PARTNERS IN CARE

Ohio • Spring 2014

Practitioner Credentialing Rights: What You Need to Know

Molina Healthcare has a duty to protect its members by assuring the care they receive is of the highest quality. One protection is assurance that our providers have been credentialed according to the strict standards established by the state regulators and accrediting organizations. Your responsibility, as a Molina Healthcare provider, includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

Molina Healthcare also has a responsibility to its providers to assure the credentialing information it reviews is complete and accurate. As a Molina Healthcare provider, you have the right to:

- **Strict confidentiality of all information submitted during the credentialing process**
- **Non-discrimination during the credentialing process**
- **Be notified of information obtained during the credentialing process that varies substantially from what is submitted by you**
- **Review information submitted from outside primary sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application, with the exception of references, recommendations or other peer-review protected information**
- **Correct erroneous information**
- **Be informed of the status of your application upon request by calling the Credentialing Department at (855) 322-4079**
- **Receive notification of the credentialing decision within 60 days of the committee decision**
- **Receive notification of your rights as a provider to appeal an adverse decision made by the committee**
- **Be informed of the above rights**

For further details on all your rights as a Molina Healthcare provider, please review your Provider Manual. You may also review the provider manual on our website at www.MolinaHealthcare.com or call your Provider Services Representative for more details.

In This Issue

MOLINA® HEALTHCARE

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Complex Case Management

Molina Healthcare offers you and your patients the opportunity to participate in our Complex Case Management Program. Patients appropriate for this voluntary program are those that have the most complex service needs and may include your patients with multiple medical conditions, high level of dependence, conditions that require care from multiple specialties and/or have additional social, psychosocial, psychological and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

The purpose of the Molina Healthcare Complex Case Management Program is to:

- Conduct a needs assessment of the patient, patient's family, and/or caregiver
- Provide intervention and care coordination services within the benefit structure across the continuum of care
- Empower our patients to optimize their health and level of functioning
- Facilitate access to medically necessary services and ensure that they are provided at the appropriate level of care in a timely manner
- Provide a comprehensive and on-going care plan for continuity of care in coordination with you, your staff, your patient, and the patient's family

If you would like to learn more about this program, speak with a Complex Case Manager and/or refer a patient for an evaluation for this program, please call toll-free (855) 322-4079.

Molina Healthcare's Utilization Management

One of the goals of Molina Healthcare's Utilization Management (UM) department is to render appropriate UM decisions that are consistent with objective clinical evidence. To achieve that goal, Molina Healthcare maintains the following guidelines:

- Medical information received by our providers is evaluated by our highly trained UM staff against nationally recognized objective and evidence-based criteria. We also take individual circumstances and the local delivery system into account when determining the medical appropriateness of requested health care services.
- Molina Healthcare's clinical criteria includes McKesson InterQual® criteria, Hayes Directory, Medicare National and Local Coverage Determinations, applicable Medicaid Guidelines, Molina Medical Coverage Guidance Documents (developed by designated Corporate Medical Affairs staff in conjunction with Molina Healthcare physicians serving on the Medical Coverage Guidance Committee) and when appropriate, third party (outside) board-certified physician reviewers.
- Molina Healthcare ensures that all criteria used for UM decision-making are available to practitioners upon request. To obtain a copy of the UM criteria used in the decision-making process, call our UM Department at (855) 322-4079.
- As the requesting practitioner, you will receive written notification of all UM denial decisions. The notification will include the name and telephone number of the Molina Healthcare physician that made the decision. Please feel free to call him or her to discuss the case. If you need assistance contacting a medical reviewer about a case, please call the UM Department at (800) 642-4168.

It is important to remember that:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.
2. Molina Healthcare does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
3. UM decision makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
4. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.
5. Medicaid members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network, Molina Healthcare will arrange for a member to obtain the second opinion out of network at no additional cost to the member than if the services were obtained in-network.
6. Some of the most common reasons for a delay or denial of a request include:
    - Insufficient or missing clinical information to provide the basis for making the decision,
    - Lack of or missing progress notes or illegible documentation, and/or
    - Request for an urgent review when there is no medical urgency.

Molina Healthcare's UM Department staff is available for inbound collect or toll-free calls during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the UM staff, please call (855) 322-4079. You may also fax a question about a UM issue to (866) 449-6843. The Medical Director is available for more complex medical decision questions and explanations of medical necessity denials.

