to configuration to validate ADA compliance, addresses/phone numbers, available hours, closed or open panels, and other critical information. We will also offer technical assistance to independent peer/consumer and family-operated organizations to ensure we have accurate and complete Provider data.
- **Conducting pre-implementation claims testing.** We have developed a pre-implementation claims testing plan that confirms the accuracy of Providers' data configuration prior to submission of actual claims. We will execute this plan across all Provider types to ensure we have tested as many services as possible. We will meet with Providers early and often during implementation to execute testing, reduce the likelihood of administrative claims denials, and resolve any other issues that arise.

Exhibit 22-1 illustrates the workflow of our contracting/credentialing processes.

Exhibit 22-1. Molina's Contracting/Credentialing Workflow Management Platform.
Automated workflows ensure consistency, accountability, and quick turnaround times.



As an indicator of the effectiveness of Molina's contracting/credentialing processes, the current turnaround time for initial credentialing across all affiliate health plans is 16 days. Our initial credentialing **turnaround times in Iowa and Nebraska, our two newest markets, are 13 and 15 calendar days**, respectively, which exceeds KDHE's 45-day requirement.

[redacted]

Supporting Centralized Credentialing. Molina acknowledges the State's plan to implement centralized credentialing/recredentialing as part of the ongoing implementation of new capabilities in the KMMS, and we offer our full support during that transition. Our affiliates have a long history of collaborating with Providers, state agencies, external credentialing verification organizations, and other MCOs to ease administrative burden in credentialing. For example, they have set clear standards across participating MCOs for both individual practitioner and facility credentialing and align recredentialing due dates across MCOs to reduce duplication of Providers' efforts. Our affiliates in Arizona, Kentucky, and Texas currently participate in centralized Provider credentialing processes led by an alliance of Medicaid health plans. Affiliates in Mississippi and Ohio collaborate with their respective state agencies for centralized Medicaid credentialing solutions. We look forward to sharing with the State our affiliates' lessons learned and becoming an active partner in meeting the State's goals for centralized credentialing.

Network Development Timeline

Molina will leverage the best practices and recent successful Medicaid/CHIP market entries of our affiliates to carefully track network activities and milestones for KanCare. **Table 22-1** summarizes the timelines for key network development activities we will complete before go-live.

Table 22-1. Molina's Provider Network Development Timeline for KanCare

Provider Network Development Activities	Activity Dates
Network Analysis • Identify potential rural and urban coverage shortages/issues • Identify specialty coverage shortages/issues • Identify prospective network Providers	[redacted]
Recruitment and Outreach • Develop plan/approach to fill network gaps • Conduct targeted outreach through calls, letters, and virtual/in-person meetings • Develop and mail LOIs to key Providers	[redacted]
Provider Incentives/VBP Strategies • Develop incentives/strategies to reflect KanCare requirements and goals • Obtain approval of incentives/strategies • Make good faith efforts to enter into VBP arrangements with interested Providers	[redacted]

Provider Network Development Activities	Activity Dates
Contracting and Credentialing • Convert LOIs into Provider agreements • Negotiate and execute Provider agreements • Credential Providers	[redacted]
Onboarding and Training • Develop Provider onboarding/training schedule • Develop and disseminate Provider materials • Conduct Provider orientation and training	[redacted]
Network Readiness • Meet network adequacy standards • Configure system and load Providers into system • Conduct pre-launch claims testing • Participate in network readiness review	[redacted]
Day 1 of Go-live	01/01/2025

Examples of Molina Partnerships with KanCare Providers

Kansas Partner

Molina's relationships with Providers extend far beyond simply contracting with them to join our network. We work continually to establish meaningful, collaborative partnerships that reflect our shared commitment to improving Members' health and well-being. Below, we provide examples of Molina partnerships with FHQCs, CCBHCs, IDD and BH Providers, I/T/U Providers, and community support Providers for KanCare.

[redacted]

[redacted]

Serving Members with Complex BH Needs and IDD

As a network Provider, Benchmark will help close care gaps while supporting and training CCBHCs and IDD Providers on innovative approaches to BH crisis and complex care delivery. 096.e.ks23

[redacted]

Expanding Access to Youth BH Services

Roya Health will open a **new pediatric residential treatment center** in Kansas to help reduce out-of-state placement of youth requiring residential BH services. 096.f.ks23

[redacted]

[redacted]

Community Paramedicine Makes a Difference

Recently, a community paramedic was talking about medication management with a Member in the Member's home. When the paramedic looked in the refrigerator to examine the Member's diabetes medication, they noticed there was almost no food. They immediately connected the Member to a local food pantry for needed supplies.

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[redacted]

Managing a Qualified Provider Network for the KanCare Program

Molina's approach to managing the KanCare network is built on the strengths of our experienced staff, our targeted training and education offerings, and Providers' easy access to a wide range of tools, resources, and supports. These strategies are summarized below.

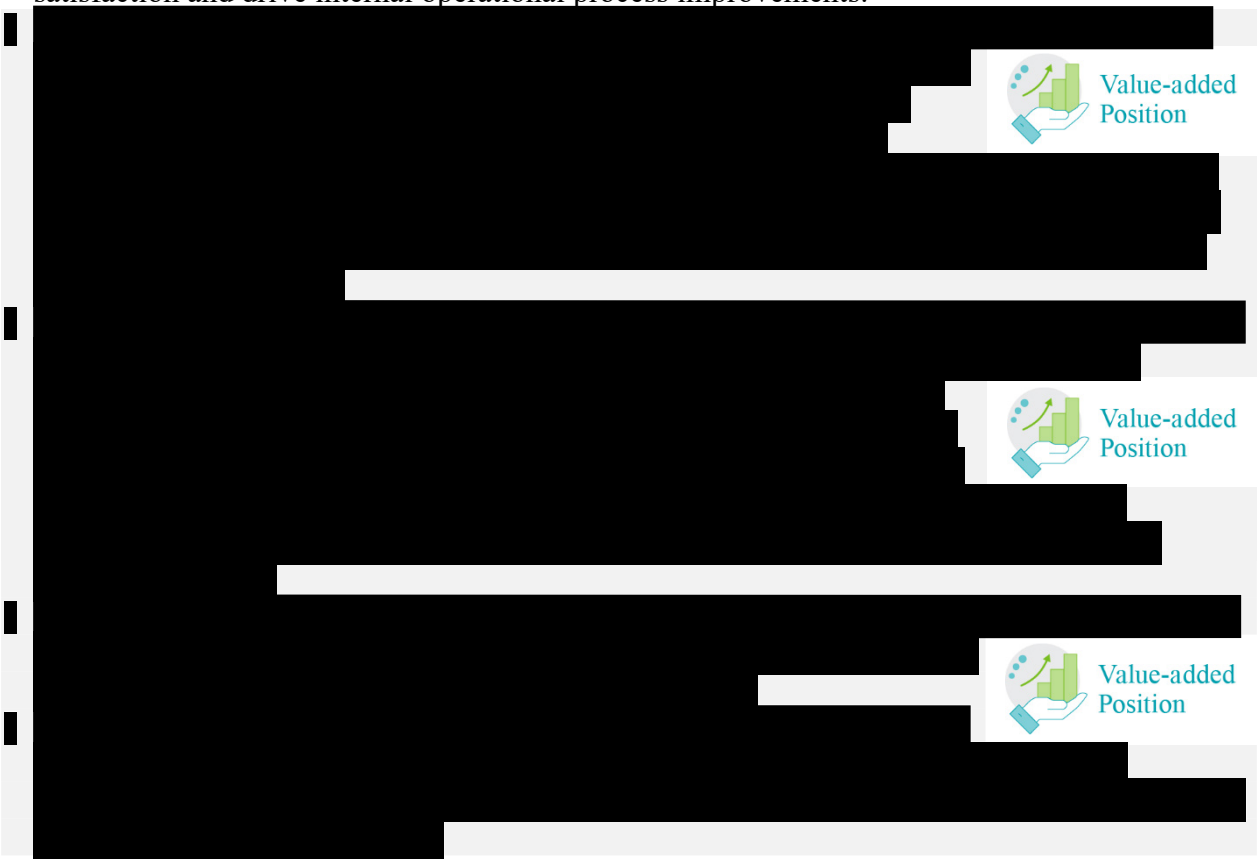
Staffing

To ensure Providers receive timely support and services, Molina's Network and Contracting staff will be assigned to strategic locations throughout the State. Our experienced Kansas-based Network and Contracting team will include the following staff:

- **Network Management and Contracting Director.** This individual will be responsible for overseeing Molina's Network and Contracting staff, developing/implementing/evaluating our network approach, and assessing network adequacy and availability.
- **Provider Representatives.** Locally based Provider Representatives will serve as a single, consistent point of contact with Providers and will support continuous feedback, timely data sharing, local accountability for issue resolution, and provision of relevant resources. In collaboration with our Network and Contracting team, Provider Representatives will

preemptively identify gaps in timely access and adequacy and address them at the individual and systemic levels. In addition to the RFP-required BH, LTSS, and Pharmaceutical Provider Representatives, we will offer hospitals and FQHCs the services of specialized **Hospital Provider Representatives** and **FQHC Provider Representatives** who understand those Providers' unique needs and situations.

- **Provider Concierge team.** Our Network and Contracting staff participate in a cross-functional Provider Concierge program to proactively review claim denials, appeals, and call data to identify Providers who might benefit from additional assistance and education. Our goals are to increase Provider satisfaction and drive internal operational process improvements.



Provider Training and Education

Molina offers New Provider Orientation and ongoing training through multiple modalities, including in-person, virtual, email/fax blast, and written communications. Training materials are easily accessible to Providers and their staff 24/7/365 through our website and Provider portal or, if requested, in hard copy. In addition to training on Molina and KanCare policies and processes, we offer relevant training throughout the year through various methods that are designed to appeal to Providers and their staff. We update and develop new educational programs and materials to reinforce the State's quality of care and equity goals and Providers' engagement in the program.

Access to Tools, Resources, and Supports

To ensure that KanCare Providers understand the program and can quickly access needed information, supports, and services, they can access Molina resources, such as:

- Our Provider services call center for general support and specific initiatives
- Our Provider website, newsletters, fax blasts, bulletins, FAQs, and blast emails for vital information
- Our Provider Handbook containing KanCare policies, processes, and updates
- Our Provider portal, which gives Providers a single-source, secure suite of tools to access program information, submit claims and prior authorization requests, verify Member eligibility/enrollment, and more
- In-person or virtual contact from a Provider Representative at least twice a year
- Joint Operating Committee meetings with health systems, hospitals, and large Provider groups, which provide training, ongoing education, and updates
- Provider Advisory Committee meetings with our Medical Director to collaborate on initiatives such as best practices, access to care, and preventive services

Giving Providers the Information They Need to be Successful

As part of initial and ongoing Provider training, we thoroughly explain KanCare requirements (e.g., related to network availability and accessibility) and reinforce that information through newsletters, bulletins, the Provider Handbook, Provider portal, and other communication channels. 096.h.ks23

Because Providers and office staff may need information that is distilled and quickly accessible, we also offer Quick Reference Guides and specialty-specific Provider toolkits that include screening tools, diagnostic criteria, clinical guidelines, interventions, and links to additional clinical resources.

Monitoring a Qualified Provider Network for the KanCare Program

Molina's network monitoring approach prioritizes continuous network assessment. Our Network and Contracting team will actively review/analyze every possible indicator of network adequacy to resolve individual complaints and identify systemic issues (e.g., trends and care gaps) that require solutions. As noted in **Table 22-2**, we will conduct monitoring activities daily, monthly, quarterly, and annually using data sources such as GeoAccess, claims, and Member-to-Provider ratio reports; accessibility audits; and Member and Provider feedback obtained through social media platforms, complaints and grievances, and satisfaction surveys.

Table 22-2. Network Monitoring to Identify Network Trends and Gaps

Monitoring Frequency	Data Sources and Descriptions
Daily	• **Social media platforms.** A social media monitoring unit within Member Services actively monitors multiple platforms for negative comments and hashtags related to Provider access. • **Online Provider Directory.** This directory allows Members to rate and review each Provider. We monitor feedback to identify Providers who receive low ratings or negative access comments. • **Member feedback.** Provider Relations, Member Services, Care Coordination, and call center staff identify network access and availability issues during their interactions with Members and Providers.
Monthly	• **Member-to-Provider ratios and closed panel reports**. These reports give Member-to-Provider ratios for PCPs and all specialty Provider types, including identification of Providers with closed panels.

Monitoring Frequency	Data Sources and Descriptions
	• **Out-of-network referrals and paid claims reports**. These reports track out-of-network referrals, single-case agreements, and out-of-network paid claims. • **Network terminations report**. This report identifies Providers with terminated contracts, including the reason(s) for the termination.
Quarterly	• **Accessibility audits.** We conduct these audits on a defined sample of PCPs and specialty Providers to assess compliance with appointment, availability, and after-hours accessibility. • **GeoAccess reports.** These reports present Member-to-Provider analyses by Provider type, location, and time/distance access standards. • **Grievances and appeals reports.** These reports include Member and Provider complaints about access, scheduling delays, wait times for appointments, and other barriers to care. • **You Matter to Molina forums.** This Provider outreach program offers easy ways for Providers to communicate with us about issues and concerns, including network adequacy and accessibility. Providers can contact us by mail using postage-paid cards, by email to our You Matter to Molina email box, during meetings and training sessions, or through a link in our Provider portal.
Annually	• **Satisfaction surveys.** Using an external survey vendor, we conduct annual Member and Provider satisfaction surveys to help us evaluate and improve our performance. The surveys include questions on satisfaction with our KanCare network. • **Network availability survey.** We conduct this survey of Providers' ethnicity, gender, and primary languages to ensure the network is adequate to meet the needs and preferences of Members. • **CAHPS survey.** This survey includes questions about Member satisfaction with Provider appointment times and Provider interactions.

When monitoring identifies trends or care gaps, Molina's network plan gives us the flexibility to quickly address capacity problems and Provider shortages. Our solutions will include:

- Executing single-case agreements with a Member's out-of-network Provider of choice to bridge the network gap and deliver timely services (and following up with contract offers to have the Provider join our network)
- Identifying new targeted Providers for recruitment/contracting and reaching out to those Providers to discuss their interest in joining our network
- Working with Providers with closed panels to encourage them to reopen their panels (e.g., by offering them financial incentives to open their panels and offering alternative modes of service delivery, such as telehealth and mobile urgent care services)
- Contacting Providers who have chosen to terminate their contracts with us to identify opportunities to ease their administrative burden, with the goal of having them rejoin our network

- Re-auditing Providers who do not meet network requirements and, if needed, following up with refresher training and/or CAPs
- Leveraging telehealth and other technologies to deliver services in a timely manner

To anticipate and quickly respond to the ever-changing needs of KanCare Members, our Health Equity, Growth and Community Engagement, Quality Management, and Care Coordination teams will also monitor targeted aspects of the network to ensure quality, appropriateness, and compliance. Network monitoring is the overall responsibility of our Network and Contracting staff under the leadership of our Network Management and Contracting Director, who reports directly to our Plan President and CEO. Ultimate accountability for network performance lies with Molina's Board of Directors.

How Molina Will Address Anticipated Challenges and Network Gaps

With our enterprise's almost 30 years of Medicaid experience and the valuable feedback we have received from KanCare stakeholders, Molina is acutely aware of the State's unique Provider network challenges and will work continually to solve them throughout the Contract term. Even as we bring our existing system-wide network into the program, we understand that maintaining and building the network is about much more than contracting with Providers. It's also about our network's never-ending evolution to expand access and capacity so that every Member—regardless of location or background—has the opportunity to receive high-quality, equitable care across every Provider type and throughout the State.

Below, we present our strategies to address five critical challenges identified by KanCare stakeholders: healthcare workforce shortages, dental care Provider shortages, BH Provider shortages, maternal healthcare deserts, and access gaps in rural and underserved areas. Our solutions for addressing these challenges clearly illustrate Molina's strengths in analyzing issues and implementing initiatives that will make a positive difference in Members' access to care and overall health. Each solution is multifaceted, providing needed services and supports while also easing Providers' administrative burdens. As part of these solutions, we also discuss how we will use telehealth and other technologies to address care gaps.

Challenge #1: Addressing the Healthcare Workforce Shortage

Like many states, Kansas faces a shortage in healthcare workers such as direct care workers and HCBS and BH Providers. To address this shortage, Molina's initiatives include:

- **Sponsoring apprenticeship programs.** [redacted] We will also partner with employers to provide on-the-job learning, pay progressively higher wages as skills increase, and identify experienced mentors to work with apprentices.
- **Supporting individuals with disabilities who seek healthcare careers.** [redacted]

[redacted]

Our locally based Workforce Development Manager, who is experienced in HCBS and BH workforce development and management, will serve as the single point of accountability for Molina's annual workforce development plan and activities. This individual will also be our primary liaison with the State, other MCOs, Providers, and stakeholders as we collaborate to strengthen the HCBS and BH workforces to serve KanCare Members.

Challenge #2: Addressing Dental Care Provider Shortages

To overcome dental care shortages, we are focusing on expanding the dental network through strategies such as identifying general practitioners who can also provide specialty services. To expand access to dental care, we will contract with a dental partner to provide supplemental dental telehealth interactions—for example, having dentists and registered dental hygienists prescribe interim solutions pending an in-person visit. In addition, we are investing in loan repayment for dental professionals who agree to serve underserved areas and populations.

Challenge #3: Addressing BH Provider Shortages

Molina recognizes the significant difficulties that KanCare Members currently face in accessing BH Providers across the continuum of BH care. Our strategies to expand the BH workforce include growing the number of contracted BH Providers *and* the availability of mental health resources statewide. We present examples of our proposed strategies below.

Molina Contracts Directly with BH Providers
Our KanCare network of BH Providers will be non-delegated and managed in-house, allowing us to focus on fully integrating physical and BH services delivery. 096.i.ks23

Supporting BH Specialist Training and Licensing. [redacted]

Investing in New Technology
We will provide grants of $100,000/year to help CCBHCs adopt new technology to support measurement-based care. 096.j.ks23

Investing in the CCBHC Model of Care. [redacted]

Offering Mental Health First Aid Training. We have invested in mental health training as part of first aid certifications and will continue this partnership with ACMHCK to sponsor and fund training sessions for first responders. Molina will also invest in NAMI Kansas' community trainings to ensure Providers across Kansas have access to these critical trainings. Participants will learn how to recognize when someone may be thinking about suicide, provide skilled intervention, and develop a safety plan with the person that connects them to further support. Molina will offer this training as part of first aid certifications for all BH Provider types.

Challenge #4: Addressing Maternal Healthcare Deserts

[redacted]

Virtual App Drives Positive Outcomes

Mae reports consistently seeing more than a 30% reduction in cesarean births and a 50% reduction in preterm births for women using any combination of their services, including their birth plan tool, weekly platform check-ins, and doula services.

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[redacted]

Challenge #5: Addressing Access Gaps in Rural and Underserved Areas

Providing equitable coverage statewide and across all Provider types requires a tailored approach to address the health challenges that rural communities face. Drawing on our knowledge of the Kansas landscape, augmented by our affiliates' experience in predominantly rural states such as Iowa, we will ensure Members receive the care they need no matter where they live. To address access gaps in Kansas' rural and underserved areas, Molina's solutions include:

[redacted]

- **Telehealth and other technologies.** We will partner with telehealth Providers who offer primary care services, BH services, SUD treatment, specialized care for Members who are IDD, specialist support for PCPs, peer consultations, and other needed services.

In addition, we will develop VBP models that offer enhanced support to rural Providers, including through the establishment of clinically integrated networks. These networks will offer the infrastructure needed to facilitate virtual collaborative relationships across the continuum of care, which will benefit Providers who otherwise may not have the capabilities or resources to advance to higher APM models. For rural Providers, achievable incentives are a significant factor in their ability to stay in business.

Use of Telehealth and Other Technologies

Increasing Provider Access and Capacity
Molina's telehealth and other technology solutions will bolster immediate Provider access and capacity, reducing barriers to care while enhancing Members' flexibility and choices. 096.1.ks23

To strengthen Provider capacity while supporting network Providers, we will offer telehealth solutions that bring immediate access and capacity to Kansas Members. Our approach includes adding capabilities through national telehealth solutions, encouraging KanCare Providers to support the use of telehealth services, promoting the availability of telehealth to Members, and investing in technologies and supports to make telehealth more readily available and culturally competent.

To help bridge access gaps, Molina allows appropriate covered benefits to be delivered via telehealth by PCPs, BH Providers, and other specialist Providers who have the technology to deliver those services. We also have contracts with vendors to provide Member-facing virtual support and services. **Table 22-3** presents examples of physical health and BH telehealth solutions and how they will expand access to care in Kansas.

Table 22-3. Examples of Telehealth and Other Technology Solutions.

Our Solutions That Expand Access	Description
Virtual visits for primary care, BH, and/or urgent care services	[redacted]

Our Solutions That Expand Access	Description
	[redacted]
Virtual counseling services	• Members with opioid use disorder can access MAT and high-quality group counseling through **Groups Recover Together**, an online community support platform that helps Members solve underlying issues associated with opioid addiction.
Virtual support services	• For community-based Members receiving LTSS and those on a waiting list, our multidisciplinary clinical services Provider places a cell-enabled device in the Member's home for visits with physicians, nurse practitioners, pharmacists, BH specialists, therapists, and other health professionals. This team provides a person-centered approach to respond to each Member's unique needs. Virtual interventions, including a red button on the device for accessing 24/7/365 support, promote timely and culturally appropriate access to care, even in the most rural settings.
Services that support Member engagement	[redacted]
Peer consultation services	[redacted]
Complex case management services	[redacted]

Our Solutions That Expand Access	Description
Maternity health services	[redacted]
Teledentistry	[redacted]

Kansas Partner

[redacted]

4.3.I.23 Approach for Addressing Workforce Development Challenges for HCBS and Behavioral Health (BH) Services

23. Increased demand for HCBS and Behavioral Health Services has created challenges in ensuring an adequate workforce to provide HCBS and Behavioral Health Services. Describe the bidder's approach for addressing workforce development challenges for HCBS and Behavioral Health Services.

Investing in Workforce Development
Molina will expand capacity, provide training and career paths, and offer VBP arrangements to grow a sustainable labor pool to meet KanCare's long-term HCBS and BH workforce needs.
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A robust and stable workforce, particularly of HCBS direct care workers and BH Providers, is critical to ensuring delivery of integrated, person-centered care to KanCare Members. In alignment with the State's Provider network and direct care workforce goals, Molina's approach for addressing workforce development challenges for HCBS and BH services focuses on expanding capacity, providing training and career paths, and offering VBP arrangements to support recruitment and retention of high-quality Providers. [redacted]

In conversations and listening sessions with KanCare stakeholders over the past months, Molina has heard that caregiving as a career can be difficult to achieve, especially in rural and frontier areas. HCBS Providers lack knowledge about or pathways to career ladders, and BH Providers face challenges in meeting licensure requirements due to a lack of fully licensed therapists to oversee required clinical supervision hours. Under the direction of our Plan President and Chief Executive Officer (CEO), Aaron Dunkel, who has extensive Kansas Medicaid leadership experience, our Workforce Development Manager will partner with entities such as the Association of Community Mental Health Centers of Kansas (ACMHCK), InterHab, KanCare Advocates Network, and Kansas Advocates for Better Care to address those challenges, developing valuable career pathways while simultaneously supporting the needs, preferences, and care of Medicaid Members. Our locally based Workforce Development Manager, who is experienced in HCBS and BH workforce development and management, will serve as the single point of accountability for Molina's annual workforce development plan and activities. This individual will also serve as our primary liaison with the State, other MCOs, Providers, and stakeholders as we collaborate to strengthen the HCBS and BH workforces to serve KanCare Members.

> Molina has engaged in meaningful discussions on how to bring their healthcare experience to the Kansas Medicaid system and develop partnerships with senior care Providers. [We are] encouraged to see a company like Molina endeavoring to join the KanCare program, and we feel they would be an improvement over the current options in the system.
>
> *Douglas Yoder, Executive Director*
> *Progressive Healthcare Alliance*
> *Lawrence, Kansas*
>
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Approach to Addressing HCBS Workforce Development Challenges

HCBS workforce shortages in Kansas are projected to become more acute as the aging population grows faster than the labor pool. As the State's residents get older and the population of young people declines, the pool of informal caregivers providing unpaid HCBS services is

decreasing. In addition, direct care work, which is often perceived as a job rather than a career, competes for labor with higher-paying service and retail industry employers. Because Molina views direct care workers as critical participants in Members' care and well-being, we work continuously to tap into new labor pools, reward quality and retention, and elevate the profession by providing training and career ladders. As discussed below, our approach to addressing HCBS workforce development challenges in Kansas includes expanding capacity through training and apprenticeships, VBP arrangements, supports for informal caregivers, and technical assistance.

Training and Apprenticeships

Training and apprenticeships play a critical role in attracting untapped labor pools and providing motivation to remain in health care service delivery positions. To create paths for caregivers, students, retirees, immigrants, peers, and others to progress to paid healthcare extender positions, we will collaborate with government entities, community colleges, and other stakeholders to:

- Reduce turnover in positions with high attrition rates, such as home health workers and certified nursing assistants
- Support direct care workers who want to advance in the field but lack requisite education or credentials
- Offer comprehensive instruction for graduates of certificate programs who lack some of the skills needed to be fully competent
- Build healthcare career ladders and lattices that support employee retention and minimize the need for onboarding costs
- Provide on-the-job experience to healthcare workers, with guidance from experienced mentors or coaches

Molina will evaluate healthcare extender training programs and registered apprenticeship programs throughout the State to identify partners with whom we can strategically address shortages of home health workers, certified nursing assistants, licensed practical nurses, and other types of HCBS Providers. Two examples of proposed initiatives are described below.

[redacted]

Supporting the DSP+ Apprenticeship Program. We are excited to help expand DSP+, a new registered apprenticeship program through InterHab and the Kansas Office of Registered Apprenticeship. DSP+ provides a pathway to further professional advancement for Kansas direct support professionals who provide services to persons with IDD. [redacted]

[redacted]

VBP Arrangements

[redacted]

Supports for Informal Caregivers

Informal caregivers provide essential day-to-day care for Molina Members (e.g., those with LTSS needs and significant chronic conditions) that allows Members to remain in community-based settings for as long as possible. To support caregivers' delivery of services while ensuring their mental health and well-being, we offer them customized training, support groups, job boards, toolkits, transportation, incentives for completing caregiver screenings, expanded respite, and individual therapy sessions. This strategic array of tools and supports was informed by input from KanCare Providers/stakeholders and our affiliates' caregiver advisory workgroups. It also reflects the findings and policy solutions documented in the "Strengthening the Direct Care Workforce: A Framework for Leveraging the Rise of MLTSS MCOs to Address the Workforce Crisis" white paper released in September 2023 by the National MLTSS Health Plan Association. Molina leadership collaborated with the association, home care Providers, and other MCOs on the white paper to share emerging best practices for informal and formal caregivers.

To illustrate our approach to supporting informal caregivers, below are descriptions of three key offerings: customized training, caregiver support groups, and caregiver job boards.

Positive Outcomes Using Trualta
A peer-reviewed clinical study with University of Florida Health found positive outcomes after just 30 days of access to the platform, including a:

- 12% decrease in behavioral symptom severity
- 10% decrease in caregiver distress
- 30% increase in caregiver fulfillment

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Customized Training. [redacted]

Caregiver Support Groups. For caregivers at high risk of burnout, we will offer support through our evidence-based Caregiver Support program. Used with great success by our affiliates, this program averages 200 registrations per live event, with 96% of participants reporting that they learned something new and 82% reporting lower isolation scores following the event. Caregivers also have the option to receive online support through TCARE, a Medicaid-approved family caregiver solution that uses intelligent, predictive technology to target and map interventions based on specific caregiver stress and burnout risk factors. Through the company's TCARE Assist Caregiver Platform, Molina can determine when caregivers need help and how best to assist them through targeted outreach and assessment.

Positive Outcomes for Participants in Our Caregiver Support Program
Across our affiliate health plans, this program has demonstrated improved HEDIS® measures, a 20% reduction in the need for HCBS services, and Members' ability to stay in their communities for an average of 21 additional months.
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[redacted]

Technical Assistance and Administrative Support

[redacted]

Approach to Addressing BH Workforce Development Challenges

While demand for mental health and substance use treatment is greater than ever, Kansas Providers report not being able to meet the demand, due in part to a shortage of therapists and BH support positions. Nationally, 57% of individuals who have a degree in mental health do not become licensed due to financial, time, and regulatory barriers. BH workforce development challenges in Kansas include limited access to training for specialized BH services, difficulty securing supervisory oversight to complete licensing requirements, and scarce resources to help BH Providers transform their practices to meet Members' needs. The result is a significant lack of access to BH services, especially for Members with complex needs. To address this BH workforce crisis, Molina will:

- Invest in the State's CCBHC model through [redacted]
- Contract with nationwide BH and IDD Provider groups to provide specialized services that expand our KanCare BH Provider network

- Implement long-term solutions such as grants, apprenticeship programs, virtual supervision opportunities, targeted trainings, and continuing education to meet the growing demand for all BH Provider types

Our approach reflects both our collaborative planning sessions with Kansas Providers and KanCare stakeholders and the BH workforce experience of our 18 affiliated Medicaid health plans. Molina's investments in KanCare's BH workforce will address the entire continuum of services, including peer supports certification and clinical supervision for licensed clinical professional counselors, licensed marriage and family therapists, ABA therapists, and SUD Providers such as licensed associate counselors and master addiction counselors. We are committed to supporting the BH workforce development strategies summarized below.

Contracts with Provider Groups

During our meetings with KanCare stakeholders, we heard frequently from CCBHCs and IDD Providers about a significant service gap in BH crisis and complex case services. [redacted]

[redacted]

Long-term Solutions to Meet the Growing Demand for BH Providers

Molina is investing in long-term solutions to meet the growing demand for all BH Provider types. Our strategies include strengthening the peer support workforce; supporting individuals with disabilities seeking healthcare vocations and careers; offering resources for virtual supervision; offering targeted trainings, evidence-based education, and continuing education credits; and introducing children to healthcare career opportunities. We present descriptions of these strategies below.

Strengthening the Peer Support Workforce. Individuals with lived experience play an integral role in extending/supplementing Members' clinical care through supportive services and community-building. To help realize the full possibilities of peer support competencies and impact, Molina will explore connections to and investments in training and continuing education for the peer support specialist, peer mentor, and parent peer specialist workforce. For example, we will

Success Stories: Strengthening the BH Peer Support Workforce

Our **Arizona** affiliate invested $100,000 in capacity-building funds for the Arizona Peer and Family Career Academy, a critical state partner in peer support continuing education. In 2022, the academy hosted 59 events and trained 749 students, including specialized trainings on forensics, opioid use, and peer support supervision.

Our **Washington** affiliate awarded nearly $720,000 to in-state nonprofit organizations to improve BH access and workforce capacity while complementing local community investment strategies. To date, 200 youth and young adults have completed a six-week BH peer counseling training program through the Students Providing and Receiving Knowledge Peer Learning Center.

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work with the Kansas Department for Aging and Disability Services and its organizational and Provider partners to support EBPs and innovations such as community health worker cross-training. We will also partner with NAMI Kansas to offer peer support training and education to improve individuals' understanding of their own mental illness while empowering them to assist others in the recovery process using evidence-based family support competencies.

Supporting Individuals with Disabilities Seeking Healthcare Vocations and Careers. Through the US Department of Education recently awarded grant in Kansas for the Pathways to Partnership model demonstration projects, Molina will collaborate with Independence Inc., to support their role in the grant. We will work with them to educate transition-aged youth with disabilities about entering the workforce. We will also engage with the Kansas State Department of Education and LEAs who are involved in the Pathways to Partnership grant to have Molina's Employment Services and Supports Coordinator assist with educating Members about these programs. For example, our Employment Services and Supports Coordinator will help Members identify accessible educational programs leading to positions such as community health workers, peer support specialists, and ABA therapists.

[redacted]

Offering Mental Health First Aid Training. [redacted] Participants learn how to listen nonjudgmentally; assess situations for risk of suicide or harm; intervene appropriately in situations such as panic attacks, non-suicidal self-injury, overdose or withdrawals from alcohol or drug use, and reactions to traumatic events; and encourage appropriate follow-up activities such as seeking professional help, self-help, and other support resources. Molina will offer this training as part of first aid certifications for all BH Provider types.

Offering Evidence-based Education and Continuing Education Credits. We will provide BH information and resources through Psych Hub™, an online BH training Provider whose content is evidence-based, trauma-informed, culturally responsive, and clinically sound. Psych Hub's offerings will be available at no cost to the entire BH ecosystem, including Providers, schools, community-based organizations (CBOs), and community members. They will help expand Provider capacity at the point of care through training for PCPs, CCBHCs, and lower-level BH professionals who want to advance their skills and management capabilities.

Introducing Children to Healthcare Career Opportunities. We are partnering with the Inspire Health Foundation, a part of the Community Health Center of Southeast Kansas, to create apprenticeship programs and champion learning about careers in healthcare. One program component provides hands-on education to school-aged children to introduce them to vocations as doctors, nurses, counselors, caregivers, and other healthcare professionals.

Monitoring Workforce Development

Molina will continually monitor the workforce that provides HCBS and BH services for KanCare using both qualitative and quantitative data—for example, Member and Provider complaints, Member and Provider satisfaction surveys, CAHPS® surveys, public workforce data and studies, and feedback from the Member Advisory Committee, Provider Advisory Committee, advocacy groups, Provider forums, CBOs, and other program stakeholders. **Exhibit 23-1** illustrates the feedback channels and tools that will guide our direct care workforce initiatives for KanCare.

Exhibit 23-1. Direct Care Workforce Feedback Tools and Channels. We obtain feedback from sources such as advisory and advocacy groups, Provider forums, and surveys.

We will also form a Direct Care Workforce Advisory Group that includes representatives from HCBS and BH Providers, such as Johnson County Developmental Supports; COF Training Services, Inc.; CCBHCs; delegated community care coordination Providers; and targeted case management Providers. The advisory group will regularly review and inform our KanCare workforce development plan, which will meet RFP § 7.5.9 requirements and align with Molina's workforce development policies and processes.

Our Workforce Development Manager will incorporate the monitoring results into our annual workforce development plan. In addition, Molina will prepare monthly progress reports on workforce development activities at the State's request and present that information at stakeholder meetings.

4.3.I.24 Identification of Network Gaps in Dental Care Providers and Approach to Ensuring KanCare Members Have Timely Access to Quality Dental Care

24. Describe the bidder's identification of network gaps in dental Providers in KanCare and the bidder's approach to ensuring KanCare Members have timely access to quality dental care in Urban, Rural, and frontier areas. Include example(s) of the bidder's successful use of a comparable approach in program(s) similar to KanCare, the measurable impact achieved, and how the bidder will apply this experience to benefit KanCare.

Molina champions the pivotal role of dental health in enhancing Members' overall health and quality of life. We will bring an all-encompassing approach that seamlessly integrates dental health into every aspect of Members' overall well-being. We are committed to supporting the dental health professional community currently serving KanCare Members and will explore innovative means to expand dental health service delivery. Based on our proven approach and experience building dental care networks, we will ensure Members have timely access to quality dental care in urban, rural, and frontier areas, as described in the following pages.

