Molina Healthcare of California Quality Improvement and Health Equity Transformation Program (QIHETP) Description 2023

Important Notes:
Molina Healthcare of California (referred to herein as “plan” or “health plan”) is adopting this Quality Improvement and Health Equity Transformation Program Description for use with its members in California. This plan description builds off core principles that Molina Healthcare, Inc. (“MHI”) utilizes successfully in health plans across the country but has been customized to be exclusive to California. As reflected in this document, MHI agrees to perform specified quality management and improvement activities on behalf of the Health Plan. The Health Plan maintains responsibility for adopting, implementing, and enforcing quality assurance standards. Collectively, MHI and its health plans are referenced throughout this plan description as “Molina.”

QIC Review and Approval: May 1, 2023
BOD Review and Approval: June 15, 2023

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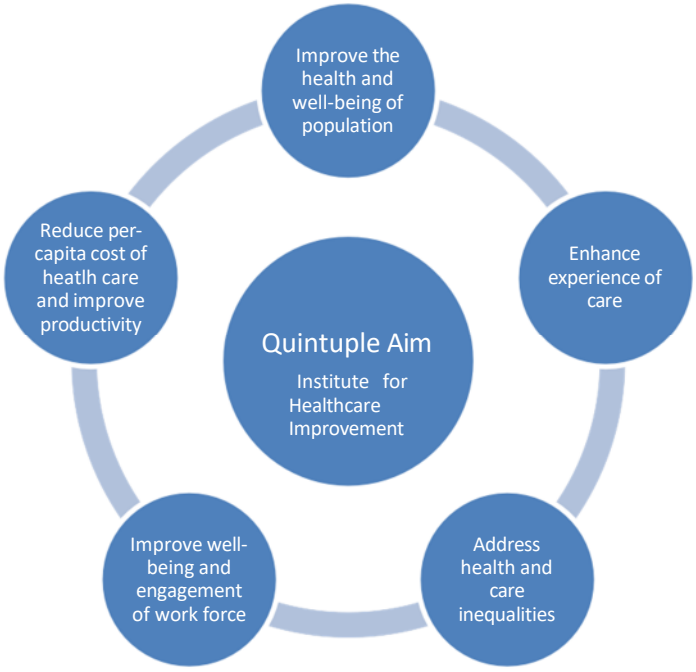
INTRODUCTION

Molina's Quality Improvement and Health Equity Transformation Program (referred to as the Quality Improvement) Program within this document: Achieving Quality Improvement Goals

Molina carries out a comprehensive and multi-functional Quality Improvement Program. Through our Program, we conduct a wide range of quality improvement activities that focus on the health care and services that our members receive across the entire health care continuum. The Quality Improvement Program complements the *Quintuple Aim* goals of the Institute for Healthcare Improvement as described below. Most importantly, we help our members achieve their person-centered social, medical, and behavioral health goals.



Measurement, improvement, and accountability are three central key concepts that drive Molina's Quality Improvement Program. Molina drives continuous improvement by using innovative tools for measurement, evaluation, tracking and trending and receiving and incorporating vital feedback from our members/authorized caregivers, practitioners, facilities, community organizations, and other stakeholders. Molina uses these strategies to meet key Program goals, which include, but are not limited to:

- making sure that health plan members receive accessible, appropriate, cost-effective, and high-quality health care and services (including physical, behavioral, and oral health as applicable) throughout the care continuum;
- emphasizing the delivery of personalized care so that the doctor or practitioner can maintain their pivotal role of managing the unique needs of our members;
- creating and implementing processes and programs that respond to and address the culturally and linguistically diverse needs of our members; and
- helping individuals navigate the health care system by reducing barriers and supporting them to reach their optimal health.

Molina's Quality Improvement Program: Key Components: Infrastructure and Framework

Molina's Quality Improvement Program provides the infrastructure and framework that allows Molina to fulfill our commitment to quality. Key Quality Improvement Program components, include, but are not limited to, the following principles.

- Molina sets up robust Quality Improvement structures, processes, plans, and strategies so that Molina can meet internal, program, and external requirements. We can then be responsive to the changing needs of our stakeholders and to the requirements of the community, federal and state governing agencies and voluntary accrediting bodies.
- Molina credentials and contracts with individual practitioners, provider organizations, facilities, and institutions to deliver health care and services to members, especially for our members who have complex health issues.
- Molina has established specific roles that are performed centrally within the national structure (which is further referenced as "MHI" within this document) and within the Molina plan. MHI agrees to perform specified quality management and improvement activities on behalf of the Health Plan. The Health Plan maintains responsibility for adopting, implementing, and enforcing quality assurance standards.
- Molina specifies detailed goals and objectives for the Quality Improvement Program. These goals and objectives are created, reviewed, and updated as needed on an on-going basis and formally at least once a year through the combined Quality Improvement/Healthcare Services Work Plan. The Quality Improvement/Healthcare Services Work Plan includes specified timelines that will allow Molina to meet highlighted goals and objectives.
- Molina defines and addresses the unique needs of members throughout the Quality Improvement Program by placing additional emphasis on: 1) identifying and stratifying members according to health care utilization and/or potential risk to manage the health care and services for individuals with catastrophic or high-risk conditions; 2) coordinating services during transitions between different health care settings to address psychosocial issues; 3) facilitating communication between providers and facilities; 4) educating and supporting members and caregivers to manage complex health, pharmacy and behavioral health issues; and 5) incorporating strategies to address the complex issues of members into the Care Management Program.
- Molina evaluates issues, problems or concerns through causal analysis that are discovered during Quality Improvement Program activities. This analysis is performed in accordance with the Quality Improvement/Healthcare Services Work Plan's methodology. Molina then develops action plans that are carried out to correct identified problems. Molina uses the following methodology for evaluation.