Molina Healthcare's regular business hours are Monday – Friday (excluding holidays) 8:00 a.m. – 5:00 p.m. Voicemail messages and faxes received after regular business hours will be returned the following business day. Molina Healthcare has language assistance and TDD/TTY services for members with language barriers or with hearing and/or speech problems.

MEDICARE ARTICLE

Non-Discrimination

As a Molina Medicare provider, you have a responsibility to not differentiate or discriminate in providing covered services to members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed health care programs. Providers are to render covered services to Members in the same location, in the same manner, in accordance with the same standards and within the same time availability regardless of payer.

Preventive Health Guidelines

Preventive Health Guidelines can be beneficial to the provider and his/her patients. 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.

These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services depending on the individual needs of the patient.

To request printed copies of Preventive Health Guidelines, please contact the **Provider Services Department** at (855) 322-4079.

You can also view all guidelines at **www.MolinaHealthcare.com.**

Behavioral Health

Primary Care Providers provide outpatient behavioral health services, within the scope of their practice, and are responsible for coordinating members' physical and behavioral health care, including making referrals to Behavioral Health providers when necessary. If you need assistance with the referral process for Behavioral Health services, please contact Member Services at (855) 322-4079.

MEDICARE ARTICLE

Care for Older Adults

Many adults over the age of 65 have co-morbidities that often affect his or her quality of life. As this population ages, it's not uncommon to see decreased physical function and cognitive ability, and increase in pain. Regular assessment of these additional health aspects can help to ensure this population's needs are appropriately met.

- **Advance care planning** – Discussion regarding treatment preferences, such as advance directives should start early before patient is seriously ill.
- **Medication review** – All medications that the patient is taking should be reviewed, including prescription and over-the-counter medications or herbal therapies.
- **Functional status assessment** – This can include assessments, such as functional independence or loss of independent performance.
- **Pain screening** - A screening may comprise of notation of the presence or absence of pain.

Including these components in your standard well care practice for older adults can help to identify ailments that can often go unrecognized and increase his or her quality of life.

Hours of Operation

Molina Healthcare requires that providers offer Medicaid members hours of operation no less than hours offered to commercial members.

Clinical Practice 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 as guides for making clinical decisions. Clinicians and their patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina Healthcare has adopted the following Clinical Practice Guidelines:

- Asthma
- Diabetes
- Hypertension
- COPD

To request a copy of any guideline, please contact Molina Healthcare's Provider Services Department at (855) 322-4079. You can also view all guidelines at www.MolinaHealthcare.com.

Member Rights and Responsibilities

Molina Healthcare wants to inform its providers about some of the rights and responsibilities of Molina Healthcare members.

Molina Healthcare members have the right to:

- Receive information about Molina Healthcare, its services, its practitioners and providers and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and their right to privacy.
- Help make decisions about their health care.
- Participate with practitioners in making decisions about their health care.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about Molina Healthcare or the care it provides.
- Make recommendations regarding Molina Healthcare's member rights and responsibilities policy.

Molina Healthcare members have the responsibility to:

- Supply information (to the extent possible) that Molina Healthcare and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Keep appointments and be on time. If members are going to be late or cannot keep an appointment, they are instructed to call their practitioner.

You can find the complete Molina Healthcare Member Rights and Responsibilities statement for your state at our website (www.MolinaHealthcare.com). Written copies and more information can be obtained by contacting the Provider Services Department at (855) 322-4079.

Standards for Medical Record Documentation

Providing quality care to our members is important; therefore, Molina Healthcare has established standards for medical record documentation to help assure the highest quality of care. Medical record standards promote quality care though communication, coordination and continuity of care, and efficient and effective treatment.

Molina Healthcare's medical record documentation standards include:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidential patient information
- Standards and performance goals for participating providers

Below are commonly accepted standards for documentation in medical records and must be included in each medical record:

- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening

For more information, please call the Provider Services Department at (855) 322-4079.