Identifying Dental Care Network Gaps in Kansas

Molina has conducted a comprehensive analysis to identify the prevalent dental care gaps within the KanCare landscape. This evaluation involved mapping the distribution of existing dental care Providers accepting KanCare in urban, rural, and frontier areas. We have identified specific regions with limited or no access to participating dental health professionals, quantifying the disparity between the population in need and available Providers. Our approach integrated data analytics, stakeholder consultations, and geographical mapping to pinpoint the network gaps detailed below:

- Lack of access to both adult and pediatric dental health Providers in rural and frontier counties
  - Zero Medicaid dental care Providers: Cheyenne, Sherman, Wallace, Lane, Ness, and Morton
  - Only one Medicaid dental care Provider: Wichita, Logan, Seward, Grant, and Hamilton
- Lack of access to dental anesthesia across the State
- Lack of access to dental care for Members who are IDD

The American Dental Association reports that merely 39.7% of dentists in the State are open to accepting Medicaid patients,[1] limiting dental care utilization for both children and older adults. The State's utilization rate ranks among the lowest national rates. Thus, KanCare Members face difficulties in locating dentists willing to provide essential oral healthcare, resulting in severe adverse outcomes—for example, older adults losing teeth due to untreated dental issues, such as tooth decay and gum disease. Because of the lack of dental health Providers, fewer than half of KanCare youth, from birth to age 20, receive the necessary dental care, in contrast to 80% of youth in the overall population.[2] Ensuring access to quality dental care for all Members remains crucial for preventing such disparities and improving overall oral health outcomes.

[1] Abundis, Megan, "Two Americas: Group Working to Combat Dentist Shortage in Kansas, Missouri," *KSHB 41 Kansas City,* Kansas City, MO, December 14, 2022.

[2] Oral Health Kansas, "Kansas' Oral Health Score Remains Low," *The 2022 Kansas Oral Report Card Announcement.* Jan 1, 2022

Ensuring KanCare Members Have Timely Access to Quality Dental Care

Molina has the experience, knowledge, and capacity to ensure delivery of quality dental health services to Members, in accordance with existing and future KanCare program requirements. Based on our affiliates' experience and comprehensive approach to Medicaid dental health services, Molina intends to leverage existing dental care capacity in Kansas and will contract directly with Medicaid dental care Providers.

We integrate dental care with our whole-person healthcare delivery infrastructure. Members in eight of our affiliated Medicaid health plans currently receive timely integrated dental health services, and this delivery is in accordance with the Medicaid program and prevailing dental health community standards. In 2021, our proprietary (in-house) dental health services networks in Michigan, Mississippi, Ohio, and Wisconsin complied 100% with contractual requirements for network time and distance. Molina's proprietary and direct-contracting dental health network model offers Members and Providers the following advantages:

- A single team manages dental health services, which creates efficiency and effectiveness. We incorporate all dental health information into the Member's personal health record, sharing a **whole-person health line of sight** to the Member's dental care needs. With this capability, we can collaborate with dentists and close access issues and gaps in care. Members receive quick, easy assistance when locating a dental care Provider or scheduling an appointment, as needed.
- Providers will benefit by having direct access to our dedicated Oral Health team members for training, questions, and support, as well as direct access to Molina's Kansas-based Oral Health Director for peer-to-peer discussions.
- Our direct-contracting model provides administrative cost savings, which we will use to increase Provider reimbursement and drive more preventive dental care to Members in need.

Building a Dental Care Network

Molina will use various sources—including websites (e.g., the government resource called 'InsureKidsNow.gov), competitor Provider Directories, and the current KMAP file—to identify all available dental care Providers in Kansas. We will examine all regions and recruit all willing and able dental care Providers. Based on our extensive research, we know the landscape has extremely limited dental care options across western Kansas. While we own and manage our dental provider network, we use a dental services subcontractor, SKYGEN USA, for administrative functions.

To ensure timely access to quality dental care across diverse geographical regions, our strategy encompasses a multifaceted approach tailored to each service area's unique needs. In urban areas, we emphasize enhancing Provider engagement through incentives and streamlined administrative processes, augmenting the network by recruiting additional participating dentists.

For rural and frontier areas, our approach involves leveraging teledentistry solutions and mobile dental care units, and establishing partnerships with local health centers, FQHCs, CCBHCs, and school-based health centers, to extend outreach. Community outreach programs and targeted awareness campaigns will also promote preventive dental care and highlight available services.

Bolstering this effort, our Network Management and Contracting Director and Provider Representatives are deeply involved, collaborating directly with our Oral Health Director to

strategize dental care Provider recruitment. We are engaging and forging collaborative partnerships with key community-based organizations, such as the Kansas Dental Association, Kansas Dental Hygienists' Association, Kansas Medical Society, and Oral Health Kansas. Our concerted efforts extend to partnerships with key FQHCs, such as the Community Health Center of Southeast Kansas, GraceMed, and Swope Health. Together, we are diligently crafting targeted and effective solutions to tackle the prevalent dental care shortages across Kansas. Molina supports all State initiatives to expand dental care coverage across Kansas, including lobbying the legislature to address the issue and increase reimbursement rates for dental care Providers.

Increased rates will work in tandem with our value-added benefits to encourage Members to receive dental care. We will also develop and implement VBP models specifically designed to encourage dentists and hygienists to participate in KanCare and increase access to dental care. We look forward to working with KDHE's Bureau of Oral Health, fellow MCOs, dental care Providers, and other stakeholders to bring high-quality dental care to all Kansans.

Molina is currently establishing its dental care network in Kansas neighboring state Nebraska. To combat the dental care Provider scarcity in Nebraska's rural and frontier areas, we have proactively engaged and contracted with dental care Providers in Kansas. As a result, we will initiate operations with a solid base of Kansas-based dental care Providers who have established affiliations with Molina. To promote timely and cost-effective access to quality dental care for every Member in KanCare, we will directly contract with a comprehensive, statewide network of dental care Providers rather than subcontracting to a dental care network.

Local Dental Services Management Team

Our Kansas-based Oral Health Director will lead our Dental Services Management team. With years of experience building and maintaining robust dental care networks for our affiliate health plans, our team comprehensively grasps the nuances and complexities of dental care in states like Kansas.

Armed with proven solutions, Molina is set to seamlessly introduce these approaches to KanCare. Collaborating closely with our dental care Provider network, we will not only implement but also refine data-sharing capabilities. Furthermore, we will educate and enlighten dental care Providers on our person-centered integrated healthcare methodology. This education ensures that our Member care plans align precisely with Members' healthcare needs and preferences.

Dental Homes

Molina strongly supports the dental home concept to ensure Members establish an ongoing relationship with a primary dentist, which will promote comprehensive, accessible, and coordinated care. Molina will assign all KanCare Members to a dental home, and all Members will receive a Welcome Letter. The letter includes their dental home assignment, contact information for the Member Services call center, and information on the importance of scheduling a visit with their dental home

Provider. In addition, our website includes information about the importance of oral health, the availability of dental health services, our dental care network, and dental health services access.

We also provide this information during Member outreach and in educational materials and mailers.

Molina understands the connection between maternal health and oral health. Lack of dental care during pregnancy is associated with preterm birth and low birth weight for babies, so we include information about dental care benefits in all prenatal and postpartum outreach materials, including information regarding our value-added dental care benefit for perinatal Members.

In our diabetes outreach postcard, we also include information about the correlation between dental health and diabetes, and how to access dental care coverage.

Addressing Dental Care Provider Network Gaps

Molina will employ a variety of solutions to expand the availability of KanCare Providers and access to dental care.

Expanding Kansas' Dental Health Workforce

Molina will explore all alternatives to find dental care Providers to work with KanCare Members, including searching in neighboring states. To encourage Kansas dentists to participate in KanCare, we will provide information about the KanCare program, our rates, and VBP programs; guidance and best practices (e.g., from fellow Medicaid dentists and our Molina Oral Health team); IT improvements (e.g., upgrading computer systems to submit claims efficiently and receive payment); and administrative support. For example, we will help dental care Provider offices navigate the State's website and follow instructions on how to enroll as a State Provider.

Bridging Network Gaps in Dental and Physical Health

Our Nebraska affiliate initiated contact with a Colorado FQHC to inquire about joining our Provider network. Recognizing their proximity to Nebraska's border counties, the FQHC identified an opportunity to enhance access to care for our Nebraska Members. Their openness to working across state lines allowed us to bridge a network gap in both dental and physical health within our Nebraska Heritage Health network.

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Molina will also seek out and enroll dental care Providers in states bordering Kansas. For example, we will approach Providers in Kay and Washington Counties in Oklahoma; Otero County in Colorado; and Atchison, Barton, Bates, Buchanan, Holt, Jasper, McDonald, Newton, and Vernon Counties in Missouri. Expanding our dental care network into these counties will increase access to dental care for KanCare Members living in frontier regions of the State. Below we list additional alternatives to supplement the Kansas Dental Workforce.

Apprenticeships for Dental Assistants. Molina will support and participate in the KANSASWORKS apprenticeship program for dental assistants. We will identify local dental care Providers willing to become single-employer sponsors and mentor future dentists through on-the-job skills training and related technical instruction. Our Provider Representatives will approach dental care Providers in partnership with FQHCs, providing local, familiar, and trusted guidance to interested dentists. We will also explore opportunities to create multi-employer intermediary groups through partnerships with fellow MCOs and Kansas dental care stakeholder groups, to provide a wider array of apprenticeship avenues for KANSASWORKS participants.

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Improving Our Dental Care Provider Network

Molina has extensive experience recruiting dental care Providers who are hesitant to accept Medicaid patients. Using a high-touch and personalized approach, we will meet with individual Providers and negotiate appropriate rates to expand KanCare's participating dental care Provider workforce.

Conducting annual dental care Provider satisfaction surveys and closely evaluating the results, we will identify strengths and opportunities to make program and process changes accordingly. We track survey outcomes and develop action plans to address areas of low satisfaction. Excellent Provider service increases Provider satisfaction and reduces Provider turnover, which helps Members build and sustain Provider relationships. Our goal is to help Members keep their preferred dental home and help Providers maintain their Members.

Improving Member Access

Molina will use the **My Molina Dental app** to send targeted outreach to Members with increased health risks, reminding them of the importance of oral healthcare and its impact on their overall health, such as notifications when they are past due for a dental care visit. The application includes access to maps, benefits tracking, teledentistry capabilities, and much more.

My Molina Dental App Survey
The My Molina Dental app will be used in Kansas to request Member feedback after a claim is received. The customizable survey will prompt Members to respond to questions about the length of time it took to receive an appointment once requested, wait time, and overall Member satisfaction. Molina will use this data to assess Provider compliance with the State's access standards for urgent and routine/preventive dental health services and will take appropriate action based upon feedback.
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Our Member Services Call Center Representatives will help connect Members to general dentists in their community who can perform specialty services (e.g., root canal or tooth extraction) as needed. Molina works to quickly identify a Provider as close to a Member's home as possible, recognizing certain specialized services may require travel beyond a certain distance. Molina keeps an internal record of which general dentists can do specialty work to help Members locate specialists in underserved areas of the State.

We will **implement enhanced Provider locators** that automatically send Members to Providers who are in reasonable proximity and are high performing, rather than to Providers who are located close by but may not be meeting performance expectations.

Teledentistry and Mobile Dental Care

Molina will deploy solutions such as teledentistry access points for all Members, with a focus on the frontier and rural areas of Kansas. Such services can expand access to care and reduce preventable visits to the emergency department (ED). Providers can triage dental ailments and prescribe interim solutions, such as antibiotics or pain relief medications, until the Member can make an in-person office visit. Members can thus choose teledentistry instead of waiting for an appointment at their dental home or visiting the ED.

[redacted]

[redacted]

Meeting Member Dental Needs
Our Ohio affiliate helped 300 Members receive anesthesia services with their general dentist without having to experience the long wait times it would take to be scheduled in a hospital or surgery center.
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[redacted]

[redacted]

We will continue to expand partnerships integrating oral health with physical and behavioral health by partnering with county health departments, school-based health centers, FQHCs, and CCBHCs. We will incentivize Providers for these integrations as a component of our value-based payment agreements as they mature across the State. [redacted]

Promoting Access to and Utilization of Dental Care Through Value-added Benefits

Value-added initiatives proposed for KanCare dental health services include:

[redacted]

Removing Barriers to Dental Services
To alleviate any barriers from legislative decisions about covered dental services, we will include value-added benefits to provide and promote use of dental services that may not be contractually covered.
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[redacted]

- **Pay for Prevention program.** This program will promote preventive dental care for children through financial incentives for pediatric and general dentists who complete an exam, a caries risk assessment, dental prophylaxis, an oral hygiene instruction consultation with a primary caregiver, application of fluoride varnish, and a session on dental anticipatory guidance on the same date of service to pediatric Members under age 3. We offer this benefit twice in a 12-month period.

- **Rating performance.** By using a Provider rating tool with customized and weighted KanCare criteria, we will identify high-performing Providers and reward them with increased Member referrals, plaques or certificates, and value-based reimbursements.

Examples of Molina's Successes in Other States and Their Application to KanCare

Molina brings the experience, knowledge, and capacity to ensure the delivery of quality dental health services to Members, in accordance with KanCare program requirements and prevailing dental health community standards. We accomplish this through the development of a proprietary dental care network, integrated with our whole-person healthcare delivery infrastructure.

Molina's Dental Services Management program values the Provider's experience. We understand that to improve care, we need to work together to build a responsive and supportive model. Below, we describe examples of measurable improvements in dental health outcomes in Mississippi and Ohio, and outcomes we will bring to Kansas.

Success with Our Mississippi Affiliate

Our Mississippi affiliate transitioned from a fully delegated dental care vendor to our proprietary dental care network model. Mississippi is a majority rural state with limited transportation systems; 65 of its 82 counties are rural. Through direct contracting with dental care Providers, the affiliate assumed responsibility for Provider onboarding, training, education, servicing, and issue resolution. Our Mississippi affiliate realized a 20% improvement in the Annual Dental Visit HEDIS® measure and is now in the 75th percentile in measurement year 2022 for this metric.

Success with Our Ohio Affiliate

Similar to Kansas, Ohio is challenged with a dental care workforce shortage. This particularly impacts rural Medicaid Members, who struggle to find dental care Providers who accept Medicaid patients. Our Ohio affiliate encountered several dental care Providers who initially refused to participate in Medicaid, rebuffing multiple attempts by our Provider Network Contracting team.

To overcome this challenge, our National Dental Director, Dr. Jacinto Beard, embarked on a statewide campaign to educate and convince Providers to reconsider their position on Medicaid. Dr. Beard personally met with dental care Providers across the state, listening to and answering questions and concerns about Medicaid. Conversations often convinced Providers to join the Ohio network.

In one such case, the only existing dental care Provider in Noble County wouldn't accept Medicaid from any MCO in Ohio. Ohio Medicaid Members account for almost 20% of the Noble County population. Dr. Beard made a personal appeal to the Provider, visiting their office for a face-to-face conversation. After a long discussion, including assurances about rates and appeals, and about the dire need of Ohioans seeking dental care, the Provider agreed to join our affiliate's network.

Dr. Beard personally connected the Provider with their assigned Provider Representative, who assisted the Provider with contracting, credentialing, and onboarding. Through this personalized, high-touch approach, we closed a known Provider availability gap in a rural county, enabling all Ohio Medicaid Members to access much-needed dental care.

Molina will bring the same high-touch, personalized approach to building our KanCare dental care network. We will leave no stone unturned and make the utmost effort to persuade reluctant dentists to join our network, even having our National Dental Director make in-person visits to assuage Provider concerns and answer questions.

Molina has a significant company history of developing, assessing, and adjusting our dental care Provider networks. We are known both for how we manage them and how we create the best possible Member experience. Over time, we have honed our approach, to meet Member and Provider needs. We are committed to bringing a well-developed and resourced dental care program to Kansas and recognize the value of good dental care to overall Member health.

4.3.I.25 Encouraging Provider Network Participation and Improving the Provider Experience

25. Describe the bidder's strategies and approaches to encouraging Provider network participation and improving the experience of Providers participating in KanCare.

Molina shares KanCare's goals of expanding Provider network capacity while improving Provider experience and encouraging Provider participation in Medicaid in the State (RFP § 1.1.E.1–4). At Molina, we continually advance the support, training, and technology we deliver to Providers to ensure their success and continued network participation.

Molina's guiding philosophy is that Providers are our partners. This philosophy is grounded in the recognition that our success and the success of the KanCare program fully depends on KanCare's Medicaid Providers as they are in the best position to identify Member needs and how to best address them. We rely on Provider insight, candid input, and transparent communication to meaningfully inform not only network design and Provider services, but also our day-to-day operations, program offerings, and approach to Member engagement. We listen to what Kansas Providers need and we use that feedback to create a tailored program that serves Providers in rural, frontier, and urban counties.

A Kansas-specific Approach
Our strategies and approach are informed by our on-the-ground work across the State. Key features include:

- **High-touch, local engagement.** Provider Representatives will live in the communities they serve and specialize in serving specific Provider types.
- **Broad network.** We will offer contracts to all willing and qualified Providers.
- **Value-based incentives.** Our VBP arrangements, that ALL KanCare Providers across the care continuum will be able to participate in on Day 1 of our Contract, will reward Providers for quality, efficiency, and outcomes.
- **Transparent data sharing.** We will share data with Providers in as near to real time as possible to help them deliver on VBP performance targets.
- **One-on-one contracting.** Providers will have a single point of contact to support them through the entire process.
- **Timely and transparent credentialing.** Providers can easily track their credentialing status online through our Provider portal.
- **Prelaunch claims testing.** We'll partner with Providers to test claims samples, identify potential billing or coding issues, and provide personalized education to resolve issues prior to go-live.

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We heard directly from Providers about their current concerns, including claims processing frustrations due to lack of prompt claims adjudication and payment; challenging credentialing processes that can impede timely contracting; cumbersome and inefficient prior authorization (PA); the lack of timely and transparent data reporting to facilitate improved Member care in real time; and the lack of prompt response to Provider calls. With these concerns in mind, we will offer scalable solutions and customized, superior service to meet the needs of Providers in Kansas.

The cornerstone of our approach is delivering a high-touch, transparent, streamlined Provider experience that advances the State's vision and goals. In our discussions with each prospective network Provider, we validate our commitment to establishing and building an effective working partnership. For example, we explain our flexible contracting options, the ability to contract for multiple services using a single Provider contract, the wide range of easily accessible Provider resources and tools through our Provider portal, and our **You Matter to Molina program that proactively solicits Provider feedback,** so we can improve the services and supports we provide.

As detailed throughout this response, our Provider engagement model will effectively address KanCare's goals of encouraging Provider participation and improving the Provider experience and will help us meet or exceed the State's RFP and Contract requirements. This model centers on a supportive Provider culture to deliver exceptional service and clear accountability, as well as more meaningful Provider relationships. Through these relationships, Molina is positioned to identify and prevent concerns before they become problems.

Strategies to Encourage Provider Network Participation

Our approach to network participation starts with building transparent and authentic relationships with Providers. We will continue to meet with Kansas Providers and community stakeholders to better understand the State's needs, gaps, and opportunities that exist to expand access to services. We have created ways to simplify the process of contracting and credentialing and will offer incentives to encourage Provider participation.

Provider Network Development Approach

Molina's network development is based on the primary principle of a broad, diverse, and inclusive open network. We offer contracts to all willing and qualified Providers to ensure the broadest possible network and offer Members ample choice of practitioners and facilities that meet their preferences. We look for those who currently provide high-quality services and who understand local health and social issues, as well as strong partners who may not currently serve individuals who receive Medicaid benefits. We consider geography, health challenges, health disparities, Member cultural and linguistic needs, and SDOH to identify and inform service gaps and our targeted solutions.

Our recruitment strategy focuses on both adding and retaining quality Providers. Network recruitment activities include in-person, onsite meetings with Providers, which we supplement with email and phone communications. We offer flexible contracting arrangements and innovative VBP arrangements to encourage higher-value care, rather than higher volume, by rewarding Providers for quality, outcomes, and efficiency. Our VBP arrangements will reward Providers for quality, efficiency, and outcomes that align with advancing the State's vision and goals. **Providers will be able to participate in our APMs on Day 1 of our KanCare Contract.**

Molina's Plan President and CEO Aaron Dunkel and members of our leadership team have been on the ground in Kansas developing VBP arrangements and partnerships with Providers and discussing the strategic use of payment models, community reinvestments, and incentives to improve health outcomes, service delivery efficiency, Member experience, and cost of care. We are collaborating with the

[redacted]

Our **Network Management and Contracting Director** will lead our contracting professionals to increase Provider resources in primary care, BH and other specialties by focusing on expanding capacity, address timely access issues in real time, and recruit new Providers and new services delivery models to Kansas and the KanCare program.

Timely and Accurate Credentialing and Contracting

From the first interactions, including credentialing and contracting, we demonstrate to Providers that we will make doing business easy. Our Network Management and Contracting staff seamlessly and simultaneously manage both Provider contracting and credentialing and has experience working with credential verification organizations to minimize barriers to enrollment and completion. We offer Providers a single point of contact to support them through the entire process, and we value efficient, transparent processes that avoid claims denials, administrative burdens, unnecessary costs, and ensuing disputes. As our solution to deliver on timely and transparent credentialing processes, Molina is also pleased to offer a **new Provider tool that allows Providers to easily track their credentialing status online through the Provider portal**.

Credentialing Policies and Procedures

Molina's contracting and credentialing processes are straightforward, streamlined, automated, and designed to shorten turnaround times and enhance the Provider experience. Our current turnaround time for initial credentialing enterprise-wide is 16 calendar days. Our initial credentialing turnaround times in Iowa and Nebraska—our two newest markets—are 13 and 15 calendar days, respectively.

Every component of our credentialing process is designed to support the Provider, lay the groundwork for their successful participation in our network, and align with the State's requirements. In addition to streamlined, simplified processes, we offer sufficient resources to walk each Provider through each step of the process with a [redacted] which will interface with CAQH to automatically pull Provider data into the portal, reducing the amount of information Providers need to provide manually. It will offer a range of self-service capabilities, such as submitting and monitoring enrollment and updating Provider data.

In 2019, the state of Ohio shared its intentions to centralize its credentialing system to make it easier for Providers to serve Medicaid Members. In preparation, Molina's Ohio affiliate worked with the Ohio Department of Medicaid to create a shared vision, discuss best practices, align project timelines, make internal process changes, and communicate to Providers. In 2022, the system launched and Providers in Ohio now use a single-point, statewide centralized Medicaid credentialing system.

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We know from experience that a uniform credentialing practice creates consistency and reduces Provider administrative burden across MCOs. We understand the State intends to implement this centralized enrollment and credentialing system, and we will bring this experience and be well-equipped to support such a standardized system. We look forward to sharing our affiliates' lessons learned with the State and becoming an active partner in meeting the State's goals for centralized credentialing.

Supporting Providers Through Education and Training

After credentialing and contracting, we begin Provider education to ensure we are setting up Providers for success and to further improve their experience. Molina supports Providers by offering excellent service, including:

- **Early onboarding.** Our high-touch Provider experience approach begins with early engagement from our Provider Relations team, including contracting, credentialing, system configuration and testing, Welcome Packet/notification, and technical assistance.
- **Comprehensive training/orientation.** We provide new Provider training/orientation approved by the State and facilitated by local Provider Representatives within 30 days of a Provider's placement on active status. This includes an overview of Molina processes and information related to the Provider Handbook and portal, claims, PA, and care coordination. This training will be for all participating Providers, including those that deliver HCBS Waiver services per RFP § 7.6.A.
- **Ongoing education.** We offer in-person and on-demand training throughout the year through various methods designed to appeal to Providers and their staff. For example, we educate on existing programs like EPSDT, new initiatives, Provider education gaps, and Member needs.
- **Easily accessible Provider tools.** Our Provider education and training tools are easily accessible via the Provider website and Provider portal, which also offer other resources to help Providers navigate administrative processes effectively (meeting or exceeding RFP § 7.6.3.D Electronic Specific and Website Requirements for Provider Information).
- **Transparent communication with a local commitment.** Our Kansas-based staff communicates with Providers openly and transparently. We follow through on our commitments and proactively seek feedback to improve our training and educational services.

Our Provider Education and Training program includes individual and group training orientations, web-based training, comprehensive education, and reference materials, such as our Provider Handbook, Provider portal, and quarterly Provider newsletters and toolkits. Our Provider Education and Training program will leverage best training practices from our Medicaid health plan affiliates, combined with the feedback and identified needs of Kansas Providers. Led by our Provider Relations Director, we will customize Provider education and training materials based on recommendations from Providers participating in our committees and on other feedback from Providers, partners, and Provider associations and organizations. We will focus on developing thorough training on topics we know are pain points for Providers, such as covered benefits, special population programs, clinical policies, PA policies and procedures, claims submission and resubmission, and timely payment.

We will be available and responsive to Providers that reach out to us for assistance and follow through when Providers express difficulty with educational concepts or implementation of requirements. We will host in-person training for any Provider who requests it, at their convenience. We will also develop specific training that focuses on behavioral health (BH), HCBS, and dentistry. We will host a comprehensive training program in all Kansas regions prior to go-live and quarterly during the first year of the Contract. **We will partner with Kansas-specific Provider organizations to participate in their conferences and collaborate on topic-specific training identified by their members.** Provider associations we are already working with and have supported include the CCNK, ACMHCK, Kansas Hospital Association, Kansas Health Care Association, LeadingAge Kansas, and InterHab. Molina will advise the State of these training sessions and appropriate State staff will be welcome to attend at their discretion.

Strategies to Improve the Participating Provider Experience

Our Medicaid-specific Provider engagement approach includes a wide range of human and technical resources that allow Providers to focus on delivering and supporting coordinated Member care and improving their experience. Our commitment to delivering excellent Provider service reduces Provider turnover and helps Members build and sustain Provider relationships.

In conjunction with the State's goals, we incorporate the following strategies to achieve Provider quality, efficiency, and satisfaction and improve the overall Provider experience:

- Reduce Provider administrative burden
- Proactively solicit Provider feedback
- Ensure timely and accurate payment to Providers
- Expeditiously resolve Provider concerns and issues

Reduce Administrative Burden

To reduce Provider administrative burden and address Provider concerns, such as claims processing frustrations, challenging credentialing processes, and inefficient PA, we offer customized, superior service to meet Provider needs in Kansas. We will exceed the RFP's technical assistance requirements and provide the necessary resources and availability to Providers as needed to improve their experience.

Under our Provider engagement model, our approach is to assure a collaborative, multidisciplinary team strategy supporting our Provider partners with a focus on reducing administrative burden and enhancing high-quality care. Overseeing our Provider Relations team will be a full-time Provider Relations Director who will be responsible for Provider relations, services, payment issues, education, and development and execution of Provider training and will function as the single point of contact to the State to address escalated Provider issues.

Once contracted, we will assign each Provider a **dedicated Provider Representative** who serves as their point of contact and coordinates with specialized Molina teams to deliver any needed support, particularly paying attention to the Provider's needs based on services they provide and Member allocation. The Provider Representatives will live in the communities they serve and offer collaborative, customized assistance on Provider-specific policies, procedures, and processes. These individuals will check in regularly with the Provider to provide technical assistance, answer questions, review performance, and anticipate areas in which the Provider may benefit from additional support. We will also assign specialized representatives to BH Providers, FQHCs, LTSS Providers, and hospital systems. These representatives will meet annually and in person with all Providers and monthly with Tier 1 Providers (i.e., a preferred Provider, group, or hospital system based on Molina membership attribution and medical spend allocation). This streamlines the Provider experience and enables deeper relationship development while also ensuring timely Provider access to specialized assistance.

As part of our enhanced Provider engagement model, we will visit every Provider in our network at least semiannually, but will offer Providers the opportunity to meet quarterly or more frequently based upon their preference, exceeding RFP § 7.6.6.H.

Value-added Position

We will include at least one BH, LTSS, and Pharmaceutical Provider Representative, which are required roles, and at [redacted] under the Health Equity team, and Provider Services Call Center Representatives.

We provide quality support for Providers with a **dedicated Practice Transformation Team**. **As an enhanced offering, the value-added Practice Transformation Team focuses on helping Providers meet their quality goals**, which is a critical element of Molina's KanCare program. The team professionals, who are usually registered nurses or have degrees in business, healthcare, nursing, or related fields, support Providers beginning with assessing Provider readiness for varying levels of APMs based on the Health Care Payment Learning & Action Network APM Framework. They deliver quarterly quality and risk reports and work with Provider staff to close gaps in preventive and chronic care for their Molina patients, increase payments to address low reimbursement rates, and conduct coding improvement activities. They also support Providers who want to transform their practices toward **greater integrated care and increased value-based contracting**.

Our Operations Support team works in the background with the multidisciplinary team led by that Provider's dedicated Provider Representative. Each operational area has professionals focused on addressing administrative issues Providers may face, including claims resolution, grievances and appeals, and enrollment issues. For example, in addressing issues that require system updates to meet RFP § 7.6.F, we will enter the issue in the KanCare claims resolution log within 30 business days of receipt for tracking and reporting the root cause, as well as the date the system will be fixed and the date Providers can expect claims to be adjusted. We know that Providers in Kansas have faced significant challenges with Member assignment and attribution from the existing MCOs. To address this, we are building in extra supports to validate Member assignment within the Member Assignment team and its workflows.

We provide clinical support through our team led by our local Medical Director's office. Our Medical Directors support evidence-based care protocols, Joint Operating Committees, and Provider training, while our team offers **embedded or readily available Molina Community Health Workers (CHWs), Care Coordinators, and specialized SDOH support**, so Providers have access to an array of resources to better coordinate care for their Molina Members.

[redacted]

[redacted]

We foundationally support all these Provider relations activities through our call center as well as via a variety of self-service tools, including the Provider portal and interactive voice response functions that allow Provider offices to navigate these layers of support easily and at their own pace. In fact, **we will extend our Provider call center availability for KanCare Providers two hours** beyond RFP § 7.6.5.B requirements. Through these fully integrated tools and technologies, Providers can easily access a range of resources, such as training information, PA lookup, and gaps in care and claims data.

Proactively Solicit Feedback

We use multiple modalities to solicit Provider feedback to better understand Provider challenges and barriers and to enhance collaboration to improve the healthcare delivery system. We proactively solicit feedback through our You Matter to Molina Provider support and engagement model, which offers Providers a direct connection to share ideas with the goal of making it easier for them to work with Molina. You Matter to Molina provides easy methods for offering feedback, including a postage-paid postcard that Provider engagement specialists make available at conferences and during office visits, a dedicated email box, a link on our Provider website, and annual Provider Satisfaction Surveys that allows Providers to rate our performance in areas such as claims processing, PA timeliness, usefulness of written communications, and Provider Relations staff responsiveness.

Our teams focused on Provider engagement also gather feedback from advocacy groups, our Provider Advisory Committee, Quality Committee, and through Provider Forums, which will be held quarterly for the first two years, exceeding requirement RFP § 7.6.G. This engagement enables us to gain insight into billing and claims issues and identify ways to reduce Provider burden. Additionally, our Plan President and CEO Aaron Dunkel will meet with associations and engage frequently with Providers in person to ensure all populations are heard and addressed. Mr. Dunkel will hold **CEO-led listening sessions with Providers**, including sessions dedicated to specialized groups such as BH and rural Providers so they can directly connect with Molina leadership. Held in person with an option to participate virtually, Providers can easily attend these quarterly sessions, offer their feedback, and ask questions.

During quarterly Provider Advisory Committee meetings, Providers collaborate on improving patient care and identifying potential network adequacy risks, such as access-to-care issues. Our monthly Joint Operating Committee meetings with health systems and large Provider groups include discussions on operational, claims, and utilization topics to enhance Provider collaboration; review of detailed reports of paid, pended, and denied claims and PA requests; and discussion of results to improve success with VBP engagement. Feedback is then shared with designated Provider engagement specialists and network leadership, and trends are presented to the Quality Committee and the Provider Advisory Committee for tracking, as appropriate.

Ensure Timely and Accurate Payment

Timely and accurate claims payment is critical to Provider recruitment and retention and to ensure a positive Provider experience. As we prepare to go live in Kansas, we are committed to having our Configuration team actively engaged in developing customized system updates, implementing identified system changes necessary to accommodate Kansas requirements, and testing each update manually to ensure claims will be paid appropriately and on time.

New Market Claims Performance
In the first 90 days of operation, our Iowa affiliate had the following claims processing results:

- 90.4% auto-adjudication rate
- 99% rate of electronic claims submission in claims processing turnaround time
- 8% denial rate
- 2.7% rework rate

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Prior to go-live, we will supply Providers with key information and materials on billing, such as a billing guide with all the necessary information. Molina's claims processing system and our processes are fully capable of meeting or exceeding the requirements contained in RFP § 7.14, Claims Management.

An essential element of our claims processing success is Molina's innovative **prelaunch testing service**, where we partner with Providers to test claims samples, identify potential billing or coding issues, and provide personalized education to resolve issues prior to go-live. Testing in advance ensures that Providers can review claims status online and understand the appeals process, supporting timely and accurate payment and fostering a positive experience. **We will conduct end-to-end contract configuration and claims adjudication testing with key Kansas Providers around the State before go-live.** If we notice any aberrant patterns, we will proactively engage and work to address them before go-live. Several key partners have already agreed to participate in our system testing before go-live. These partners include physical health, BH, IDD, and LTSS Providers and specialized Providers.

We **proactively monitor claims data** to identify opportunities to improve validation rules, pre-payment controls, adjudication edits, and automation to enhance the Provider experience. Rigorous claims auditing processes confirm timeliness and accuracy against Provider contract terms and adherence to regulatory and internal guidelines and policies. Informed by audit results, we conduct root-cause analysis and develop focused action plans to drive improvements.

Dedicated Provider Concierge staff will monitor, track, and trend claims performance; research root causes; and lead resolution efforts. All identified and resolved claims issues will be reported to the assigned Provider Representative, who will personally reach out to the affected Provider and confirm that concerns are resolved to the Provider's satisfaction. We will also track Provider grievances related to claims payment issues and claims disputes to identify trends and refer findings for root-cause analysis, problem resolution, and monitoring. This creates opportunities to enhance and improve our claims payment accuracy and implement best business practices.

Molina leadership, including our Plan President and CEO and Chief Operating Officer, will **meet daily with Configuration, Provider Data Management, and Claims teams** for the first 30 days of implementation and weekly thereafter for 60 days. These reviews will ensure that Molina meets claims timeliness and accuracy standards.

Expeditiously Resolve Provider Concerns and Issues

Our approach to addressing Provider inquiries and grievances/complaints is grounded in our commitment to timely, thorough, and efficient issue resolution to reduce Providers' administrative burden and support delivery of Member services. Grievance/complaint research and resolution gives us the opportunity to identify areas where we can improve policies, processes, and initiatives and increase Provider satisfaction.

