QUALITY IMPROVEMENT

Molina Healthcare maintains an active Quality Improvement (QI) Program. The QI program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The identified goals are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Contracted Providers and Facilities must allow Molina Healthcare to use its performance data collected in accordance with the provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced member cost sharing.

Quality Improvement Program Goals

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

 Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in quality of care, member safety and quality of service.

 Design and maintain programs that improve clinical care and service outcomes within identified member populations.

 Ensure program relevancy through understanding of the health plan's member demographics and epidemiological data and provide services and interventions that address the diverse cultural, ethnic, racial and linguistic needs of Molina Healthcare's membership.

 Improve the quality, safety, 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 structure, processes, and outcomes.

 Develop processes to continually measure and improve member and provider satisfaction with Molina Healthcare's services, including behavioral health.

 Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals.

 Encourage and support a collaborative relationship among members, providers and regulators to promote health management and wellness education.

 Apply sound approaches and methods in the development of indicators that are objective and clearly defined using a systematic collection of valid and reliable data reported at the contract and plan level.

 Provide data on quality and outcomes to enable Molina Healthcare members to compare and select from among health coverage options.

 Align activities to comply with accreditation requirements.

 Foster a shared, organization-wide approach to protecting the privacy and security of confidential member and provider information in accordance with State and Federal requirements and accreditation standards.

 Facilitate organizational efforts to sustain CMS, State and Federal regulatory compliance

 Facilitate organizational efforts to achieve and maintain NCQA accreditation.

Program goals are designed to identify and monitor the most vulnerable members, and address the needs of all members. Important subpopulations, such as the frail/disabled, multiple chronic conditions (medical and behavioral), End Stage Renal Disease (ESRD) and those nearing end of life are identified through the following mechanisms and data analysis:

Identification, stratification and monitoring activities to identify high priority needs-
 Risk assessments
 Home visits
 Predictive modeling
 Claims data review/analysis
 Pharmacy data review/analysis
 Care/case/disease management activities
 Self-referrals by members/caregivers
 Member self-referrals through Member Services and Nurse Advice Line
 Referrals from Network Providers

The needs of the most vulnerable populations are met through the Molina Medicare Model of Care through early identification and designation to a higher stratification / priority in Molina programs including Disease Management, Care Management, and Case Management. These members are managed more aggressively and more frequently by the Integrated Care Team. This activity assures that they are receiving all necessary services and that they have adequate care plans before, during and after transitions in health care settings or changes in healthcare status.

Scope of Program Activities
The Molina Healthcare QI Program encompasses the quality of acute, chronic and preventive health care and services provided in both the inpatient and outpatient setting to Molina Healthcare's 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 behavioral health. Contracted provider groups, primary care and specialty practitioners and ancillary providers may render these services.

Molina Healthcare's Behavioral Health (BH) is committed to comprehensive behavioral health care management in partnership with the member and the practitioner. The BH Program coordinates and monitors the delivery of BH services to all members as designated in their assigned benefits. Full consideration of general medical issues in the management of BH care delivery is provided to enhance the quality of care through improved treatment delivery and outcomes as well as strengthen member and provider satisfaction.

HEALTH MANAGEMENT PROGRAMS

Molina Healthcare's Health Management programs provide patient education information to Members and facilitate Provider access to these chronic disease programs and services.

Asthma program

- Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with asthma. A Registered Nurse (RN) Care Manager calls all patients hospitalized for complications related to asthma. The RN Care Manager completes an assessment of the patient's medical needs and works with the PCP to resolve concerns. A copy of the assessment is then faxed to the PCP's office.

- Asthma Clinical Practice These guidelines can be reviewed from the Molina Healthcare website at: http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx

- Asthma Registry – Molina Healthcare established an asthma registry. The registry uses available claims and pharmacy information to identify and track asthma Members in the program.

- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified Members. You can receive a copy by calling our Quality Improvement Line at (800) 423-9899, Ext. 141428.

- Asthma Camp Opportunities – Molina Healthcare provides American Lung Association camp scholarships to children selected from nominations made by PCPs.

- Smoking Cessation – The *Free and Clear* program is available to Molina Healthcare Members ages 18 and over. We encourage Providers to refer Molina Healthcare Members to this program. For Members or family Members not enrolled, the Washington State Tobacco Quit Line number is (877) 270-7867.

- Asthma Profiles – We send PCPs a report or profile of patients with asthma. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare asthma patients not included in the profile.

