

QUALITY IMPROVEMENT PROGRAM

Introduction

Molina Healthcare of Michigan serves Michigan members in counties throughout Michigan. Molina Healthcare of Michigan has served Medicaid patients since 2000. For all plan members, Molina Healthcare emphasizes personalized care that places the physician in the pivotal role of managing healthcare. Molina Healthcare is responsible for managing the provision of accessible, appropriate, cost-effective, high quality health care services for its members throughout the continuum of care. The health plan assists members as they move through the managed care system, reducing barriers to care, and supporting members in reaching optimal health. Molina Healthcare credentials and contracts with individual practitioners, provider organizations, facilities and institutions to deliver health care and service to members. Molina Healthcare delegates the authority to perform specified plan functions and services, while maintaining oversight responsibility for delegated and non-delegated activities.

The Quality Improvement Program (QIP) is established to provide the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement of care and service, and improvement of the health of its members. The QIP assists Molina Healthcare to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, regulatory and accrediting bodies.

The following QI Program Description includes discussion of program philosophy, scope, structure, and methodology.

Program Philosophy

Molina Healthcare of Michigan maintains the following values, assumptions, and operating principles for the Quality Improvement Program:

- The QIP provides a structure for promoting and achieving excellence in all areas through continuous improvement.
- Improvements are based on industry "best practice" or on standards set by regulators or accrediting organizations.
- The QIP is applicable to all disciplines comprising the organization, at all levels of the organization.
- Teams and teamwork are essential to the improvement of care and services.
- Data collection and analysis is critical to problem-solving and process improvement.
- Each employee is highly valued as a contributor to quality processes and outcomes.
- Compliance with National Committee for Quality Assurance (NCQA) Standards and achievement of accreditation demonstrates Molina Healthcare's commitment to quality improvement.
- Information about the QIP is available for members and providers upon request.
- Internal and external feedback about Molina Healthcare's programs and processes is integrated into the improvement efforts.

Quality Improvement Program Goals

Molina Healthcare of Michigan has defined the following goals for the QI Program:

- Design and maintain programs that improve the care and service outcomes within identified member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to members. Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare of Michigan (also referred to as MHM) structure, process, and outcomes.
- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals and to ensure participation of community providers in the MH Michigan network.
- Facilitate organizational efforts which achieved and maintain regulatory compliance and NCQA Accreditation-Excellent in 2005.

Quality Improvement Program Objectives

QIP objectives direct personnel, activities, and resources to achieve Program goals. Written objectives address:

- Activities planned,
- Methodologies,
- Persons responsible, and
- Time frames for meeting each objective

Scope of Program Activities

The Molina Healthcare QI Program encompasses the quality of acute, chronic and preventive health care and service provided in both the inpatient and outpatient setting to our population as determined by age, disease categories, risk status and products. The scope of service includes but is not limited to, those provided in institutional settings, ambulatory care, home care and mental health. Contracted provider groups, primary care and specialty practitioners and ancillary providers may render these services.

Important Aspects of Care

To provide for overall quality functioning as a managed care plan, Molina Healthcare continuously monitors important aspects of care. These aspects or activities of care/service include, but are not limited to:

- Access and Availability
- Continuity and Coordination of Care ,
- Health Management Systems
- Under and Over Utilization
- Behavioral Health Care
- Chronic and Acute Care
- Member Safety and Error Avoidance
- High-Risk/High-Volume/Problem-Prone Care
- Preventive Care and Services
- Member and Practitioner Satisfaction/Dissatisfaction
- Guideline Management; Clinical Practice and Preventive Guidelines
- Health Plan Service Standards
- Quality of Care Complaint Review and Clinical Case Review
- Pharmacy Services

Data Sources

Quality Improvement is a data driven process. Molina Healthcare utilizes multiple data sources to monitor, analyze and evaluate the QI program and planned activities. These sources include, but are not limited to the following:

- Encounter and Claims data
- Pharmacy Benefit Manager data
- Pertinent medical records (minimum necessary)
- Utilization reports and case review data
- Provider and member complaint data obtained through call tracking, Utilization Management (UM), Provider Services and other sources
- Provider and member satisfaction survey results
- Appeal information
- Statistical, epidemiological and demographic member information
- Authorization and denial reporting
- Enrollment; regional, disenrollment
- HEDIS
- Behavioral Health data
- Geo-Access provider availability data and analysis
- Feedback other than complaints regarding services and programs from members and providers.
- CAHPS

Quality Improvement Strategy

Quality Improvement Activities

To meet the purpose, goals and scope of this program, QI activities as reflected in the QI Work Plan will be focused in the following areas.