  Molina: 1) identifies the type of corrective action to be taken; 2) states the goals of the corrective action plan; 3) determines the timeline and work plan needed to address the corrective action; 4) makes changes in processes and/or structure, (including any applicable changes to existing case management programs, member/provider outreach activities, and/or education to internal staff/external stakeholders); 5) sets proposed and existing performance measures and thresholds for improvement; 6) makes sure that the improvement actions were taken; 7) performs an evaluation to check the effectiveness of the corrective action; and 8) conducts on-going monitoring to prevent the recurrence of identified problems.

1.0 Program Philosophy

Molina embraces the following key values, assumptions, and operating principles for Molina's Quality Improvement Program. Molina:

- maintains a program structure that allows Molina to achieve and maintain excellence in all areas through continuous improvement;
- defines and addresses the health care and health outcome needs of members who experience a higher burden of chronic conditions (medical and behavioral health), who are frail or disabled, who come from culturally and linguistically diverse backgrounds, and who have complex and/or unresolved needs and undergo multiple care transitions;
- carries out improvement activities based on effective practices or rules set by regulators or accrediting organizations;
- makes sure that the Quality Improvement Program applies to all health plan functional areas at all levels of the health plan;
- ensures that teams and teamwork are vital to the improvement of health care and services;
- conducts data collection and analysis to solve problems and improve processes;
- values each employee as a contributor to health plan quality processes and results;
- displays Molina's commitment to quality improvement through achieving and maintaining National Committee for Quality Assurance Health Plan accreditation and maintaining compliance with National Committee for Quality Assurance accreditation standards, and federal and state regulations, including those promulgated by the Centers for Medicare & Medicaid Services;
- makes information about the Quality Improvement Program available to members and providers on the Web site and in hard copy upon request; and
- solicits and incorporates feedback from health plan members, caregivers, providers and practitioners, community organizations (as applicable) and internal staff into the design and implementation of Molina's programs and processes.

The Quality Improvement Program is designed to ensure that all medically necessary covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, sex, sexual orientation, gender identity, health status, physical or mental disability or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.

2.0 Quality Improvement Program Goals

Molina has defined key goals for the Quality Improvement Program that focus on structure, process, and outcomes. These Program goals are consistent with the Donabedian Model, one of the most well-known concepts in quality improvement (Avedis Donabedian, “The quality of care: How can it be assessed.” JAMA, 260 (12): 1988).

Through the Quality Improvement Program, Molina:

- defines and demonstrates Molina’s commitment to quality through activities that achieve improvements in quality of care and health outcomes, member safety and quality of service;
- improves the quality, safety, appropriateness, availability, accessibility, coordination and continuity of health care and services delivered to members;
- plans and maintains programs designed to improve the health and health outcomes of health plan members;
- reviews, analyzes, and understands Molina’s member demographic and epidemiological data to identify and address member needs;
- helps make sure that health care and services and interventions address the varied cultural, racial, and ethnic, linguistic, and additional unique needs of Molina’s members;
- conducts ongoing and systematic reviews to design effective interventions that mitigate barriers to improve Molina’s structure, processes, and outcomes;
- develops structure and processes to measure and improve member and provider satisfaction with the medical and behavioral health care and/or services delivered by providers and practitioners and/or Molina;
- uses a multidisciplinary committee structure to further the achievement of Quality Improvement Program goals;
- encourages and supports a collaborative relationship between members, providers, and regulators to promote effective health management, health promotion and wellness education;
- applies sound approaches and methods to develop objective and clearly defined indicators and performance measures using systematic collection of valid and reliable data;
- provides data about the quality program and outcomes to health plan members and prospective members to allow individuals to compare and select from among health coverage options;
- designs and carries out programs for network practitioners, providers and facilities that are focused on topics, such as improving health outcomes, reducing hospital readmissions, improving member safety, and reducing medical errors, and reducing health and health care disparities for network practitioners, providers and facilities that use increased reimbursement or other market-based incentives to stimulate achievement of Quality Improvement goals;
- aligns activities to meet external voluntary accreditation requirements;
- fosters a shared organization-wide approach to protect the privacy and security of private member and provider information in line with Federal and State requirements and accreditation standards;
- facilitates health plan efforts to maintain Federal and State regulatory compliance, including distribution of validated information and data in a form, manner, and reporting frequency as determined by regulatory agencies to support evaluation of Quality Improvement strategies;
- ensuring that our members receive culturally- and linguistically appropriate services that provide equitable health care and identify and address social determinants of health (including social risks and social needs); and
- oversees and organizes health plan efforts to achieve and maintain National Committee for Quality Assurance accreditation.