Drug Formulary and Pharmaceutical Procedures

At Molina Healthcare, the Drug Formulary (sometimes referred to as a Preferred Drug List or PDL) and pharmaceutical procedures are maintained by the Pharmacy and Therapeutics (P&T) Committee. This committee usually meets on a quarterly basis, or more frequently if needed. It is composed of your peers – practicing physicians (both primary care physicians and specialists) and pharmacists from areas Molina Healthcare practitioners are located. The committee's goal is to provide a safe, effective and comprehensive Formulary/PDL. The P&T Committee evaluates all therapeutic categories and selects the most cost-effective agent(s) in each class. In addition, the committee reviews prior authorization procedures to ensure that medications are used safely, and in accordance with the manufacturer's guidelines and FDA-approved indications. The Committee also evaluates and addresses new developments in pharmaceuticals and new applications of established technologies, including drugs. Molina Healthcare has two PDLs, one is for over-the-counter (non-prescription drugs) and the other for prescription drugs.

Medications prescribed for Molina Healthcare members must be listed in the Drug Formulary/PDL. The Drug Formulary/PDL also includes an explanation of limits or quotas, any restrictions and medication preferences, and the process for generic substitution, therapeutic interchange and step-therapy protocols. Select medications may require prior authorization, as well as any medication not found on the listing. When there is a medically necessary indication for an exception, such as failure of the formulary choices, providers may request authorization by submitting, via fax, a Medication Prior Authorization Form or by calling the Pharmacy Prior Authorization Department for the plan. Printed copies of the Drug Formulary/PDL may be obtained by calling the Provider Services Department.

The drug formulary/drug listing, processes for requesting an exception request and generic substitutions, therapeutic interchanges and step-therapy protocols are distributed to our network providers through fax and/or mail once updates are made. These changes and all current documents are posted on the Molina Healthcare website at www.MolinaHealthcare.com.

When there is a Class II recall or voluntary drug withdrawal from the market for safety reasons, prescribing practitioners are notified by Molina Healthcare within 30 calendar days of the Food and Drug Administration notification. An expedited process is in place to ensure notification to prescribing practitioners of Class I recalls as quickly as possible. These notifications will be conducted by fax, mail and/or telephone.

Featured at www.MolinaHealthcare.com:

- Clinical Practice and Preventive Health Guidelines
- Disease Management Programs for Asthma, Diabetes, Hypertension, CAD, CHF & Pregnancy
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Claims/Denials Decision Information
- Provider Manual
- Current Formulary & Updates
- Pharmaceutical Management Procedures
- UM Affirmative Statement (re: non-incentive for under-utilization)
- How to Obtain Copies of UM Criteria
- How to Contact UM Staff & Medical Reviewer
- New Technology

If you would like to receive any of the information posted on our website in hard copy, please call (855) 322-4079.

Patient Safety

Patient Safety activities encompass appropriate safety projects and error avoidance for Molina Healthcare members in collaboration with their primary care providers.

Safe Clinical Practice
The Molina Healthcare Patient Safety activities address the following:

- Continued information about safe office practices
- Member education; providing support for members to take an active role to reduce the risk of errors in their own care
- Member education about safe medication practices
- Cultural competency training
- Improvement in the continuity and coordination of care between providers to avoid miscommunication
- Improvement in the continuity and coordination between sites of care such as hospitals and other facilities to assure timely and accurate communication
- Distribution of research on proven safe clinical practices

Molina also monitors nationally recognized quality index ratings for facilities from:

- Leapfrog Quality Index Ratings (www.leapfroggroup.org)
- The Joint Commission Quality Check® (www.qualitycheck.org)

Providers can also access the following links for additional information on patient safety:

- The Leapfrog Group (www.leapfroggroup.org)
- The Joint Commission (www.jointcommision.org)

Care Coordination & Transitions

MEDICARE ARTICLE

Coordination of Care during Planned and Unplanned Transitions for Medicare Members

Molina Medicare is dedicated to providing quality care for our Medicare members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina Medicare member is discharged from a hospital. By working together with providers, Molina Medicare makes a special effort to coordinate care during transitions. This coordination of specific aspects of the member's transition is performed to avoid potential adverse outcomes.

To ease the challenge of coordinating patient care, Molina Medicare has resources to assist you. Our Utilization Management nurses and Member Services staff are available to work with all parties to ensure appropriate care.

In order to appropriately coordinate care, Molina Medicare will need the following information in writing from the facility within one business day of the transition from one setting to another:

- Initial notification of admission within 24 hours of the admission
- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

This information can be faxed to Molina Medicare at: (888) 295-4761

To assist with the discharge planning of Molina Medicare members, please note the following important phone numbers:

- Medicare Member Services & Pharmacy: (866) 472-4584
- Behavioral health services and substance abuse treatment for Molina Medicare members can be arranged by contacting: (800) 642-4168 Option 1, 2, 2, 2
- Transportation services for Molina Medicare Options Plus members may be arranged by calling LogistiCare at: (866) 475-5423
- The Nurse Advice Line is available to members 24 hours a day, 7 days a week at: (888) 275-8750. For hearing impaired, call TTY: 711.