- Improvement of the health status of the health plan membership through:
- Implementation of programs to address the priority needs associated with the major high-risk, acute and chronic illnesses faced by plan members. These programs will include preventive health, health education, disease management (health management), and care guidelines.
- Monitoring the outcomes of care against national and available regional practice standards.
- Utilization of multi-disciplinary and multi-dimensional teams to address process improvements that can enhance care and service, including primary, specialty and behavioral health practitioners.
- Oversight of delegated processes to ensure delegated organizations MHM standard.
- Identification of appropriate safety and error avoidance initiatives for MHM members in collaboration with the primary care provider through:
 - Evaluation of pharmacy data for provider alerts about drug interactions, recall, and pharmacy over and under-utilization.
 - Education of members regarding their role in receiving safe, error free health care services through the member newsletter and the Molina web site.
 - Education of providers regarding improved safety processes in their practice through the provider newsletter, member profiles and the Molina web site.
- Dissemination of information regarding important safety activities and Health Delivery Organization (HDO) audit findings for safety concerns to members and providers.
- Evaluation for safe clinic environments during office site reviews.
- Education to members regarding safe practices at home through health education and incentive programs.
- Intervention for identified safety issues as identified through case management, care management and the grievance and clinical case review process.
- Collection of data regarding hospital activities relating to member safety.
- Dissemination of information to providers and members regarding activities in the network related to safety and quality improvement.
- Evaluation of the continuity and coordination of care through annual analysis of data to include:
 - Transition of Care processes and the effectiveness of inter-provider communications and documentation.
 - Medical record audits.
 - Tracking quality of care issues, including adverse events.
 - Focused health management programs.
 - Member and practitioner satisfaction surveys and complaint and appeal review.
- Identification of chronically ill or complex new patients through assessment processes.

- Oversight of delegated activities.
- Monitoring over-utilization and under-utilization through:
- Tracking quality of care issues, including adverse outcomes and sentinel events.
- Review of clinical performance measures including HEDIS to identify actions for improvement oversight of member satisfaction.
- Review all sources of member satisfaction including but not limited to CAHPS Survey disenrollment information, complaints and appeals to identify opportunities for improvement.
- Member complaint and appeal review.
- Utilization review and case management reports.
- Practitioner medical, pharmacy and utilization profiles.
- Performance measures relative to implementation of preventive and clinical practice guidelines
- Oversight of delegated group member satisfaction and utilization.
- Evaluation of access and availability of care and service through:
- Measurement and evaluation of geographic access to primary care physicians, key specialists, hospitals and other health care services.
- Evaluation of appointment access and availability of after-hours care and after hour information offered by practices.
- Evaluation of MHM Member Services telephone access.
- Evaluation of all satisfaction measures for availability and access to care.
- Oversight of delegated activities.
- Management of Molina Healthcare's interface with practitioners, providers, members and state agencies to implement programs, including:
- Inclusion of contracted practitioners and providers in the planning and implementation of clinical programs.
- Review, approval, and dissemination of preventive health and clinical practice guidelines and measurement of adherence with current recommendations.
- Review of clinical performance measures including HEDIS results to identify actions for improvement.
- Identification of legislative and benefit changes that enhance health promotion.
- Annual review of practitioner surveys and proposed activities for improvement.
- Management of health care practitioner and provider credentialing/recredentialing to include:
- Review of credentialing/recredentialing policies and procedures.
- Peer review of credentialing/recredentialing decisions.
- Peer review of investigated quality of care issues and proposed corrective action plans.
- Oversight of delegated credentialing activities.
- Ensure that medical records comply with standards of structural integrity and contain evidence of appropriate medical practices for quality care by:
- Review of medical record audit results and corrective actions.
- Practitioner education and corrective action where indicated.
- Oversight of member satisfaction measurement and improvement activities:

- Review of all sources of member satisfaction information including, but not limited to, CAHPS Surveys, disenrollment information, complaints and appeals and identify opportunities for improvement.
- Design and evaluate initiatives to improve satisfaction.
- Evaluation of the effectiveness of QI activities in producing measurable improvements in the care and service provided to members through:
- Organization of multi-disciplinary teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
- Track the progress of quality activities through appropriate quality committee minutes and review/update the QI work plan quarterly.
- Revise interventions as required based on analysis.

Quality Improvement Methodology

A cyclic, continuous, systematic process is used to improve performance and communicate clinical and service quality issues. This process is used throughout the organization to help individuals improve procedures, systems, quality, cost, and outcomes related to their areas of responsibility. The model includes the following steps:

- Establish standards and benchmarks
- Collect data
- Analyze data and determine performance levels
- Identify opportunities for improvement
- Prioritize opportunities
- Establish clear improvement objectives
- Design and implement interventions
- Measure effectiveness

Organizational Structure Supporting Quality Improvement: Accountability

The Board of Directors

Molina Healthcare of Michigan's Board has ultimate authority and responsibility for the quality of care and service delivered by MHM. The Board is responsible for the direction and oversight of the QI Program and delegates authority to the Quality Improvement Committee (QIC) under the leadership of the Chief Medical Officer. The President/CEO also serves as a member of the Molina Healthcare of Michigan Board of Directors.

The Quality Improvement Committee (QIC)

The QIC is responsible for the implementation and ongoing monitoring of the Quality Improvement program. Through the Quality Improvement Sub-committees, the QIC recommends policy decisions, analyzes and evaluates the progress, results and outcomes of all quality improvement activities, institutes needed actions and ensures follow-up.

The QIC sets the strategic direction for all quality activities at Molina Healthcare. The QIC receives reports from all QI sub-committees, advises and directs the committees on the focus and implementation of the QI program and work plan. The QIC reviews data from QI activities to ensure that performance meets standards and makes recommendations for improvements to be carried out by sub-committees or by specific departments.

The QIC is chaired by the Chief Medical Officer, and is composed of management of key health plan functions and network practitioners. The QIC confirms and reports to the Board that plan activities comply with all state, federal, regulatory and NCQA standards. The QIC reports to the Board any variance from quality performance goals and the plan to correct the variance. The QIC submits to the Board approved, signed, minutes reflecting committee decisions and actions of each meeting. In addition it presents an annual QI program, work plan and prior year evaluation, as well as quarterly summaries of important activities to the Board.

Standing Quality Improvement Sub-Committees

The QIC delegates QI functions to specific sub-committees. Each of these sub-committees is guided by a description that outlines its composition, meeting frequency, standards and responsibilities. All MHM Quality Sub-committees meet at a minimum quarterly and all keep contemporaneous minutes using a standard format.

The activities of all quality committees are treated in a confidential manner, as outlined in their policies. (Please refer to attached 2005 Committee Purpose and Meeting Dates, APPENDIX B for a full description of sub-committee membership and responsibilities)

- The Quality Improvement Committee (QIC). Information from the QIC is reported to the Board of Directors on a quarterly basis or more often as appropriate.
- The Peer Review/Credentialing Committee (PRC). The PRC reports to the QIC.
- The Member and Provider Satisfaction Committee. Reports to the QIC.
- The Pharmacy and Therapeutics Committee (P&TC). The P&TC reports to the QIC.
- The Utilization Management Committee (UMC). The UMC reports to the QIC.
- The Compliance Committee (CC). The CC reports to the QIC.