3.0 Quality Improvement Program Objectives

Molina establishes Quality Improvement Program objectives focused on the use of staff, completion of activities, and needed resources to reach Program goals. Written objectives specifically address:

- planned quality improvement activities and interventions that address the quality and safety of clinical care, service, and member experience;
- Quality Improvement Program scope;
- Quality improvement methodology and assessment;
- persons assigned, responsibilities and training;
- time frames for meeting each objective;
- monitoring of previously identified issues; and
- coordinated strategies to carry out the Quality Improvement Program.

Molina reviews and modifies Program objectives as needed on an on-going basis and formally at least once a year. Specific activities are identified to support the achievement of Program objectives. Program activities are tracked and recorded in the annual Quality Improvement Work Plan.

4.0 Scope of Program Activities

Molina carries out a broadly defined Quality Improvement Program that fully addresses multiple and wide-ranging topics within the scope of quality improvement. Through Molina's Quality Improvement Program, Molina focuses on activities that encompass the member's entire health care experience. Our scope includes addressing the member's entire health care experience through the facilitation of equitable, culturally- and linguistically appropriate health care and services that address the physical, behavioral health, social needs, and social risks.

Molina's Quality Improvement Program scope includes, but is not limited to, medical, behavioral health and LTSS care and services supplied in institutional, outpatient, home care, and/ or even the member's home, including a focus on ensuring that our members receive equitable, culturally, and linguistically appropriate health care and services that consider the social needs of the community and social risks of our members. Contracted provider groups, primary care and specialty practitioners, facilities and ancillary providers may render these services.

Molina's Quality Improvement Program includes a focus on all types of health care and services, such as preventive health care, acute care, and/or the management of chronic/complex conditions. Molina also routinely assesses the needs of the health plan member population by age, race and ethnicity, language, disease categories, risk status, disability status (as available), health equity (as available), social determinants of health, such as social needs (as available), and lines of business/product lines, with the aim of better meeting the needs of our members.

Molina is fully invested in making sure members receive timely and appropriate behavioral health care and services in collaboration with network providers. Through Molina's Quality Improvement Program, Molina evaluates how well medical and behavioral health care and services are coordinated and delivered to health plan members as designated within member's assigned benefits. Management of behavioral health care and services is evaluated along with any medical issues that may impact the health of members. Molina takes this holistic approach to ensure that there is effective coordination between medical and behavioral health providers, case managers and care coordinators (as available) so that members are highly satisfied. The holistic approach further incorporates the identification and analysis of social risks and social needs to ensure our members are being supported to maintain their health.

Continuously Evaluating Important Aspects of Care and Service

Molina continuously monitors important aspects of health care and services to ensure that health plan members get timely, appropriate, effective, efficient, and safe care in the right setting at the right place. Molina checks key aspects or activities that include, but are not limited to:

- access/availability as evaluated through health risk assessments, appointment scheduling, network composition through assessment by volumes and type of providers, and geographic analysis;
- continuity/coordination of care as evaluated through analysis of the health care and services provided on member movement between practitioners, such as between medical and behavioral health providers, primary care physicians and/or specialists; member movement across settings of care, such as between primary care providers, specialists, hospitals, LTSS providers, rehabilitation facilities, emergency departments, urgent care centers, and/or skilled nursing facilities; information and services that are provided by case managers, providers and members; information that is provided between providers and facilities; and findings from collaboration between medical and behavioral health providers on topics such as diagnosis, treatment and referral of behavioral health disorders, appropriate use of psychotropic medications, management of coexisting medical and behavioral health conditions, prevention programs for behavioral healthcare and activities for members with severe and persistent mental illness;
- case and health (e.g., disease) management as measured using and measuring compliance with evidence-based guidelines and processes for structured assessment and follow-up;
- appropriateness of care as measured by comparison of performance to established benchmarks, review for potential over- and under-utilization, use of and compliance with clinical practice guidelines, grievance and case review processes, and distribution of enrollee rights and responsibilities;
- Behavioral health, substance abuse, chemical dependency care and services as measured by using and measuring compliance with clinical practice guidelines;
- Long Term Care and Long-Term Services and Supports (as applicable) as provided to health plan members;
- management of chronic conditions and acute care for individuals;
- improvements in member safety/medical error reduction/avoidance;
- high-risk/high-volume/problem-prone care (activities are also designed to improve member safety, reduce, or avoid medical errors and/or prevent hospital readmissions);
- preventive care and services as measured using and complying with clinical practice guidelines (activities are also designed to focus on wellness and health promotion);
- activities that focus on members with special health care needs;
- activities that focus on members with complex health needs who may need case management and/or care coordination (activities are also designed to improve health outcomes, improve member safety and/or reduce/avoid medical errors and/or prevent hospital readmissions and/or reduce health and health care disparities);
- outreach to members to ensure effective coordination of services (i.e., clinical services, transportation, support to access care). Activities are also designed to improve health outcomes, improve member safety and/or reduce/avoid medical errors and/or prevent hospital readmissions and/or reduce health and health care disparities and/or focus on wellness and health promotion;
- performance measurement collection and reporting, such as Healthcare Effectiveness Data and Information Set and other state required or federally based quality measures and activities to address performance gaps. Activities are also designed to improve health outcomes, and/or reduce health and health care disparities and/or focus on wellness and health promotion);
- member and practitioner satisfaction with medical and behavioral health care and services, through measurement such as the Consumer Assessment of Healthcare Providers and Systems survey, the behavioral health member experience survey, and provider satisfaction survey;
- medical coverage documents;