Important information you need to know about Molina Medicare Options Plus:

- All beneficiaries have rights that are defined in our provider manual. They are also available in the member EOC posted on our website at www.MolinaHealthcare.com/Medicare.
- Molina Medicare Options Plus members have Medicare and Medicaid benefits designed to meet their special needs, therefore the state agency or its designated health plans have the responsibility for coordinating care, benefits and co-payments. Please be aware of your patients' status and Medicaid benefits and bill the correct entity.
- Health plans and providers can never charge these members more than they would have paid under Original Medicare and Medicaid. Members can also call the Medicaid agency for details and have specific rights with regard to their Medicaid benefits.
- Providers are responsible for verifying eligibility and obtaining approval for services that require prior authorization as outlined in the Provider contract. Our Medicare Member Services department can assist you in this regard.

Please contact the UM Department or Medicare Member Services if you have questions regarding planned or unplanned transitions at:

UM Department: (855) 322-4079 Option 2, 2
Member Services: (866) 472-4584

Molina Healthcare ICD-10 Conversion FAQ

Will Molina meet the October 1, 2014 compliance date and be capable of accepting transactions containing ICD-10-CM/ICD-10-PCS codes and/or ICD-10 based Diagnosis Related Groups (DRGs)?

Effective October 1, 2014, Molina will accept transactions containing ICD-10 CM and PCS codes, as well as ICD-10 based DRGs.

What is Molina's approach to ICD-10 code conversion?

Molina will use GEMs (General Equivalency Mappings), as well as other coding methodologies, as a guide to assist in understanding and translating ICD-9 codes to ICD-10. Molina will remediate all systems and processes impacted by ICD-10 natively (coding to documented business requirements) and does not intend to crosswalk ICD-9 codes to ICD-10 codes.

Will Molina support dual processing of ICD-9 and ICD-10 codes?

Molina will continue to accept ICD-9 coded claims with dates of service or discharge dates prior to the compliance cutoff date of 10/1/2014. We will only accept ICD-10 coded claims for any dates of service 10/1/14 and after.

Will Molina require claims to be coded to ICD-10 even if a supplier is not covered under the HIPAA mandate?

Yes.

Does Molina plan to conduct any testing with providers? What is the expected date that testing will begin?

Molina plans to conduct testing with providers and clearinghouses but will be unable to test with every provider. We will make every effort to accommodate as many provider test requests as possible. Our primary method of external testing will request providers send us claims re-coded to ICD-10 for a set of claims that we originally processed as coded to ICD-9. Test data will need to be submitted in 837 transaction format but does not necessarily need to be transmitted through a clearinghouse.

Molina has Health Plans in multiple states and our testing windows will vary by state; overall, we anticipate initial external testing to be conducted between Q1 and Q2 2014. We encourage providers who want to test with us to contact us at Molina.ICD-10@MolinaHealthcare.com. Once we are ready to test in a particular state, we will schedule planning calls with our selected test partners.

Will Molina renegotiate the contract with providers to replace ICD-9 codes with ICD-10 codes? If so when will renegotiation process occur?

Molina will review each contract individually and formulate a strategy that meets the specific needs of that contractual relationship. Only those contracts containing specific ICD-9 codes and/or DRGs will be re-negotiated. However, all provider contracts will be amended to add verbiage regarding compliance with the CMS mandate and standard HIPAA file format transactions.

Does Molina expect delays in payment during the transition from ICD-9 to ICD-10?

Although Molina strives for minimal disruption in operations, we acknowledge that with any implementation, there is a potential for an increase in processing time and inquiries for a short period during the transition. Molina will leverage proven techniques to effectively manage increased volume in any area requiring it.

What will the appeal process be for resubmission of ICD-9-based claims with ICD-10 codes during the transition period?

Molina will follow the date of service of the claim; if it was originally filed with ICD-9 coding and the date of service was prior to 10/1/14, we will continue to accept that claim through the appeal process with ICD-9 coding.

Will Molina be changing its medical policies for ICD-10?