We inform Providers about the grievance process during new Provider orientations, on our Provider website, and in our Provider Handbook and Provider Newsletter. We give Providers multiple tools and correspondence channels for submitting grievances. Regardless of how the Provider submits the information, **our staff have the skills and expertise to resolve most issues before they escalate to grievances**. For example, Molina thoroughly trains our call center staff to identify a potential complaint or grievance even when it is not expressly stated. When staff hear Providers use key words or phrases that indicate frustration, they flag the call for a follow-up investigation. We resolve a minimum of 90% of call center phone inquiries during the first point of contact.

Tracking Grievances/Complaints

Our integrated Grievance and Appeal System supports the collection, storage, access, tracking, reporting, and analysis of Provider grievance/complaint data. The platform's flexibility and built-in logic:

- Tracks turnaround times against service levels
- Aggregates and trends issues
- Offers sorting capabilities to help prioritize cases
- Enables appropriate staff to take action to reduce or eliminate future grievances/complaints

Escalation is key to prompt resolution of Provider issues. Our Plan President and CEO, Aaron Dunkel, will examine and make these decisions so that systemic issues can be expeditiously addressed. Provider Representatives manage Provider issue resolution from beginning to end. These Representatives coordinate with key resources and departments and meet with Providers one-on-one to identify solutions, share best practices, and facilitate timely issue resolution. We expedite timely and accurate claims adjudication and payment, quickly resolve issues, and encourage continual and honest Provider feedback, which fosters trust and encourages specialist participation.

4.3.I.26 Experience Developing and Implementing VBP Arrangements

26. Describe the bidder's experience with developing and implementing value-based purchasing (VBP) arrangements designed to promote service quality, value, and outcomes over volume. Describe how the bidder will leverage its experience to successfully develop and implement VBP arrangements to improve the quality of care and Member health outcomes in KanCare. Include the following in the bidder's response:

a. The bidder's priority areas for VBP (e.g., Providers or populations) and anticipated outcomes.
b. The bidder's proposed alternative payment models (APMs).
c. The bidder's approach to identifying and supporting KanCare Providers to implement VBP arrangements.
d. The bidder's strategies to reduce administrative burden for participating Providers.
e. How the bidder will measure, monitor, and evaluate the effectiveness of the payment arrangements and outcomes.

Every conversation Molina has had with Kansas Providers has centered on the principles of value-based care. We recognize that Providers have very different capabilities, so we offer an array of VBP contracting programs tied to key quality metrics for prenatal care, well-child visits, behavioral health (BH), primary care, LTSS, and more.

Molina Healthcare's Experience in Developing and Implementing VBP Arrangements

Our affiliates have decades of experience implementing VBP arrangements that reward Medicaid-specific Providers for behaviors aligned with evidence-based guidelines and health outcomes. We rigorously manage our VBP programs through continuous monitoring, assessment, and improvement.

Nearly half our affiliate health plans have at least 70% of membership in VBP arrangements—with 32% of their spend in shared savings, shared risk, or episodic bundled payments—and 35% of membership enrolled in APM Category 3 or higher. 054.b.ks23

Our VBP arrangements will promote service quality, value, and outcomes. For example, our LTSS VBP arrangement rewards Providers for delivering high-quality care that prevents institutionalization. Our Illinois Medicaid affiliate implemented the program and has reduced its inpatient spend by $45 PMPM and its emergency department (ED) spend by $4 PMPM since January 1, 2022, for applicable Members.

What differentiates Molina's VBP arrangements is our ability and **expertise** to execute arrangements with Providers on **Day 1**. [redacted]

Our local Plan President and Chief Executive Officer, Aaron Dunkel, and members of Molina's leadership team have been on the ground in Kansas developing VBP arrangements and partnerships with Providers and discussing the strategic use of payment models, community reinvestments, and incentives to improve health outcomes, service delivery efficiency, Member experience, and cost of care. [redacted]

> At ACMHCK, we understand what Kansas's CMHCs need to succeed and support the State's vision and goals for the KanCare program. We know what we need from our partners to best serve Kansans on their behavioral health journey. To support our members and the patients they serve, we've developed a collaborative partnership with Molina that will help advance these goals and drive delivery system reform through value-based care arrangements. We look forward to working with Molina and truly believe they will be an asset to the KanCare program.
>
> *Kyle Kessler*
> *CEO, ACMHCK*

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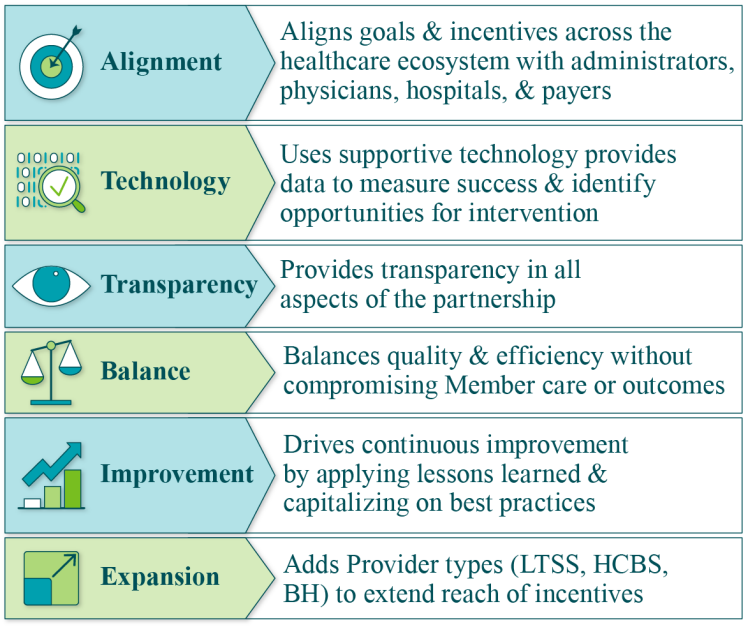
[redacted]

Exhibit 26.1. Molina's VBP Approach.



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As shown in **Exhibit 26-1**, we have leveraged our affiliates' experience to implement our formal and proven VBP approach, which aligns with State goals across the entire system of care; uses data tools, technology, and transparency to support Providers and sharpen our approach; and drives continuous quality improvement across the full spectrum of Provider types.

We will evolve and adjust our APMs to help move Providers along the APM continuum to promote whole-person, whole-family care through advanced VBP arrangements. And while we

offer a variety of models and VBP arrangement types across the APM-LAN continuum, we also adapt to individual Providers. Through our conversation with Kansas BH and HCBS Providers, we know there is frustration with one-size-fits-all VBP models that don't recognize individual Provider strengths and opportunities. Because of this, we acknowledge that if a Provider requests a specific VBP arrangement, Molina will structure their arrangement to meet the Provider's needs and align with the State's goals.

[redacted]

[redacted]

Anticipated Outcomes

[redacted]

[redacted]

Our VBP arrangements meet Providers where they are and help them progress along the APM framework. While we prescribe specific evaluation metrics for each program type, our sliding-scale measurement methods and gradual increases in targets and benchmarks allow for maximum Provider participation and success and ultimately improved Member outcomes, including health equity. A key differentiator is our collaboration with Providers to select measures meaningful to

their practices and to jointly develop designated milestones for VBP progression, paying out incentive payments more frequently than many other MCOs.

b. Proposed APMs

[redacted]

Our VBP strategy also recognizes the critical roles that SDOH, health equity, and access play in the well-being of Members and advances these elements as foundational to each arrangement. We leverage traditional and nontraditional Providers within interdisciplinary teams, such as peer recovery, family supports, and CHWs, to connect Members to needed resources. This also includes paying incentives to Providers that submit claims with Z codes, refer Members to community-based organizations (CBOs), and follow up with Members to address SDOH. Below, we describe six of our proposed VBP arrangements.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Common Elements of Our VBP Framework

Molina will submit each of our proposed VBP arrangements to the State at least 90 calendar days prior to arrangement implementation and understand the State may request additional information about a proposed VBP arrangement, make changes to a proposed or implemented VBP arrangement, or disapprove of a proposed or implemented VBP arrangement. [redacted] We will provide further detail about individual arrangements when we submit them to the State for approval.

Differentiation from Traditional Payments (RFP § 7.7.F.1.). VBP arrangements usually prioritize primary care and outcomes related to physical health. Our models consider the unique Medicaid population with complex needs to drive real value and outcomes related to physical health, BH, LTSS, and SDOH. We also refine the attribution of Members to Provider panels to align resources efficiently to Members under the Providers care; establish a baseline for quality, utilization, and efficiency performance based on Provider readiness and set attainable performance benchmarks based on quality metrics; and offer a sliding-scale provision for their initial period of VBP. Our VBP payments differ from traditional payments in that they provide funding above fee for service, tie back to a specific quality measure aligned with KanCare goals, and help Providers invest back into quality care activities.

The Role of Care Coordination (RFP § 7.7.F.3). Care coordination strategies are built into our VBP models to support the right care for Members at the right time. For example, our Pay for Quality and Shared Savings programs include synergies between Molina and Providers to identify gaps in care, schedule appointments, and coordinate with Members to close care gaps. Our Virginia affiliate, for example, partners

with Providers to adopt an automated scheduling tool that allows the MCO to help get Members into needed care and helps Providers meet their VBP targets.

More complex VBP programs, like upside and downside risk programs, incorporate care coordination strategies. These strategies include working together in practice transformation and case rounds and through Joint Operating Committee meetings to identify cost trend outliers (e.g., upticks in ED visits) that the Provider and Molina solve together. In KanCare, we enhance care coordination even more through our approach to shared responsibilities with community care coordination Providers, targeted case management Providers, and CCBHC care coordination programs. We offer support to these entities through our virtual Care Coordination Portal and SDOH platform to help Members navigate SDOH resources. We've already built care coordination fees into our VBP arrangement with CCNK's ACO and are designing similar VBP supports across Provider types.

The Role of HIT/HIE (RFP § 7.7.F.4). We will join and maintain access to the two Kansas health information organizations (HIOs) that facilitate HIE to foster the development of bidirectional data-sharing capabilities and optimize communication among Providers. These are the Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE). With Member consent, data will flow bidirectionally to and from Molina's Provider portal, enabling Providers to see any care their Members receive outside of their office. We will collaborate with two HIOs that provide information for Kansans, Velatura in Missouri and CyncHealth in Nebraska. We also offer our virtual Care Coordination Portal and SDOH platform to share data across platforms.

The Use of Telehealth and Mobile Care Solutions and Alignment with Existing Initiatives (RFP § 1.1. D.3; 7.5.F.5). Understanding the impact telehealth has on improving access to care for KanCare Members, Molina supports Providers in achieving their VBP targets by also offering telehealth and mobile options to Members who may have difficulty getting to the Provider office, particularly for those in rural or frontier areas. Telehealth will be available to all Providers in our VBP arrangements and can be used to help close care gaps and meet up to 40 HEDIS measures. We also align our VBP arrangements with existing initiatives described elsewhere in this response, such as a proposal to coordinate with Project ECHO to support Providers to achieve their VBP targets with specialized sub-populations such as individuals with IDD or children and youth in foster care.

Model (RFP § 7.7.F.6). All VBP arrangements will be statewide, except for the IDD pilot.

Measures (RFP § 7.7.F.7). All VBP models include the following universal measures: Access and Engagement, BH, Health Equity, SDOH, and Member Satisfaction, in addition to the specific VBP arrangement. Other metrics are specifically chosen in collaboration with each unique Provider and based on standardized measure sets, specialty, and APM category. We also analyze utilization data to identify health disparities and select measures relevant to equity goals. Proposed measures also reflect the targeted health condition and can be stratified by the key identified characteristic for the disparity (e.g., race, ethnicity) and lower-income neighborhoods or geographic areas. We select measures that mitigate disparities in health for priority areas, LAN categories, and Provider types.

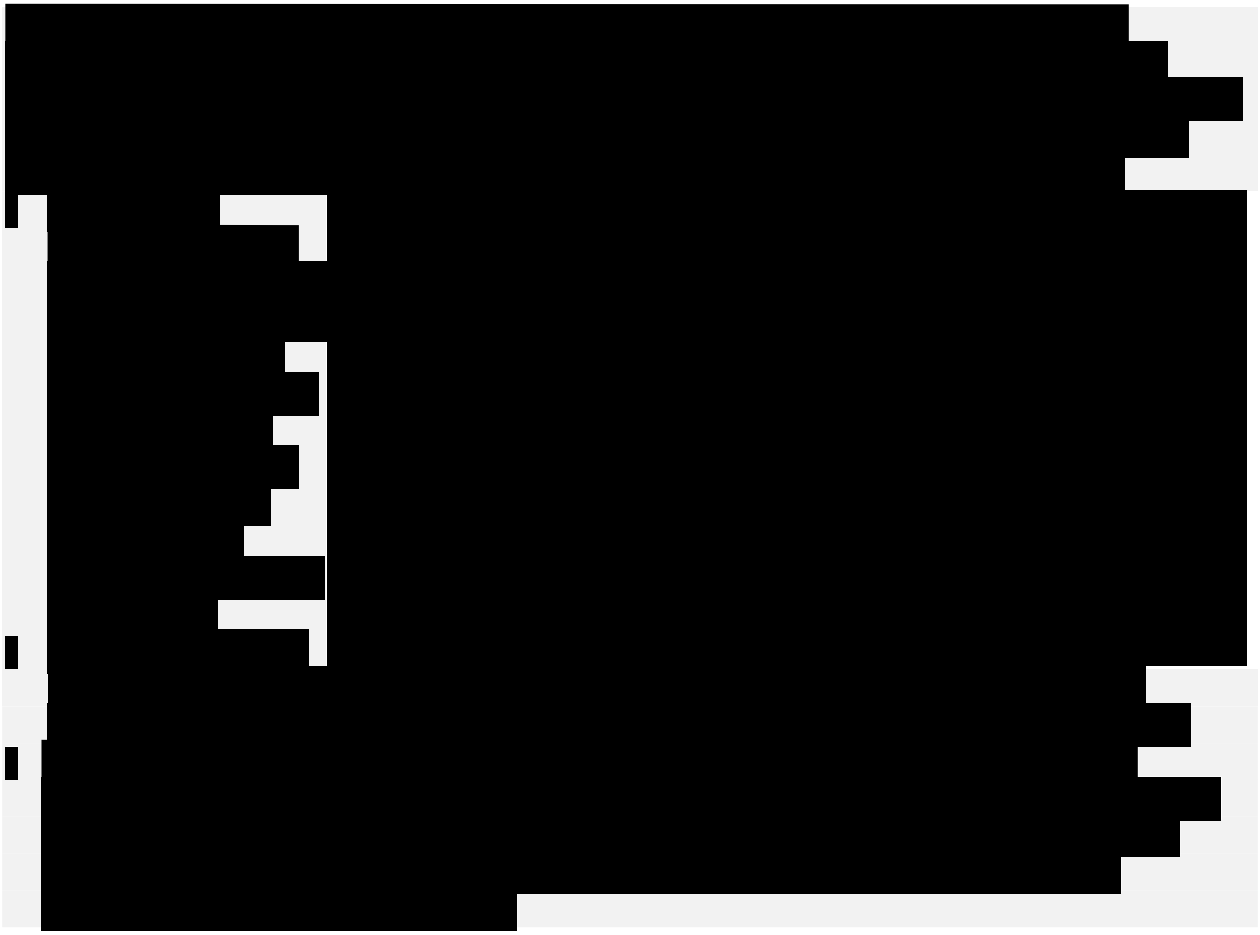
Payment Methodology (RFP § 7.7.F.7). Molina's Provider Readiness Assessment process determines which APM category fits the Provider the best by gauging readiness across several domains, including their operating model, technological infrastructure, panel size, population health management, cost management, quality management (QM) practices, use of analytics to monitor performance, level of Member engagement, and VBP experience. The APM category and level then determines the payment methodology.

[redacted]

c. Identifying and Supporting KanCare Providers in Implementing VBP Arrangements

We've been meeting in person with more than 200 Provider and community groups across the State over the last year. We listened to their thoughts about which improvements need to be made to better serve Members and Providers in the KanCare program, including the use of VBP arrangements. We took this information and designed VBP arrangements that center on Kansas' needs. We listened when local advocates and Providers throughout Kansas encouraged us to bring VBP to virtually every Provider type.

[redacted]



[redacted] We provide more detail in our response to Subsection E.

d. Strategies to Reduce Administrative Burden for Participating Providers

Our strategies to reduce Provider burden are informed by the insight we've gained throughout our year on the ground in Kansas meeting with Providers and listening to their concerns and suggestions for how Molina can simplify administration and reduce Provider burden, including the strategies highlighted below:

- **Leveraging interoperability standards.** We leverage interoperability standards to send care gap notices and ADT alerts directly to Provider EHRs, which supports timely follow-up and care coordination and helps Providers achieve VBP goals. Using Provider-approved remote access, we collect EHR data to close gaps, monitor VBP, and enhance reporting. Our Virginia affiliate implemented a supplemental data exchange, and care gap closures increased by 12%.
- **Adopting recognized measures.** Using widely recognized measures aligned with KanCare priorities eases Provider burden. Our measures align with applicable measure specifications and benchmarks used by KanCare and span quality, outcomes, utilization, cost, and SDOH.
- **Relaxing service authorization.** We reward qualified Providers who meet VBP quality measures and progress along the VBP continuum by relaxing authorization requirements for services they provide. This is an added incentive for providing high-quality care.

- **Operating a Provider Concierge program.** This innovative program seeks to improve services and supports and reduce Provider burden. An interdepartmental team reviews performance trends to identify improvement opportunities. To illustrate, six months after engaging Providers in the program in our Virginia affiliate, there was a 27% reduction in Provider services call center calls.

We also share data and performance reports with Providers at least monthly. Providers have access to information to support their efforts and prioritize Member interventions through our Provider portal. We streamline access to our systems through single sign-on capability. Providers can view lists of attributed Members and meaningful and actionable performance and claims data on quality, utilization, cost, and outcomes. This delivers optimal transparency, which helps Providers understand and accelerate performance. In addition to their individualized VBP performance data, Providers can view Member lists to close care gaps and find information on Members who frequently visit the ED. Providers can also view data on trends to gain insights into utilization patterns, which helps them identify cost reduction opportunities, such as site-of-service redirections, specialist referral patterns, and readmission rates. For Providers with in-house analytics platforms, we make raw data files available for transfer to their platforms, which reduces administrative burden.

e. Measuring, Monitoring, and Evaluating Effectiveness

Our parent company's multidisciplinary **Value-Based Contracting Center of Excellence** performs an annual, in-depth analysis of performance and alignment with local VBP goals, innovation opportunities, operational excellence, and stakeholder feedback. This effort combines with local oversight by our Medical Director and QM Director, who regularly review results of VBP programs to targets and guide continuous quality improvement. The activities to measure, monitor, and evaluate effectiveness include:

- Tracking and reporting priority performance metrics (as available) by race, ethnicity, disability status, language, gender, geography, and SDOH to evaluate program success
- Measuring improvements on key performance indicators and reductions in potential disparities
- Applying VBP program changes based on feedback from all stakeholders, including the State, Providers, Members, CBOs, and our Quality Committee

Within the analysis, we look at performance not only in aggregate, but also by individual Provider and Member race, ethnicity, disability status, language, gender, geographic region, and SDOH risk levels. Analysis at these levels helps to ensure that all populations are addressed and that we are advancing our goal and commitment to high-quality, equitable Member outcomes. We'll evaluate Provider incentive metrics for potential changes in the following year. The APM progression alone serves as a key evaluation metric. Using our Michigan affiliate as an example, in 2018 just 19.56% of its spending on healthcare services was in Category 3A APMs. Today more than 52% of healthcare service spending is through Category 3 or 4 APMs. Upon completion of our evaluation, we will implement changes at both the overall program level and within individual Provider VBP arrangements to continue driving toward the State's VBP goals. During individual Provider evaluation, we analyze earning levels for performance-based incentives and investigate why the Provider did or did not achieve all incentives available. The answers to these questions identify best practices for VBP success and identify Providers who may need new or additional support services to excel in their arrangements.

Case Scenarios (Tab 7g)

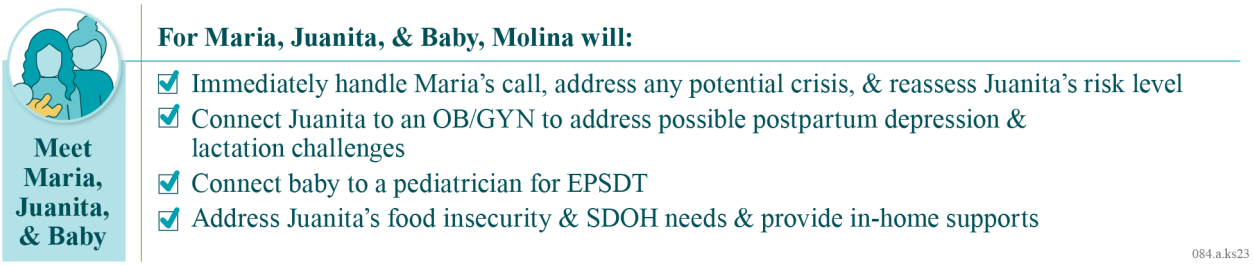
MOLINA HEALTHCARE

4.3.I.27 Case Scenarios: Maria and Juanita

27. The bidder's Member services line receives a call from Maria, the mother of a twenty-two (22)-year-old, Hispanic, female KanCare Member named Juanita. Maria's and Juanita's primary language is Spanish. Juanita delivered a baby boy approximately two (2) weeks ago. Maria is calling out of her concern for the well-being of her daughter and grandson.

Maria shares that the Member has been living temporarily with her until Juanita finds employment, transportation, childcare, and housing. Maria states while Maria works, she has been struggling to make ends meet and at times has been unable to buy groceries. Maria shares that she has recently noticed significant and increasing changes in Juanita, including bouts of crying, lack of appetite, listlessness, and frustration with caring for her baby. Maria reports that Juanita has not been sleeping much and is struggling to produce enough breast milk to meet the baby's needs. Maria thinks that the baby may be "colicky" because the baby "cries a lot" and is difficult to soothe. Maria stated that Juanita missed the first postpartum well check because the baby was finally sleeping, and Juanita did not want to wake the baby. Maria immediately called the Member services line when her daughter told her, "I can't do this anymore."

Describe how the bidder will handle the call from Maria, and the bidder's approach to meeting the needs of Juanita and her baby.



We understand the vital importance of an immediate response. This scenario outlines how we will respond upon receiving a call from a family member regarding what might be an immediate crisis with a Member, as well as how we will support a Member family's short- and long-term integrated needs, including postpartum, physical health, behavioral health (BH), and SDOH needs (e.g., employment, transportation, childcare, housing).

How Molina Will Handle Maria's Phone Call

When Maria calls our Member services line, she selects the Spanish prompt and is connected to one of our Spanish-speaking Member Services Call Center Representatives. All representatives are trained to recognize a potential BH crisis using Molina's BH crisis call guidelines and protocols.

Using active listening and motivational interviewing, the Member Services Call Center Representative asks who she is speaking to, and Maria shares that she is calling about her daughter, who is a Molina Member, and her new grandson. Because Maria is not the Member, the representative asks if they can speak to Juanita. Maria shares that Juanita is not feeling well and does not want to speak on the phone, but Juanita has given Maria permission to talk to the representative on her behalf. The Member Services Call Center Representative then asks Maria

Molina Prioritizes Spanish-speaking Member Call Center Representatives
Our Member services call center prioritizes staffing in-house Spanish-speaking representatives vs. using a translation vendor due to the value and convenience this offers Members. However, we always have translation vendor as a backup option in case the Spanish-speaking call volume exceeds capacity.
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the same HIPAA validation questions that would be asked of Juanita if she were calling herself, which Maria is able to answer correctly. The representative uses probing questions to learn more about Maria's concerns, which includes asking if there is a need for SDOH supports. When Maria shares that her daughter has said, "I can't do this anymore," the representative recognizes that Juanita might be experiencing a crisis and asks Maria if it would be okay to invite a trained clinician from Molina's 24/7/365 Member Crisis Line to join the call via warm transfer. The representative also asks Maria to confirm with Juanita that this is okay. Both Maria and Juanita consent, which is documented in the call record.

Escalation to Ensure Safety

The Member Services Call Center Representative provides a warm transfer to a licensed BH triage nurse. At the time of transfer, she communicates that Maria's preferred language is Spanish and that she will stay on the line to help translate until a medical translation specialist can join the call. The BH triage nurse, with the help of the Member Services Call Center Representative, shares with Maria the importance of speaking directly with Juanita to make an appropriate determination of risk. During this time, the medical translation specialist has joined the call and provides Maria with coaching on how to engage Juanita and encourage her to come to the phone. Although hesitant at first, Juanita ultimately agrees.

Member Crisis Line
Our Member Crisis Line is answered live by clinically trained professionals who triage calls and ensure timely, emergent, and urgent access to appropriate Providers, such as direct dispatch to a mobile crisis unit, 988, or emergency medical services in life-threatening situations.
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The BH triage nurse, like all Molina Member Crisis Line staff, is trained to use the Kansas Suicide Prevention Lifeline (KSPL) standards for risk assessment. She uses de-escalation techniques and trauma-informed motivational interviewing to gain Juanita's confidence and adequately assess Juanita's level of distress to help determine whether her situation should be classified as emergent.
The nurse understands the importance of staying fully present with Juanita throughout the call and communicating authentic empathy for her situation. The nurse begins gently probing by asking Juanita questions about her feelings: hopelessness, helplessness, whether she feels trapped or a burden on others, and whether she feels alone. She explores Juanita's statement to Maria that "I can't do this anymore." Juanita elaborates and shares that she feels overwhelmed by the lack of sleep, breastfeeding, and her baby's constant crying.

Using the protocol described and best-practice assessment techniques, the BH triage nurse relies on her clinical decision-making skills and follows evidence-based guidelines and KSPL standards, ultimately determining that there is no immediate crisis requiring referral to a crisis intervention specialist or hospital. However, due to the details Maria and Juanita have provided, the nurse is concerned that Juanita may be experiencing postpartum depression. She shows empathy and validates Juanita's feelings while reassuring her that there are supports available to help her through this difficult time of transition. Based on the probing questions she asks Juanita about herself and her baby, she recommends that, as a first step, Juanita should talk with her

Molina Care Coordinator. Understanding how difficult it is to access care with a colicky newborn, the nurse explains that the Molina Care Coordinator can help Juanita schedule all necessary appointments, including an appointment with her OB/GYN and her baby's pediatrician, and can also help her get to those appointments.

The nurse asks Juanita if it would be okay if her Molina Care Coordinator follows up with her the next morning, and Juanita provides verbal consent. She also asks Juanita's permission to speak with Maria one more time, so that she can make sure Maria understands the next steps, and can provide the Member Crisis Line direct number, so Maria can call back if she sees further signs or symptoms of a crisis.

Documentation to Ensure Continuity

The BH triage nurse lets Juanita know she has documented all her concerns and captured all the relevant details, which will be available to Juanita's Care Coordinator as soon as they hang up. The call notes, including its disposition, will appear as a recent interaction on the Member Crisis Line Dashboard, which is accessible to the entire Care Coordination team and shows the call details so that everyone can know exactly what happened, which will help them determine next steps.

The Molina Care Coordinator will call Juanita the next day to see how she and the baby are doing, assess Juanita's needs, understand her preferences, and facilitate connections to her OB/GYN and pediatrician and appropriate services and supports for the whole family to meet SDOH needs, including help with food, housing, and transportation and assistance with finding employment and childcare.

How Molina Will Meet the Needs of Juanita

A Molina Care Coordination Director reviews the call record, notes the complexity of Juanita's needs, and confirms her enrollment as a pregnant or postpartum person into the MCO Care Coordination Model. The director assigns one of Molina's Spanish-speaking Maternity Care Coordinators, Magdalena, a licensed registered nurse with two years of qualifying experience as a practicing RN, a bachelor's degree in education services, and four years of qualifying experience in care coordination for individuals with complex health conditions, including BH. Molina understands the importance of providing Members with culturally aligned Care Coordinators who live and work in the communities they serve.

If a Spanish-speaking Care Coordinator is not available in Juanita's community, we would find the best match possible for Juanita in accordance with her choice and balancing the skillset, qualifications, and expertise of available Care Coordinators with proximity, culture and language, and caseload mix, providing translation services if needed.

Before calling her, Magdalena reviews Juanita's records in the care management platform and notes that she was not previously enrolled in maternity care coordination as a pregnant Member because she did not respond to multiple attempts to reach her after her pregnancy was identified through claims. Juanita's claims history does show that she received prenatal care.

Magdalena reaches out to Juanita by phone the day after Maria's call and, using empathy and active listening, shares that she has reviewed the notes from the previous day's call and is

following up to see how Juanita and her baby are doing. Magdalena asks questions to make sure Juanita's circumstances have not escalated. She asks Juanita which appointments she has already attended. Juanita shares that she missed her postpartum well-care visit because her baby was finally sleeping, and that she has an upcoming appointment with her baby's new pediatrician. Magdalena tells Juanita that she is here to provide her with additional support for the next 12 months, and that she can begin by helping Juanita get reconnected with her OB/GYN.

Magdalena recommends that she and Juanita schedule an in-person meeting at Juanita's home within the next two calendar days to update her Health Risk Assessment (HRA); help her get reconnected to her Providers; talk about her needs and challenges; discuss postpartum, women's health, and infant health education; and help connect her and her baby to critical services and community resources. To be sure she can continue communicating with Juanita, Magdalena provides her direct contact information and asks whether Juanita has a cell phone she can use to call or text with any questions or needs. If she doesn't, Magdalena will explain that Juanita is eligible for a free smart mobile device that Magdalena can help her load with helpful apps that will connect her to live customer service to support her continued engagement. They also discuss whether Juanita wants her mother to be able to contact Magdalena, and Juanita agrees to give Magdalena's contact information to Maria. They set an appointment for the next day when Maria will be home from work to help with the baby and participate in the meeting.

In-person Visit to Update the HRA, Needs Assessment, and Level of Care Coordination

On the day of the meeting, Magdalena greets Maria, Juanita, and Juanita's newborn son at Maria's home. Magdalena first works to establish rapport by chatting briefly and admiring the baby. Magdalena reaffirms Juanita's preference about whether she would like to meet with her alone or whether her mother can be part of the meeting. Juanita says that Maria can stay. Magdalena lets Juanita and Maria know that as part of the meeting she is happy to share resources that could benefit Maria as well.

Magdalena uses her observation skills to drive her motivational interviewing and approach, noting how Juanita and her baby are interacting and how the baby is behaving, as well as the dynamic between Juanita and Maria. Magdalena takes time to walk Maria and Juanita through all the steps of the visit to alleviate any fears or concerns they may have. She explains what they should expect to happen after the visit, including who will be involved in Juanita's care and her baby's care. Magdalena emphasizes that she is there to support and understand so that they can collaborate to put the Plan of Service together. She makes sure to convey that it is Juanita's own choices and preferences that will drive the next steps, and that Juanita will be the one who determines what will be included in the Plan of Service. She also lets Juanita know that she is eligible for a **$25 gift card for the completion of the HRA**.

Using a person-centered approach, Magdalena conducts the HRA and the Edinburgh Postnatal Depression Scale. The responses Juanita provides trigger the completion of a Needs Assessment. Magdalena asks Juanita who she would like to be involved in her care planning, and she says she would like Maria

Magdalena asks Juanita:
During assessments, Magdalena asks Juanita:

- Are you taking any medications?
- Did your OB/GYN prescribe any medications?
- What transportation do you use?
- What is your highest grade of school completed?
- Do you want to pursue more education?
- Do you worry about paying your bills?
- Do you have any childcare concerns right now?
- Are there other problems or concerns that we haven't discussed?

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to continue to be a support to her and her baby. She likes her current OB/GYN and has a first appointment with the baby's new pediatrician scheduled for the next day. Magdalena talks with Juanita about how they can both communicate with the OB/GYN and pediatrician to make sure these Providers' treatment plans are included in the Plan of Service.

Based on the results of the HRA and Needs Assessment, Magdalena re-stratifies Juanita from **Low-Risk to High-Risk Maternity care coordination** because of her potential postpartum depression and SDOH. Magdalena shares her findings and recommendations, including a review of her assessment results. Magdalena explains that they will use these findings to develop a person-centered Plan of Service to address Juanita's and her baby's urgent and longer-term holistic needs, goals, and preferences.

Addressing Juanita's and Baby's Needs

The Plan of Service development process is an opportunity for the Care Coordinator and Member to explore all topics that relate to the Member's immediate and future goals. We believe that person-centered care is not something that is done for a Member, but rather is developed by the Member based on their wants and needs, with our support. Magdalena's care planning approach puts Juanita at the center of the process, so she controls decision-making. Juanita's Plan of Service also encompasses the needs of her baby, as part of our family-focused approach to care coordination. [redacted]

[redacted]

Development of Plan of Service

Magdalena first explains what a Plan of Service is: a written document that records Juanita's goals and service needs, her short- and longer-term achievable goals, and her plans for achieving them. Magdalena emphasizes that Juanita's Plan of Service will be translated into Spanish and will be designed for Juanita's use as well as the use of the people who are caring for her, so that they will understand what is important to her based on her own voice. Magdalena reassures Juanita that the Plan of Service will evolve as Juanita's and her baby's needs evolve, and that the

intensity of care coordination may also change based on Juanita's needs and preferences. She explains that the Plan of Service will include Juanita's strengths, needs, goals, lifestyle preferences, and other preferences, and that they will determine these together.

Magdalena helps Juanita explore all her expressed needs and preferences and identify her goals.

Magdalena helps Juanita translate these goals into SMART goals and actions, such as "I want to get the baby on a sleep schedule so that I can get at least six hours of sleep at night," and "I want to take my baby to regular well-baby checkups to ensure that he is getting enough milk to grow." Magdalena and Juanita talk about possible actions and interventions that Juanita can choose to help achieve her goals. Magdalena outlines the services and supports that Juanita can select to meet her identified needs—short-term, intermediate, and long-term—and who will be responsible for providing them.

They discuss and decide on next steps for follow-up with her OB/GYN and PCP, all referrals for services and supports, the role of unpaid supports (such as Maria's help with watching the baby), how Juanita's plan will continue to be reviewed and updated, the anticipated schedule and method for ongoing contact, and a disaster/emergency plan for feeding the baby. Magdalena documents all decisions made by Juanita and will upload the Plan of Service that has been signed by Magdalena and Juanita to the Care Coordination Portal, which allows the Plan of Service to be signed electronically by Juanita and her interdisciplinary team. Magdalena will ensure that the plan is signed within 30 calendar days of their meeting.

Coordinating Juanita's and Baby's Care and Follow-up

Magdalena will coordinate all Provider appointments and connect Juanita and her baby with additional services and supports.

Addressing Juanita's and Baby's Intermediate Needs

To help meet Juanita's goals and intermediate needs, Magdalena recommends weekly follow-ups, including at least one in-person visit every other month, and indicates that the frequency of contact can be decreased to no less than monthly if Juanita's risk level, needs, and preferences change. During these conversations, they review the following topics and Juanita selects the supports and services she wants to help meet her goals.