- health plan service standards and operational performance thresholds;
- activities focused on review of potential quality of care/critical incident cases, Serious Reportable Adverse Events, and Hospital Acquired Conditions. Activities are also designed to improve health outcomes, improve member safety and/or reduce/avoid medical errors and/or prevent hospital readmissions;
- medication management; Activities are also designed to improve health outcomes, improve member safety and/or reduce/avoid medical errors and/or prevent hospital readmissions and/or reduce health and health care disparities;
- activities that focus on the provision of timely and appropriate health care and services that meet the needs of members with culturally and linguistically diverse backgrounds in addition to ensuring members in all populations receive equitable services. Activities are designed to improve health outcomes and/or prevent hospital readmissions and/or reduce health and health care disparities and/or focus on wellness and health promotion;
- review and analysis of demographic, health status, and utilization patterns of members and communities. Activities are also designed to identify information that can be used to improve health outcomes and/or prevent hospital readmissions and/or reduce health and health care disparities and/or focus on wellness and health promotion;
- Health Management Information Systems performance and data capture;
- plan-determined Quality Improvement projects, internal and collaborative projects with other health plans, including but not limited to Performance Improvement Projects that will meet state and federal regulatory requirements and internal health plan needs;
- collection, reporting and analysis of applicable and appropriate measures of health outcomes and indices of quality for the target populations and sub-populations. Activities are also designed to identify information that can be used to improve health outcomes and/or prevent hospital readmissions and/or reduce health and health care disparities and/or focus on wellness and health promotion;
- activities that focus on people with co-morbid health problems and complexities linked to concurrent/on-going or unresolved medical and behavioral health issues. Activities are also designed to improve health outcomes, improve member safety and/or reduce/avoid medical errors and/or prevent hospital readmissions and/or reduce health and health care disparities and/or focus on wellness and health promotion; and
- identification, analysis and improvement of the social needs and social risks of our members to ensure members receive person-centered and whole-person care.

Employing Data Sources and Systems to Drive Quality Improvement

Molina employs a data driven process to quality improvement. Molina collects and utilizes many data sources to check, analyze and evaluate the Quality Improvement program and planned actions to address all target populations. Sound approaches, and methods are used to build indicators that are objective, clearly defined, accurate and complete. Molina uses systematic steps to assure valid, reliable, and population-appropriate data are reported for each line of business. Data that measure health outcomes and indices of quality are built specific to Molina's targeted activities and Program goals.

Molina applies rigorous quality methodology which is further described under Section 5.0: Quality Improvement Strategy. Measures and indicators are developed using available published methods; when none are available, tests are carried out to assess the validity and reliability of the applied methods. Molina staff assess data accuracy and completeness before the release of reports and analysis. Molina's Improvement Methodology outlines the employed approach to taking action to correct problems that have been revealed through Quality Improvement activities. The Improvement Methodology is applied annually to the entire Quality Improvement Program as part of the Annual Quality Program Evaluation. This methodology is further described in Section 10.0: Quality Improvement Program Evaluation.

Molina utilizes many data sources to check, analyze and evaluate the Quality Improvement Program and planned activities. These sources include, but are not limited to, the following:

- medical and behavioral claims and encounter data;
- pharmacy data;
- laboratory data and results, as available;
- pertinent medical records (minimum necessary);
- utilization reports and case review data;
- provider and member feedback, complaints, and grievances through standard intake process and from all internal departments such as utilization management, provider services and other internal and external sources;
- provider and member satisfaction survey results;
- grievance and appeal information (internal and external review);
- statistical, epidemiological, and demographic data as well as data that identifies the cultural, racial, and ethnic and linguistic needs of members;
- authorization and denial reporting;
- diagnosis information (laboratory, pathology, and radiography results);
- enrollment and disenrollment data;
- quality improvement indicators including Healthcare Effectiveness Data and Information Set®, state-specific measures and all other Quality Improvement data that have been collected and/or reported;
- behavioral health data;
- provider accessibility availability data and analysis focused on geographic access, access to appointments and after-hours access;
- Consumer Assessment of Healthcare Providers and Systems survey results;
- behavioral health member experience analysis;
- case and health (e.g., disease) management program data;
- Health Risk Assessment information;
- social determinants of health data, including a focus on social risks and social needs;
- enrollment and disenrollment data; and
- Contact Center data (Member Services and Nurse Advice Line).