No, we do not currently intend to change our overall internal medical policies due to ICD-10. We utilize third-party systems to validate medical necessity.

Will Molina's pre-authorization policy and guidelines for requesting pre-authorizations change with the implementation of ICD-10?

We do not anticipate changing our pre-authorization policies. We use third-party systems to validate that services are necessary and appropriate for a given diagnosis.

What is the earliest date (prior to 10/1/2014) that your health plan will accept pre-authorization requests with ICD-10 codes/ descriptions?

We will begin to accept pre-authorization requests coded to ICD-10 as of 9/1/14 for services that are anticipated to be performed after 10/1/14.

Will providers have to request new authorizations coded to ICD-10 where the service dates of the current authorization cross the 10/1/14 transition date?

We do not believe so. We will be testing our pre-authorization logic for this scenario to validate it, and if any changes are needed, we will reach out to those impacted providers directly.

How do you keep your providers informed of your ICD-10 changes? Do you have an ICD-10 communication forum that we can participate in?

Molina anticipates providing information via existing communication vehicles such as provider manuals and newsletters, Molina's website, as well as provider service representatives' on site visits, and will communicate as frequently as necessary to keep open channels of communication. We will publish key updates on our website: http://www.molinahealthcare.com/providers/common/medicaid/hipaa/Pages/codesets.aspx

Advance Directives

MEDICARE ARTICLE

Helping your patients prepare Advance Directives may not be as hard as you think. Any person 18 years or older can create an Advance Directive. Advance Directives include a living will document and a durable power of attorney document.

A living will is written instruction that explains your patient's wishes regarding health care in the case of a terminal illness or any medical procedures that prolong life. A durable power of attorney names a person to make decisions for your patient if they become unable to do so.

The following links provide you and your patients with free forms to help create an Advance Directive:

- http://www.nlm.nih.gov/medlineplus/advancedirectives.html
- http://www.nia.nih.gov/sites/default/files/End_of_Life_care_0.pdf
- http://aging.utah.edu/programs/utah-coa/directives/
- www.caringinfo.org

For the living will document, your patient will need two witnesses. For a durable power of attorney document, your patient will need valid notarization.

A patient's Advance Directive must be honored to the fullest extent permitted under law. Providers should discuss Advance Directives and provide appropriate medical advice if the patient desires guidance or assistance, including any objections they may have to a patient directive prior to service whenever possible. In no event may any provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an Advance Directive. Patients have the right to file a complaint if they are dissatisfied with the handling of an Advance Directive and/or if there is a failure to comply with Advance Directive instructions.

It is helpful to have materials available for patients to take and review at their convenience. Be sure to put a copy of the completed form in a prominent section of the medical record. The medical record should also document if a patient chooses not to execute an Advance Directive. Let your patients know that advance care planning is a part of good health care.

Risk Adjustment and Accurate Reimbursement

With regard to Risk Adjustment, clear, concise, consistent, complete and legible documentation is crucial to receive accurate reimbursement. Here is a list of common documentation errors that can affect the level of reimbursement:

1. **Using the term *abuse* vs. *dependence*** – In many instances, the provider documentation says a patient has abuse of a drug and he or she has been taking a drug of the same family for a long time. As a provider, please ensure any noted signs of drug abuse are not actually drug dependence. Drug dependence has a risk-adjusting value, whereas drug abuse does not.

2. **Using the term *chronic*** – Certain conditions will risk-adjust if they are documented as chronic, such as Chronic Hepatitis and Chronic Renal Insufficiency. If a condition is truly chronic, be sure to accurately document and provide a complete description of the diagnosis.

3. **Documenting a secondary code –** Some conditions are a result of another condition. For example, Diabetes can be due to a manifestation. The manifestation must be documented as well (e.g. Diabetes with neurological manifestations and Diabetic neuropathy). Another common example is the presence of pressure ulcers. These must be fully documented to reflect the location and stage of the ulcer.

4. **Documenting the *status* of conditions –** Ensure the status of a condition is fully documented. Some examples where status is important include a tracheostomy, artificial openings, amputations and dialysis. It should be clear that the statuses of these conditions are current at the time of service.

5. **Documenting mental health conditions –** Many mental health conditions will risk adjust and should be addressed. Be sure to include documentation of any current medication or treatment plan (e.g. Major depression, stable on Prozac).