- Members can obtain additional information on Asthma on Molina Healthcare's Staying Healthy Webpage: http://www.molinahealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Healthy Living with Diabetes

Molina Healthcare has a diabetes health management program called *Healthy Living with Diabetes* designed to assist Members in understanding diabetes and self-care.

The *Healthy Living with Diabetes* program includes:

- Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with diabetes. An RN Care Manager calls all patients hospitalized for complications related to diabetes. The RN Care Manager completes an assessment of the patient's medical needs and works with the PCP to resolve concerns. A copy of the assessment is then faxed to the PCP's office.

- Diabetes Clinical Practice Guidelines These guidelines can be reviewed from the Molina Healthcare website at: http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx

- Diabetes Registry – Molina Healthcare established a diabetes registry. The registry uses available claims and pharmacy information to identify and track diabetic Members in the program.

- Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic Members. You can receive a copy by calling our Quality Improvement Line at (800) 423-9899, Ext. 141428.

- Care Reminders and Age-Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to Members with diabetes.

- Diabetes Education – Diabetes education is covered for all Molina Healthcare Members. We encourage Providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease.

- Smoking Cessation – The *Free and Clear* program is available to Molina Healthcare Members ages 18 and over. We encourage Providers to refer Molina Healthcare Members to this program. For Members or family Members not enrolled, the Washington State Tobacco Quit Line number is (877) 270-7867.

- Diabetes Camp Opportunities – Molina Healthcare provides diabetes camp scholarships to children selected from nominations made by PCPs.

- Diabetes Profiles – We will send the PCP a report or profile of patients with diabetes. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare diabetic patients not included in the profile.

- Members can obtain additional information on Diabetes on Molina Healthcare's Staying Healthy Webpage: http://www.molinahealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Heart Healthy Living Cardiovascular program

Molina Healthcare has a Cardiovascular Health Management Program called *Heart Healthy Living* aimed at assisting Members with their understanding and management of cardiovascular disease (CVD). We have focused on five specific areas:

- Hyperlipidemia
- Congestive Heart Failure
- Hypertension
- Myocardial Infarction
- Angina

Molina Healthcare believes excellent care starts in your office. Our role is to provide additional services to complement your care.

The *Heart Healthy Living program* includes:

- Hospital Follow-up – An RN Care Manager from Molina Healthcare calls all patients after they are discharged from the hospital for complications with CVD. The Care Manager assesses your patient's medical needs and works with you to resolve any concerns. A copy of the assessment will be faxed to your office.

- Cardiovascular Disease Clinical Practice Guidelines These guidelines can be reviewed from the Molina Healthcare website at: http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx

- Registry – Molina Healthcare has a registry that uses available claims and pharmacy information to keep track of Members in the program with CVD.

- Newsletters – Molina Healthcare distributes cardiovascular newsletters to identified Members.

- Care Reminders – Molina Healthcare provides its Members with individualized reminders and educational tools important for self-management.

- Smoking Cessation – The *Free and Clear Program* is available to Molina Healthcare Members ages 18 and over. We encourage providers to use this service.

- Cardiovascular Patient Profiles – Molina Healthcare creates profiles for your cardiovascular patients. This report is mailed to you on an annual basis and lists all of your CVD patients who have Molina Healthcare coverage. The cover page of the profile lists all of your CVD patients. For each patient, we also send you a one-page, patient-specific report. This shows patient utilization information regarding medication use, emergency department visits, and hospitalizations. Each patient-specific report will be on a separate page so that you can file it in the individual's chart. Included with your patient profiles will be a cardiovascular profile fax back form for your use.

- Members can obtain additional information on Cardiovascular Disease on MHW's Staying Healthy Webpage: http://www.molinahealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Chronic Obstructive Pulmonary Disease program (COPD)

Molina Healthcare has a Chronic Obstructive Pulmonary Disease (COPD) Health Management Program aimed at assisting Members with their understanding and management of COPD. Molina Healthcare believes excellent care starts in your office. Our role is to provide additional services to complement your care.

COPD program includes:

- Hospital Follow-up –An RN Care Manager from Molina Healthcare calls all patients after they are discharged from the hospital for complications with COPD. The Care Manager completes an assessment of the patient's medical needs and works with you to resolve concerns. A copy of the assessment will be faxed to your office.

- COPD Newsletters – Molina Healthcare distributes diabetes newsletters to COPD Members.

- COPD Clinical Practice Guidelines These guidelines can be reviewed from the Molina Healthcare website at: http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx

- Registry –Molina Healthcare has a registry that uses claims and pharmacy information to track Members with COPD.

- Care Reminders and Tools – Molina Healthcare provides its Members with individualized reminders and educational tools important for self-management.