Molina collects and processes data from all activities through several methods such as electronic software and applications, manual collection processes, and available external resources.

Molina uses a core health information technology system and a web-based member-centric health management software application to help accomplish the Quality Improvement Program objectives. Through Molina's health information technology systems. Molina can manage and track the activities and progress of members throughout the course of care management. Data, reports, and analysis are made available to state and federal regulatory agencies as asked.

Molina's systems meet the requirements to submit performance reports and adherence to written policies, procedures as requested by Centers for Medicare & Medicaid Services. Systems also involve processes to send data appropriate and required for public review that informs stakeholders about Molina's performance. Public data and reports include some or all the following:

- performance measures included in the Healthcare Effectiveness Data and Information Set developed by the National Committee for Quality Assurance;
- Consumer Assessment of Healthcare Providers and Systems survey results; and
- Behavioral health member experience analysis.

Maintenance and storage of all Quality Improvement Program activity documentation, including medical, behavioral, pharmacy, lab, race and ethnicity, disability status, health equity, including gender identity and sexual orientation, language preference, social needs, and social risk data (as available) is housed in MHI's HIPAA-compliant and secure web-based systems and platform. Molina maintains reasonable and appropriate levels of safeguarding practices to protect electronic and other sensitive member information, to limit incidental uses or disclosures. All electronic information will be used, stored, handled, and transmitted in accordance with all applicable legal, regulatory, contractual, and company policies, standards, and requirements.

Molina's health information systems are utilized by the staff responsible to collect and integrate data, run analyses, and carry out Quality Improvement activities. At a minimum, Molina maintains dedicated quality staff and analytical resources to implement the quality improvement program. Key staff and resources include, but are not limited to, the following positions:

- Plan President (oversees the program);
- Chief Medical Officer;
- AVP, Quality;
- Managers, Quality;
- Quality Improvement Program Manager (s), Specialist (s);
- Designated behavioral health practitioner; and
- Analyst(s).

Additional quality improvement expertise in additional key functional areas also oversee key components of the quality improvement program. These positions, may include, but are not limited to teams/staff that focus on:

- Utilization management and/or Healthcare Services;
- Care, case, management, community connectors, and/or care coordination;
- Care models focused on specific topics/critical areas, such as behavioral health and kidney disease management, among others;
- Social work and others, including a focus on social determinants of health;
- Behavioral health;
- Nurse Advice Line;
- Health (e.g., Disease) Management and Population Health Management;
- Pharmacy;
- Contact Center (e.g., Member Services);
- Member and community engagement and outreach;
- Medical and healthcare informatics and analysis;
- Network management and operations;
- Credentialing and recredentialing;
- Government contract management;
- Finance;
- Compliance;
- Privacy, security, and confidentiality; and
- Training and development.

5.0 Quality Improvement Strategy

Molina is dedicated to improving the health status of health plan members through focused Quality Improvement activities. Molina carries out focused Quality Improvement strategies and activities to meet the Quality Improvement Program goals, objectives, and scope.

Molina employs strategies to improve the health status for health plan members. These strategies, include but are not limited to: design of a wide-ranging Quality Improvement strategy that incorporates key elements, but are not limited to: 1) description of the relevance of the quality improvement strategy to Molina members; performance measures and benchmarks/goals and thresholds; 2) activities in place to reduce health care disparities, improve health outcomes, improve member safety and reduce medical errors, prevent hospital readmissions, and address social determinants of health to ensure members receive timely and appropriate care; and 3) inclusion of program goals, timeline and information about barriers and mitigation planning. (Molina publishes the list of activities and methods, timelines, individuals responsible, and set goals within the annual Quality Improvement Work Plan).

Implementing Focused Quality Improvement Strategies and Activities

Molina implements the following key processes and activities to support Molina's Quality Improvement strategy. These activities include, but are not limited to:

- identifying priority areas and improvement opportunities that are formalized through development of Quality and Performance Improvement Projects;
- implementing quality interventions and programs focused on preventive health, health education, health (e.g., disease management), care coordination, case management, complex case management, identification and addressing the social risks and social needs of members, and the use of clinical practice and preventive health guidelines, that address the priority and/or complex health needs associated with the major high-risk, acute and chronic health and social risks/needs and problems faced by plan members;
- detecting topics through the yearly program evaluation that are formalized as a Quality Improvement Project and/or activity to address clinical and/or service aspects of care;
- identifying topics and focus areas linked to critical national, state and/or plan quality improvement priorities, including but not limited to, improving health outcomes, preventing hospital readmissions, improving patient safety, and reducing medical errors, facilitating wellness and health promotion, and reducing health and health care disparities, and addressing social risks and social needs;
- identifying Quality Improvement activities and interventions that may address gaps in operational systems, functions, inter-departmental linkages, as well as activities that directly impact members, caregivers and/or providers;
- formalizing Quality and Performance Improvement Projects with project-specific goals, objectives, and metrics with indices to check results against applicable national practice standards and initiating actions to address identified gaps;
- classifying Quality Improvement activities that may: 1) result in organizational policies and procedures; 2) address gaps in staffing patterns or personnel, or training needs; 3) deploy tools, materials, processes, and protocols to address member needs; and/or 4) support providers in the delivery of services;
- evaluating Quality Improvement and Performance Improvement Project results to demonstrate improvements over baseline along with periodic follow-up to foster sustained improvements;
- using multi-disciplinary and cross-dimensional teams to address process improvements that can enhance health care and services, as well as primary, specialty, and behavioral health practitioners, as appropriate;
- documenting clinical and non-clinical improvement activities in required templates; and
- overseeing delegated processes to make sure delegated groups meet Molina requirements.