Providers that follow the above principles will, first and foremost, ensure that the patient is being diagnosed appropriately and with the highest level of specificity. It will also make sure that the diagnoses are captured for risk adjustment purposes. Lastly, with the transition from ICD-9 to ICD-10, specificity will be crucial as "unspecified" codes will be rare or non-existent.

If you have any questions regarding risk adjustment, please contact the Risk Adjustment Department at RAMP@MolinaHealthCare.com.

Quality Improvement Program

The Molina Healthcare Quality Improvement Program (QIP) provides the structure and key processes that enable the health plan to carry out our commitment to ongoing improvement in members' health care and service. The Quality Improvement Committee (QIC) assists the organization 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 key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health status
- Collaboration with our contracted provider network to identify relevant care processes, develop tools and design meaningful measurement methodologies for provided care and service
- Evaluation of the effectiveness of programs, interventions and process improvements and determination of further actions
- Design of effective and value-added interventions
- Continuous monitoring of performance parameters and comparing to performance standards and benchmarks published by national, regional, or state regulators, accrediting organizations, and internal Molina Healthcare threshold
- Analysis of information and data to identify trends and opportunities, and the appropriateness of care and services
- Oversight and improvement of functions that may be delegated: Claims, UM and/or Credentialing
- Confirmation of the quality and adequacy of the provider and Health Delivery Organization network through appropriate contracting and credentialing processes

The QIP promotes and fosters accountability of employees, network and affiliated health personnel for the quality and safety of care and services provided to Molina Healthcare members.

The effectiveness of QIP activities in producing measurable improvements in the care and service provided to members is evaluated by:

- Organizing multi-disciplinary teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
- Tracking the progress of quality activities and goals through appropriate quality committee minutes and reviewing/updating the QI work plan quarterly.
- Revising interventions based on analysis, when indicated.
- Evaluating member satisfaction with their experience of care through the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey.
- Reviewing member satisfaction with their experience with behavioral health services through a focused survey and evaluation of behavioral health specific complaints and appeals.
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral, and case management.

Molina Healthcare would like to help you to promote the important care activities you have undertaken in your practices. If you would like to have your projects and programs highlighted on the Molina Healthcare website, please contact the Quality Improvement Department at (855) 322-4079.

If you would like more information about our Quality Improvement Program or initiatives and the progress toward meeting quality goals, or would like to request a paper copy of our documents, please call the Quality Improvement Department at (855) 322-4079. You can also visit our website at www.MolinaHealthcare.com to obtain more information.

Health Management Programs Improve Member Health

Molina Healthcare offers focused Health Management Programs that can significantly influence the health of our members and provide a variety of helpful services for those with chronic conditions such as asthma and diabetes.

Molina Healthcare offers the following Health Management Programs to our members:

- Molina Breathe with Ease® - asthma program is for children and adults age 2 years and older.
- Molina Healthy Living with Diabetes® – diabetes program is for adults age 18 years and older.
- Heart Healthy Living℠ – cardiovascular program is for members 18 years and older who have one or more of these conditions: coronary artery disease, congestive heart failure or high blood pressure.
- Healthy Living with COPD - COPD program is for members who have emphysema and/or chronic bronchitis.
- Motherhood Matters® Pregnancy Program – assists new mothers and their babies with support and education for a healthy pregnancy. Special care is given to those who have a high risk pregnancy.

All Health Management Program interventions are targeted to the specific needs of each member. Members are automatically enrolled based on medical and pharmacy claims. Program materials include condition specific pamphlets and brochures, workbooks, patient logs, action plans, newsletters and other tools that educate the patient on how to manage their condition. In addition, nurses or health educators reach out to patients and provide case management to those who will benefit the most from more frequent, in-depth follow-up. Physicians receive results of their patient's self-assessments and updates describing interventions and education offered to members. In addition, practitioners receive notifications and patient profiles on all members enrolled in any of the Health Management Programs.

At each point of contact, members are encouraged to discuss their care with their provider and follow their plan of treatment. Other services available to members include having access to the 24-hour nurse advice line. Members can call and speak to a nurse for advice on any health problems. All Health Management Programs are voluntary, and members can stop participating at any time. If you have a Molina Healthcare patient you think will benefit from receiving educational materials or talking with a Case Manager, please refer them to our Health Management Programs by calling our Member Services Department at (800) 642-4168.

You can find more information about our programs on the Molina website at www.MolinaHealthcare.com.