OB/GYN Appointments. Magdalena coordinates with Juanita to determine the best day for her to reschedule Juanita's OB/GYN appointment. She lets Juanita know she is eligible for transportation assistance to her appointments, including mileage reimbursement for either her or Maria, whoever drives, as long as Magdalena arranges the requests so she can approve and help coordinate. She also lets Juanita know that she can take the baby in his car seat to these appointments. Magdalena is able to e-schedule Juanita's postpartum OB/GYN appointment for

within a few days and shares that she is available to help Juanita prepare for the appointment and organize the questions she'd like to ask. She also offers to talk with Juanita after the appointments to help her understand what the OB/GYN and pediatrician recommend for follow-up. Should Juanita have to wait for an appointment, Molina could ensure immediate care by bringing in a women's health nurse practitioner from our Molina in-house **Care Connections program** to meet with Juanita to provide care and support. Should Juanita prefer an alternative to discussing breastfeeding with her Providers, Care Connections nurse practitioners can provide her with in-home lactation supports.

During their next call, Magdalena asks Juanita how her appointment with her OB/GYN went. Juanita shares that her doctor stated that her combined challenges—sleep deprivation, problems with lactation, a colicky newborn, and stressors related to her SDOH needs—are responsible for how she is feeling. Her OB/GYN provided support and education, including practical tips for getting her baby on a schedule and how to address sleep hygiene and sleeping based on her baby's schedule.

They talked about peer maternity supports and stress relief techniques. Her OB/GYN also discussed nutritional requirements for breast milk production in addition to other therapies and techniques (i.e., use of a breast pump and medications). Her OB/GYN was glad to hear that she had a Care Coordinator to assist with her SDOH needs and recommended she seek additional advice from her baby's pediatrician concerning feeding and to obtain recommendations about her baby's fussiness and potential colic.

The OB/GYN reviewed additional symptoms Juanita should be on the lookout for that could indicate postpartum depression and what she should do if she is feeling any of those symptoms. Follow-up was recommended for one week later to reevaluate Juanita's mood, sleep, and milk production. Magdalena confirms Juanita's preferences for the follow-up appointment, including alternatives such as telehealth, if the Provider consents, and promises to check with the Provider and make the follow-up appointment for the agreed-upon day next week. She asks if Juanita would like to include the OB/GYN's recommended supports, including peer maternity supports and stress relief techniques, in her Plan of Service, and Juanita says she would. Magdalena updates the Plan of Service per their discussion.

Pediatrician Appointments. During her in-person meeting with Juanita, Magdalena offers to check with the new pediatrician to see if translation services (paid for by Molina) are needed for the appointment, and Juanita agrees that she should. They discuss questions Juanita may wish to ask the pediatrician, and she makes notes to take to the appointment. Magdalena also arranges for transportation to the appointment and reminds Juanita again that the transportation benefit allows her to take the baby in his car seat.

During their next week's call, Juanita indicates that she had a good appointment with the pediatrician, who provided information on how to assess whether her baby's crying is due to hunger and how to identify symptoms of colic, what causes them, and how to treat them (i.e., soothing strategies, feeding practices, and changes to Juanita's diet). Juanita shares that she feels much better after talking to her pediatrician and that she doesn't have any additional questions regarding their recommendations. Juanita and Magdalena talk about the proper schedule for the

baby's checkups, screenings, and immunizations, and put those recommendations into Juanita and baby's Plan of Service so that Magdalena can help arrange appointments and transportation scheduling.

BH. To address Juanita's postpartum challenges and to monitor closely with her OB/GYN for postpartum depression, Magdalena makes Juanita aware of (and separately consults with her OB/GYN by phone concerning) appropriate BH services from her local CCBHC or FQHC, if the OB/GYN determines that such services are needed. Magdalena educates Juanita on which symptoms to look out for if she ever feels depressed again and how to seek out treatment and support, including talking to her doctor and connecting with the CCBHC or FQHC BH specialist. She lets Juanita know she can also connect her to various community supports that she can choose from, such as parent support groups. Magdalena will check in with Juanita's OB/GYN after regular appointments to hear firsthand how Juanita is doing, so she lets Juanita know this and obtains her written consent for this communication.

Self-care and Ongoing Support. Magdalena helps Juanita learn to recognize the signs and symptoms of being overwhelmed and depressed, discusses the importance of self-care and sleep hygiene, and provides resources and information about regular exercise and relaxation techniques. Magdalena also connects Juanita with a local Promotora who is a certified CHW. These highly specialized community health workers support pregnant and postpartum Hispanic mothers and will give Juanita another level of localized and ongoing support.

Food and Nutrition. Magdalena provides information on the resources available to support Juanita's nutritional needs. She also shares information on resources that can benefit Maria. For Juanita these include **home grocery delivery services** of up to $300 total in value for a 6-month period. Juanita is also provided with information on WIC and SNAP and agrees to have Magdalena help her apply for both.

Magdalena also offers to connect the family to farmer's markets that accept SNAP and follows up to connect them to **Kansas Food Bank** pantry partners, a program that serves more than 226,000 Kansans every month, and other resources that participate in **Kansas Double Up Food Bucks**. Magdalena will follow up with the promotora to connect Juanita and Maria to any of these programs that they choose.

Transportation. Magdalena outlines the transportation benefits Juanita can use, including **transportation to food banks, WIC, domestic violence agencies, housing authorities, and job interviews or job training**. She notes that Juanita will need to request transportation and receive approval for her requests.

Magdalena will work with the NEMT provider to schedule transportation to appointments and will train Juanita to schedule for herself, including setting up preset appointments based on her scheduled needs. Magdalena reminds Juanita about mileage reimbursement for traveling to appointments, which is available to both her and Maria, whoever is driving.

Ongoing Follow-up and Support

Magdalena continues her weekly touchpoints with Juanita, including one in-person visit every other month, to monitor the health and well-being of both Juanita and her baby, to update the Plan of Service as needed, and to continue offering additional services to meet the family's needs and Juanita's goals as they evolve. During this period, they discuss the following additional supports.

Maternal Home Visiting Program. Magdalena educates Juanita about the local Parents as Teachers program. Magdalena explains to Juanita how this program educates young parents on early childhood development and positive parenting practices and connects families to supportive resources. If Juanita is interested, Magdalena will support Juanita in enrolling in the program. Molina has a letter of intent with Parents as Teachers programs to support the facilitation of these connections.

Employment. Once Juanita's situation is stable, she and Magdalena discuss Juanita's need for employment, and Magdalena educates her about Molina's SDOH platform and the role of our Employment Services and Supports Coordinator.

This coordinator will be available to talk with Juanita about vocational training needs, education, employment, and employment assistance. Magdalena suggests that when Juanita is ready, it will be important to talk about what her childcare needs will be during working hours.

As Juanita's postpartum period progresses, Magdalena continues to provide regular touchpoints with both Juanita and her care team to ensure that her goals, preferences, and needs continue to be addressed. During this period, they review additional resources as needed.

Education. Juanita was attending the local community college to pursue a certificate when she became pregnant. She would like to complete this certificate once her baby is old enough to enroll in the Early Head Start Program. Magdalena explores with Juanita what her goals are for reentering the workforce, what her interests are, and what she needs to do to develop the necessary employment skills.

Magdalena recognizes that Juanita may not be ready right now, but lets Juanita know that when she is, there are community resources available for her, including educational programs that she can participate in while still at home with her baby.

Housing Needs and Preferences. Magdalena recognizes that a longer-term goal of Juanita's is to find her own apartment. Knowing how scarce affordable housing is, Magdalena tells Juanita that she can help her explore her housing needs and preferences more fully when she's ready.

Magdalena will use the services of Molina's Housing Services and Supports Specialist**,** who can help Juanita to explore options. Magdalena lets Juanita know that she will continue to include this topic in their regular phone calls.

Magdalena continues to follow up with Juanita for 12 months postpartum with at least monthly telephone contacts (weekly if her risk level remains elevated) and in-person visits every other month to discuss any new needs that arise.

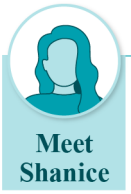
4.3.I.28 Case Scenarios: Shanice

28. Shanice is a twenty-three (23)-year-old, black, female KanCare Member who was brought to the Emergency Department (ED) by police due to injuries sustained during a fight with another person in a downtown homeless shelter. While her injuries do not appear to be life threatening, Shanice sustained injuries around her face and head and exhibits odd behavior.

Shanice has a history of opioid use disorder, benzodiazepine use disorder, and stimulant use disorder in addition to co-morbid schizoaffective disorder and major depression disorder with psychotic features. Her drug screens at the ED are positive for opioids and benzodiazepines.

Shanice has been receiving services through a CCBHC, but has been inconsistently engaged in treatment and has presented to the ED multiple times for either drug intoxication or withdrawal in the past year. She is unstably housed and lacks any form of Transportation. Tests conducted during the ED stay indicate that Shanice is pregnant.

Describe the bidder's approach to addressing Shanice's needs.



For Shanice, Molina will:

- ☑ Reengage her in mental health/SUD treatment and recovery with CCBHC care coordination
- ☑ Engage her in high-risk OB care
- ☑ Address housing and social needs

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How Molina Identifies and Finds Shanice

We receive notice of Shanice's emergency department (ED) visit at Ascension Via Christi St. Joseph via automated ADT notices through KHIN. Shanice is eligible for our SPMI/SUD care model due to her complex co-occurring conditions, social needs, and history of ED use. She received services through COMCARE in Sedgwick County and enrolled in the CCBHC care coordination program with our supporting care coordination. However, given her unstable housing, we are unable to contact Shanice despite ongoing outreach attempts from both her Molina Care Coordinator and her CCBHC community care coordinator and outreach team.

The ADT alert triggers automated alerts through our bidirectional Care Coordination Portal, notifying not only Molina's Care Coordination team but also Shanice's CCBHC care team, including her CCBHC community care coordinator. Knowing the importance of timely engagement at the point of care and noting her "unable to contact" flag, Molina immediately works to help find Shanice and support her reengagement with the CCBHC.

To find Shanice and reengage her as quickly as possible, Molina's Member Outreach Relationship Experience program coordinates with the CCBHC to identify the right combination of resources to locate and engage with Shanice, such as the CCBHC's community outreach team and peer support specialists or Molina Community Health Workers (Molina CHWs). For Members who are unhoused, like Shanice, street outreach initiatives and shelter partnerships are often effective. At an affiliate plan, these strategies resulted in a **51% success rate of finding and connecting hard-to-reach individuals to care**.

We have also partnered with the **Kansas Statewide Homeless Coalition** and will develop HIPAA- and PHI-compliant strategies to identify and engage Members who are unsheltered.

In Shanice's case, a Molina CHW works with [redacted], a peer-run organization that Molina is bringing to Kansas, with the primary goal of finding and engaging hard-to-reach Members. We will collaborate to provide short-term bridge services from nurse practitioners, social workers, and peers who support Members in reconnecting to community-based network Providers. The Firsthand peer connects with homeless shelters in the area with which we have pre-existing relationships to determine Shanice's whereabouts. Once she is found, the firsthand peer visits the shelter where Shanice is staying and encourages her to come to the **Molina on the Move** unit currently in the area to complete an updated Health Risk Assessment and behavioral health (BH) assessment. Shanice agrees, and the firsthand peer accompanies her to the mobile unit. The Molina CHW conducts the assessments and during this process learns that Shanice received a positive pregnancy test result in the ED. The Molina CHW uploads the updated assessments to our Care Coordination Portal, and both Molina's Care Coordination Director and Shanice's CCBHC care coordinator at COMCARE receive immediate notification that the assessments have been completed. The Molina CHW reassures Shanice that both COMCARE and Molina have extensive experience working with pregnant and parenting women with BH concerns. Shanice says she would be willing to talk with someone about reengaging in care.

Reengaging with Shanice in the CCBHC with the MCO Care Coordination Model

Within 24 hours of Shanice's updated assessments, Molina's Care Coordination Director reassigns Shanice to a new Care Coordinator with experience in high-risk OB. **Misty, a Molina High-risk OB Care Coordinator** and registered nurse trained in trauma-informed care, has experience working with pregnant and parenting individuals with co-occurring BH disorders. Misty immediately understands her role is to collaborate with the CCBHC to oversee and ensure that Shanice's whole-person needs are addressed during her mental health care, SUD recovery, pregnancy, and 12-month postpartum period.

Misty calls COMCARE to plan for reengaging Shanice in their care. Because Misty's role will be to support the CCBHC care coordinator and help reconnect Shanice to her care coordination when gaps occur, she discusses with COMCARE's clinical manager Shanice's past disengagement with care coordination, which may indicate a lack of connection with her COMCARE community care coordinator. At Molina, we know a Member's relationship with their care coordinator can influence their experience and willingness to engage with the healthcare system.

COMCARE is receptive to the feedback and, given Shanice's pregnancy, assigns a new community care coordinator who is a licensed clinical social worker specializing in supporting pregnant and parenting individuals with co-occurring disorders. The new CCBHC community care coordinator has recently been certified as a CHW through Molina's certification program in Kansas, and she now has additional expertise and knowledge of health education and health literacy across BH, physical health, and SDOH needs.

When Misty speaks with the new CCBHC community care coordinator, they discuss roles and responsibilities and collaborate on helping Shanice reengage with COMCARE. If Shanice agrees to reengage, the CCBHC community care coordinator will lead care coordination for Shanice's

BH care and primary and preventive physical healthcare. Misty will support the CCBHC care coordinator to facilitate high-risk maternity services for Shanice and her baby throughout the pregnancy and for 12 months postpartum. Misty and the CCBHC community care coordinator will collaborate to address Shanice's SDOH needs. Misty will continue to work behind the scenes as a partner to the community care coordinator, facilitating Shanice's care team; ensuring her CCBHC Care Plan is finalized, appropriate, and aligned with her goals, needs and preferences; and monitoring adherence and progress toward achieving Shanice's goals.

They agree to meet Shanice in person together at the shelter where the Molina CHW regularly co-locates to engage with Molina Members who are dealing with homelessness and connect them to resources.

Assessments and Care Planning to Meet Shanice's Needs

To prepare for the meeting, Misty reviews Shanice's CCBHC Care Plan, claims, pharmacy, and other information in our integrated care coordination system, which includes information available through KHIN. Molina incorporates KHIN data into Molina Insights, which in turn is included within Shanice's personal health record in the care coordination system.

Misty and COMCARE's CCBHC care coordinator attend one of Molina's daily clinical rounds to review Shanice's case with an interdisciplinary team that includes Shanice's PCP and Molina's BH Medical Director. During this round, the BH Medical Director identifies Shanice's dual diagnoses, major depressive disorder with psychotic features and schizoaffective disorder. These are "rule out" diagnoses for each other, which means she cannot have both at the same time. These conditions have different prognoses and implications for BH treatment, medications, treatment goals and outcomes, and prenatal/postpartum care. It is recommended that Shanice be reevaluated because her diagnostic picture is unclear, especially given her substance use. The CCBHC care coordinator agrees to consult with clinicians at COMCARE to conduct the reevaluation and coordinate necessary BH services. Misty offers the CCBHC care coordinator support in identifying key resources and community services for consideration when addressing Shanice's SDOH needs.

The CCBHC care coordinator and Misty meet with Shanice and let her know that the CCBHC care coordinator will be her main point of contact, and Misty will support and help with wraparound support and services for Shanice.

At the meeting, the CCBHC care coordinator takes the lead, and with humility and compassion she tells Shanice that they want to understand her care preferences and any past or current barriers to care, including her experience with COMCARE and relationship with her prior CCBHC care coordinator. It is crucial to understand why Shanice disengaged from services, what concerns she may have about reengaging, whether she wants a new Provider, and how we can advocate for her in order to develop trust and promote a positive experience to support her recovery and wellness for both Shanice and her child.

Misty and the CCBHC care coordinator create a safe space for Shanice to lead the conversation, using her prior assessments and history as a guide, so Shanice does not have to retell her story. Because of Molina's cross-training with CCBHCs, Misty knows that the CCBHC care coordinator will use motivational interviewing to gather information about Shanice's current

health status and circumstances. Misty weaves in questions from the ASAM Criteria screener and SUD assessment to determine the extent of her substance use and appropriate level of care and uses the integrated PRAPARE® tool to assess SDOH needs. She screens for suicidality with the C-SSRS and asks Shanice if she wants to talk about her past mental health diagnoses; any challenging and intrusive thoughts; intimate partner violence; and Shanice's relationship with the baby's father, her family, or other individuals and whether those relationships feel safe. Misty enters notes in real time to our clinical care coordination platform, noting Shanice's physical health, BH, and SDOH needs, including housing, transportation, food insecurity, and cell phone access.

With the assessments complete, the community care coordinator discusses with Shanice the possibilities of prenatal care and SUD treatment with recovery supports. Misty affirms that recovery is possible and that many women have healthy pregnancies and deliver healthy babies without child welfare or justice system involvement**.** With compassion and acceptance, this discussion helps evoke Shanice's desires for her pregnancy, her maternity care Provider preferences, and her willingness to participate in Molina's Healthy Moms, Healthy Babies care coordination program**.**

Shanice shares that she did not know she was pregnant before the ED visit and agrees to reengage with care coordination and BH treatment because she is in shock and feels like she needs help with withdrawal. She is afraid to stay in the shelter and is estranged from her family.

Misty affirms that Shanice's recovery is the most important factor in influencing positive health outcomes for mom and baby and that many women are motivated to begin and maintain recovery because of pregnancy. Misty and the CCBHC care coordinator are realistic that Shanice will have a long journey that may include setbacks, but they discuss the importance of developing simple, realistic, and attainable goals with small, self-defined rewards as Shanice achieves those goals.

At the visit, the CCBHC care coordinator connects with Shanice about setting up an appointment to see her BH Provider for an evaluation and arranges for Shanice to receive transportation to COMCARE using the Transportation Trip Management app.

Misty obtains Shanice's signature on releases to share clinical information with her interdisciplinary team and provide health records to any community-based BH Providers she agrees to see. This includes HIPAA Part 2 release authorization for SUD. Misty educates her and gives her pamphlets on Member rights and responsibilities, what to do in an emergency or after hours, and how to file grievances and appeals. The CCBHC care coordinator shares her contact information during business hours. Together, and with Shanice's desires and goals at the center, they begin to assemble an interdisciplinary team. The CCBHC care coordinator explains that Shanice can determine which interdisciplinary team members can receive treatment records and automatic updates to her CCBHC Care Plan through the Member portal. Misty helps Shanice add the new CCBHC care coordinator to her interdisciplinary team so the care coordinator can upload the assessment results and BH clinical notes to the portal. **Shanice is elevated from Care Coordination Level II to Level III/High Risk Maternity.**

Misty, the CCBHC care coordinator, and Shanice work together to articulate Shanice's goals and update her Care Plan to facilitate a healthy pregnancy, reduce substance use and risks, reengage in mental health and SUD treatment, use covered services and community resources to secure safe housing, and address SDOH needs. They empower Shanice to self-direct her care, offering tools, programs, and resources to choose the Providers, supports, and service delivery methods that best fit her needs and preferences. They explain that Shanice is the ultimate decision-maker, and she can direct the frequency of meetings, her interdisciplinary team, and updates to her Care Plan.

Shanice's Goals

What Shanice would like to achieve:

- ☑ I want to stop using.
- ☑ I want to make sure my baby is OK.
- ☑ I want to stay somewhere I feel safer.

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They make sure Shanice knows that her Care Plan and interdisciplinary team will evolve over time, especially as she gets established with maternity care and BH treatment. Shanice likes the idea of working with both the CCBHC care coordinator and Misty**.** They agree that the interdisciplinary team will meet every two weeks for the first 90 days, and Misty will reach out to the CCBHC care coordinator on a weekly basis to align on communications with Shanice, convening the interdisciplinary team, sharing information, providing updates, and offering support and resources as Shanice's goals and needs evolve. Misty explains that all of this will be documented in the Care Plan, Misty, the CCBHC care coordinator and Shanice will review and sign the Care Plan (including the ability to sign electronically, if Shanice wishes).

How Molina Will Address Shanice's Goals and Needs

Interventions: 12–16 Weeks

Misty ensures that the CCBHC care coordinator arranges for the following services for Shanice in the short term, and Misty helps support by connecting Shanice to agreed-upon services.

Residential Treatment. The results of Shanice's evaluation at the CCBHC indicate that Shanice is eligible for ASAM Level 3.5 (residential treatment), which will provide her with short-term housing, integrated recovery, and BH support. The CCBHC care coordinator advises Shanice that she has two residential options that specialize in treating pregnant and parenting women and have rapid admission options: DCCCA's Women's Recovery Center **or** Miracles, Inc**.** The CCBHC care coordinator explains that Shanice's choice to receive residential treatment is voluntary. If she wants something different, they can discuss outpatient SUD treatment, including medication for opioid use disorder and BH treatment and supports through COMCARE. Shanice selects DCCCA but shares her fears about and hesitancy to receive residential treatment. To help address her concerns, the CCBHC care coordinator suggests that a CCBHC peer specialist can help her throughout her journey and asks if Shanice would be willing to talk to them. The CCBHC care coordinator shares with Shanice that COMCARE has peer specialists with

Best Practices for Peer Support
We use **SAMHSA's trauma-informed approach** to gain trust, inspire hope, and increase access to services through our **field-based Peer Support Specialists who work in tandem with our interdisciplinary teams** to effectively engage Members. **Molina Peer Support Specialists share their recovery journeys, destigmatize treatment, and model that recovery is possible.**

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similar lived recovery experiences as a pregnant and parenting woman with co-occurring mental health conditions and SUD.

The CCBHC care coordinator sets up an intake appointment at DCCCA and arranges medical transportation. Shanice has asked that COMCARE's peer specialist accompany her to her DCCCA appointment to help her check in**.** COMCARE's peer specialist also offers to visit Shanice during her stay and throughout her recovery.

At DCCCA, Shanice receives a comprehensive psychiatric evaluation by a psychiatrist for diagnostic clarity. This includes medication reconciliation to ensure her medications are appropriate for her diagnoses and are not contraindicated for pregnancy and for her specific trimester. The CCBHC care coordinator works with DCCCA's clinical care team and, with Shanice's consent, adds a DCCCA clinician to the interdisciplinary team and to the Care Coordination Portal to share Shanice's inpatient service plan. Through the Care Coordination Portal, the CCBHC care coordinator collaborates with Misty on updates to Shanice's Care Plan to reflect changes in her diagnosis, medications, and ongoing BH care recommendations. Misty ensures that Shanice's OB/GYN and BH Providers are aware of and aligned with her Care Plan, treatment, and medications through ongoing interdisciplinary team meetings and internal clinical staffing rounds.

High-risk OB/GYN. Misty works with the CCBHC care coordinator and Shanice to identify a high-risk OB/GYN with specialization to treat pregnant women with SUD and mental health conditions. Shanice selects a female board-certified OB/GYN, and Misty schedules a rapid appointment**,** coordinates with DCCCA, and arranges NEMT**.** She does this for all prenatal appointments and offers to attend or follow up after each appointment. With Shanice's consent, her OB/GYN will be added to her interdisciplinary team, and results of Shanice's assessments and her Care Plan are shared automatically through our Care Coordination Portal.

Medication. Misty and the CCBHC care coordinator coach Shanice on the importance of taking prescribed medications and their potential interactions, side effects, and safety during pregnancy, reassuring Shanice that her BH Providers and OB/GYN support her medication regimen. They discuss pain management medications appropriate for pregnancy and recovery and the impact of illicit substance use on pregnancy, fetal health and development, and birth outcomes.

Housing. The CCBHC care coordinator, with the support of Molina's Housing Services and Supports Specialist, develops an intermediate and long-term housing plan that includes immediate referral to the Wichita Housing Authority, **step-down** supportive housing options, **and** shelter options for pregnant and parenting women. They assist Shanice with completing and submitting applications, including obtaining valid identification, as needed. The housing plan is incorporated into Shanice's Care Plan.

[redacted]

Maternity Care Coordination Outcomes
Molina's Ohio Safe and Sound intensive care coordination program addressed the needs of pregnant Members with SPMI and SUD.

- **100% of Members in the program completed a prenatal visit in the first trimester.**
- **40% used postpartum contraceptives.**
- **0% had a baby with low birth weight.**
- **0% had a baby admitted to the NICU.**

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Crisis, Safety, and Relapse Prevention Plan. The CCBHC care coordinator provides education on ED alternatives, including the Molina Member Crisis Line, 988, Mobile Crisis teams, detox and crisis facilities, and crisis services offered by COMCARE. At DCCCA, Shanice develops a plan that outlines coping strategies, sources of support, possible triggers for relapse, and what to do in those circumstances. Misty ensures that Shanice's plan is accessible to the interdisciplinary team via our integrated Care Coordination Portal. Misty helps Shanice develop harm reduction strategies in the event of relapse**,** like safer use strategies, take-home Naloxone, and training for those around her on its use.

Discharge Planning. Misty supports the CCBHC care coordinator, DCCCA staff, and Shanice in developing an appropriate and safe discharge plan that aligns with Shanice's goals.

Justice Involvement Support. To support Shanice in the aftermath of police involvement following the fight at the shelter, the CCBHC care coordinator collaborates with a Molina CHW to obtain and review the police report to determine whether our Victim Services Advocacy team needs to follow up with their contacts in local law enforcement (e.g., whether Shanice needs to appear in court to follow up on her victim statement or press charges).

Interventions: 17–28 Weeks

Misty collaborates with the CCBHC care coordinator to ensure that Shanice's transition of care from DCCCA accords with KanCare's Transition of Care Policy, supports reduction in Shanice's ED use and justice system involvement, and promotes Shanice's long-term recovery and engagement with community-based care. The CCBHC care coordinator and Misty educate Shanice about her ongoing care options, including ASAM Level 3.1 **(**supportive housing) or family shelters with outpatient BH services through COMCARE to support her recovery and wellness. Together, they develop a comprehensive transition plan that includes the following.

Medication. The CCBHC care coordinator works with DCCCA and Shanice to select a pharmacy in preparation for her discharge, coaching Shanice on how to access her prescriptions and electronically refill prescriptions through the Molina Member portal. Misty and the CCBHC care coordinator educate Shanice on medication adherence strategies for therapeutic BH medications. Misty checks and advises on which of Shanice's medications can be filled using 90-day prescription fills. The CCBHC care coordinator helps Shanice set up routines and reminders, use pill boxes, and request blister packs to make it easier to see which medications she has taken.

BH Services. The CCBHC care coordinator arranges for an evaluation for assertive community treatment through COMCARE, depending on her mental health diagnosis. Shanice has the option of continuing outpatient treatment through DCCCA but chooses the comprehensive services and care coordination at COMCARE. The CCBHC care coordinator arranges for Shanice to receive outpatient medication for opioid use disorder and SUD recovery supports, including individual and group therapy; referral to abstinence-based 12-step groups that support individuals who use narcotics and methamphetamines; and biweekly meetings with the COMCARE peer specialist, who encourages her to get a sponsor. Misty educates Shanice on Molina's BH self-help resources**,** including telehealth, peer support, and addiction support apps. The CCBHC care coordinator educates Shanice about family therapy sessions and family support services at COMCARE to support Shanice's goal of reengagement with her family of choice.

Addressing SDOH Needs. Misty or the CCBHC care coordinator make all referrals through our closed-loop SDOH platform and are documented in Shanice's Care Plan so Misty and the CCBHC care coordinator can ensure receipt of services. [redacted] The CCBHC care coordinator assists Shanice with applying for WIC**,** SNAP, and TANF. As Shanice gets closer to delivery, the CCBHC care coordinator will connect her to local organizations, such as Trusted Community Partners of the Southeast, for car seats and installation, diapers, clothing, and other household and infant supplies.

Prenatal Care. Misty and the CCBHC care coordinator support Shanice in attending her OB/GYN appointments. Shanice says she wants to keep her baby but is worried about child welfare involvement, so Misty refers Shanice to infant care classes and legal aid and advocacy organizations and works with the CCBHC care coordinator and Shanice's interdisciplinary team to create a Plan of Safe Care for the baby. Misty explains doula support, a value-added service for prenatal and postpartum visits, delivery assistance, and emotional support. She helps Shanice identify a doula with experience caring for women in recovery through the Kansas Birth Justice Society. Shanice's doula completes a second trimester evaluation and educates her on the signs of preterm labor.

Home Visiting. The CCBHC care coordinator and Misty provide Shanice with information on options for home visiting programs—such as **Healthy Families America,** through the Kansas Children's Service League, and **Parents as Teachers®—**that can support her while she is pregnant and postpartum and address her baby's needs through the toddler stage. Home visiting programs help new parents with education and resources on safe-sleeping practices**,** well-baby visits**,** and EPSDT visits. Through Healthy Families America and Parents as Teachers, Shanice can access parent groups and connect to Head Start and other childcare services. If Shanice decides to enroll in a service, Misty will coordinate with her selected program to streamline service delivery and mitigate service duplication.

Interventions: 29 Weeks–Birth

During this period, Misty and the CCBHC care coordinator will help Shanice prepare for the upcoming birth and postpartum period.

Birth Plan. Misty and the CCBHC care coordinator encourage Shanice to work with her doula and OB/GYN to discuss delivery hospital options. They encourage Shanice and her doula to tour the hospital(s) where her OB/GYN has privileges to ensure she is comfortable with her choice.

Misty asks whether Shanice has developed a birth plan with her doula. If so, she encourages Shanice to share the birth plan with her OB/GYN and provides self-advocacy tips for when she goes to the hospital (e.g., giving the birth plan to her labor and delivery nurse, having extra printed copies available). The CCBHC care coordinator and Misty encourage Shanice to:

- Develop a pain management plan with her OB/GYN and BH Providers for labor and delivery
- Identify postpartum supports and resources, including the safe care of her baby, natural supports, trusted individuals, and/or short-term respite options
- Learn about neonatal abstinence syndrome, how to identify and manage infant substance exposure, and how and when to ask for help
- Revisit her crisis, safety, and relapse prevention plan to update sources of support, coping strategies, and infant and family support strategies (identified above)

The CCBHC care coordinator and Misty provide information and resources on prenatal classes such as Baby Talk. These programs cover topics including how to have a health pregnancy, labor, and delivery; feeding and infant health; and postpartum health. Misty explains to Shanice that if she completes all sessions, she will be eligible for a free infant safety item, such as an infant car seat. Misty also supports Shanice in identifying a pediatrician.

Reducing Disparities in Postpartum Care
Our California affiliate was awarded the state's first Health Equity award for our Care Connections program, attributed to **reducing disparities in postpartum care rates for Black women by 37% over a 3-year period.** Compliance with childhood immunizations among this group of children **was 9% higher** during the same period.
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Molina's Care Connections program can provide Shanice with in-home visits (including at her sober living home) from nurse practitioners to support her with culturally competent education and postpartum services. The Care Connections program is proven to have long-term, positive maternal-child impacts through in-home appointments, including postpartum depression screening and EPSDT services.

Infant Feeding Support. The CCBHC care coordinator, supported by Misty, provides judgment-free and compassionate support with whatever feeding solution Shanice chooses for her baby and her interdisciplinary team recommends given her prescribed BH medication(s). [redacted]

Planning for Shanice's Postpartum Needs and Caring for Her Child. The postpartum period represents a time of increased vulnerabilities for Shanice because she has an increased risk of relapse and escalation of her mental health conditions. Before Shanice's 37th week, Misty and the CCBHC care coordinator schedule a joint in-person visit with Shanice to ensure that she feels prepared for delivery and to discuss risks in the postpartum period, including lack of sleep, reduced drug tolerance, and increased risk of overdose. They develop a transition plan from the hospital that includes follow-up post-discharge, ensuring scheduling and transportation to the

first well-baby visit, and an in-person assessment (in coordination with her home visiting program and/or doula) after birth to check on Shanice and her baby.

They agree to increased postpartum monitoring appointments at COMCARE, screening for postpartum depression and Shanice's BH needs, and coordinating transportation from Shanice's sober living home for each appointment. They also discuss possible readmission to DCCCA with her newborn if she feels like she needs additional support. Misty will support Shanice in attending her appointments and coordinate her [redacted]

She provides education on infant safe-sleeping practices and arranges [redacted] Misty also ensures that the CCBHC care coordinator asks Shanice the One Key Question® to understand Shanice's desire to get pregnant again and, based on her goals, ensures that Shanice is educated on family planning options, including the use of long-acting, reversible contraceptives.

[redacted]

NICU. If Shanice's child is admitted to the NICU, Molina's NICU program will coordinate all aspects of her child's care and any family support needs, including education, support, discharge planning, transition support, and follow-up, and will ensure that she receives a [redacted] Misty will help Shanice identify any needed specialist(s) to assess and treat her child's specific healthcare needs.

Ongoing Follow-up and Support

Recognizing the complexity of Shanice's needs, the nonlinear nature of recovery, and the challenges of managing her pregnancy and treating co-occurring BH conditions, the CCBHC care coordinator and Misty will continue to follow her progress and ensure that Shanice adheres to her Care Plan and appointments.

When the baby is born, they will support Shanice and her baby through the 12-month postpartum period, including navigating additional medical, BH, and social supports as her needs and goals evolve. Support will include regular biweekly check-ins from Molina's Care Coordinator and CCBHC care coordinator plus check-ins, from a Peer Support Specialist to help her navigate her fourth trimester and beyond.

4.3.I.29 Case Scenarios: Robert

29. Robert is a twenty-five (25)-year-old, white, male KanCare Member with Cerebral Palsy enrolled in the IDD HCBS Waiver. He is currently being treated in an acute care hospital for an upper respiratory infection and is nearing discharge. In addition to having a limited ability to meet his basic personal care needs, Robert is wheelchair dependent and requires an augmentative communication device. Robert is currently living with his grandmother, Betty, who has been providing the majority of support for his personal care needs.

Betty recently learned that she has stage 4 rectal cancer and is gravely concerned about her ability to continue to care for Robert when he is discharged, and anxious about who will take care of him when she dies. There are no additional family supports for Robert.

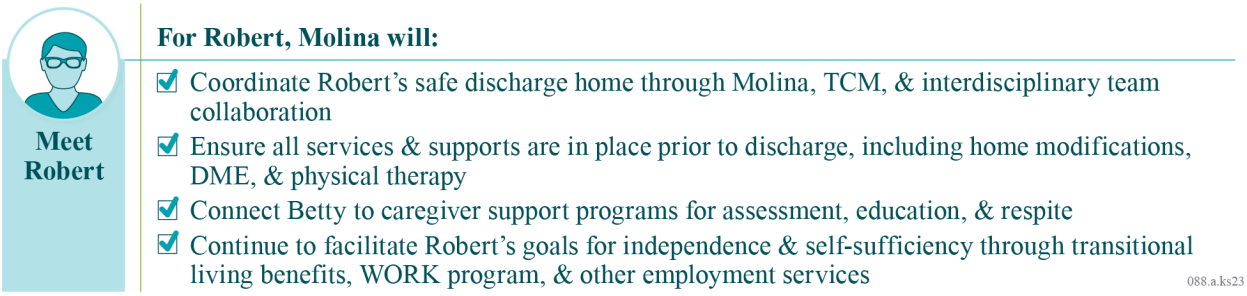
Robert is very intelligent and close to getting a bachelor's degree in computer programming. He would like to live independently, complete his schooling, and obtain employment.

Describe the bidder's approach to supporting the hospital discharge planning process and to initiating and managing Robert's follow-up care to assist him in meeting his short- and long-term needs and personal goals upon discharge.