Identifying and Establishing Priorities for Quality Improvement

Molina staff, health plan Medical Directors, external providers and organizations, members and/or caregivers and other stakeholders may submit priority areas for improvement. Focus areas are prioritized through the Molina National Quality Improvement and Health Equity Transformation Committee, the Molina Healthcare of California Quality Improvement and Health Equity Transformation Committee and subcommittees, MHI Healthcare Services and MHI Quality staff, and senior management for development based upon the following information, such as:

- high volume, high cost, high utilization; and/or
- availability of scientific research to evaluate the technology; and/or
- service or care found to have a high potential for harm; and/or
- activities or services that are of great importance to members and providers; and/or
- impact to quality of life, functional status, and health; and/or social risks/social needs;
- known or suspected overutilization or inappropriate usage; and/or
- other critical topics identified for improvement.

Using an Established Methodology to Implement Quality Improvement Activities

Molina uses various ongoing measurement and analysis tools to prioritize topics, implement evidence-based guidelines, design interventions, and evaluate the effectiveness of the Quality Improvement Program. Molina then develops interventions based on a review of potential barriers and gaps in care and/or service and evaluation of existing interventions.

Molina applies the Model for Improvement as developed by the Associates in Process Improvement. As shown on the next page, there are three key steps applied within the Model for Improvement followed by the Plan, Do, Study, Act model. The three key questions included in the model specify three requests that should be answered prior to the start of a Quality Improvement activity. These questions are:

1) What are we trying to accomplish?
2) How will we know that a change is an improvement?
3) What change can we make that will result in improvement?

These concepts help to frame the work that will be carried out during quality improvement activities. Within the Model for Improvement, the second component is the PDSA concept. Molina identifies specific Quality Improvement activities for implementation and then addresses the key components of this model.

Molina plans the Quality Improvement activity by defining the objective, predicting the potential outcome, developing the project and data collection plan to guide the activity. Molina then **does** the intervention, documents the findings –both quantitative and qualitative – to determine the results, and captures the data needed for analysis. Molina then **studies** the data, compares the results to the initial objectives and study questions and summarizes the findings of the Quality Improvement activity. Finally, Molina **acts** to identify the changes that may be made to the intervention and determines the next timeframe or cycle for improvement.

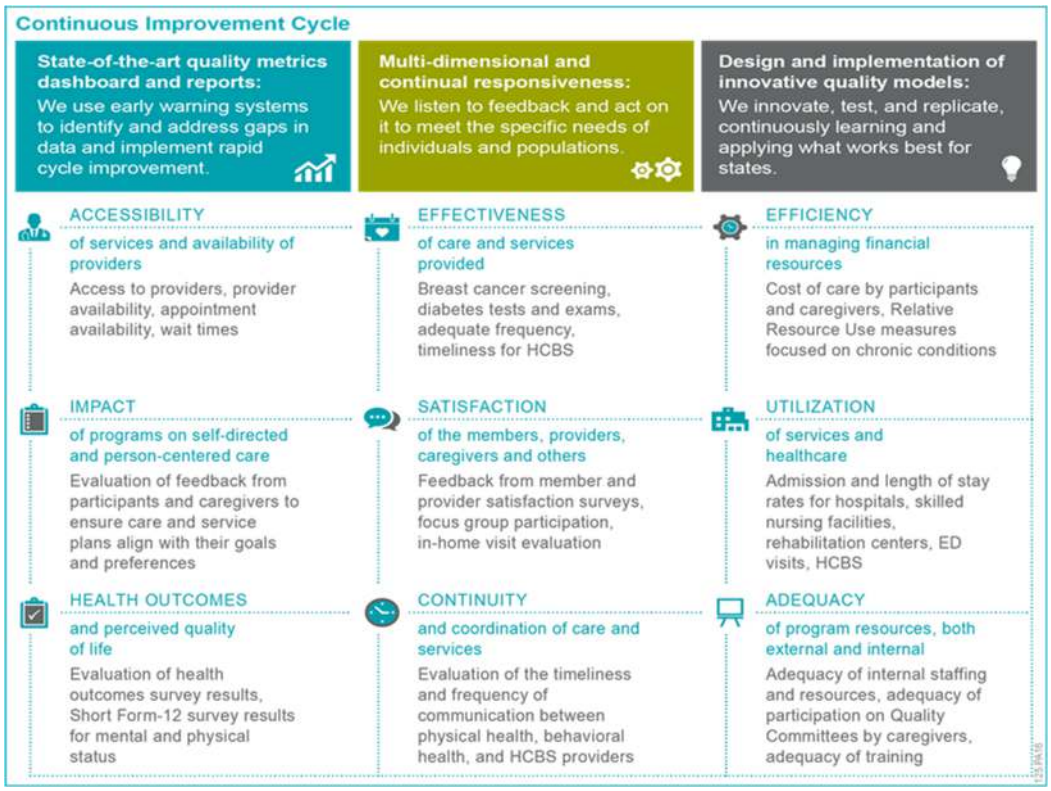
Molina Improvement Methodology: Model for Improvement