- Smoking Cessation – The *Free and Clear Program* is available to Molina Healthcare Members ages 18 and over. We encourage providers to use this service.

- COPD Profiles – Molina Healthcare also creates COPD profiles for Members identified for the program. This report is mailed to you on a semiannual basis and lists all of your COPD patients who have Molina Healthcare coverage. The cover page of the profile lists all of your COPD

patients. For each patient, we also send you a one-page, patient-specific report. This shows patient utilization information regarding medication use, emergency department visits, and hospitalizations. Each patient-specific report will be on a separate page so that you can file it in the individual's chart.

- Members can obtain additional information on COPD on MHW's Staying Healthy Webpage: http://www.molinahealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

Molina Healthcare is working toward improving care and service for Enrollees with Special Healthcare Needs. Molina Healthcare in collaboration with its providers assist enrollees and families with coordination of care and to provide information regarding available resources.

Special health care needs may include but are not limited to:

- Those who have or are at increased risk of serious and/or chronic physical, developmental, behavioral or emotional conditions, substance use disorder
- Require health and related services of a type or amount beyond what is generally necessary
- Inappropriate (over and under) utilization of services including prescription use
- Specific diagnoses of children with special health care needs include: asthma, diabetes, heart disease, obesity, cancer, autism, cerebral palsy, Down's syndrome, cleft lip and/or palate, attention deficit hyperactivity disorder, prematurity, speech/language delay, sickle cell anemia, diabetes, arthritis, blindness, hearing loss, gross and/or fine motor delay and multiple sclerosis.

Providers who are caring for enrollees with Special Healthcare Needs are required to develop an individualized treatment plan and coordinate care with clinical and non-clinical services, such as community resources.

The treatment plan should include the following:

- Short and long term goals
- Enrollee participation
- Modified based on enrollee's changing needs
- Barriers and how they were addressed

Case Management services are available for those Enrollees with Special Healthcare Needs. Refer to Medical Management section 6 of the Provider Manual.

PREVENTIVE CARE AND CLINICAL PRACTICE GUIDELINES

Clinical and Preventive Evidence-Based Guidelines

Clinical practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The recommendations for care are suggested guides for making clinical decisions. Clinicians and patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina has adopted the following clinical practice guidelines:

- Asthma
- Diabetes
- Gestational Diabetes (GDM)
- Immunizations
- Chlamydia
- Treatment of Bipolar Disease
- ADHD
- Cardiovascular Disease - Heart Failure
- Hypertension
- Hyperlipidemia
- Depression
- Chronic Kidney Disease
- Preventing Heart Attack
- Judicious Use of Antibiotics
- Colorectal Cancer Screening
- Substance Use Disorders in Children and Adolescents
- Substance Use Disorders in Adults
- Chronic Obstructive Pulmonary Disease
- Preventive Health Guideline: Children and Adolescents (Birth – 21 years of age)
- Preventive Health Guideline: Adults (22-64 years of age)
- Preventive Health Guideline: Seniors (65 years of age and older)
- Preventive Health Guideline: Pregnant women

Additionally, to meet the EPSDT guidelines, Molina uses preventive health guidelines based on U.S. Preventive Services Task Force Recommendations.

To evaluate effectiveness, Molina measures performance against important aspects of each clinical practice and preventive guidelines using, but not limited to, the following:

- Emergency Room visit rates, if applicable
- Hospitalization Rates, if applicable
- HEDIS rates
- Member/family satisfaction with the program for those members receiving active care management.

Guidelines can be reviewed from the Molina Healthcare website at:
http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx

and
http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_prevent.aspx

If you would like a printed copy of this information, you may request it by calling Member Services or our QI Compliance Line at 800-869-7175 x147181.

MEASUREMENT OF CLINICAL AND SERVICE QUALITY:

- Healthcare Effectiveness Data and Information Set(HEDIS)
- Consumer Assessment of Healthcare Providers and Systems(CAHPS®)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives
- **Health Outcome Survey (HOS) is conducted for Medicare members**

HEDIS

Molina Healthcare utilizes NCQA HEDIS as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS is conducted annually in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, appropriate use of asthma medications, and prenatal and postpartum care.

HEDIS results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare's clinical quality improvement activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS results are provided to HCA as part of our contract Health plans also submit results directly to NCQA, consistent with the original intent of HEDIS – to provide health care purchasers data with which to make informed decisions. The data is also used by NCQA to establish health plan performance benchmarks and are an integral part of the NCQA health plan accreditation process.