Robert's needs are complex and require coordination of LTSS, discharge planning, access to follow-up care, and caregiver/family supports to ensure his grandmother and primary caregiver, Betty, can take care of her own healthcare needs. Robert's enrollment in the IDD HCBS Waiver has provided him with the ability to live in the community. As part of the unique population included in the waiver, Robert is enrolled in targeted case management (TCM) with the MCO Care Coordination Model.

His Molina **Care Coordinator, Michelle,** is alerted to his acute care hospitalization and begins discharge planning from Day 1 in close collaboration with Robert, Betty, his TCM, and his community care team. They will build a person-centered discharge plan for Robert to ensure his updated Person-Centered Service Plan (PCSP) includes changes to prevent readmission and address long-term goals, as Betty's ability to care for Robert is impacted by her illness.

At every point of planning, Michelle elevates Robert's voice and facilitates his decision-making to ensure his preferences are honored by all members of the treatment team.



Our Approach to Supporting Robert's Discharge

The TCM will be Robert's primary point of contact with Michelle serving as the hub for care coordination and authorization and linking him to community resources. Michelle and Robert's TCM collaborate closely and share information frequently about his care. Both meet with Robert together and separately, as needed, to understand his discharge needs. The TCM will continue to collaborate with Robert and Michelle throughout the updates of his PCSP. Michelle, the TCM and Robert will sign the PCSP at each update.

During discharge planning, Michelle coordinates with the hospital discharge staff to understand Robert's needs when discharged, and she will provide oversight to ensure he receives services and supports documented in the PCSP. Michelle and the TCM consult the hospital Provider and Robert's interdisciplinary team frequently for clinical care guidance and to keep the team apprised of Robert's progress as he discharges and returns to the community.

To ensure Robert can discharge home safely, Michelle assesses Robert's changes in needs and works with the TCM to update the PCSP, ensuring we incorporate the person-centered support plan and the behavior support plan into the PCSP. Michelle will initially monitor Robert weekly when he discharges to ensure his continued safety and health. Every activity is done in consideration of Robert's abilities and communication preferences, given his use of an augmentative communication device.

Once Robert is able and ready, Michelle and the TCM meet with him to discuss his holistic needs related to his discharge. They address the necessary measures to minimize the chance Robert will experience a readmission or a recurrence of his upper respiratory infection. Michelle uses motivational interviewing and her experience and training working with individuals with IDD to understand, from Robert's perspective, what he feels contributed to his respiratory infection and his hospital admission.

They also reiterate that Robert has a choice of Providers and others he engages with as he discharges and returns home. The TCM and Michelle assess immediate support needs Robert may receive post-discharge, such as DME. They discuss additional therapies and how these may change if they find themselves in a position where Betty can no longer provide them for Robert.

Prior to the meeting, Michelle confirmed with Betty that Robert was told about her diagnosis, so they can discuss Robert's feelings. The TCM and Michelle discuss Betty's condition with Robert and listen with empathy and compassion to understand how he feels about her illness. Recognizing the potential emotional impact this news may have on Robert, the TCM asks about his coping mechanisms and whether he has sought support from any support groups or behavioral health (BH) resources to help him navigate this challenging situation.

The TCM and Michelle help Robert brainstorm ways to address his feelings associated with Betty's illness. The TCM discusses with Robert his existing PCSP and assesses the current living situation, including his functional, physical health, BH, LTSS, and SDOH needs and preferences, aligning them to person-centered service planning that enables Robert to remain safely in the community considering Betty's illness and treatment needs. They discuss Robert's preferred short- and long-term housing options. They gather information on resources that will support his

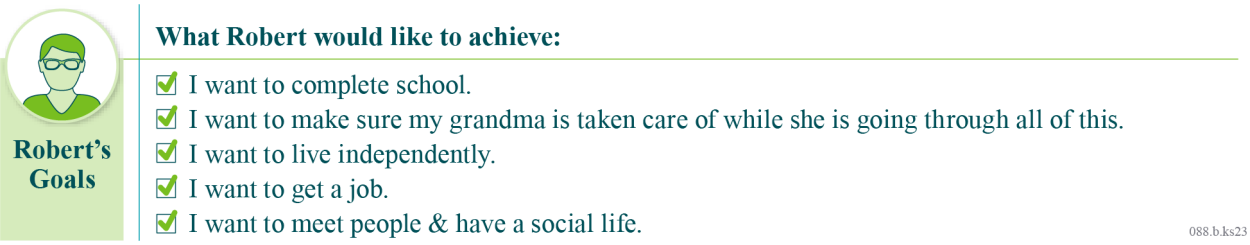
preferences, any specific needs he identifies, and any challenges or barriers he foresees. Robert wants to return to the community and live there as long as possible.

The TCM and Michelle discuss Robert's education and determine if the hospitalization has had an impact on his schoolwork or progress towards his bachelor's degree. They gather information to determine if support and accommodations are needed to address any setbacks Robert has experienced. Michelle asks about his transportation to and from school to determine if any transportation is needed and ensures that appropriate transportation services are in place, if necessary.

Due to the changes in Robert's risk factors related to Betty's illness and his hospitalization, **Robert is elevated from Care Coordination Level II to Level III**, with more intensive care coordination conducted to meet Robert's acute and complex needs.

Robert's Goals

Michelle documents Robert's personal goals in his PCSP with information from the TCM, as captured in Robert's person-centered support plan and behavior support plan. Michelle will help Robert link his personal goals to physical health, BH, and SDOH interventions and resources to help him live the life he wants for himself.



Understanding Betty's Immediate and Future Needs. While our focus centers on Robert and his person-centered service planning, it is important to consider Betty's needs and abilities as a caregiver. Michelle facilitates a meeting with Robert, Betty, and the TCM to ask about Betty's concerns and needs as a caregiver. Michelle acknowledges the range of emotions evoked with a terminal diagnosis and acknowledges her possible emotional challenges. Michelle provides a safe space for Betty to express her concerns, fears, and anxieties. During this joint conversation, Michelle ensures Robert's preferences to continue to live in the community are known.

Knowing Robert's preferences, the TCM asks Betty how she feels about Robert's discharge to home if he can receive assisted care to relieve her from her caregiving duties, as well as if this can be a long-term solution as she undergoes cancer treatment. Betty feels confident that with additional supports, Robert can continue living at home with her once discharged. Given her diagnosis, we ask if Robert will retain the house if she were to pass on to determine if home modifications may be needed in the future.

This evaluation with Betty enables the TCM to identify additional support services required, such as in-home nursing care, home modifications, therapy services (e.g., physical therapy, speech therapy, occupational therapy), or other assistance required for Robert.

Discharge Planning to Ensure Robert's Safe Return Home

Discharge planning is driven by Robert at every stage with the guidance of the interdisciplinary care team, which includes Roberts Providers (e.g., his PCP, inpatient facility providers, occupational therapists), natural supports, and others he chooses to include.

Interdisciplinary Team Transition Plan Meeting. During Robert's transition plan meeting, his interdisciplinary team (which includes his PCP) discusses his current progress towards discharge, needs, preferences, and consideration of Betty's condition. As the central member of this team, Robert shares his perspective, needs, and challenges or barriers he faces. Michelle supports Robert by facilitating a conversation with him and his interdisciplinary team to discuss his needs and any changes that may be required in the future.

The team discusses Robert's current medical condition, progress, and any ongoing medical needs to be addressed post-discharge—this includes medication management, follow-up appointments, and necessary medical equipment (DME) (e.g., breathing machine or oxygen).

The team discusses Robert's housing environment, while considering both Robert's and Betty's health conditions. They discuss modifications or support services that may be required for Robert to alleviate some of Betty's concerns and requirements to assist him at home. The team discusses Betty's ability to care for Robert and explores available support options, such as in-home health aids, assistance from friends, or community resources.

The team reviews Robert's therapy needs, including physical therapy, occupational therapy, and any other necessary therapies (e.g., family therapy, grief counseling). They discuss the availability of therapy services and explore options for in-home therapy or transportation to therapy appointments. Robert's PCP is engaged in post-discharge care and shares his thoughts on monitoring Robert to ensure the upper respiratory infection does not reoccur.

The targeted case manager discusses opportunities for Robert to engage in social activities and participate in community programs, such as local support groups, recreational activities, or vocational training to enhance Robert's socialization and overall well-being.

The team listens to Robert as he shares his long-term goals and aspirations, including his desire to complete his bachelor's degree, and the team discusses how they can support him in that area. The team discusses independent living goals and any necessary legal or financial planning, given Betty's condition.

Once the interdisciplinary team gains a clear understanding and perspective from Robert, Michelle updates Robert's PCSP to meet his needs based on his changes in condition and circumstances. The updated PCSP includes:

- The person-centered support plan, which addresses life changes and additional natural supports not currently being used.
- Discharge-to-home plan to ensure appropriate supports are in place.
- Emotional support for Robert, if needed.
- Long-term housing options, educational and vocational support, legal/estate planning support, benefit counseling, supports for Robert's caregiver(s), advance directives, practical assistance to connect with the community, and supports that address his social needs.

- Caregiver support for Betty, including connection to legal planning assistance, if needed; assessment and clinically validated training to enhance her skills and confidence necessary to support Robert; and access to peer support groups. Through Molina's value-added benefit offering, Betty can receive 60 hours of respite care annually to take time to rest and recharge.

Coordinating Services and Supports

Since Robert wishes to return home, Michelle and the TCM remove barriers that could prevent his successful return to the community. Michelle works with the Utilization Management team to ensure services and supports are in place prior to Robert leaving the hospital, which may include home health services, home modifications, and DME; value-added benefits like home-delivered meals; and links to community resources, if he has additional SDOH needs.

Robert is discharged with a short course of home-based physical therapy to increase his strength. In addition to in-home therapy services, Robert is provided with in-home assisted care for personal activities of daily living needs. Within 14 days of notification that Robert will discharge from the hospital, an occupational therapist evaluates Robert's home for necessary modifications. Once the occupational therapist finishes the evaluation, Molina coordinates completion of home modifications, if required, to increase his independence and safety.

Robert is offered a choice of home modification Providers, such as **LifewiseCHM**, and we obtain permission from the homeowner or landlord if home modifications are required. Molina has built a relationship with LifewiseCHM, which can provide Robert with various choices to meet his preferences and needs. Michelle is empowered to assist Robert in real time through Member care grants, which can be used for transitional costs like emergency utility assistance, pest control, and more.

Robert's treatment plan also requires DME. Michelle works with the DME provider to deliver DME to his home. If the equipment requires explanation or training, Michelle arranges for Robert and Betty to receive training while he is still inpatient to ensure their questions are answered. The same training occurs on the same type of equipment they will have at home to ensure they are familiar with the DME's features, get answers to any questions, and identify obstacles to using the DME properly.

Robert's discharge plan includes a follow-up appointment with his PCP within seven days of discharge. Michelle documents when this appointment is scheduled and arranges for Robert's transportation. Molina provides a carved-in NEMT benefit that allows for wheelchair van transport through our subcontracted broker, with one additional passenger allowance.

Michelle also asks Robert if he would like to have an additional person accompany him, such as Betty, who has typically attended appointments with him in the past. Our value-added benefits also include transportation to SDOH resources like community-based organizations, job counseling, and interviews. A caregiver can also accompany Robert on these trips.

With Robert's discharge approaching, Michelle connects Betty to Molina's Caregiver Support program and other caregiver resources (e.g., connections to counseling or therapy, support groups with individuals facing similar circumstances) and arranges respite services to provide

Betty much-needed breaks from her caregiving duties when she needs them. Michelle also educates Betty on self-care techniques, relaxation exercises, and stress management strategies.

Michelle introduces Robert and Betty to the Fall Reduction program, which is offered virtually with community partnerships to reduce the likelihood of falls that may result in institutionalization or prevent transition. This program introduces strategies and builds awareness of how falls can occur and how to prevent them.

Ongoing Follow-up and Support

When Robert is discharged home, Michelle and the TCM are available throughout the day. Michelle will also conduct a follow-up with Robert and his treatment team within 48 hours of discharge to ensure post-discharge services have been provided and to answer any additional questions that have come up since returning home.

After Robert is discharged, the TCM and Michelle initially communicate with Robert at least weekly, and more frequently if requested by Robert, to ensure ongoing monitoring, support, and adjustments to his PCSP are being provided, as needed. As long as Robert remains in Level III Care Coordination his Molina Care Coordinator and TCM will collaborate on connecting with him every month by telephone and in person every three months.

As Robert's stability and support network strengthen, frequency of outreach decreases to monthly; however, Michelle and the TCM continue to assist Robert to assess his progress with school and work, connect him to peer support, and help him build a social network. They help Robert with his longer-term goals regarding post-college employment plans, including a referral to vocational rehabilitation, which includes evaluation of compensatory strategies necessary to support successful employment outcomes.

Robert is provided education on self-direction, the Working Healthy/WORK program, STEPS program, and other employment programs and supports for Members who choose to self-direct certain services. Robert may need financial and legal assistance for establishing advance directives and for coordinating with Betty on estate planning.

Michelle can also connect Robert to Kansas Legal Services. As Robert's needs evolve or change over time, or if Betty's prognosis changes, Michelle and the TCM reassess his goals, adjust services, explore additional resources to meet Robert's needs for independent living, and ensure his overall well-being based on his updated preferences. Michelle and the TCM ensure Robert's interdisciplinary team is working collaboratively to meet his changing needs and goals.

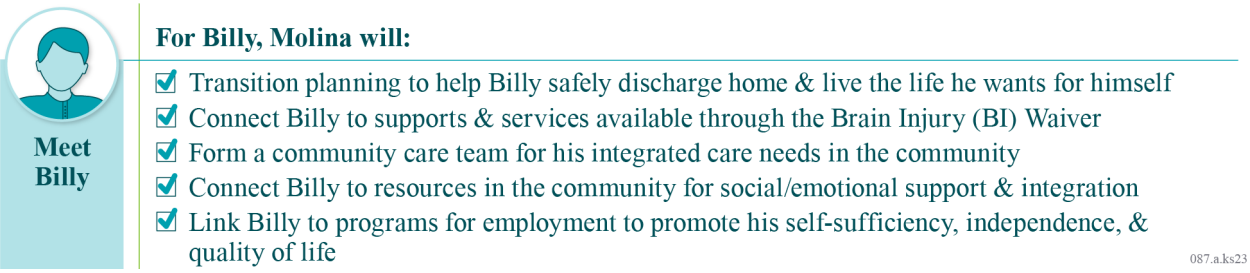
With this ongoing support, Robert will have the best environment with the resources he needs to maximize his opportunity to thrive in the community and to reach and maintain the level of independence he wants for himself.

4.3.I.30 Case Scenarios: Billy

30. Billy is a thirty (30)-year-old, white, male KanCare Member currently residing in a skilled nursing facility (NF) as a result of injuries sustained in an automobile accident, including a traumatic brain injury. Billy has been living in the skilled NF for the last 14 months. Billy receives physical and speech therapies but continues to struggle with slurred speech, coordination, and balance. He is eager to move back into his home, eventually go back to work, and "get his life back".

Billy recognizes that he may still need assistance in order to manage basic needs in his home, but finds being in a "nursing home" is depressing and lonely. In addition to his physical and speech challenges, Billy is overweight and developed a stage 3 pressure ulcer. He also experiences periodic incontinence.

Describe how the bidder will assist Billy in planning for and implementing Billy's transition, including monitoring post-transition and assisting him to achieve his personal goals.



Molina will assist Billy to plan his transition from the long-term skilled nursing facility (NF) to a community-based home using a person-centered approach that respects Billy's right to choose the least restrictive setting. We facilitate Billy's active engagement in service planning, choosing Providers and his community-based team, and defining his personal goals.

With Billy as the driver of his care**, his Molina Care Coordinator, Matthew,** acts as his primary point of contact and hub for communication, and provides coordination for all interdisciplinary team participants, including Billy, the skilled NF Provider, his Provider specialists, pharmacist, nurse, Housing Services and Supports Specialist, and anyone else Billy requests to be part of his team (e.g., family/friend and other natural supports, other Providers).

When Billy was admitted to the skilled NF 14 months ago, Matthew was assigned as his Molina Care Coordinator. Matthew has been working in coordination with the skilled NF Provider to ensure delivery of Billy's integrated care. **Currently Billy is enrolled in Level III Care Coordination.**

Matthew, as one of our dedicated, and highly skilled NF Care Coordinators, is trained in addressing complex issues and the social needs of Members residing in LTC facilities. He routinely visits Billy and other Members residing in his assigned facilities and has developed strong relationships with the skilled NF staff. Billy is regularly assessed for his preference for living in the community.

Billy's Transition to the Community

Now that Billy has expressed his desire to return to the community, Matthew begins discharge and transition planning in collaboration with Billy and the interdisciplinary team.

Building Billy's Transition Plan

Our person-centered transition planning begins with a conversation with Billy about his needs and preferences, what is important to him, and how he envisions his life in the community. In preparation for the meeting with Billy, Matthew reviews his skilled NF chart, including the PHQ-9 portion and the information from the last Minimum Data Set evaluation, paying special attention to Section Q and Billy's responses regarding Member participation, returning to the community, and community referral.

Matthew conducts a preassessment conference with the skilled NF case manager, social worker, and any other available health professionals on Billy's interdisciplinary team to gain current insights about Billy's medical conditions, recovery progress, feelings of depression, updated treatment plans, and transition goals.

Understanding Billy's Personal Goals and Preferences. When Matthew meets with Billy, Matthew uses motivational interviewing to focus on how Billy views independence and what supports and resources Billy believes he requires when discharged from the skilled NF. Matthew guides Billy to consider his strengths, concerns, and barriers, while helping Billy to connect his personal goals to practical supports, such as housing, wound care, therapies, primary care, supports with daily activities, and transportation.

Matthew talks with Billy about the support systems he had prior to his injury (e.g., family and friends), whether he has maintained contact with them through recovery, and if Billy wants to maintain or renew those relationships as he returns to a community home.

Additionally, Matthew requests permission from Billy to engage family or friends in the transition planning process. Matthew asks Billy about his feelings of depression and loneliness with empathy.

Matthew asks Billy if he is open to talking with a behavioral health Provider or peer. Billy shares that he wants to focus first on leaving the skilled NF, which he feels would improve both of these concerns immediately.

Neuropsychologist's Evaluation. To further understand Billy's needs, and in consultation with Billy's PCP and coordination with the skilled NF, Molina authorizes a neuropsychologist's evaluation, if appropriate, to determine Billy's current level of functioning, learning styles, communication, and cognitive strategies that may impact his ability to live more independently.

Additionally, this evaluation provides information on supports necessary for success in activities of daily living (ADLs), communication strategies, employment opportunities, and other supports needed. This information will be built into Billy's Plan of Service which will be signed by Matthew and Billy and updated based on changes to Billy's needs.

Billy's Goals

Billy identifies the following priorities and goals, which informs the interventions captured in Billy' s Plan of Service. Matthew helps make connections from Billy's personal goals to benefits, services, programs, and supports available to Billy in the community.

What Billy would like to achieve:

- ☑ I want to leave this place.
- ☑ I want to improve my strength, so I am more balanced.
- ☑ I want to be able to exercise again.
- ☑ I want to go back to work.
- ☑ I want to go back to the way things were before the accident.

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Preparing for Billy's Return to the Community

In preparation for Billy's discharge home, Matthew coordinates key activities to ensure everything Billy needs is in place.

Coordinating HCBS for Billy's Return to Community Living. Matthew knows Billy will require skilled NF-level services and supports delivered in his own home. Matthew explains to Billy that he will benefit from BI Waiver services and that he will coordinate the referral to the Aging and Disabilities Resource Center (ADRC). Informed by Billy's person-centered goals and his health information, Matthew submits the referral to the ADRC at least 30 calendar days prior to the anticipated discharge date.

To ensure the referral is complete, Matthew includes the required documentation, including medical records showing the BI diagnosis and KDADS' Brain Injury Eligibility Attestation form (if required). Matthew coordinates with the ADRC to ensure timely waiver approval and keeps Billy apprised of the progress of the referral.

Billy's Interdisciplinary Team and Recommendations for Discharge and Community Living. The interdisciplinary team includes Billy; Matthew; the skilled NF facility staff (e.g., Provider, social worker, nurses, and therapists who have been providing care during Billy's stay); Billy's new PCP who will take over his care post-discharge; specialists; and any identified family/friend supports that Billy wishes to be included.

The meeting begins with a review of Billy's progress since admission, including medical treatments, therapies, and any improvements or challenges observed. Billy's skilled NF medical team presents his current health status, functional abilities, cognitive skills, and any ongoing care needs, including the results of the neuropsychologist's evaluation. Billy shares his perspective on his progress and expresses any concerns or specific goals he has for discharge.

Additionally, the medical team provides information on Billy's medical stability and functional abilities and what they believe he needs to achieve a safe return to his home. They review his ability to perform ADLs independently or with minimal assistance. The team considers Billy's cognitive abilities, mobility, communication skills, and overall well-being.

Billy's PCP discusses his ongoing medical care needs following discharge. Home health services, including skilled nursing for wound care, speech therapy, physical therapy, and occupational

therapy are arranged, as needed. They also discuss his living arrangements and the need for an assessment of the home environment for accessibility and safety.

Additionally, Matthew educates the interdisciplinary team on Molina's Provider portal for medical record exchange and coordination of services for Billy.

The team is educated and trained on using the Provider portal and, as permission is granted by Billy, plan updates are shared. The portal is part of our fully integrated and comprehensive care coordination system that promotes coordinated care, services, and improved outcomes at the individual, Provider, and systemic levels.

This integration of the member record helps to maintain accurate Member care and disease management data, care plans, stratification, and interventions, consistent with Medicaid requirements, and fully integrates with our claims systems, as well as both the Provider and Member portals. With Billy's permission, all identified Providers are added to the portal to continue collaboration.

Upon approval of the BI Waiver, we engage Billy's choice of community care coordinators and integrate this individual into Billy's interdisciplinary team. The community care coordinator assumes responsibility for coordinating the delivery of Billy's services and supports and acting as his primary point of contact once Billy is living in the community. Matthew and the community care coordinator collaborate on transitioning Billy's Plan of Service to a Person-Centered Service Plan (PCSP) which will be signed by Matthew, the community care coordinator and Billy.

Provider Choice Counseling. The community care coordinator works with Billy to inform him about other individuals and resources available to support his journey to the community. Billy chooses **Minds Matter, LLC,** and their **Navigating Home program**. This Molina partner helps people like Billy move safely home, find employment, and regain their independence. Minds Matter leverages its statewide resources of social workers; occupational, physical, and speech therapists; and housing and employment specialists to connect Billy to community services in advance of his discharge. They will partner with him and his interdisciplinary team to coordinate and manage all health-related care needs and ensure he continues to thrive in the community.

Kansas Partner

Matthew, the Minds Matter transitional living staff, and community care coordinator collaborate closely to identify Billy's community home, coordinate planned services based upon his transition plan, and routinely engage with Billy to support his progress. They help to secure supports through the State's Money Follows the Person program to ensure Billy obtains funding and financial resources for his move.

Molina is offering a [redacted] About a month before Billy is discharged, Billy visits his community home with Matthew, the community care coordinator, and Minds Matter transitional living staff, including an occupational therapist, to evaluate Billy's ability to independently navigate the new home environment.

Measurement of Billy's Level of Independence Through an Occupational Therapy Assessment. This assessment is performed to determine skills and abilities at tasks like budgeting, cooking, meal planning, meal shopping, preparation, house cleaning, bathing, and grooming in his current and new home environment to inform his PCSP.

The Minds Matter transitional living staff work with Billy in his community home to assess for safety and any home modification needs that may be required. The transitional living staff will work with the community care coordinator and Matthew to get approvals for the selected home modification provider.

Home Modifications. Matthew and the community care coordinator present Billy with choices of home modification providers. Billy chooses **LifewiseCHM.** The LifewiseCHM occupational therapist works with the Minds Matter transitional living team to assess all needed home modifications. The LifewiseCHM team will coordinate with the community care coordinator and Matthew on getting these modifications approved and completed prior to Billy's discharge from the skilled NF.

Transportation Services. Matthew coordinates and schedules transportation services with the skilled NF, using Medicaid transportation benefits for Billy when skilled NF transport is not available, so he can attend scheduled appointments, and any other appointments or activities where NEMT and non-medical transportation may be needed.

Billy's team recommends supports and services based on his strengths, needs, and preferences to maximize his ability to perform daily activities on his own. Accommodations may include a combination of assistive services, personal emergency response system, personal care via self-direction or agency, rehabilitation therapies, transitional living skills, and home-delivered meals.

Nutritional Supplementation to Encourage Wound Healing. Matthew arranges a meeting with Billy and the skilled NF facility wound care nurse to discuss what Billy will require when returning to the community. It is determined that home health can provide his dressing change, monitor his nutritional status, and provide a visiting wound nurse upon discharge.

Matthew ensures DME supplies and pressure-relieving devices are established prior to discharge. To also encourage wound healing, Matthew arranges for weekly home health service upon discharge as recommended by the interdisciplinary team.

Home-delivered Meals. Matthew works with the Minds Matter transitional living skills staff to approve Billy's home-delivered meals benefit through the BI Waiver. Matthew also educates Billy about the [redacted]

Therapy Services. Minds Matter's Transitional Living Skills Program will support Billy with continued occupational therapy in his community home. These services will focus on Billy's independence in ADLs (e.g., bathing, dressing, grooming, and eating) and developing strategies and adaptive techniques to overcome any physical or cognitive challenges he may experience.

YMCA Referral and Tours. To help Billy meet the goal to improve his strength and balance as a supplement to facility-based therapies, he wishes to begin using YMCA facilities. The

community care coordinator refers Billy to a local YMCA and attends a tour with him. They tour the facility together with YMCA staff to show Billy the features of the facility, including a pool, fitness area, and classes that are free to YMCA members.

The community care coordinator arranges transportation for Billy, at his request, to visit the YMCA several times to exercise his independence prior to discharge and to get used to exercising in a public setting. [redacted]

Support Groups. Billy is interested in a support group for individuals with BI diagnoses. Matthew links Billy to the Brain Injury Association of Kansas and Greater Kansas City (BIAK-GKC). This resource provides seminars, informational resources, and support groups for Billy to connect with others facing similar challenges.

Additionally, there is a forum for problem-solving, managing change, and therapy alternatives. Billy gets the opportunity to interact with other young people who are BI survivors to help him understand his "new normal," the ability to lead a good life, and living with a BI.

When Billy identifies family/friend or other natural supports, Matthew educates them on BIAK-GKC's services in support of caregivers and families, which include support groups comprising individuals with lived experience.

Matthew also shares Molina's caregiver support solutions with those Billy identifies as his primary caregivers to help them prepare for Billy's transition, access free training, and connect them with caregiver supports.

Support for Billy in His New Community Home

With Billy's chosen community care coordinator now serving as his primary point of contact, Matthew remains a collaborative partner in supporting Billy, attending visits and calls, as needed. The success of Billy's transition depends on continued coordination of the services and supports that reflect Billy's changing needs and evolving goals.

These goals may include treatment for Billy's depression and loneliness if these continue to be a concern after transition. Matthew coordinates with the CCBHC to ensure Billy can receive services as soon as he is ready and ensures Billy's preference for in-person or telehealth services is considered.

Building a social network is also critical to Billy's success. To identify opportunities for Billy, the community care coordinator considers the types of activities Billy likes and where he likes to gather with others. The community care coordinator also assists Billy with transportation to attend activities in his neighborhood.

One of Billy's personal goals includes returning to work. Minds Matter helps prepare him for employment, engaging a specialist to help him practice interviewing, develop his resume, and identify meaningful employment opportunities.

Billy continues to receive weekly home health services for his wound care, if not fully healed by discharge. The frequency of these services will decrease to monthly, when appropriate. Billy also continues speech and occupational therapy to build skills for his independence.

Ongoing Follow-up and Support

Matthew continues to coordinate with the community care coordinator and Minds Matter's transitional living team. Billy's community care coordinator and Matthew continue to meet with Billy in person to assess his progress, update his goals, address any current needs or challenges that may arise, and make necessary adjustments to the PCSP, as deemed appropriate.

Billy's BI Waiver provides him with continued access to the Minds Matter team to focus on teaching him transitional living skills to enhance his ability to function independently in the community.

This targeted support equips Billy with the tools necessary to navigate his daily life with confidence, and may include adaptive and communication devices, ongoing transportation services when needed, and referrals for increased community engagement.

The community care coordinator works with Billy to make his desire to drive again a reality by scheduling driving tests and arranging for vehicle adaptation devices to be installed in his car. Services not covered under the waiver are coordinated using Molina's value-added benefits and community resources.

Billy's employment goals are a focal point for his long-term success and self-sufficiency. Minds Matter will help Billy find meaningful employment and secure accommodations, if needed, for his success. The community care coordinator and Minds Matter will connect Billy with financial and benefit specialists to help him understand how his employment impacts his Medicaid benefits.

If Billy's income level rises above the Medicaid allowable levels, Billy may qualify for the WORK program. Although he will be disenrolled from the BI Waiver, he will continue to receive Medicaid supports for daily activities if he meets the spend-down requirements.

As Billy adjusts and finds stability in his new environment, Matthew and the community care coordinator agree to **move Billy from Level III to Level II care coordination**. They continue to follow up with Billy, as specified in Billy's PCSP. Typically, this involves monthly contact with a minimum of an in person visit every three months to remain updated on Billy's progress and address any evolving needs.

Matthew provides support to the community care coordinator and the Minds Matter team to ensure Billy is receiving services in a manner that continues his progress. In-person interdisciplinary team meetings continue each month to ensure a comprehensive approach to Billy's well-being.

4.3.I.31 Case Scenarios: Mary

31. Mary is a twenty-eight (28)-year-old, white, female who is incarcerated at a correctional facility serving a two (2) year sentence for a felony conviction. Her estimated release date is in two (2) weeks. Prior to her incarceration, Mary was enrolled in KanCare; however, her KanCare enrollment was suspended upon incarceration. Mary will be a Member of the bidder's plan upon release.

Mary has a history of schizoaffective disorder and substance use (marijuana and alcohol). She has been receiving medication for her mental health condition (Abilify and Depakote) throughout her incarceration but has not received treatment for substance use. Mary does not believe she has had or has a problem with substance abuse, though her prior usage led to her inability to maintain employment and housing.

Mary has "burned bridges" with her family and friends and will not have a place to live upon her release. She is, however, optimistic about her future and is willing to do "whatever it takes" to get back on track.

Describe the bidder's approach to planning for and addressing Mary's needs to support her successful re-entry into the community.

For Mary, Molina will:

- ☑ Meet prior to release for in-person Health Screen & assessment
- ☑ Develop a discharge/transition plan for reentry into the community
- ☑ Coordinate & support care planning with CCBHC care coordinator
- ☑ Identify benefits, services, & value-added benefits available to support reentry & SDOH needs

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Because Mary is joining the special population of "Adults recently released from incarceration," she is enrolled in Molina's Care Coordination program as soon as we are aware of her release and enrollment in Molina's MCO. As a part of the MCO Care Coordination Model, Molina will assume responsibility for all care coordination functions, including transition and reentry into the community.

Molina's Care Coordination team brings the knowledge and training necessary to successfully support Mary as she reenters society, providing support and resources to meet her behavioral health (BH) and SDOH needs and to improve her overall well-being.

As noted in the scenario below, once safely transitioned to the community, Mary would transition to the category of "Behavioral Health (Adults)" and choose a CCBHC, at which time she would transition to the CCBHC with an MCO Care Coordination Model.

Identification

The KDOC case manager begins transition planning 60 days prior to Mary's release. Molina's Justice System Liaison receives a file via email alerting us to Mary's upcoming release. At the time of notification, KDOC determines Mary's level of needs (i.e., Level I, Level II, or Level III) and tells Molina the services and supports recommended for Mary upon her release. Molina

collaborates with KDOC through our [redacted] to ensure a seamless transition and to support interactions with our Care Coordination team.

[redacted]

Upon notification of her upcoming release, Mary is assigned to **Melissa, a Molina Care Coordinator**. Melissa is a licensed BH clinician with specific training in motivational interviewing, cultural competency, and trauma-informed care as well as experience working with individuals involved in the criminal justice system.

Until Mary completes her initial reentry and transition plan and is connected with a CCBHC care coordinator to ensure continuity of care, Melissa will serve as Mary's primary point of contact to develop and implement her discharge/transition plan.

Health Screen, Health Risk Assessment (HRA), and BH Assessment

Molina's [redacted] coordinates with KDOC to facilitate at least one in-person meeting between Mary and Melissa before Mary's release so that Melissa can introduce herself; conduct an initial Health Screen, HRA, and other assessments that branch from the HRA based on Mary's results; and begin the service planning process.

Molina will be responsible for all care coordination activities, including these initial assessments and development of Mary's transition plan and initial Plan of Service. Melissa will ensure that Mary is ultimately connected with a CCBHC in the area in which she intends to reside upon her release, and eventually certain elements of care coordination will transition to the CCBHC care coordinator.

During their initial meeting, Melissa uses motivational interviewing to conduct a person-centered interview, which includes assessing Mary's goals, needs, and preferences for her physical health, BH, and SDOH, to confirm risk stratification. Melissa helps Mary develop initial SMART goals for reentry.

Additionally, Melissa requests consent from Mary to obtain medical records from the contracted KDOC facility healthcare Provider to help with the development of a comprehensive care plan upon assessment completion. She also requests consent to share assessment findings and treatment plans with Mary's interdisciplinary team through our Care Coordination Portal.

During this conversation with Mary, Melissa weaves in questions to complete a comprehensive BH assessment to identify any additional needs not indicated in the initial screening. These assessments enable Melissa to determine whether Mary has been properly stratified by KDOC.

The screenings used during the assessment include the WHODAS for SPMI and the ASAM Criteria for SUD. As a result of these assessments, and due to her SPMI diagnosis, substance use,

history of incarceration, and significant SDOH needs, **Mary is stratified at a Level III**. This stratification will guide the frequency and intensity of care coordination as Mary is released.

Taking a collaborative partnership approach, Melissa asks Mary how she is doing, what her goals and preferences are, what she has already worked on during KDOC's discharge planning process, what has been coordinated so far, and how comfortable she is with the current treatment plan.

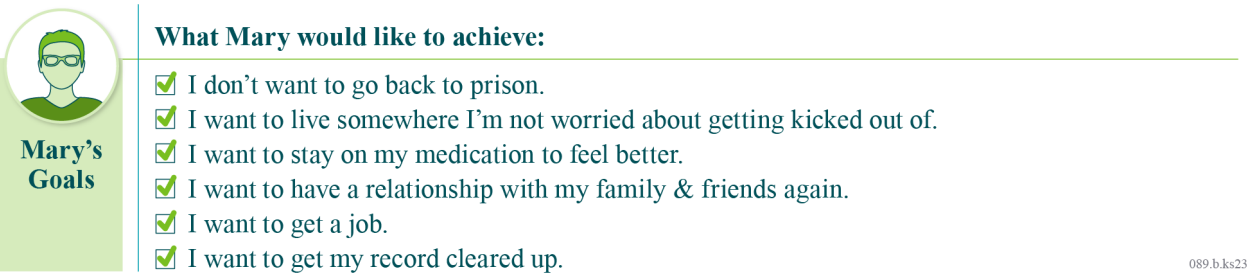
Melissa also helps identify any gaps that may require additional support. Additionally, while engaging in conversation, Melissa observes Mary to help assess her stability and functioning and whether her current plan appears to be working.