Molina utilizes the enhanced Model for Improvement to implement and evaluate a systematic Quality Improvement activity. Molina also uses this process as part of an on-going cycle of evaluation through planning, interventions, evaluation, and re-measurement. Once approved for implementation, various departments and subcommittees continuously monitor the activities and track the performance measures that have been defined.

Through the Quality Improvement program and committee structure, Molina instills rapid-cycle process improvements based on member outcomes, and appropriate recommendations are then made to senior leadership, who then develop a course of action and applicable interventions with the collaboration of the Quality Improvement and Health Equity Transformation Committee. Molina's improvement methodology is also designed to address gaps in performance. Modifications made to address potential gaps in performance may include, but are not limited to, the following activities. These activities, include, but are not limited to:

- development, modification or updates for organizational policies and procedures;
- changes to staffing patterns or personnel, or training needs;
- modification in network providers or scope of services supplied;
- tools, materials, processes, and protocols to address member needs and services;
- materials and systems to support providers in the delivery of care;
- deployment of new or modified systems, operations, and tools; and
- communication of results, changes, and updates internally and externally.

Our continuous quality improvement cycle also includes three major steps, which we apply to the measures we collect and the outcomes we seek to achieve. As shown below, we implement quality metrics dashboards as an early warning system to identify and address potential gaps in data; create feedback mechanisms to receive input from our members, providers, and other stakeholders to ensure we continually respond to identified issues and innovate, test, and replicate to improve our performance based on what works the most effectively. We evaluate our Quality Improvement Program and strategies continuously throughout the year, analyzing relevant performance measures and preparing accurate and compliant reports.



Facilitating Patient Safety Initiatives in Collaboration with Network Providers and Education to our Members

Molina identifies and facilitates appropriate patient safety improvement initiatives to make sure that Molina members get safe and high-quality care. Patient safety initiatives are employed in collaboration with network primary care providers and other practitioners through:

- evaluation of pharmacy data for provider alerts about drug interactions, recall, and potential pharmacy over- and under-utilization; and
- education of members about the role in receiving safe, error-free health care services through the member newsletter and/or Molina website; and
- education of providers about improved safety practices through the provider newsletter, member profiles and/or Molina website; and
- education to members about safe practices at home through health education and health (e.g., disease) management; and
- evaluation of safe clinic and/or medical office environments during office site reviews (as applicable); and
- intervention for safety issues identified through case management, care management and the grievance/appeal and clinical case review process; and
- collection of data about hospital activities linked to member safety, along with prevention of hospital readmissions; and
- dissemination of information to providers and members about activities in the network related to safety and quality improvement.

Facilitating Patient Safety Initiatives: Medical Management Activities

Molina also conducts medical management activities to ensure that care delivered by network providers is consistent and compliant with medically accepted standards of practice. In addition, Molina reviews Serious Reportable Adverse Events, potential pharmacy over- and under-utilization, sentinel events, Potential Quality of Care cases, Critical Incident in collaboration with Healthcare Services, and potential fraud and abuse cases. Serious reportable adverse events are tracked, and trended, and adverse occurrences are identified during daily utilization management activities.

Facilitating Patient Safety Initiatives: Identification and Investigation of Potential Quality of Care cases, adverse and sentinel events

Review of Potential Quality of Care referrals are evaluated by quality improvement clinical staff through a documented process. Components in the process include investigating the issue, including outreach to providers for related medical records, as applicable; documenting the summary of the investigation for the Chief Medical Officer or Medical Director; preparing an individual case for the Chief Medical Officer or Medical Director to present to Professional Review (e.g., Credentialing) Committee; tracking data to determine case resolution and completion times; and reporting trends to appropriate committee.

Molina identifies an unexpected occurrence involving death or serious physical or psychological injury, or “the risk to this type of injury” as a sentinel event. Molina investigates any serious injury that specifically includes unexpected loss of limb or function. These events are referred to as “sentinel”, as the events signal the need for immediate investigation and response. An annual report of sentinel events is included in the Quality Improvement Annual Program Evaluation.

Review of Potential Quality of Care referrals are carried out by the Quality Department by:

- investigating the issue; and
- documenting results of the review and closure by the Chief Medical Officer/Medical Director; and
- tracking data to determine case resolution time frames; and
- reporting individual cases and quarterly trended reports to the Professional Review Committee and systematic trends, at least annually, to the Quality Improvement and Health Equity Transformation Committee.