Your office may be requested to submit documentation from medical files as part of the HEDIS data collection process.

CAHPS

CAHPS is the tool used by NCQA to summarize Member satisfaction with health care, including Providers and health plans. CAHPS examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Providers Communicate, Courteous and Helpful Office Staff, and Customer Service. The CAHPS survey is administered annually in the spring to randomly selected members according to contract.

CAHPS survey results are used in much the same way as HEDIS results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina Healthcare's quality improvement activities and are used by external agencies and health care purchasers to help ascertain the quality of services being delivered.

Provider Satisfaction Survey

Recognizing that HEDIS and CAHPS both focus on Member experience with health care Providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey each year. The results from this survey are very important to Molina Healthcare, as this is one of the primary methods we use to identify improvement areas pertaining to the Provider network. The survey results have helped establish improvement activities relating to Molina Healthcare's specialty network, inter-provider communications, and pharmacy authorizations. This survey is conducted by an external vendor and is sent to a statistically valid, random sampling of Providers each year. If your office is selected to participate, please take a few minutes to complete it and send it back.

Effectiveness of Quality Improvement Initiatives

Molina Healthcare monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating a best practice. The Clinical Quality Improvement Committee (CQIC), which includes Members from the Provider network, evaluates clinical metrics on an ongoing basis. Results of these measurements guide activities for the successive periods.

Clinical Metrics include but are not limited to the following

Clinical Practice Guideline Compliance measurement:

- HEDIS measures for asthma, diabetes, and chlamydia screening
- Use of short-acting beta-agonists for Members with asthma
- Use of antibiotics for upper respiratory disease

Effectiveness of interventions in *Healthy Living with Diabetes, Heart Healthy Living, Chronic Obstruct Pulmonary Disease (COPD)* programs:

- Post-hospital follow-up rate with PCP or Specialist
- Inpatient and emergency department utilization
- Readmission after primary diagnosis of asthma, diabetes, COPD or a cardiovascular condition
- Key clinical metrics including but not limited to: annual A1c and eye exams for diabetics and beta-blocker use and cholesterol testing after an acute cardiac event

Service Improvement Metrics include but are not limited to:

- UM authorization turn around times
- Pharmacy authorization turn around times
- Member Services response time
- Satisfaction with Molina Healthcare specialty network (as measured through CAHPS and Provider Satisfaction Survey)

PREVENTIVE HEALTH, HEALTH EDUCATION AND INCENTIVE PROGRAMS

Molina Healthcare integrates Health Education and Health Management Program goals with HEDIS Effectiveness of Care and Access rate improvement efforts. Molina Healthcare members receive telephonic and mail outreach promoting the importance of the needed preventive visits. Assistance is offered to schedule appointments as well as for needed transportation. Health fairs and provider events offer member education and services in culturally appropriate settings. Additionally, members may be eligible for incentive rewards for completing targeted preventive visits in a timely manner.The following table further details the leading preventive health topics promoted via these programs:

HEDIS Measures	Pharmacy Reporting 2014	Member Education and Outreach 2014	Member Incentive 2014
Adolescent well child		X	X
Depression	X		
Comp Diabetes Care; Eye Exam		X	X
Comp Diabetes Care; HBA1C	X	X	X
Breast Cancer Screening	X	X	X
Prenatal and Postpartum Care		X	X
Well Child 15 Months; Six well child visits		X	X
Well Child 3-6 Years		X	X
Childhood Immunizations		X	X

Preventive care guidelines for all ages can be reviewed and downloaded at:
http://www.molinahealthcare.com/medicaid/Providers/wa/resource/Pages/guide_prevent.aspx

DELEGATION OVERSIGHT

Molina Healthcare delegates credentialing, utilization management, and claims payment to Physician Hospital Organizations, Independent Physicians Associations, and other large Provider organizations able to perform delegated functions in a manner consistent with Molina Healthcare's requirements. Molina Healthcare does not delegate quality improvement, preventive health, or Member rights and responsibility activities. For more information regarding delegation oversight, see section 14.

Molina Healthcare may delegate Credentialing, UM, claim payment and grievance and appeals to provider groups or HDOs 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.

Delegation Oversight activities and reports are directed to the QIC. The QIC requires corrective action of delegates when necessary. The department manager of the specific delegated function is responsible for the delegation oversight process, which includes coordinating and conducting annual on-site assessments, monitoring monthly reports, overseeing the corrective action process, and reporting to QIC.

Delegation policies and procedures describe in detail the indicators and goals used by Molina to evaluate delegates' performance and determine the need for corrective actions.