Discharge/Transition Planning with Mary

During the initial conversation, Mary shares her preferences regarding Providers. Melissa educates Mary on the role of a CCBHC and offers to arrange for an initial appointment for Mary with a prescriber at the CCBHC upon Mary's release—a critical priority to ensure Mary has no lapse in her medication.

Melissa also explores with Mary her belief that her past substance use is not a problem and whether she feels engaging in SUD treatment and supports would aid in accomplishing her goals. Melissa also asks Mary about her current medications and educates her on one of the medications that can be administered as an injectable instead of orally.

Additionally, Melissa asks Mary about her interests and what she enjoyed doing prior to incarceration. During the conversation, Mary shares her goals.



Melissa reassures Mary she will be supported throughout her transition and connected to all the resources necessary to aid in achieving her goals. Melissa recognizes the importance of proactively arranging services to support Mary upon her release.

Melissa uploads the results of Mary's assessments to our Care Coordination Portal and, with Mary's consent provided during her initial assessment, contacts the local CCBHC to initiate the steps necessary for Mary to receive immediate services and support upon release, including coordination of her preventive and primary care.

Melissa works with Mary to begin identifying her interdisciplinary team, including at a minimum Mary's parole officer, PCP, and CCBHC care coordinator once enrolled, so they are ready to support her upon release.

Melissa and the Molina Justice System Liaison coordinate a second meeting—virtual this time—prior to release, with Mary and any pre-identified members of her new interdisciplinary team.

During the meeting, Melissa supports Mary in sharing her goals, preferences, needs, and identified supports upon release, with a focus on the immediate priorities of ensuring medication adherence and addressing SDOH needs, such as stable housing, food, and steps toward employment that are a condition of her parole. Melissa shares the transition plan she has developed, which aligns with and meets Mary's needs.

With Mary's permission, the parole officer shares pertinent aspects of Mary's parole conditions, such as whether she is required to undergo drug testing or SUD treatment. The team also discusses Mary's medication regimen and upcoming appointment with a prescriber at the CCBHC to avoid any gaps in her care. Melissa tells Mary she has also arranged transportation for this appointment.

Finally, Melissa works with the KDOC reentry team to ensure Mary has temporary housing upon her release, since she doesn't have a place to stay, and begins a plan for permanent housing in collaboration with Molina's Housing Services and Supports Specialist.

Melissa also helps Mary apply for a phone one week prior to her release. Molina partners with [redacted]. Melissa also reviews the available value-added benefits that could help Mary once she is released, including employment and SDOH supports and incentives.

Implementing Mary's Transition Plan

After release, Melissa visits Mary at her new residence to provide her with a Member kit that contains items such as a pill holder/reminder, personal hygiene items, and the phone with preloaded applications and Melissa's direct contact information. Melissa educates Mary about using the Molina 24/7/365 Member Crisis Line and other resources.

They confirm the day and time of Mary's initial appointment at the CCBHC, and Melissa lets her know that she is also scheduled for a psychiatric evaluation that day. Melissa coordinates transportation for Mary to and from these appointments.

Melissa advises Mary that during the coming weeks, she will continue to stay involved, meeting with her weekly by phone or in person to monitor her progress toward her goals, make sure she's taking her medication as prescribed, determine her preferences, and coordinate referrals to the SDOH supports she needs to continue her successful transition out of incarceration.

She also explains that a care coordinator from the CCBHC will become engaged in the process once Mary begins treatment there and walks through how the two will work together to help Mary have a smooth reentry into the community.

CCBHC Care Plan

As Mary succeeds in her immediate transition plan—connecting with the CCBHC, staying on her medication, and adhering to her parole conditions—Melissa's role evolves to supporting the CCBHC care coordinator and providing resources; ensuring that Mary's CCBHC Care Plan aligns with her needs, goals, and preferences; and ensuring that it is signed by Melissa, the

CCBHC care coordinator and Mary and documented in the CCBHC system and the Molina Care Coordination Portal.

When appropriate, Melissa will offer to arrange for referrals and connections to services using Molina's SDOH platform to make closed-loop referrals. Melissa will continue to attend the weekly meetings with Mary and the CCBHC care coordinator, and Melissa also agrees to be in contact with the CCBHC care coordinator regularly to offer additional support and resources.

The CCBHC care coordinator assumes responsibility for day-to-day care coordination to meet Mary's needs, offering Mary the following additional integrated BH, physical health, and SDOH needs services for consideration.

PCP Connection. The CCBHC connects Mary with an integrated PCP and shares all appropriate information across Mary's interdisciplinary team so that Mary can stay up to date on wellness visits.

SPMI Supportive Housing. While Mary is in the temporary reentry housing, the CCBHC care coordinator, with Melissa's assistance, will help Mary apply for and secure appropriate long-term housing in a stable living environment that supports her mental health needs. The Molina Housing Services and Support Specialist also works behind the scenes to find her permanent supportive housing, if she's eligible, or advises on more permanent and independent housing for Mary.

Employment Support. A referral to vocational rehabilitation was a condition of Mary's release. The CCBHC provides a referral to a vocational rehabilitation job coach to assist Mary with navigating the job market and maintaining employment. Melissa connects the CCBHC care coordinator to Molina's Employment Services and Supports Coordinator to identify job opportunities and provide additional advice and support for seeking employment.

Mary receives employment coaching from the CCBHC, such as interviewing practice, addressing her felony record, resume development, and building job skills. Mary also identifies her strengths, interests, and abilities to find suitable employment opportunities.

In addition, she is supported in applying for The Women's Network's Path to Purpose program, affording her full-time work in medical or manufacturing jobs created and operated by **the Women's Network**, one of Molina's community partners.

Peer Support Programs. Mary agrees to participate in the CCBHC peer support program to help her throughout her transition. The CCBHC care coordinator will contact program leaders to ensure that Mary has opportunities to connect with peers with shared experiences.

The Clubhouse Model. Mary is introduced to the Breakthrough Clubhouse, a supportive community environment where she can engage in meaningful activities with others during the day. Breakthrough Clubhouse can help Mary to build connections. Mary agrees, and her CCBHC care coordinator helps her apply to the program.

Community Connection Through NAMI. Mary is connected with NAMI to participate in community activities and events that align with her interests, which affords her opportunities for socializing, support, and finding enjoyment in meaningful activities with others. Mary chooses to sign up for the local recovery support group at NAMI, and the CCBHC care coordinator ensures she has all the information she needs to attend her first meeting.

The CCBHC care coordinator works with Mary on reconnecting with family and friends and conducts practice sessions on how to rekindle and rebuild relationships through open and honest communication. They educate Mary on family support offered through the CCBHC and their ability to facilitate the healing process and improve her familial relationships.

Mary shares that she is open to this support. Recognizing that not all past relationships need to be rekindled, Mary works to build healthier friendships by working on social skills through the CCBHC. CCBHC family sessions are arranged for Mary to address her family situation.

Mary receives assistance with earning an independent income. This support may involve connecting her to resources and programs that can help her secure financial stability and independence. If Mary finds it challenging to secure employment, volunteer opportunities are provided that align with her interests and abilities.

These opportunities enable her to engage in meaningful activities and experience a sense of accomplishment and dignity while building her resume and demonstrating employability. Eventually, Mary may be interested in referrals to a community-based organization that can help her with expungement of her record, and Melissa will present options for her to consider.

Ongoing Follow-up and Support

Melissa ensures the CCBHC care coordinator continues to reassess Mary's needs, typically every 90 days. She addresses any new needs and barriers and tracks graduation markers, such as continued utilization of outpatient services, avoidance of law enforcement involvement, and goal attainment, to determine when Mary's care coordination intensity can decrease.

Melissa monitors Mary's integration into the CCBHC and provides ongoing support and services and supports the CCBHC Care Coordinator to ensure that Mary has monthly contacts that include a minimum of an in person visit every other month while she is in Level III Care Coordination.

4.3.I.32 Case Scenarios: Pedro

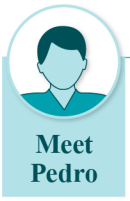
32. Pedro is a seventeen (17)-year-old, Latino, male KanCare Member living in foster care. Pedro was diagnosed with asthma at four (4) years old and uses an inhaler to manage. his symptoms, with varying success.

At his last health care visit, Pedro and his foster mother shared with Pedro's Primary Care Provider (PCP) that Pedro is having more difficulty breathing and more frequent asthma attacks. When the PCP inquired about the precipitating circumstances, the PCP learned that the breathing problems and asthma attacks have been occurring when Pedro is at home — not at school or other locations, leading his PCP to think that there may be an environmental trigger in the home.

Pedro has had four (4) ED visits in the last twelve (12) months due to his asthma. Pedro's case file also states he experienced significant physical and emotional abuse during his early childhood, resulting in his placement in foster care. Pedro was once active in school and extracurricular activities but recently has become more withdrawn, leading his foster parents to suspect marijuana or other substance use, which they have expressed to his PCP.

Pedro's PCP has contacted the bidder's Care Coordination team to request assistance with assessing and addressing the potential environmental trigger exacerbating Pedro's asthma, and to make the care coordinator aware of Pedro's possible behavioral needs.

Describe how the bidder will respond to the PCP's request and how the bidder will support and coordinate Pedro's health needs.



For Pedro, Molina will:

- ☑ Ascertain & address environmental triggers in Pedro's home
- ☑ Assess for BH & SUD needs
- ☑ Reengage in school & extracurricular activities
- ☑ Promote positive condition management for Pedro

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Responding to the PCP Outreach

As a 17-year-old foster care Member, Pedro is enrolled in the **Molina Care Coordination model as moderate needs** and has a dedicated Molina Care Coordinator who coordinates his care and services along with an engaged interdisciplinary team that includes his PCP, foster care Case Management Provider (CMP), foster parents, any BH specialists, and school personnel who work with Pedro. Pedro's **assigned Molina Care Coordinator, Marta**, has developed relationships with the team members and regularly shares updated assessments and Plans of Service with them. Because Marta has shared Pedro's Plan of Service with his PCP through the Availity Provider portal, the PCP office has up-to-date contact information for Marta. The PCP contacts her, lets her know of their concern for Pedro, and requests a scan of Pedro's home. Marta communicates regularly with Pedro and his foster family no less than twice a month. When they shared information about the ED visits, the family indicated that the exacerbation of symptoms appeared random. During these touch points, Marta shared information from the Molina My Health Asthma Disease Management program regarding triggers and strategies to

ensure the family knows how to handle episodes. During the most recent call, she helped the family arrange a visit with Pedro's PCP to see if something new was happening to make his asthma worse.

Once Marta finishes speaking with Pedro's PCP, she reaches out to the CMP to discuss the concerns relayed by the Member's PCP regarding potential environmental triggers exacerbating Pedro's asthma symptoms along with the need for a reassessment of the home environment. The outreach also prompts Marta to document the need for a reassessment and refreshing of his Plan of Service in our care management platform, which is needed based on the news of Pedro's issues. Once Marta and Pedro's CMP agree on a plan, Marta contacts Pedro's foster family to schedule a home visit and collects signatures on the Plan of Service from Pedro, the CMP and Pedro's Foster Family.

During this conversation, Marta shares with Pedro and his foster parents the PCP's concerns regarding the exacerbated asthma symptoms and potential environmental triggers that may be contributing to his health issues. Marta explains to Pedro's foster family that a Molina Community Health Worker (Molina CHW) is available, with their permission, to conduct the in-home environmental assessment while she conducts a new assessment given the PCP's recommendations and Pedro's recent ED visits. The in-home assessments are scheduled within 24–72 hours and at the family's earliest convenience.

Pedro's PCP and the CMP are alerted about the scheduled in-home assessment through our Care Coordination Portal. This portal serves as a fully integrated and comprehensive care coordination system that promotes coordinated care, services, and improved outcomes at the individual, Provider, and systemic levels. This cohesion between the PCP and CMP helps to maintain accurate Member and disease management data, service plans, and stratification and interventions. It is consistent with Medicaid requirements and fully integrates with our core care coordination and claims systems, as well as with our Provider and Member portals.

In-home Reassessment

To ensure Pedro's ongoing well-being and effectively manage his asthma, a comprehensive in-home reassessment is conducted, encompassing a discussion about his evolving needs as well as an environmental assessment to identify any potential triggers exacerbating his condition.

Environmental Assessment

The Molina CHW conducts an in-home environmental assessment to determine and remediate barriers to care and SDOH needs. Molina's CHW has been trained to conduct environmental assessments by completing the standardized training, **Healthy Home Principles and Assessment Practice for Health Educators and Community Workers** through **Children's Mercy Kansas City**. The Molina CHW will use the "Home Characteristics and Asthma Triggers—Training for Home Visitors" checklist developed by the CDC, EPA, and HUD. The checklist includes action steps to assist Pedro and his foster family with reducing asthma triggers related to each subject area.

Comprehensive Health Risk Assessment, Including BH

Pedro's immediate need is to manage his asthma along with exploring potential BH issues he may be experiencing. Because his foster parents may not know how Pedro is feeling about his

overall health, Marta asks permission from his foster parents to speak privately to Pedro during the reassessment. To effectively engage Pedro in an open and transparent conversation using motivational interviewing, Marta begins by sharing with Pedro that his foster parents have noticed he has become more withdrawn, less engaged in extracurricular activities, and less engaged in school, and they have expressed that they are worried about him, especially since his asthma is uncontrolled.

Marta asks Pedro if he is taking his asthma control medications as prescribed and assesses whether there is another type of medication that may be easier for Pedro to use, such as changing his Singulair tablet to a chewable or changing routine inhalers to nebulizer treatments. Through our gaps-in-care reporting on the Asthma Medication Ratio (AMR) HEDIS measure, we capture Pedro's noncompliance with his asthma controller medication and share it with his PCP.

To address BH concerns, Molina uses two specialty care models as the framework for identifying, assessing, assisting, and measuring progress for Members with SPMI, SED, and SUD. For children and adolescents, we use the PedsQL™ as a screening tool for mental health concerns. We use the ASAM Screener as the assessment tool for SUD to determine whether Pedro requires a higher level of care coordination and to help facilitate a person-centered conversation focused on Pedro, his desires and preferences for his Plan of Service, and any connections to community services and partners he might need. This documentation within Pedro's Plan of Service serves as a meaningful way to demonstrate measurable progress and enables Pedro to see how far he has come.

Leveraging the PedsQL to guide the conversation, Marta asks Pedro whether he has withdrawn intentionally or if he is struggling with something. This conversation enables Marta to better understand whether Pedro is worried about the foster care placement ending and learn which supports he feels he needs to transition to where he wants to be afterward. Marta also engages Pedro in discussions to understand whether he wants to reunite with his biological parents or other family members and his feelings about this. Marta asks Pedro where he and his family were born, whether there are things about his culture that he misses, and if he would like assistance reconnecting with his family. She also allows Pedro to educate her about what he finds special about his culture.

Throughout this conversation, as Pedro continues to engage, Marta checks the ASAM Screener to identify whether he is indeed using substances, such as marijuana, smoking/vaping, or something else. Based on his responses, Marta explores why he may be using substances, what problems it may be solving for him, whether he is socializing with a new peer group, and other considerations. She educates Pedro on the dangers of using substances, how this can impact his asthma, appropriate usage, and support for quitting or reduction, if he is interested. Marta also identifies healthier options as alternatives to substance use. If Pedro admits to using substances, Marta collaborates with him to identify short-term goals for quitting. Finally, Marta discusses with Pedro his short- and long-term educational and employment goals, such as attending college, pursuing vocational training, or pursuing full-time work. Once Pedro shares his goals and aspirations, Marta assists him with outlining the steps, services, and resources required to achieve his desired outcomes.

Plan of Service Update

In collaboration with Pedro's interdisciplinary team, Marta reviews the assessment results, Pedro's expressed goals and desires, and any concerns he may have. Additionally, the team reviews his current transition plan for aging out, which was developed when he turned 16, and collaborates to make any updates to the plan to reflect Pedro's current needs and supports. They discuss the starting point of any changes in Pedro's health and his activities before, during, and after the asthma attacks.

With increased insight into these aspects, Pedro's interdisciplinary team can better tailor their support and recommended interventions to promote his overall health and well-being. It is agreed that Pedro, who is currently considered moderate risk, should be moved to the complex/high-risk level due to ongoing asthma exacerbation and potential BH issues.

Marta updates Pedro's Plan of Service to address his stated goals. As part of our best practices, elements of his transition plan are included in his Plan of Service, affording him a central source to view his goals and progress. This approach enables the interdisciplinary team to support him in building his skills toward readiness for independence.

Marta and the CMP agree on the Plan of Service proposed to Pedro's foster family. We acquire Pedro's guardian/legal representative signature for the Plan of Service (an electronic signature option is available to them).

Once the Plan of Service is developed and updated, Providers can review, track, trend, and address Pedro's gaps in care via the **Availity® Provider portal**. Additionally, the interdisciplinary team can identify any outlying trends, such as high ED utilization or low preventive care utilization.

Pedro's Goals

What Pedro would like to achieve:

- ☑ I want to be able to breathe.
- ☑ I want to stop feeling anxious when I think about leaving foster care.
- ☑ I want to meet kids like me.
- ☑ I want to have a good relationship with my foster family & make sure they are proud of me.

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Care Coordination

As part of our collaborative, person-centered approach to meeting Pedro's goals, Marta implements the following short-term interventions based on Pedro's preferences.

Environmental Remediation

If environmental triggers are identified, Marta collaborates with community-based organizations to support Pedro and his family in addressing any identified housing concerns. Based on the results of the environmental scan, the Molina CHW links Pedro's foster family with local resources to mitigate issues exacerbating Pedro's asthma in his living environment, such as dust, mold, smoke, and other asthma triggers.

As part of our care management outreach, we coordinate the delivery of a HEPA air purifier and/or other asthma-minimizing approaches, such as a dehumidifier or carpet cleaning, to Pedro's family. In addition to home modifications, we offer value-added benefits, such as a mattress and/or pillow covers, as needed.

If the assessment finds there are no significant asthma triggers in the home environment, the Molina CHW provides general recommendations, such as always using the exhaust fan or keeping a window open when cooking, routinely changing air filters in the heating/air system, and using a humidifier or dehumidifier.

The Molina CHW also reminds the family of the importance of maintaining a smoke- and vape-free home and ensuring Pedro is not exposed to secondhand smoke in any settings the family routinely visits.

Part of his Plan of Service includes an ongoing plan for assessing environmental triggers and corresponding contingencies (e.g., home weatherization and evaluating humidity levels) as well as evaluation of any future living environments due to his near-term transition to adult services.

Asthma Support

Marta collaborates with Pedro's PCP on any medication adjustments and referrals to other Providers, such as a pulmonologist or asthma educator. Marta also reviews tools and strategies that educate and empower Pedro and his foster family to effectively manage his conditions. Marta provides education to increase Pedro's knowledge about his condition, encourages him to learn about and avoid triggers, aids in the development of a self-management plan with his Providers, and supports him in choosing Providers and establishing care to promote independent life skills while fostering adherence to a prescribed treatment plan and/or medications.

Providing Disease Management and Education on Accessing Appropriate Care. Since Pedro is enrolled in our evidence-based Molina My Health Asthma Disease Management program, Marta shares asthma-specific Member materials and resources with him and his foster family. These resources are available in different languages to meet Members' preferred communication methods. Resources include a blank asthma action plan that his foster parents and Pedro can take to Pedro's next PCP appointment. Marta ensures Pedro's asthma action plan is on file with the school nurse, along with any medications (e.g., nebulizer) to prevent exacerbation of his asthma and subsequent ED visits.

Marta emphasizes the importance of Pedro's PCP in managing Pedro's asthma, the PCP's role in coordinating care with other Providers and specialists (e.g., a pulmonologist), and completion of preventive well care. She also provides education on the use of Molina's Nurse Advice Line and confirms that his foster parents have important contact numbers, access to health benefits and value-added benefits, and information on how to obtain referrals or use community-based services.

As part of our Quality campaign for Members (ages 5–64) with asthma, Pedro and his foster parents receive an asthma stoplight magnet with exacerbation warning signs and information reinforcing the appropriate sites of care.

Connection to Evidence-based BH and SUD Treatment

Integrated Whole-person Care

Because Pedro shows signs of escalating symptoms, withdrawal from extracurricular activities, decreased engagement in school, and a positive result on the ASAM Screener, Marta speaks to Pedro about reengaging in BH counseling. Marta asks Pedro about his previous BH services and experience and gains his input on whether he wishes to return to the same therapist or visit someone new. Pedro states it has been a while since he visited the previous therapist and that he stopped going because he felt as though it was no longer helpful.

Marta recommends trying someone new who specializes in young adults and substance issues such as DCCA or Family Service and Guidance Center, which are known in their communities for these services. While Pedro may have been referred to or received clinical BH counseling in the past because of his trauma, Marta talks with the family about expanded programs through other organizations that offer BH and substance abuse programs that focus are trauma-informed, such as trauma-focused cognitive behavioral therapy.

Pedro agrees, and they work together to identify a new Provider. Emphasizing the importance of evidence-based treatment for Pedro's past trauma and current substance use, Marta explores with Pedro his preferred modalities for BH service, such as in-person and telehealth options. She educates Pedro on the differences between in-person and telehealth services, assists him with identifying the most appropriate Providers from which he can choose, and supports him and his foster parents in making the initial appointment.

Marta shares this information with Pedro's foster parents and informs them about this plan. Additionally, Marta obtains any necessary releases to communicate with the Providers and with his foster family's consent, we add Pedro's selected Providers to our care coordination platform to afford them a bidirectional ability to communicate and coordinate with Pedro and his other Providers, including his PCP.

Marta reviews all environmental trigger assessments, ER records, and BH/SUD evaluations and determines to move Pedro into complex/high needs care coordination until there is stability in these conditions.

[redacted]

Ongoing Care and Support

Throughout this effort, Marta collaborates with the CMP to provide Pedro's foster care parents with additional supports that Molina offers to foster care parents. Marta also encourages Pedro's foster family to actively participate in caregiver support programs, such as the Kansas Foster and Adoptive Parent Association, where they can connect with other caregivers facing similar situations and shared experiences.

Marta provides guidance on effective communication techniques to facilitate open and transparent conversations with Pedro about his goals, desires, and concerns regarding the transition. Additionally, Marta helps Pedro's foster family build on the active/reflective listening skills they learned in foster parent training by teaching them basic motivational interviewing skills. She offers resources to promote emotional well-being and resilience within the foster family, empowering them to navigate any potential challenges that may arise during the transition.

Marta recognizes the dynamic nature of Pedro's transition and his evolving healthcare needs. Ongoing follow-up and updates to his Plan of Service are conducted in active collaboration with his interdisciplinary team, Pedro, and his foster family to assess and address any gaps in his healthcare needs. To ensure Pedro's Plan of Service remains effective, Marta schedules routine interdisciplinary team meetings with Pedro and his foster family.

During interdisciplinary team meetings, Pedro, his PCP, BH Provider and his foster family discuss Pedro's progress, any challenges he may be facing, and potential updates required in his Plan of Service based on Pedro's needs or changes to his health. Marta also continues to monitor Pedro's service utilization, including ED visits, and adherence to preventive care recommendations, including follow-through on referrals.

Marta conducts weekly telephonic meetings with Pedro and his foster family while meeting with them in-person every other month. Marta encourages Pedro and his foster family to reach out for support outside of these regular check-ins as needed, including alerting her to any urgent care needs or asthma-related issues. Because Pedro is the key stakeholder, Marta ensures his voice and perspective is heard in all meetings and integrated into his Plan of Service.

As Pedro nears age 18, his transition plan within his Plan of Service is continuously updated to facilitate his transition from child and adolescent services to adult services. In accordance with Pedro's transition plan, he receives independent living skills training through collaboration with one of the statewide independent living coordinators.

He is also eligible for an education and training voucher that covers college or trade school tuition, room and board, books, materials, and more, which he can participate in for a total of 5 years or until he turns 26. Marta encourages Pedro to serve on the Youth Advisory Council in his region. Marta continues to support him throughout his transition.

4.3.I.33 Case Scenarios: Henry

33. Henry is a twelve (12)-year-old, white, male KanCare Member who has complex medical needs, including significant IDDs with co-occurring severe Behavioral Health issues. In recent months, Henry has become increasingly aggressive towards other people and the family pet, with behavioral episodes that are both more frequent and more severe. These episodes have resulted in repeated crisis interventions, visits to the hospital ED, inpatient psychiatric stays, and calls to law enforcement. Henry's most recent episode of aggression resulted in his current stay in a psychiatric hospital.

Henry's mother, Shauna, is a single parent to Henry and his two (2) younger siblings, a brother who is eight (8) and a sister who is five (5). Shauna has been very involved in and supportive of Henry's treatment. While Henry has not harmed his siblings to date, his increasing aggression has left her afraid both for her own safety and the safety of her other children.

As part of the planning for Henry's discharge from inpatient psychiatric care, Shauna requested residential treatment for Henry to stabilize his Behavioral Health condition and work on managing his aggressive behaviors before Henry is returned to her home. The team involved in Henry's discharge planning is encountering difficulties in identifying an appropriate and available placement option to meet Henry's IDD and behavioral health needs. The inpatient facility is pressing for the Member's discharge and has suggested intensifying outpatient services until a suitable placement is available. Shauna has stated that while she wishes things were different, she is unable to allow Henry to return home in his current condition — that the threats to the safety of the family have grown to an unacceptable level, and that if forced, she will request that he be placed in state custody.

Describe the bidder's approach for addressing the Member's discharge needs, including how the bidder will support care planning and transitions to meet Shauna's goal of having Henry return home to his family.

Meet Henry (and his mom, Shauna)

For Henry, Molina will:

- ☑ Authorize & reimburse extension of inpatient hospitalization
- ☑ Support safe discharge to residential Provider through Molina ILOS
- ☑ Benchmark wraparound to provide continuity of care for Henry, Provider training, & family support & education
- ☑ Support the family to learn new parenting skills, navigate Henry's transitions, & prepare to receive Henry home

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Molina's care model and discharge planning for Henry uses a person-centered, trauma-informed care coordination approach driven by the family and in consideration of their concerns, preferences, and strengths. This scenario assumes that, given his status and age, Henry would be on the waiting list for the IDD HCBS Waiver. For this reason, Henry is **enrolled in targeted case management (TCM) at Level III** using the MCO Care Coordination Model.

Henry's assigned **Molina Care Coordinator, Max**, is well-versed in working within the TCM model. He also recognizes that in times of transition, their collaboration intensifies as Henry, his

family, and his Providers need all the support they can get. Max is alerted by the Molina Utilization Management (UM) team as soon as Henry is admitted to the hospital.

Max reaches out to the targeted case manager to keep them apprised of the admission. During the time when Henry is not in a community setting, Max takes on a more prominent role and becomes the primary point of contact for Shauna and Henry, keeping the targeted case manager informed to prepare for Henry's eventual return to the community.

Max begins planning as soon as Henry is admitted, working in concert with Molina's UM team, the hospital discharge planner, and the community-based clinical care team. Max, a Kansas-licensed behavioral health (BH) clinician with multiple years of experience, has expertise in working with children who have complex BH and physical health needs. He has training in evidence-based practices related to children with IDD.

Approach to Addressing Henry's Discharge Needs

At each step of the discharge planning process, Max works closely with Shauna to understand her concerns and goals for Henry and their family. Understanding Shauna's wishes and Henry's history of treatment from her perspective is critical to developing a successful discharge plan that Shauna will support and act upon.

Max contacts Shauna to offer an in-person meeting, and Shauna agrees. When they meet, Max uses his skills in motivational interviewing and a conversational tone to ask questions from Molina's comprehensive BH assessment (based on Henry's age) and the parent-reported PedsQL™. Max affirms and summarizes Shauna's concerns from a safety perspective, ensuring these concerns will be addressed as they build the discharge plan.

Max helps Shauna identify her strengths, perspective, and short- and long-term goals for Henry and their family. Max emphasizes family voice and choice, asking Shauna about her preferences regarding Henry's plan for treatment following discharge from his inpatient stay.

Max gains an understanding from Shauna of her routines within the household and how she responds when Henry becomes aggressive. She expresses that she does not want Henry back home with her until it is safe for his siblings, and she has the supports that she needs. With Shauna's permission, Max also spends time with Henry to observe him and assess his needs and goals as he can express them.

Shauna's Goals for Henry and Her Family

What Shauna would like to achieve:

- ☑ I want my other children to be safe.
- ☑ I want him to stop being aggressive toward the dog.
- ☑ I want to learn how to support Henry when he gets upset & learn ways to calm him down.
- ☑ I want him to come home & be with his family.

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Henry's Goals

Inpatient Facility Support

The Molina UM team initiates a conversation with the facility to gather information about the reasons behind their discharge recommendation. They explore the possibility of extending Henry's stay and funding it until a suitable solution is identified.

Max quickly schedules a peer-to-peer meeting between the inpatient treating psychiatrist at the facility and Molina's Behavioral Health Medical Officer/Medical Director (BH-CMO), a board-certified psychiatrist who has extensive experience with children with behavioral challenges and their families.

The Molina BH-CMO seeks clarity on whether the facility requires assistance to find an alternative care setting or if they have exhausted all available options for Henry's current stay. Because we take a proactive and high-touch approach and authorize additional time, the hospital agrees to extend Henry's stay while a new and adequate discharge plan is put into place. Molina's UM team authorizes an extended stay, which includes reimbursement to the facility.

The peer-to-peer meeting participants review details about Henry's current medications and therapeutic interventions, enabling a comprehensive evaluation of his progress and the effectiveness of his ongoing treatment plan. The BH-CMO ensures that recommendations for Henry adequately address his aggressive behaviors and achieve stabilization.

While Molina can offer a series of wraparound, in-home supports that would allow Henry to return safely home now, Max and the team hear Shauna's escalated concerns and the measures she's willing to take to secure the safety of the family. Because of this, the team agrees that an intermediate level of care between hospital and home will help Shauna and the family better prepare for Henry's return, while also giving Henry more tools to control his behaviors when he does eventually return home.

To that end, they recommend a short-term PRTF stay for Henry. Max is well-versed on the challenges of finding PRTF beds and leverages the extensive relationships and supports Molina has built to find an available spot for Henry.

Molina is building relationships with in-state and out-of-state PRTFs (even working with a new Provider to add varying levels of care to meet emerging needs) to serve Members like Henry. These relationships and the added supports we describe in this scenario help PRTFs manage Henry's IDD and his behaviors, but also help get Henry prioritized for treatment in a facility.

Meeting of Henry's Interdisciplinary Team. After gathering all the necessary information from the hospital and from Shauna, along with clinical recommendations from the peer-to-peer meeting, Max begins transition planning and care coordination activities with Henry and his

family. Max uses a family-driven, youth-guided approach that gives the family the ability to voice their preferences and make informed healthcare decisions. He collaborates with Shauna to identify the individuals she wishes to include on Henry's interdisciplinary team.

The interdisciplinary team will include Shauna, Max; the targeted case manager; the social worker from Henry's inpatient Provider, who understands Henry's complex co-occurrence of IDD and BH conditions; Henry's PCP, who has been treating his complex physical health needs; and once engaged, **a Positive Behavior Support facilitator (PBS facilitator)** from Benchmark who will assess Henry in multiple settings and help support him throughout his treatment.

Since Henry's needs are complex, the interdisciplinary team consults with Molina's team of internal experts as needed, which includes our BH-CMO; Behavior Supports Director, who is an advanced practice registered nurse with experience in behavior modification and support; Pharmaceutical Director; Care Coordination Director; a registered nurse Care Coordinator to consult for physical health; and a Peer Support Specialist credentialed in parent peer support.

During the initial meeting of the interdisciplinary team, Max assists Shauna with advocating for herself to ensure the team fully understands her current concerns, needs, and preferences and to ensure that Shauna expresses what she believes to be her strengths and Henry's strengths. The team hears Shauna's concerns about an immediate return home in light of Henry's increased aggression, and they brainstorm potential solutions.

The interdisciplinary team supports transitioning Henry from the inpatient setting to a PRTF as soon as possible. Max teaches Shauna about Molina's Care Coordination Portal**,** where she can view Henry's Person-Centered Service Plan (PCSP) sign all updates and access information about all members of Henry's interdisciplinary team. Henry had been transitioned to a PCSP because of his BH needs.

Molina is bringing Benchmark Human Services to Kansas. Benchmark is a highly specialized Provider that has proven its ability nationally to improve systems that support vulnerable populations with complex needs, including individuals with dual diagnoses of IDD and BH conditions.

Benchmark partners with BH and IDD organizations to enhance the ability and expand the capacity of these Providers to serve Members with needs like Henry's. The interdisciplinary team engages with Benchmark, who will provide immediate crisis support and stabilization for Henry, his family, and his PRTF.

As shown in **Table 33-1,** Benchmark's services span all transitions and remain in place as Henry receives treatment. Benchmark's multidisciplinary team acts as a clinical link between Henry's residential setting and the home environment and includes training and support for the PRTF to enhance their abilities to serve Members like Henry.

Table 33-1. Benchmark Human Services. Benchmark provides continuity of care across settings and develops treatment plans that reinforce Henry's desired behaviors using the same strategies consistently within these settings among facility staff, Providers, and the family.

Inpatient	PRTF	Home
Benchmark Multidisciplinary Team		
• Introduction • Consents • Assessments • Development of treatment plan • Client skills training and consultation • Individualized support of the PBS facilitator	• Therapy and BH support for Henry • Parent training • Support for PRTF staff through consultation and monitoring interventions • Discharge planning • Continued support of the PBS facilitator	• Transition of interventions to the home • Modifications to interventions, as needed • Handoff to outpatient Providers • Continued individualized support of the PBS facilitator • Discharge of Benchmark services to community care team

Assessing Henry's Immediate Needs Concurrently with Immediate Interventions. Benchmark conducts intensive assessments with Henry over the next 30 days while providing immediate interventions, including a Functional Behavior Assessment conducted by the Board Certified Behavior Analyst® Mental Health Intake Assessment with diagnostic clarification conducted by a licensed clinical social worker; in-depth crisis safety assessment, which includes an in-person review of current environment and supports; and an in-depth, person-centered needs assessment that captures client preferences and ensures use of a trauma-informed care approach.

These assessments inform Henry's positive behavior support plan/behavior intervention plan; mental health treatment plan; Crisis Safety Plan, which accounts for environment and available supports; person-centered programming recommendations; and trauma-informed considerations. The treatment plans are built into Henry's PCSP and documented in his Member record so that all interdisciplinary team participants are informed of their contents.

Upon engagement, the Benchmark PBS facilitator will work with Max and the inpatient staff to conduct functional behavioral assessments, interviews, and observations using PBS tools. The PBS facilitator shares this information with the interdisciplinary team to develop the plan for discharge to the PRTF and will follow Henry throughout his treatment and when he returns home.

Benchmark immediately dispatches a multidisciplinary team to provide ongoing support to Henry, his family, and his current treatment team. The Benchmark team will meet with the entire treatment team to introduce their supports and services, perform a preliminary crisis safety assessment, create an interim treatment plan based on Henry's needs, and design a Crisis Safety Plan.