Confidentiality

Molina Healthcare of Michigan is authorized by specific regulatory agencies and by members to obtain and review medical records, including member and practitioner identities. Authorization is subject to all state and federal laws and regulations, including Title 42 Code of Federal Regulations, Molina Corporate Employee Handbook, Section B, Security and Confidentiality. Use of Protected Health Information (PHI) is outlined in a privacy notice distributed to all members.

All Molina Healthcare personnel sign a Confidentiality Agreement and a Code of Conduct and Employee Handbook Acknowledgment form. Signed documents are on file in the Human Resources Department. In addition, non-Molina Healthcare members of QI committees sign a confidentiality statement when attending committee meetings and are protected from being required, with some exceptions, to testify in civil actions related to specific committee activities and actions.

As an approved Coordinated QI Program by MDCH, information and documents created specifically for, and collected and maintained by an approved program receive protections from public disclosure. Molina Healthcare's QI documents are maintained in compliance with all legal requirements and include, but are not limited to, internal reviews, including patient care review studies, QI studies and reports, minutes of QI committees and administrative (i.e., non-clinical) processes having a direct impact on the provision of care or service. The findings of all Molina Healthcare QI committees are part of the QI Program. Such findings will not be released to any outside agency without the express permission of the originating agency and assurance that confidentiality will be maintained.

The Board assigns the responsibility of managing and reviewing confidentiality issues to the Government Contracts and Compliance Department. A Compliance Committee has been formed as directed by the Compliance Plan. This committee addresses issues of confidentiality.

Conflict of Interest

No reviewing physician may perform a review on one of his/her patients, the patients of his/her partners, or cases in which the reviewing physician has a proprietary financial interest in the site providing care.

Delegation Activities

Molina Healthcare of Michigan may delegate Credentialing, UM, and Claim activities to provider groups that meet delegation requirements. Prior to delegation, Molina Healthcare conducts on-site delegation pre-assessments to determine compliance with regulatory and accrediting requirements. The health plan monitors ongoing compliance with review of monthly reports and annual on-site assessments.

The QIC monitors ongoing delegate compliance with regulatory and accrediting requirements. The committee requires corrective action of delegates when necessary. MHM's Director, QI is responsible for the delegation oversight process, which includes coordinating and conducting annual on-site assessments, monitoring credentialing reports, overseeing the corrective action process, and providing staff support.

MHM currently delegates the following:

- Credentialing
- Quality Improvement for Behavioral Health
- Utilization Management for Behavioral Health

Program Evaluation and Revision

The Quality Improvement Program Description and Work Plan govern the program structure and activities for a period of one calendar year. At least annually, the QI Department will facilitate a formal evaluation of the QI Program. Evaluation of all quality activities will include a description of limitations and barriers to improvements.

The annual QI evaluation identifies the outcomes and includes the following areas:

- Evaluates the results of each QI activity implemented during the year and identifies quantifiable improvements in care and service.
- Where available, includes a trended indicator report and brief analysis of changes in trends and improvement actions taken as a result of the trends.
- Identifies opportunities to strengthen member safety activities.
- Evaluates resources, training, scope, and content of the program and practitioner participation.
- Identifies limitations and barriers and makes recommendations for the upcoming year, including the identification of activities that will carry over into next year.
- Evaluates the overall effectiveness of the QI Program.

Governing Body Review and Approval

Molina Healthcare of Michigan's QI Program is accountable to and reports activities to the Board of Directors through the Quarterly and Annual Reports. The Quality Improvement Program Evaluation, the QIP and the Work Plan are submitted to the Board of Directors for review and approval.

Glossary

BH	Behavioral Health
CAHPS	Consumer Assessment of Health Plans
ED	Emergency Department
HCA	Health Care Authority
HDO	Health Delivery Organization
HEDIS	Health plan Employer Data and Information Set
MDCH	Michigan Department of Community Health
NCQA	National Committee for Quality Assurance
PRC	Peer Review Committee
P&T	Pharmacy and Therapeutics
PHI	Protected Health Information
PCP	Primary Care Provider
QIC	Quality Improvement Committee
QIP	Quality Improvement Program
UM	Utilization Management
UMC	Utilization Management Committee