As soon as Benchmark is engaged, all interdisciplinary team participants have immediate access to Benchmark's suite of services, including:

- In-person client skills training within 24 hours, conducted for all members of the treatment team.
- Staff/caregiver coaching for individuals currently supporting Henry. This consists of a combination of in-person and remote interventions and provides real-time feedback on how to respond to crisis behaviors.
- Remote crisis supports available 24/7/365. This allows Henry, his caregiver, or staff an opportunity to access crisis support from professional staff. The goal of crisis intervention is to maintain placement wherever the individual is living.
- Crisis debriefing within 24 hours following any crisis incidents with relevant treatment team members. This allows an opportunity to provide support to those involved in the crisis while making real-time adjustments to programming to prevent future crisis situations. This also includes 24-hour follow-up with Henry to provide additional supports as needed.
- Henry and his family may participate in individual therapy, family therapy, or group therapy as necessary. Benchmark clinicians are trained to serve individuals with dual diagnosis, IDD, and complex BH needs.

Benchmark becomes part of the interdisciplinary team and reports weekly to provide updates on Henry's progress.

Identifying a PRTF for Henry. While Henry continues to receive care from the inpatient facility, Max and the Benchmark team conduct outreach to PRTFs and educate the PRTF staff on how we will be using Benchmark to support them in their services for Henry.

Max and Benchmark identify a minimum of two PRTFs that are willing to serve Henry and share these options with Shauna. Max, Shauna, and the Benchmark team assess the choices and collaborate on which one is the best option for Henry and Shauna.

Coordinating Discharge from the Inpatient Stay. In collaboration with Benchmark's team and the hospital discharge planner, Max develops an immediate plan for Henry's care and closely monitors its progress to get Henry placed in the PRTF, ensuring he receives the necessary support during this critical period.

The BH-CMO and the UM staff collaborate with the inpatient Provider to ensure all safety needs are targeted for discharge, while Max coordinates discharge referrals, transition time, and availability of services.

Supporting PRTF Staff in Preparation for Henry's Treatment. Benchmark provides supports to the PRTF, which may not be adept at serving children with co-occurring IDD and BH conditions like Henry.

The Benchmark team works with the PRTF staff to build their skills and ability to deliver high-quality, effective care not only for Henry, but also for other children that they may treat in the future.

Our partnership with Benchmark will expand the capacity of the Providers they touch, so that they will be better equipped to serve Members with complex needs.

Roya Health: Expanding Youth BH Services

Molina understands that finding an appropriate placement for youth who require BH stabilization in a residential setting can be difficult due to a lack of Providers. We are expanding access to youth BH through a partnership with Roya Health to support opening a new **pediatric residential treatment center** and help reduce out-of-state placements. They will offer assertive community treatment, High Fidelity Wraparound services, and evidence-based counseling to youth KanCare Members, including those in foster care and those within the IDD population. 100.ks23

With Shauna's consent, Max works with the targeted case manager to collect information from Henry's school. He obtains Henry's Individual Education Plan (IEP) and information about his behaviors and performance, identified unique needs, and any specialized educational programs Henry participates in. This information will inform Henry's longer-term goals as he is reintegrated into the school environment.

Supporting Henry and the PRTF During Treatment. Benchmark continues to support the PRTF staff as they provide treatment to Henry, acting as an extension of the PRTF team to ensure Henry's care is effective and transitions smoothly to the home.

Benchmark's team's approach to wraparound ensures a smooth clinical transition of services necessary to maintain Henry and his family's safety, to prevent behavior regression, and to facilitate continued progress.

While Henry receives treatment in the PRTF, the Benchmark team works to build a foundation of behavior expectations with the family and with the inpatient care staff. First and foremost, the issues in the home guide how issues are handled and addressed in the residential setting.

The behaviors that have been identified (e.g., aggressive behaviors) are reinforced by their consequences, and the family requires training to provide different consequences for these behaviors as well as a dense schedule of reinforcement for engaging in appropriate behaviors.

A comprehensive program of parental training and alignment is necessary to transition the behavioral approaches used in a residential setting to the home environment. This requires fading protocols to more effective responses for the family to reinforce desired behaviors.

Specific activities are planned to mimic the different environments that Henry will be in and the behavioral expectations within those environments. One of the most important aspects of a successful transition is to make sure the family and those in the targeted environments are trained in the behavioral programs shown to be successful in the residential environment.

Benchmark focuses training primarily on Shauna, as she seems to be the target of most of the aggressive episodes. The Benchmark team identifies a robust behavioral incentive program that

can be implemented in the family home to provide a dense level of reinforcement for engaging in appropriate responses, as that level of reinforcement has obviously not been provided in the past.

Discharge Planning for Henry to Return Home

While Henry receives treatment in the PRTF, Max works with Benchmark to align additional resources to ensure Henry's return home can be achieved safely. Max will educate Shauna on the SED Waiver and make the referral to the CCBHC, and as part of the discharge planning, he will set up the appointment with the CCBHC for evaluation for the SED Waiver.

Max coordinates an in-person visit from the CCBHC Provider with the Benchmark team, Henry, and Shauna as part of his discharge planning. This meeting serves to establish Henry's care with a community BH Provider, introduces Shauna to the Provider, and identifies assistance the CCBHC may need to serve Henry's complex needs.

Benchmark will support the CCBHC Providers in making real-time adjustments to programming to prevent future crisis situations, building capacity at the CCBHC to serve Members with high needs.

As Henry makes progress, Benchmark begins to discuss family reunification and his transition back to the home. Benchmark makes recommendations to ensure that discharge planning is tailored to Henry, his mother, and his environment, such as the management of crisis behaviors or environmental modifications.

The internal Molina team starts the approval process for wraparound supports ILOS to begin immediately upon discharge from the PRTF to home until Henry's SED Waiver is approved.

Max and Benchmark collaborate with Shauna, the CCBHC Provider, Henry's school, and other caregivers to support Henry upon discharge. The goal of this partnership is to build the skills and capacity of Henry's treatment team so that they can meet Henry's complex needs.

Benchmark provides the treatment team with additional coaching and performance feedback to ensure plan fidelity upon discharge. They implement a data collection system to monitor progress or barriers to progress, and if interventions appear to be ineffective, Benchmark clinicians update the strategies and adjust Henry's PCSP with additional coaching, crisis support, and therapy as needed.

Max continues collaborating with Shauna, as needed, and as a part of the interdisciplinary team, with a family-driven approach to ensure a strong support system for both Henry and Shauna. Max reinforces Benchmark's behavior coaching and the contents of the Crisis Safety Plan to ensure Shauna is prepared for the possibility of Henry displaying aggressive behaviors.

Max educates Shauna on stress management techniques for herself and how to balance her attention between Henry and her other children. He also addresses caregiver self-management issues. Max provides Shauna with information on additional services and supports she can choose from, described below.

Parent Peers and Support Groups. Shauna has access to parent peer partners with lived experience, a fundamental element of our approach to bolstering caregivers. Parent peers help Shauna with stigma-free, empathetic guidance to help navigate all aspects of caring for Henry.

Max provides Shauna with information about local support groups available for parents of children with IDD. These groups give Shauna additional opportunities for connection with others who may be experiencing similar situations (e.g., CCBHC parent peer support; Keys for Networking, Inc.; NAMI; Families Together, Inc.).

TCARE®. Max refers Shauna to TCARE, an evidence-based family **caregiver burnout prevention solution**. The TCARE program provides Shauna with an assessment and helps her develop a care plan with the assistance of a personal TCARE specialist to address her needs as a caregiver. The care plan includes the use of caregiver supports, such as additional respite hours, support groups, and other caregiver assistance.

If Shauna's needs exceed the TCARE benefit, **Molina extends respite** through our enhanced respite benefits, as needed—available through specialized care coordination services—upon review between Max and Shauna and approval by Molina's Behavioral Health Medical Director.

Psych Hub's Mental Health Ally Platform. This resource offers educational assets, including video and audio podcasts, for family members who want to learn more about mental health and best practices.

Max continues to ensure Shauna is supported as she advocates for herself with the interdisciplinary team and provides her with questions she can ask from a BH condition management perspective to actively participate in Henry's recovery process.

Henry's Discharge from the PRTF to Home

As Henry's return to home approaches, Max works with the targeted case manager and the CCBHC to determine the appropriate community care coordination for Henry at this period in his treatment. Max, the targeted case manager, and Shauna agree to have a CCBHC care coordinator assigned to Henry.

Max and the CCBHC care coordinator meet with Shauna to discuss the role of the CCBHC care coordinator and establish that he will be supporting Henry and Shauna.

Max and the Benchmark team are present and available when Henry is discharged to home. They coordinate multiple visits to the home to ensure successful transition. Shauna will continue to be supported by Benchmark crisis supports, caregiver coaching, and therapy.

Max and the CCBHC care coordinator will convert Henry's PCSP to a CCBHC Care Plan. Benchmark transitions to supporting the CCBHC with Henry's therapeutic services. They also hand off behavior interventions to the school and IEP team.

Benchmark will perform weekly evaluations of needed supports with the CCBHC and will gradually be removed from services as the CCBHC and Shauna feel comfortable with Henry's behaviors and services.

Max and the CCBHC care coordinator facilitate a discharge meeting with Benchmark, the CCBHC, and Shauna to review Henry's current data, the transition plan, and review of Henry's progress. They ensure all parties are aware of their roles.

Max continues his collaborative relationship with Shauna and supports the CCBHC care coordinator in evoking and affirming Shauna's vision for Henry over the long term. Until Henry is approved for the SED Waiver, Max keeps Shauna informed of the referral's status.

Max and the CCBHC care coordinator ensure Shauna is supported through the interdisciplinary team to implement and continue to update Henry's IEP to ensure his success within the school environment. The CCBHC care coordinator helps Shauna develop questions to ask the school, along with school goals to include in Henry's IEP.

Shauna is educated on the importance of planning regarding Henry's condition and developing building blocks to ensure Henry is as independent as possible. The CCBHC care coordinator assures Shauna that she can access a CCBHC crisis stabilization program if Henry displays escalating behaviors. These programs are available to all children in Kansas who are experiencing a crisis.

The CCBHC care coordinator also discuss natural supports for Henry when he is older, such as engaging in a youth peer support group. They provide Shauna with information on family therapy and the importance of engaging the whole family, as this affects Henry, Shauna, and his siblings.

Ongoing Follow-up and Support

Max and the CCBHC care coordinator continue to contact Shauna twice monthly and in person every three months to ensure continued stability. Henry is reassessed with the PedsQL at least quarterly, or more often if there is a change in status, to ensure his CCBHC Care Plan reflects both his progress and any new challenges or barriers to success.

4.3.I.34 Case Scenarios: Alice

34. Alice is a three (3)-year-old, white, female KanCare Member who lives in Holcomb and was referred by her pediatrician to a developmental pediatrician for further assessment. Alice is an only child. She started using words at 16 months of age, but her use of language has regressed. She communicates primarily using hand and body gestures.

In order to provide an opportunity for social engagement, Alice's parents enrolled Alice in day care. Alice attends day care three (3) days out of the week for four (4) hours per day. Contrary to Alice's parents' intentions, daycare staff report Alice isolates from and is unable to effectively communicate with other children and staff. Staff also report Alice engaged in head banging and hand flapping when they tried to engage her in activities.

Alice was assessed by the developmental pediatrician as being at risk for autism. The developmental pediatrician recommends Applied Behavior Analysis (ABA) therapy for Alice, specifically, early intensive behavioral intervention. The developmental pediatrician's office has contacted the bidder's Provider services line to assist with locating a Provider because the coordinator was unable to find an ABA therapist within a reasonable distance from the Member and her family.

Describe the process the bidder will follow to respond to the Provider's call and assist the Member and her family to ensure adequate and timely access to ABA therapy services.

For Alice, Molina will:

- ☑ Respond to Provider's call, & assign Alice's Molina Care Coordinator
- ☑ Alice's Care Coordinator contacts the developmental pediatrician to confirm diagnosis of autism
- ☑ Connect Alice to ABA therapist for intensive behavioral intervention
- ☑ Coordinate any additional therapies for Alice
- ☑ Address SDOH needs (transportation); in-home peer supports
- ☑ Support Alice's family to complete Autism HCBS Waiver application, if appropriate

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In the realm of child development, early intervention plays a crucial role in addressing the concerns of children with developmental delays. At Molina, we understand the significance of timely support and are well-prepared to navigate the challenges posed by wait times and Provider shortages. Our primary goal is to ensure the best possible outcomes for children like Alice and her family, while creating a person-centered Plan of Service that will significantly impact Alice's future development and quality of life. To achieve these goals, we are actively forging relationships with Providers and partners, aiming to facilitate earlier evaluations and interventions for children in need.

Responding to the Provider

Our Provider Services Call Center Representative, trained in active listening, receives a call from Alice's developmental pediatrician and works to fully understand the request. The Provider Services call center team in the State undergoes comprehensive training on covered behavioral health (BH) benefits, including autism spectrum disorder (ASD) awareness. While the representative has the pediatrician's office on the phone, he conducts a search for ABA Providers

in Holcomb, and since he can't find one in the Provider Directory, he commits to researching available options, such as in-home therapy or telehealth therapy provided by a therapist in a nearby community. He explains that a Molina Care Coordinator will call the Provider back with next steps to address the diagnosis and prescribed therapy. The representative reaches out to the Molina Care Coordination Director and explains the developmental pediatrician's request along with providing information on the inability to find an ABA therapist within distance standards. Molina's Care Coordination Director identifies a Molina Care Coordinator in Finney County with experience in child and adolescent cases.

The Care Coordinator, Michael, calls the Provider the next day and confirms Alice has been diagnosed with autism and not just at risk, as previously noted. Additionally, Michael explains to the Provider how Molina has an assigned Network and Contracting representative for the region that includes Holcomb who works to bring additional Providers into the Molina network.

The representative is working on identifying an early intensive behavioral intervention therapist. Michael informs them that both in-home and telehealth ABA services are appropriate options for Alice, and that once a therapist is identified, he will work to secure an appointment for Alice.

Care Coordination for Alice and Her Parents

Michael contacts Alice's parents to introduce himself, explain his role, and establish a comfortable and nonjudgmental environment. Michael actively listens to Alice's parents' concerns and emotions, showing empathy and understanding for the challenges they are facing. Using motivational interviewing, Michael asks Alice's parents to share their observations, worries, and any previous experiences related to Alice's development.

Michael also provides basic information about ASD, education on ABA therapy, and discusses any concerns they may have regarding their daughter's diagnosis. In addition, Michael delves into the specific behaviors Alice is exhibiting and asks Alice's parents to describe when these behaviors began, the frequency, and any patterns or triggers they have noticed, which enables him to gain an understanding of Alice's unique challenges and develop appropriate interventions.

Michael educates Alice's parents on the Autism Waiver, helps them with the application process, and provides necessary assistance to complete the application. Michael collaborates with Alice's parents on goal development and their desired outcomes for Alice's overall well-being. He outlines the next steps of the care planning process, including referrals to alternative therapies. Michael provides his contact information and explains that he serves as their single point of contact. Lastly, he confirms his focus and immediate next step is on finding an ABA Provider as prescribed by the pediatrician and assisting with scheduling therapy. **Alice is enrolled in Level II Care Coordination**.

Ensuring Timely Access to ABA Therapy

Michael helps Alice enter ABA therapy within a reasonable time frame. Michael works with the Provider Services Call Center Representative to locate a therapist at **Kansas Behavior Supports** prior to scheduling the initial appointment. The following options for direct support are provided to Alice's parents.

In-home Therapy with Kansas Behavior Supports. Molina has a letter of intent (LOI) with Kansas Behavior Supports, which provides in-home ABA therapy. They specialize in early intensive behavioral intervention, which has been recommended by Alice's developmental pediatrician. Michael has noticed that they are not listed in the Provider Directory within the appropriate time and distance range for specialists in Holcomb. Since their main office is located in Russell, they were not listed as a Provider for Holcomb. However, Michael confirms that they employ remote therapists who reside in different regions across the State and provide in-home therapy within Alice's specific region. Michael communicates with the Provider Relations Representative who will ensure the Provider Directory now reflects the service locations that can be served by the remote therapists.

Telehealth ABA Services. Through Molina's discussions with advocates, experts, and families, we acknowledge that Telehealth ABA services have gained popularity among parents and children, as it has been recognized as an effective form of therapy and access to in-person ABA services is not as widely and consistently available, as needed. As noted above, Molina has an established LOI with Kansas Behavior Supports, an organization that employs experienced ABA therapists specializing in telehealth ABA services.

If Alice' parents decide to schedule ABA telehealth services, Michael will discuss what to expect, ensuring they know what the limitations will be, the technological specifications required, and the type of involvement they will need to have as parents (compared to in-person ABA services).

Additional Options to Support Alice and Her Family

Goals for Alice

What Alice's family would like to achieve:

- ☑ I want her to be able to communicate with us.
- ☑ I want her to stop head banging & flapping her hands.
- ☑ I want her to be social with others & engaged in activities.
- ☑ I want her to live a normal, happy life.
- ☑ I want her to do well in school even with her challenges.
- ☑ I want to know how I can better support her.

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Ongoing Care and Support

To provide comprehensive care for Alice, Michael ensures that her parents are aware of the various services and supports available to them. In addition to receiving ABA therapy, Michael shares additional services and supports, which can include occupational therapy, speech therapy, school assistance through the development of an Individual Education Plan, exploration and enrollment in additional waiver programs, family support, and participation in peer support groups.

Occupational Therapy. Michael shares with Alice's parents that occupational therapy can address her sensory processing issues, motor skills, and daily living activities along with addressing the headbanging and hand-flapping.

Speech Therapy. Due to Alice's communication regression, Michael educates Alice's parents on how speech therapy can assist Alice in developing her speech, language, and social skills, using various techniques to improve her communication abilities.

School Assistance. Michael presents two school options, **Russell Child Development Center** or **Garfield Early Childhood Center**, both of which are located in Garden City within a 15-minute drive of Holcomb, are equipped to support children like Alice, and employ specialized staff who can better meet her needs.

In addition to qualified staff, these schools also create accommodations that foster an optimal learning environment for children who may require additional attention in the classroom. Michael provides education and resources on how to navigate positive relationships with the school-based team, what to expect when meeting with the team during the development of an Individual Education Plan, assists with required medical documentation showing Alice's specific needs, and generates letters of support for any concerns in the school environment. He also offers to attend meetings with the school, serving as an advocate and providing support.

Additional Waiver Exploration and Enrollment. Once Alice turns 5 years old, she will be removed from the Autism Waiver if she is approved. Michael educates Alice's parents on the IDD Waiver and works to identify whether she will qualify. If Alice qualifies for the IDD Waiver, Michael assists Alice's parents with the application process, as needed.

[redacted]

[redacted]

Michael also provides Alice's parents with information on the **Kansas Family Support Center.** This center provides **training and services for caregiver support** and professionals who **serve children with IDD, ASD, or other behavioral support needs**. One offering is OASIS training, which includes an online introduction to ASD and behavioral treatment. This training covers the general understanding of ABA and consists of 10 online modules and pre-/post-tests. This is a self-paced training designed to be completed within six months. Alice's parents receive a supporting parent handbook in the mail.

The goal is to introduce autism and behavioral treatment, measuring and recording data, principles of behavior, and stimulus control; conduct teaching sessions; determine the function of behavior; and decrease behaviors using antecedent strategies and consequences, team meetings, and wraparound services.

Other Resources. Michael provides resources to keep Alice's parents connected, such as the **SDOH platform**, which connects them to local community-based organizations. Additionally, he educates Alice's parents on the **Parents as Teachers program**, a home visiting program that supports families of children with developmental disabilities from prenatal to kindergarten age. This program helps Alice's parents increase their knowledge of early childhood development, detect developmental delays early on, and prepare her for school. It also affords them an opportunity to connect with other parents facing similar challenges.

Follow-up

Ongoing evaluation and Plan of Service updates are essential components to ensure Alice's progress and address her evolving needs. Understanding that individuals with developmental delays have varying degrees of impairment, evaluating the effectiveness of treatment is difficult and outcomes differ, particularly over time.

Treatment and therapies vary based upon the severity of Alice's condition. Michael continues to partner with Alice's parents to complete routine wellness checks, while her PCP assesses whether Alice's treatments are meeting her needs, adjusting them as necessary. Throughout Alice's ABA treatment program, Michael reviews and monitors her treatment outcomes.

By continuously evaluating and updating Alice's Plan of Service, her interdisciplinary team ensures her needs are met, her progress is monitored, and appropriate adjustments are made to optimize her development and overall well-being. Michael will follow-up with Alice's parents at least monthly with a minimum in-person visit every three months.

4.3.I.35 Case Scenarios: Ernest

35. Ernest is a senior executive with a hospital in a Rural area of the State. He reaches out to the bidder's Provider services call center seeking to find someone to speak to at an appropriate level in the MCO who will "take this situation seriously" and "has the authority to do something to try to fix this." Ernest explains that, as a Rural hospital, the ED provides a particularly important service for the community and surrounding area. The ED has, however, been struggling with the challenge of KanCare Members who present at the ED with significant psychiatric issues and who end up staying in the hospital's ED for extended periods because of a lack of available and suitable discharge options for them.

Ernest reminds your Provider services representative that the ED is small and that as a Rural area, the community heavily depends on being able to access ED services. He shares that providing "psychiatric boarding" in the ED for these Members is problematic for many reasons, including: the loss of available treatment space; the challenges presented to his staff, who are not trained to provide psychiatric care; Members' agitation and other disruptive behaviors that escalate as the ED stay lengthens; and the effect of the Members' behaviors on other ED patients.

Ernest states that he is concerned about the ED's ability to continue to ensure access to other patients in need of ED services, and that his staff, already under significant strain, may begin to leave hospital employment. Additionally, Ernest shares his concern that KanCare Members with psychiatric conditions do not have appropriate discharge options. Ernest says that while he recognizes this problem is not just limited to the bidder's MCO, your MCO is a contributor to the issue. Earnest wants to speak to the "right person" to understand what the bidder will do to address his concerns.

Describe how the bidder will route and handle the call from Ernest, and the bidder's approach to addressing the Provider's concerns.

For Ernest, Molina will:

- ☑ Rapidly respond to and engage with Ernest to address issues
- ☑ Collaborate to discharge patients with behavioral health (BH) issues in Mercy Hospital's emergency department (ED) appropriately and reduce future unnecessary visits
- ☑ Convene stakeholders to address systemic issues across the region

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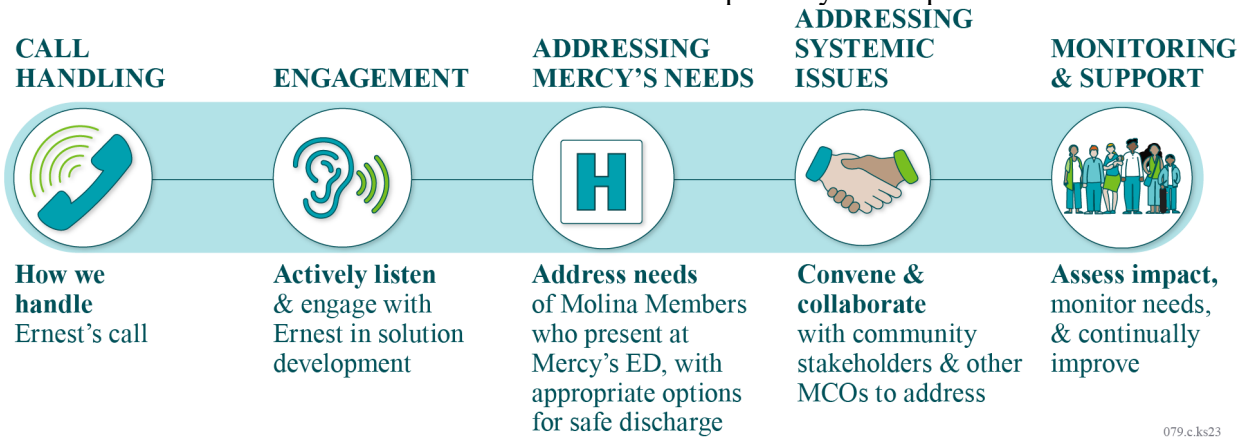
How We Will Address Ernest's Concerns

Molina is committed to ensuring a positive Provider experience, and when one of our valued network partners expresses frustration, we take it very seriously and address the matter quickly. We will address and respond to Ernest's concerns in five stages, as outlined in **Exhibit 35-1**.

Exhibit 35-1. Steps in Addressing Ernest's Concerns. Molina engages and immediately addresses Provider issues and works to improve systemic problems.



How Molina Handles Ernest's Call

Extended Hours for Our Provider Services Call Center
Molina's Provider services call center strives to be available to its Providers as much as possible. Our Provider services call center hours are **extended** and available from 7:00 a.m. to 6:00 p.m. central time.
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Molina's Provider Services Call Center Representative receives a call from Ernest, a valued partner at Mercy Hospital in rural Moundridge, Kansas. Ernest expresses frustration and seeks to find someone at Molina who can "take this situation seriously" and "has authority to do something to try to fix this." Our call center representative, trained in active listening, acknowledges Ernest's frustrations and remains calm, focusing on understanding his concerns.

The Provider Services Call Center Representative uses Molina's assignment matrix tool to identify Ernest's assigned **Hospital Provider Representative, Maya**. The representative provides Ernest with her contact information and asks if he would like to be transferred to her. Ernest also has on-demand access to the assignment matrix tool via the Provider portal and Provider website. Ernest agrees to speak to Maya and restates his dissatisfaction and concern. The representative warm-transfers Ernest's call to Maya's direct line.

Exceptional Performance: Speed to Answer
Molina's Provider Services Call Center Representatives' average speed to answer, year-to-date, is 14 seconds, significantly exceeding the contractual requirement of having 90% of calls answered within 30 seconds.
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Maya, who has experience supporting the unique requirements and complex needs of rural hospitals, is the assigned Hospital Provider Representative for Ernest and Mercy. Maya empathetically acknowledges Ernest's frustrations. Ernest shares more details regarding his experience with other MCOs and his disappointment with the absence of viable solutions and collaborative efforts. Maya illustrates to Ernest her understanding of the concerns and agrees with him that the issue is larger than Molina Members using the ED. She explains that Molina has created an escalation path to raise issues with senior leaders. She informs him that she will promptly reach out for direction and will call back by the end of the day with next steps to address his concerns. Ernest acknowledges the plan.

Molina's escalation path includes Provider Relations leadership, Medical Directors, Operations leaders, and Plan President and CEO, Aaron Dunkel. Aaron regularly holds meetings with

Provider Representatives and employs an open-door policy that facilitates direct access to raise individual or trending Provider concerns. Understanding the urgency of this issue, Maya immediately informs Aaron of Ernest's concerns, and Aaron promptly gathers the Molina Leadership team to collaborate on next steps.

Before the end of the day, Maya calls Ernest back and schedules time for Ernest to meet via telephone with the Molina Leadership team the following day. Aaron, the BH Medical Officer/Medical Director (BH-CMO), and the Provider Relations Director will attend the meeting.

Provider Engagement

The following day, on the call, Aaron expresses his sincere appreciation for Ernest's feedback, emphasizing the value we place on his time and partnership in collaboratively addressing his concerns. The Molina Leadership team empathizes with Ernest and with the hospital's frustrations. They discuss the challenges and barriers faced by Mercy, such as the lack of Providers to whom they can safely discharge Members with significant psychiatric issues, inadequate transportation options for Members, and a limited number of social supports. Together, they commit to creating both a short-term plan for Molina Members who enter the ED and a long-term solution, including dialogue with other MCOs, as well as key stakeholders and partners in the system of care. At the close of the call, they schedule a future in-person meeting at Mercy, and Aaron provides Ernest with his contact information, ensuring that Ernest has direct access to discuss concerns in the future.

What Ernest would like to achieve:

- ☑ I want to protect access to the ED for people who need it.
- ☑ I need to reduce the burden on my ED staff from patients with psychiatric issues.

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Addressing Mercy's Short-term Needs

Aaron, the BH-CMO, the Provider Relations Director, and Maya travel to Moundridge to convene a meeting with Ernest and other Mercy staff, including ED leadership, the hospital's discharge planning team, and others of Ernest's choosing, at their earliest convenience. During this meeting, they discuss in further detail the situation Ernest faces regarding Medicaid patients in the ED who need an appropriate and safe option for discharge to BH services. While the group acknowledges that much of the issue is systemic in nature and will likely require convening community stakeholders to develop longer-term solutions and expand the continuum of BH care in the region, they can develop the following short-term solutions to address provision of discharge options for Members with BH issues in Mercy's ED and decrease the number of Members inappropriately presenting at the ED.

Addressing Discharge Options for Molina Members in the ED

Molina's approach to discharge options includes the following solutions:

- Molina agrees to assign a dedicated Molina Care Coordinator who has experience in BH and will perform weekly rounds at the hospital to help initiate on-site care coordination for

Members served by Molina. Ernest and his team will work with this person to determine optimal times and frequency for these rounds.

- Ernest and his team agree that Mercy staff will promptly notify the dedicated Molina Care Coordinator of any Molina Member who presents at the ED with symptoms indicating a BH crisis, so the Care Coordinator can reach out as soon as possible to start planning needed follow-up care for a safe and appropriate discharge to a more suitable setting. Either the Molina Care Coordinator or, if they are unavailable, Molina's Utilization Management Discharge Planner assigned to the hospital will be available to confer with the local CCBHC for evaluation of the Member for more appropriate inpatient or outpatient BH treatment.

- Molina and Mercy will engage in biweekly clinical Joint Operating Committee meetings to address the use of the ED by Molina Members, identifying those who use the ED frequently; discuss needed supports to connect Members with resources and solutions; communicate any changes to workflows or points of contact; and ensure coordinated discharge planning and connection to treatment and support resources are established and sufficient for follow-up care. We will encourage and partner with CCBHC clinical leaders and CCBHC care coordinators to participate in the hospital Joint Operating Committees, as appropriate, to connect Members to care and educate Mercy about the current capabilities of the local crisis system.

- Molina's Care Coordinator will connect with and support CCBHC care coordinators for follow-up after ED utilization and screening/assessment for private or State psychiatric inpatient hospital admission or outpatient BH treatment. Mercy staff can leverage crisis system resources, such as local CCBHC Prairie View in Newton, and educate their patients at discharge and can also provide information about 988 and the Molina Member Crisis Line.

- Molina's Provider Relations staff will commit to more frequent meetings, including with the CCBHC care coordinator, to assess the impact of these interventions and continue to monitor any concerns for Members and staff at Mercy.

Diverting Members with BH Needs to More Appropriate Settings

Molina's approach to diverting Members to more appropriate settings includes the following solutions:

- At the meeting, Molina shares statistics about Members who repeatedly use the ED for BH services. Aaron and his team commit to ongoing outreach to and education for these Members and their Providers, so they can plan for intervention before the Members' conditions escalate to future ED visits.

- They also discuss deploying **Molina's ED Diversion program** in Moundridge to proactively address having Molina Members frequent the ED, with a key focus on Members presenting with BH issues and BH care coordination needs. Molina's ED Diversion program focuses on connecting Members to a CCBHC or PCP and educating Members on seeking the appropriate level of care to meet their health needs. Additionally, the program identifies and addresses SDOH needs and addresses structural or systemic barriers to care.

- Molina agrees to conduct a Member and Provider education campaign that will educate BH Providers, PCPs, and Members on the availability of Molina BH telehealth and the Member

Crisis Line, available to Members 24/7/365 to help with crisis prevention and early intervention. In some cases, this intervention may prevent a crisis from escalating to a higher level of care.

Molina's leaders and Ernest discuss the necessary steps and attendees for a community stakeholder meeting in Moundridge to collaborate across the region to develop longer-term, more systemic solutions for all KanCare Members. They also establish the first date for the Joint Operating Committee meeting and the frequency for follow-up meetings, and identify the attendees and modality (e.g., in person or via video). At the end of the meeting, Maya confirms the next steps in addressing Ernest's concerns.

Developing Long-term Solutions to Systemic Issues with MCOs and Community Stakeholders

Identified Stakeholders
- Other MCOs
- CCBHCs
- City and county law enforcement agencies
- Representatives from NAMI Kansas
- The community's leading human service providers, including those with housing insecurity experience

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Aaron commits to convening the collaborative meeting with other MCOs, Providers, and community stakeholders (State stakeholders, law enforcement, community-based organizations [CBOs], colleges/universities, and nonprofit organizations) in the region to discuss longer-term, more systemic solutions for KanCare Members experiencing BH issues. He and his team reach out to and meet with stakeholders and other MCO executives to discuss the issue and gain their support and commitment to attend. Aaron and his team also communicate with the group to reach consensus on a meeting date, time, and location. Molina and Mercy offer to jointly host the first meeting.

At the meeting, held at a local venue in Moundridge, Aaron and Ernest invite stakeholders to engage in meaningful discussions about the systemic problems of capacity and access to the BH continuum of care in their region and the need for more effective collaboration and integration between physical health and BH Providers and services. As a group, they identify shared obstacles, underlying challenges (such as housing insecurity and other SDOH issues), and opportunities for enhanced collaboration.

By working together, these stakeholders not only address Ernest's specific concerns regarding KanCare Members' behaviors but also consider issues that substantially impact the entire community, showing their commitment to the greater well-being of Moundridge.

Together, the stakeholders identify the following opportunities to address Ernest's concerns:

- **Improve care coordination referrals and workflows.** Work across MCOs and Providers to enhance access to available resources. The teams carefully evaluate integrations with Kansas' HIEs and effective methods to integrate with MCO resources, facilitating easy and direct access and guaranteeing a smooth and efficient experience for both Providers and Members.

- **Trainings for ED staff, PCPs, and law enforcement.** Plan trainings in areas such as recognizing psychiatric symptoms, employing de-escalation techniques, and establishing safe environments when needed. Trainings will be coordinated through partnerships with State universities, the Crisis Prevention Institute, and SAMHSA. Additionally, technical assistance will be secured through the Mental Health Technology Transfer Center. The center will also

offer training and resources for workforce support on secondary trauma and community resources for staff.

- **Rural Hospital Innovation Grant.** Provide writing assistance for the grant, which could be used to help cover Mercy and other hospitals' costs for implementing enhancements to strengthen, improve, and increase access to healthcare services. Grant funds may be used for acquiring and implementing new technological tools, improving telehealth resources that may provide psychiatric services**,** and providing training to support the psychiatric needs of patients presenting at the ED. Additionally, Aaron notes the potential for matching grant funds with Molina's community reinvestment dollars, which may be used to help hire staff who are specifically trained to support psychiatric patients.

- **Crisis Intervention Team program.** Partner to deploy a program with local hospitals, law enforcement agencies, and BH partners, which has already been launched across the State in eight regions. [redacted]

- **Expand CCBHC capacity to offer crisis services.** Work to expand CCBHCs to offer such solutions as a mobile crisis team and "no wrong door" crisis receiving center, [redacted] Molina would lead the way by committing to leverage a best practice from another affiliate health plan. This approach deploys our BH Practice Optimization Team to work directly with BH Providers. The team has clinical leads who have deep knowledge of CCBHCs, crisis intervention best practices, and data analytic knowledge.

  We would convene a workgroup with local CCBHC leadership and enlist technical assistance from the State and the Association of Community Mental Health Centers of Kansas. Value-based payments, a focus on quality of care, and practice optimizations would support seamless integration of these crisis resources, providing crucial assistance and enhancing the continuum of care for Members among all MCOs within the community. Molina would assist in educating Mercy's team, stakeholders, CBOs, and the local Provider community on the crisis services as an added resource.

- **Housing and homeless continuum of care collaboration.** Collaborate with those working in the housing and homeless continuum of care. This effort would use established relationships with local CBOs, such as **New Hope Shelter, Inc.,** in Newton. It would also enhance referral pathways and follow-ups for Members accessing coordinated entry points in McPherson County and the broader Wichita region.

- [redacted]

Molina will also apply our learnings in the Moundridge area to other rural communities within Kansas, ensuring that we share successful lessons learned within the region to promote Member health while providing a positive Provider experience across Kansas.

Molina is committed to ongoing community investment. Our focus is not only on financial contributions but also on identification of emerging gaps within the community and collective work toward solutions. No one MCO, Provider, CBO, or other stakeholder can solve a system-wide issue. Our commitment extends beyond offering one-off solutions to working with others in the development of comprehensive support to address and bridge these identified gaps, ensuring a holistic approach to population-level improvements. Through continuous assessment, collaboration, and action, we will contribute meaningfully to the well-being and growth of the community we serve.

Long-term Monitoring and Support

Molina is dedicated to nurturing enduring partnerships with local organizations in Moundridge and in rural and frontier Kansas. Engaging our BH Practice Optimization team, we commit to collaborating with Providers and the State and assessing the impact of our efforts.

To this end, we will:

- Review crisis utilization and ED visits, seeking tangible improvements in upstream utilization of outpatient care, lower utilization of higher levels of care, lowered number of days in the ED after stabilization, increased engagement in crisis services, improvements in measures for follow-up care, and improvements in functional outcomes for Members and in their recovery—all resulting from our concerted efforts with Mercy and CCBHCs
- Maintain regular Joint Operating Committee meetings, fostering open and ongoing dialogue to measure progress and quickly identify and address any new challenges that may arise
- Analyze Member-related workflows to determine ways we can enhance the Member experience
- Review the efforts associated with and outcomes of our community reinvestment dollars, evaluating their alignment with the agreed-upon goals
- Support any additional improvements identified through these efforts

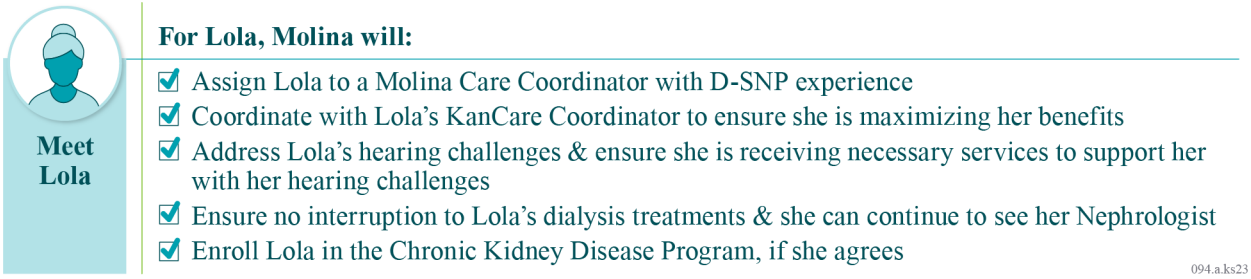
In our ongoing commitment to Ernest and the Mercy team, as well as the well-being of KanCare Members in Moundridge and across the State, Molina remains a steadfast partner. We understand that true support must include dedicated investment of resources and time.

Recognizing that success is strongly linked to community support and collaboration, Molina works with Providers, community leaders, other stakeholders, and State agency officials overseeing these critical programs.

4.3.I.36 Case Scenarios: Lola

36. Lola is a black female KanCare Member who just turned sixty-five (65) years of age and enrolled in the bidder's dual eligible special needs plan (D-SNP). She lives by herself in Abilene. Lola has high blood pressure and kidney disease. She receives dialysis twice a week and requires Transportation to access care because she does not have a vehicle. Lola has a difficult time hearing, making it difficult for her to communicate on the phone, schedule appointments and Transportation, and understand treatment recommendations from her Providers. While Lola's Primary Care and dialysis Providers are in the bidder's D-SNP network, her Nephrologist is not.

Describe the bidder's approach to meeting Lola's needs.



Lola, a recently enrolled Member in Molina's D-SNP who lives in Abilene, Kansas, receives her Medicaid services through a separate health plan. At Molina, we take pride in serving as Lola's primary health plan and taking charge of managing her acute care and care coordination needs. We understand Lola's other Medicaid plan covers acute benefits beyond Medicare coverage limits, as well as behavioral health (BH) and LTSS if she meets the qualifications. To truly meet Lola's unique care needs, our approach involves close collaboration with her Medicaid plan. Together, we ensure Lola maximizes her benefits and receives the personalized care and unwavering support she deserves to achieve her overall well-being. (If Lola was an aligned D-SNP Member, she would receive a singular care coordination experience from our aligned Medicare-Medicaid care coordination approach.)

Care Coordinator Assignment Upon Enrollment

Upon Lola's enrollment in our D-SNP, a Molina Care Coordination Supervisor assigns **Mark, a Molina Care Coordinator** with D-SNP experience who resides in Lola's area and brings experience in treating complex conditions including dialysis. Mark reviews Lola's medical records and utilization history, including her usage of a nephrologist outside our network, and gathers the contact information on the KanCare coordinator, so he may speak with him regarding Lola's needs.

Mark contacts the KanCare coordinator, introduces himself, and exchanges contact information. During this phone call, he and the KanCare coordinator discuss pertinent information about Lola, including her medical history, specific healthcare needs, and any existing Plans of Service. The KanCare coordinator confirms Lola does not have a community care coordinator and shares information on natural supports, preferred interdisciplinary team members, and NEMT and other Medicaid value-added benefits Lola is using or may find helpful. Additionally, the KanCare

coordinator informs Mark that Lola is assessed for **Care Coordination Level II** for healthcare-related needs and services. The KanCare coordinator also shares with Mark that Lola is hard of hearing and experiences difficulty communicating over the phone, making in-person interaction the best way to communicate with Lola.

Mark and the KanCare coordinator agree that the ultimate goal is to help Lola maximize the benefits offered to her. Given Lola's complex needs and hearing loss, the KanCare coordinator agrees to have Mark attend Lola's next in-person monthly visit, which is scheduled 10 days from this phone call. This collaborative approach enables both care coordinators to work together, leveraging their expertise and resources to provide Lola with comprehensive and coordinated care.

Prior to the in-person visit with Lola, Mark contacts Lola's PCP and other Providers to confirm information in her personal care record (e.g., most recent visits, upcoming visits, completed wellness activities, and recent screenings for fall risk, social isolation, loneliness, depression, and hearing). Mark also asks the PCP whether Lola's hearing loss has resulted in a referral to an audiologist or speech and language pathologist for testing and treatment, which may be helpful to address Lola's communication needs. Additionally, Mark confirms medications prescribed for Lola and asks about medical nutrition therapies, the potential for food insecurity, social needs, and any additional referrals, as needed.

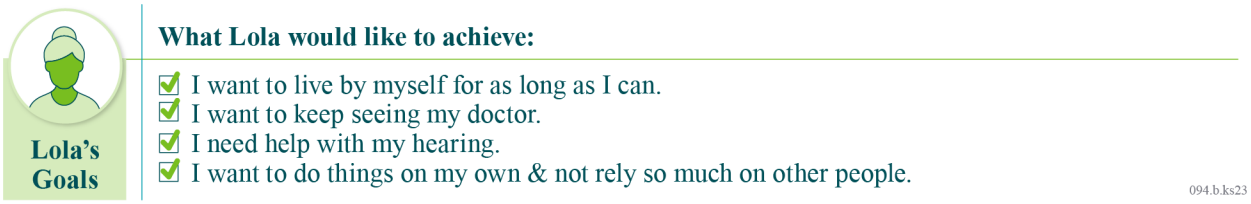
In-person Visit with Lola

Mark attends Lola's in-person meeting with the KanCare coordinator. He introduces himself to Lola and shares his primary objective to discuss and strategize ways to maximize her benefits while achieving her healthcare goals. He assesses her healthcare needs, preferences, and eligibility for various services and resources while observing her in her home environment. Additionally, he reviews her medical history, including her high blood pressure and dialysis, current medications, and treatments, and gains an understanding from Lola about her care needs and preferences.

Lola confirms her recent visit with her PCP after transitioning to Molina's D-SNP and reported completion of wellness activities, including receiving the flu and pneumonia shot and coordination of a mammogram screening. Mark also asks about her social support network, current transportation services (and whether she is encountering any issues), and any other services she may be using that are not noted in the care record review. Mark also assesses Lola's BH and emotional health, along with any other challenges or stressors that may be affecting her overall well-being.

The KanCare coordinator and Mark explain to Lola her current Medicare and Medicaid coverage. Mark asks Lola to explain why she chose the Molina D-SNP and whether there are specific benefits that caught her interest during the selection process. Mark reviews the specific benefits offered by Molina's D-SNP, such as hearing aids; assistive listening systems; patch cords; captioned telephone systems; transportation; Chronic Kidney Disease program; wellness activities (e.g., flu and pneumonia shots); MTM program; social isolation support; home safety devices (e.g., personal emergency response systems, grab bars, toilet seat risers, carbon monoxide and smoke detectors with visual alerts); and more.

Mark explains to Lola he will serve as her primary point of contact moving forward and that the KanCare coordinator will continue to collaborate to address Lola's ongoing needs. Mark shares with Lola that he and the KanCare coordinator will work together, with the goals of enhancing her access to necessary services, improving her health outcomes, and optimizing her overall well-being. He provides her with his contact information and shares that he will continue meeting with her in person monthly.



Care Planning and Coordination

Based upon the assessment findings, Mark, the KanCare coordinator, and Lola collaborate to develop a Plan of Service that is tailored to meet her specific needs. They discuss strategies to maximize her benefits while addressing her hearing difficulty and continuation of ongoing dialysis treatments.

Hearing. Mark and the KanCare coordinator discuss with Lola her hearing challenges and how others in similar experiences address hearing needs. Lola learns that exams and hearing aids are covered as value-added benefits. Mark provides Lola with the names of in-network audiologists with her Molina D-SNP and explains he will assist her in scheduling an appointment and transportation to the Provider she chooses. Additionally, Mark informs Lola of benefits and services that may be available and are important to discuss with the audiologist or her PCP, such as **assistive listening systems, including patch cords to plug in directly to a personal assistive listening device; captioned telephone systems; and/or telephone amplification systems.**

Continuation of Care. Mark and the KanCare coordinator also focus on Lola's dialysis needs and develop a plan around continuing to ensure Lola can remain with her nephrologist. Mark calls Lola's dialysis center to discuss Lola's D-SNP coverage to confirm they are aware that her treatment schedule is unchanged and ensure there is no interruption to her care. Mark also sends a referral to Molina's Network and Contracting team to begin the process of direct contracting with Lola's out-of-network nephrologist or facilitating a single case agreement. Meanwhile, Lola continues to visit her Provider based on Molina's continuity of care policy. Mark informs Lola that he has notified her Providers of the insurance change and has proactively initiated a request to help her nephrologist join our network, ensuring Lola's seamless continuation of visits.

Transportation. Lola expressed a desire to live independently for as long as possible and wishes to maintain some level of independence, regardless of her health challenges. Mark explains to Lola that in addition to transportation covered by her Medicaid plan, her D-SNP **supplemental benefits provide 60 1-way rides for her NEMT needs**.

To help her achieve a goal of independence, Mark educates Lola on which transportation service to use to best maximize her D-SNP and KanCare program transportation benefits and explains he can always help her, when needed.

If a situation arises where back-up transportation is required, Mark educates Lola on **GoAbilene** public transportation and how to schedule transportation through their services, and shows her how Members can schedule transportation directly through our transportation vendor-managed mobile app or website or using single-sign on through the My Molina app or the Member portal. He also explains to Lola that Molina provides mileage reimbursement when transportation is provided by a friend or family member when attending Medicaid-covered appointments.

Kidney Support. Mark and Lola discuss her kidney disease, treatments, diet, and medications. Mark tells Lola about Molina's specialized Chronic Kidney Disease program. He explains she can access clinical-level case managers who specialize in kidney disease, have relationships within Lola's community, and can provide alternative supports, should they arise.

If Lola agrees to enroll in the Chronic Kidney Disease program, Mark makes the referral to the program and helps to coordinate the in-person visit with a nurse practitioner. If Lola does not agree to enroll in the program, she continues to receive regular care coordination, and her nephrologist will continue to manage her kidney disease needs.

Blood Pressure. To address Lola's high blood pressure, Mark and the KanCare coordinator review her current treatment plan, including medications and lifestyle modifications, and assess its effectiveness. They discuss and identify support services to optimize her blood pressure management along with the need to provide education to Lola on the importance of routine blood pressure monitoring and self-care.

Nutrition. As Mark and Lola discuss her dietary needs and ability to obtain food, he confirms whether she has previously seen a dietitian at the dialysis center and lets Lola know that she also can connect with a registered dietitian through her Molina D-SNP. If Lola wishes to visit a dietitian to support her needs, Mark helps to coordinate a referral to the dietitian and ensures an appointment is scheduled for her.

Mark also emphasizes to Lola that Molina is committed to supporting access to food that is necessary to help her manage her health conditions and shares the options available. Through Molina, Lola can access a **food and produce allowance, a value-added benefit,** and she has the option to access food from **The Cedar House Food Bank in Abilene.**

Medications. Mark and the KanCare coordinator discuss Lola's upcoming appointments with her Providers, and the status of her medications. Mark confirms medications for Lola's high blood pressure and kidney disease, explores any challenges for her to obtain and take medications, and asks her about additional health conditions.

Mark collaborates with a local pharmacy, **Harvey Drug Abilene**, and a Molina Community Health Worker (Molina CHW) to deliver Lola's medications to her home every 90 days. Mark also partners with Harvey Drug Abilene to address polypharmacy and potential unintended

consequences of medications, and to assess for factors impacting Lola's quality of life, such as an increased fall risk.

Specialized Needs Assessments. Because Mark knows that Lola lives alone, he screens her for social isolation and loneliness. If the screening results in positive identification, Mark follows up with a depression screening. Recognizing the impact of loneliness and depression, Mark explores with Lola her interest in community engagement and integration options.

Community Engagement. Mark and Lola discuss daily activities at **Abilene Senior Center,** and she relays that her neighbors and friends attend regularly. The two discuss Lola's preferences to ride with her friends and neighbors, and that if there is ever a need, she will use her Medicare supplemental transportation benefit or public transportation services that Mark previously explained to her.

Home Safety. Mark provides Lola with information on various safety measures to enhance her well-being if she continues to prefer to live alone. They cover topics such as personal emergency response systems, grab bars, and toilet seat risers, as well as carbon monoxide and smoke detectors equipped with visual alerts, to ensure Lola is well-informed and secure in her living environment. Should Lola express interest in any of these measures, Mark promptly initiates a touch point with the KanCare coordinator and the Molina CHW to identify any KanCare supplemental benefits. Mark and the Molina CHW will coordinate with community-based partners on any additional needs.

Ongoing Follow-up and Support

Ongoing follow-up and support are paramount to ensuring Lola's Plan of Service continuously meets her ongoing needs and preferences. Mark coordinates monthly check-ins with the KanCare coordinator and Lola to monitor her progress and address any concerns or challenges she may face. He maintains open lines of communication with her healthcare Providers, including her PCP, nephrologist, and audiologist, to ensure he remains updated on her medical status and coordinates any adjustments to her care plan.

Mark continues to support Lola in accessing audiology services and obtaining any necessary assistive devices. He also continues to provide education and resources to help her adapt to her hearing loss and improve communication in her daily life. Mark and the KanCare coordinator encourage Lola to remain an active participant in her own care and self-management. They provide her with educational materials, support groups, and other resources to empower her to take control of her health and well-being.

By maintaining ongoing follow-up and support, Mark and the KanCare coordinator continue to advocate for Lola's needs, coordinate her care, and ensure she receives the necessary services to manage her hearing loss, high blood pressure, dialysis needs, and transportation requirements effectively. Through their collaborative efforts, Lola receives comprehensive and personalized care, resulting in improved health outcomes and an enhanced quality of life.

4.3.I.37 Case Scenarios: Jason

37. Jason is a twenty-eight (28)-year-old, male, American Indian who is currently living with his family on the Potawatomi Indian Reservation, but intermittently moves off and on the Reservation. The bidder has just been notified of Jason's Enrollment in the bidder's MCO. Not only is Jason a new KanCare Member, he is also new to managed care.

Jason moved home after he was evicted from his apartment in Topeka for non-payment of rent. He has been unable to maintain ongoing employment due to inconsistent attendance.

Prior to Enrollment with the bidder, Jason was recently seen at a nearby non-participating Indian health care Provider (IHCP) where he was diagnosed with type 2 diabetes. Jason has a Hemoglobin A1C of 8.76 and has a history of binge drinking since age sixteen (16). He said he drinks when he is depressed and that his drinking and depression have created problems for his maintaining work and in his relationship with his family and friends. The nurse practitioner at the IHCP prescribed Metformin, recommended Jason consider participating in a special diabetes program offered through the Tribe, and provided Jason with a referral to a non-participating Provider for a Behavioral Health assessment and treatment. Jason has not followed up on either the recommendation or the referral.

Describe how the bidder will identify the needs of this KanCare Member, the bidder's approach to meeting the needs of the Member, and how the bidder will coordinate the Member's care.

Meet Jason

For Jason, Molina will:

- ☑ Reengage in treatment
- ☑ Educate, encourage, & engage Jason to help ensure he makes informed decisions on care options
- ☑ Coordinate & integrate care among IHCP & MCO Providers
- ☑ Help Jason select a preferred Provider while ensuring coordination & integration (e.g., IHCP, non-IHCP), as appropriate
- ☑ Promote & support recovery
- ☑ Address housing & SDOH needs

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Engaging Jason

We receive Jason's enrollment through the 834 enrollment file and complete a new Member Welcome Call within 48 hours. Using a best practice from our Medicaid affiliates, we identify Members' tribal affiliation through the 834 file and document the status in our care coordination portal. We use this information to assign Jason's Welcome Call to a **Molina Community Health Representative (CHR)**. Molina actively recruits and hires CHRs from tribal communities to ensure our Care Coordination teams comprise diverse cultural representation from the State. CHRs play a critical role in promoting cultural confidence among the Members we serve. They are specially trained to support individuals in understanding and using health-related information and services that align with their cultural background. These representatives are well-versed in navigating the often-disconnected health systems that serve American Indians, ensuring Members are afforded the knowledge and resources necessary to make informed decisions about their healthcare. Our CHRs are distinguished by their close understanding and connection to

American Indian communities. As trusted members of these communities, they are uniquely qualified to serve and engage with tribal Members. In addition to conducting outreach and engagement activities, including in-person meetings, when necessary, these representatives work alongside Molina's Care Coordinators to address the specific needs and preferences of tribal Members.

The collaboration between our CHR and the Molina Care Coordinator is essential to ensuring the overall well-being of Members. They work in tandem to provide the necessary support, whether it's coordinating transportation, scheduling appointments, or connecting Members with community resources. Together, they empower tribal Members to achieve their healthcare goals necessary to live healthier lives. Our CHRs and Molina Care Coordinator strive to bridge the gaps in healthcare access and provide comprehensive support to tribal Members.

Our CHR calls Jason to confirm his address and communication preferences. The CHR conducts an initial Health Screen, and based upon his score and responses, along with the referral to an out-of-network behavioral health (BH) Provider, the CHR details the ways in which Molina can help Jason achieve his healthcare goals, access services, and partner to address his holistic physical health, BH, and psychosocial needs. The CHR explains Molina's Care Coordination program and informs Jason he will be **assigned to a Care Coordinator, Milton**, who will help the CHR coordinate and support his care. Additionally, the CHR informs Jason about a local CCBHC, Valeo Behavioral Health, which can conduct the BH screening and discuss with Jason any concerns about his alcohol use. Jason agrees to use the CCBHC services, and as an adult member with behavioral health needs, he's enrolled in CCBHC with MCO Care Coordination model.

The CHR asks Jason if he is interested in meeting with the CHR, Milton, and the CCBHC care coordinator to discuss his needs and concerns, as well as determine his desire, or lack of desire, to enroll in ongoing services through the CCBHC. Jason agrees, and the in-person assessment is scheduled to occur at his parents' home on the Prairie Band Potawatomi Nation in five days.

Identifying Jason's Needs

Milton, our CHR, and the CCBHC care coordinator meet with Jason **in person.** The CCBHC care coordinator explains his role and educates Jason on the benefits of accessing BH services at the local CCBHC. Additionally, the CCBHC care coordinator asks Jason **what is important to him, what are his immediate and long-term goals, and what makes it difficult to achieve those goals.** He seeks to understand Jason's reasons for not following up with prior treatment recommendations, his preferences for Providers (i.e., I/T/U, non-I/T/U), and his SDOH needs and barriers. Milton and the CHR are supportive voices for Jason and encourage him to respond at his own pace, while allowing Jason to dictate the speed and progress of the conversation. The CCBHC care coordinator follows Jason's lead to ensure the process is conversational and affirms Jason's preferences and priorities.

Assessment

The CCBHC care coordinator completes the Health Risk Assessment and supplemental assessments, including the Drug Abuse Screening Test (**DAST-10)**, **ASAM Criteria screener,** and **C-SSRS,** to assess for **SUD, level of care,** and **suicidality.** A **PRAPARE®** assessment explores Jason's SDOH barriers—such as employment, environmental issues, and nutrition—

which may contribute to his diabetes and other conditions. **The CCBHC Care Coordinator and Milton determine Jason's care coordination meeds as a Level II.**

What Jason would like to achieve:

- ☑ I want to find an apartment & get a good paying job.
- ☑ I want to drink less.
- ☑ I want to get my diabetes under control.
- ☑ I want to reconnect with my friends & family.

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Person-centered Care Planning

Molina provides care coordination through a multispecialty interdisciplinary team that integrates our evidence-based disease management and SUD Care Coordination programs with care and system coordination across I/T/Us, IHCPs, and physical health and BH Providers, including CCBHCs and CCBHC care coordinators. Milton asks if there are other individuals Jason desires to include (e.g., a **spiritual leader/healer, a CHR, and/or CCBHC-certified Peer Support Specialist)** and explains to Jason his interdisciplinary team can evolve as he meets his goals and his needs change. If Jason prefers to keep his care planning confidential and limit interdisciplinary team members, Milton respects Jason's request.

Jason's Interdisciplinary Team

- Jason
- Milton - Molina Care Coordinator
- CHR (no name)
- CCBHC care coordinator (no name)
- IHCP, PCP, specialists, and/or care coordinators
- Molina Housing Services and Supports Specialist

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Technology to Support Care Coordination

Our Care Coordination Portal offers the ability to track, submit, and share Member information, enabling collaboration with Providers and interdisciplinary team members in real time. We maintain Member care and disease management data, Person-Centered Service Plans, and information on interventions. These data are fully integrated with our claims system, Provider and Member portals, and the KHIN and LACIE for ADT information for emergency department and inpatient admissions.

Molina leverages the **Epic EHR platform**, one of the most used EHR systems, to support seamless, real-time data sharing and coordination between health plans and healthcare Providers. To support the use and expansion of integrated HIT with I/T/Us and IHCPs, and to improve information sharing and coordination of care for tribal Members, we will seek to establish data-sharing agreements and encourage participation in information sharing.

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In collaboration with the CCBHC care coordinator, Milton facilitates coordination with Jason's chosen interdisciplinary team participants and exchanges information through informal conversations, regular (monthly) formal meetings, and HIPAA-compliant integrated care coordination tools and technology. After reviewing Jason's assessment results with the team, the CCBHC care coordinator presents Jason with various treatment options that align with his preferences. This collaborative effort results in a CCBHC Care Plan that reflects Jason's goals and includes achievable milestones. Jason asks if he must stop seeing his IHCP at Prairie Band Potawatomi Health Center and is assured he can continue to see any IHCP, regardless of whether they are in Molina's network. Jason discusses with Molina's CHR that he is hesitant to join the Diabetes Prevention program, so Molina's CHR offers to accompany him in enrolling and help ensure he is comfortable with the program.

Jason is provided the CCBHC care coordinator's contact information and advised that they will serve as

his main point of contact. If for any reason Jason needs additional support in contacting the CCBHC care coordinator, he can contact Milton for assistance. The CCBHC care coordinator and Jason agree to meet weekly via telephone or in person. As Jason progresses through his treatment interventions, this schedule may decrease. The CCBHC care coordinator shares with Jason that while they are committed to meet in person every three months, they are glad to meet in person as often as Jason prefers.

As Jason attends appointments and receives care, the CCBHC Care Plan is updated based upon the outcomes, with recommendations from his interdisciplinary team. Each time the CCBHC Care Plan is revised, Jason reviews and provides sign-off via electronic signature on the changes made. To ensure continuity of care and Jason's overall well-being, Milton supports the CCBHC care coordinator to facilitate the exchange of medical records with other healthcare Providers involved in Jason's treatment. This affords a seamless flow of information and ensures the coordination of all aspects of Jason's care. We promote such sharing between Milton and the interdisciplinary team via the Care Coordination Portal. Both Milton and the CCBHC care coordinator remain committed to maintaining consistent communication throughout this process.

Care Coordination

Jason is provided with the following services and supports to address his BH concerns along with managing his diabetes.

BH

To provide Jason with the necessary BH care, the CCBHC care coordinator arranges for a variety of services and interventions.

To help Jason identify negative thought patterns and behaviors that contribute to his SUD and depression, he is encouraged to participate in **cognitive behavioral therapy**. Working together with a therapist, Jason develops strategies to replace these patterns with healthier coping mechanisms and more positive thinking. In addition to individual therapy, Jason is enrolled in **peer support and SUD recovery services** with a licensed addiction counselor, meetings with a CCBHC Peer Support Specialist (either virtually or in-person), and with a local Alcoholics Anonymous program. Jason's CCBHC Peer Support Specialist can accompany him to support groups and/or participate as a member of his interdisciplinary team, if Jason prefers.

Valeo Behavioral Health's telehealth capability expands access in underserved areas, serves as a safety net for BH services if in-person appointments are not possible, and is available to individuals who may fear the stigma associated with accessing BH care in traditional settings. It is also helpful to support continuity of care, given Jason's history of frequent moves.

Reconnecting with family and friends represents an important aspect of Jason's recovery. The CCBHC care coordinator collaborates with Jason on reconnecting with family and friends, providing practice sessions on how to rekindle and rebuild relationships through open and honest communication. The CCBHC care coordinator educates Jason on family therapy and family support offered through the CCBHC and its ability to facilitate the healing process and improve his familial relationships.

Recognizing setbacks can occur, a **crisis, safety, and relapse prevention plan** is developed to address potential crises and to provide strategies to manage high-risk situations. The CCBHC care coordinator provides education on the 24/7/365 Molina Member Crisis Line, 988, Valeo Behavioral Health-operated mobile crisis teams, and crisis-receiving center and stabilization options, including options for crisis services on the Prairie Band Potawatomi Nation. The CCBHC care coordinator and Jason develop a crisis and safety plan, in Jason's own words, detailing coping strategies, sources of support, and potential triggers for a suicidal crisis or relapse in his recovery journey. Milton, the CCBHC care coordinator, and Jason review his CCBHC Care Plan and ensure it is up-to-date and accessible to Jason's interdisciplinary team via our integrated Care Coordination Portal. Jason is encouraged to download a free safety plan app to his phone (e.g., myPlan, Stanley-Brown Safety Plan) for easy access and to share with his natural supports, if he feels comfortable doing so.

Molina's Suicide Prevention Approach

American Indians are disproportionally affected by suicide, with rates consistently surpassing all other demographic groups. Molina has adopted a comprehensive suicide prevention approach that acknowledges historical and intergenerational trauma associated with colonialism, genocide, and forced loss of culture for American Indian Members. This approach includes:

- Adoption of the Zero Suicide framework
- Systemwide training on suicide prevention and interventions, including trauma-informed care specific to the American Indian population
- Identification of individuals at risk through comprehensive screening and assessment
- Completion and integration of crisis and safety plans for all Members receiving care coordination
- Promotion of harm and means reduction (e.g., access to gun locks/safes, instructions on safe handling of medications)
- 24/7/365 access to crisis services and follow-up after hospitalization or crisis system engagement for BH treatment and coordination of care

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Diabetes Management and Physical Health

The CHR helps Jason enroll in the diabetes program at the **Prairie Band Potawatomi Health Center**. Milton, the CCBHC care coordinator, and the Molina CHR, in partnership with the PCP from the Health Center, incorporate diabetes interventions into one holistic CCBHC Care Plan that supports Jason's physicians and interdisciplinary team in addressing his needs. Molina's CHR shares with the PCP that Molina offers evidence-based disease management programs for diabetes, weight management, and depression that can educate and empower Jason to effectively self-manage and coordinate his care, and update the IHCP on how Jason's choice to remain with an IHCP Provider is fully supported and guided by **Molina's shared coordination process.** The Care Coordination team works in close collaboration with Health Center staff, including them in Jason's interdisciplinary team to ensure he receives comprehensive and coordinated care. Milton and our CHR monitor Jason's needs, ensure prior authorizations, assist with all care needs, and maintain and update Jason's CCBHC Care Plan. In addition, Jason can select an array of **in-home and telehealth supports provided by Molina** as follows.

The CCBHC care coordinator and Molina's CHR work together to ensure Jason has **ongoing access to a glucometer and test strips** to check blood sugar; the CHR coordinates this effort through the Health Center. If in the future Jason's need for blood sugar monitoring meets the criteria for continuous glucose monitoring, Milton and the CCBHC care coordinator will coordinate with Jason's PCP for approval. Additionally, Jason is educated on **24/7/365 telehealth access** to physical health, BH, and select specialty services, including urgent care visits, follow-up Provider visits, and post-hospitalization visits. We are aligning our offerings to include certain

synchronous and asynchronous activities, such as **remote patient monitoring**, **e-visits, and televisits**, available statewide through The University of Kansas Health System.

As Jason works to reduce his alcohol use, our CHR provides **health coaching** and shares with Jason that changes may impact his blood sugar levels and metformin dosage. He encourages and supports Jason in being forthcoming with the Health Center about his alcohol use and any changes to it. The CHR also confirms Jason is comfortable with him discussing this topic during interdisciplinary team meetings.

Due to the significant role that diet plays in managing diabetes, Molina provides Jason with **in lieu of medical nutrition therapy services**. These services are key to ensure Jason can make informed choices that support his overall health and blood sugar control. Jason can access medical nutrition therapy with a local Provider, either in-person or via telehealth, or he can utilize our virtual food care ecosystem, which provides access to a telenutrition network of registered dietitians, along with a digital platform that contains nutrition reference resources and an online marketplace. In addition to counseling, the CHR refers Jason to the **Prairie Band Potawatomi Food Distribution Program and SNAP**. Our CHR offers to assist with his applications and asks Jason how this food may help and align with the work he is doing in his diabetes program. Jason is also informed he is also eligible for **Molina's value-added Healthy Foods program and home-delivered meals**.

Our CHR ensures Jason maintains routine visits with his PCP at the Health Center to manage his diabetes. He also encourages Jason to attend **annual wellness exams, receive vaccinations, and follows up to coordinate any ongoing care** with the Health Center and/or specialists, such as an endocrinologist, as appropriate. Should Jason prefer to change PCPs or choose to receive services from a non-I/T/U Provider, Milton shows him how to access the Provider Directory through his **My Molina app**, where he can search for Providers according to their location and specialty. He can also search for Providers who are American Indian and/or have specialized skills/expertise necessary to serve American Indian Members. Additionally, our CHR confirms Jason is comfortable using the **Health Center's pharmacy**. Through Molina, he can also access a **mail-order pharmacy** and Member portal, enabling him to review and electronically refill prescriptions at a pharmacy of his choice. Our CHR also educates Jason on a [redacted]

Other Services and Supports

While Jason has access to a vehicle, Milton provides information on how to self-access **Molina's NEMT benefits** to receive rides to appointments for Medicaid services. [redacted] Our CHR works with **Molina's Housing Services and Supports Specialist** to support Jason in finding housing. The CHR partners with Jason to identify his preference in working with the Prairie Band Potawatomi Nation Housing Department or the Topeka Housing Authority to coordinate Jason's application for subsidized or affordable housing.

Molina's CHR discusses Jason's desire to return to community employment, along with his available resources and opportunities. The CHR connects with the **Employment Services and Supports Coordinator** to identify any employment programs for which Jason qualifies. Molina's CHR also connects Jason with the **Prairie Band Potawatomi Nation Job Placement and Training Program,** which enables tribal Members to train for a variety of positions.

Ongoing Follow-up and Support

Ongoing follow-up and support are integral to Jason's care journey, facilitated through the coordinated efforts of the CCBHC care coordinator, the CHR, and Milton. The CCBHC care coordinator takes the lead in ensuring Jason receives consistent and comprehensive care. **They check in with Jason monthly with a minimum in person visits every three months to monitor his progress, address any concerns or challenges that may arise, and to make necessary adjustments to his CCBHC Care Plan.** This ongoing support aims to optimize Jason's overall well-being and help him achieve his goals.

Working together, the CCBHC care coordinator, our CHR, and Milton afford Jason additional assistance and guidance. Serving as a support system for Jason, they answer questions and connect him with relevant resources and services, as needed. Their collaborative approach ensures Jason receives holistic and continuous care throughout his journey.

By maintaining open lines of communication and actively involving Jason in decision-making processes, the CCBHC care coordinator, CHR, and Milton strive to empower Jason and foster a sense of ownership in his individual health. Their ongoing care coordination ensures that Jason's evolving needs are met and that he receives the support necessary to thrive on his path toward improved well-being.

Molina's Experience in Tribal Health

Outreach and engagement with American Indian Members is most successful when performed at the **community level through trusted entities or individuals**. With recognition of the sovereignty of the State's four federally recognized tribes, we have reached to meaningfully engage out to and meaningfully engaging with each nation's tribal leadership to **understand their desires and preferences to improve coordination and collaboration for tribal Members.** Tribal Members have a range of entry points through a complex network of tribal, Federal, and State healthcare systems. In our Arizona, California, New Mexico, and Washington affiliates, we **partner with tribes to participate in shared care coordination and engagement of tribal Members**, including:

- Fostering a consistent, in-person presence, as invited
- Reinvesting in key tribal nation priorities, building upon strengths and meeting the needs of each community
- Advocating for services in the continuum of care, including traditional healing practices, which meet tribal Members where they are
- Formalizing right of entry and permission to provide services on tribal land
- Formalizing successful VBP arrangements for delegated care coordination partnerships with I/T/Us, including tribal FQHCs
- Partnering with tribal community health representatives to conduct outreach, engagement, and education