Facilitating Patient Safety Initiatives: Review of Potential Pharmacy Management Issues

Molina also checks for potential pharmacy over- and under-utilization by investigating provider prescribing patterns, provider adherence to clinical practice guidelines and medication recall notices. Molina uses member clinical information for effective medication management. Molina investigates pharmacy utilization patterns that may require immediate intervention or detailed investigation and analysis to improve member/patient safety. This process involves checking for potential drug-drug interactions, drug disease interactions, product recalls and drug product safety warnings and other medication safety concerns. Molina ensures the health and safety of our health plan members by making sure prescriptions are reviewed as the prescriptions are submitted within the context of the member's medication history.

Addressing the Needs of our Most Vulnerable Members: Identification and Evaluation of Services Provided

Molina implements Quality Improvement Program activities to identify and evaluate the health care and services given to the health plan's most vulnerable members to meet the unique needs of health plan members. Molina accomplishes this objective using systematic methods and analysis to identify vital subpopulations, such as members who are frail/disabled, and/or members who have many chronic medical and/or behavioral health conditions and/or members who have End Stage Renal Disease (ESRD), and/or members who are nearing the end of life through these methods and data analysis.

Molina identifies, stratifies, and checks the high priority needs of health plan members through data and information gathered through:

- health risk assessments; and/or
- home visits; and/or
- predictive modeling; and/or
- medical, behavioral health, laboratory and pharmacy claims and encounters data review and analysis, as applicable; and/or
- care/case/health (e.g., disease) management activities and review of social determinants of health; and/or
- self-referrals by members/caregivers; and/or
- member self-referrals through Member Services and Nurse Advice Line; and/or
- referrals from network providers.

Molina carries out and evaluates a comprehensive care model to meet the needs of vulnerable populations. Molina identifies members early and places individuals who are identified as a higher priority or in a higher level of stratification in designated programs. Designated programs include Health (e.g., Disease Management), Care Management, and/or Case Management and/or care coordination. Molina manages the health care and services for these members more aggressively and more often. Molina can ensure that the most vulnerable populations receive timely and appropriate services through this approach. Molina Case Managers also create/modify care plans before, during and after transitions in health care settings and/or changes in the health status as needed for these members.

Managing the Complex Needs of our Members through Case Management

Molina defines complex case management as the coordination of care and services supplied to members who have experienced a critical event or diagnosis needing the wide use of resources and who need help navigating the healthcare system to aid appropriate delivery of care and services. Complex case management involves comprehensive assessment of the member's health issue; determination of available benefits and resources; and ongoing management through the development and implementation of a care plan with performance goals, designated follow-up schedule, and progress assessments. Molina carries out our Complex Case Management program to help members retain optimum health and/or improved functional capacity, in the right settings and in a cost-effective manner. The components of the

population health program are related to the Quality Improvement Program as both programs address the member's complex needs through appropriate case management operation processes and monitoring through evaluation activities. ***Details about the Complex Case Management Program are contained in the Healthcare Services Program Description***.

Molina uses needed electronic systems to further the complex case management process. The process is supported by a clinical system that allows for the completion of individualized member assessments, stratification of members by acuity, development of a care plan for each member, reassessments for members, and evaluation of program results.

Molina has designed its complex case management program and processes that include, but are not limited to: 1) development of a population assessment that involves a review and evaluation of the demographics of the member population, relevant subpopulations, children and adolescents, individuals with disabilities, and individuals with serious and persistent mental illness; 2) review of complex case management processes and resources; 3) offering of an opportunity for the member and/or authorized caregiver to decline participation or disenrollment from case management programs; 4) documentation of timely and appropriate assessments and care plans; 5) assessment of member experience, including member feedback and analysis of complaints and appeals; 6) review of social determinants of health, including social risks and social needs; and 6) assessment of the effectiveness of the program.

Molina facilitates the delivery of effective, quality health care and services to members with complex or special health care needs, including but not limited to physical and developmental disabilities, chronic conditions and/or severe and persistent mental illness.

Molina accomplishes this strategy through:

- timely identification of members with special health care needs and subsequent enrollment in complex case management, including behavioral health case management, as appropriate;
- facilitation of continuity/coordination of care for members with special health care needs through the case management process;
- enrollment of members with chronic health care conditions in health (e.g., disease) management programs as appropriate;
- recommended use of preventive health care services for members with chronic health problems (e.g., diabetes, asthma) through health education and member incentive programs;
- evaluation of measures related to treatment effectiveness, symptom management, functional status, and health status; and
- distribution of clinical practice guidelines specific to chronic conditions prevalent in the member population (e.g., asthma, Attention Deficit and Hyperactivity Disorder, Chronic Obstructive Pulmonary Disease, depression, and diabetes) to members and practitioners.

Evaluating Timely and Appropriate Continuity and Coordination of Health Care and Services

Molina evaluates the timely and appropriate continuity and coordination of care and services for health plan members through yearly analysis of data. This evaluation comprises, but is not limited to:

- review of transition of care processes and the effectiveness of internal provider communications for members with complex needs and documentation that states that the member's approved care representative helped make care or treatment decisions for members with mental or physical incapacities;
- facilitation of arrangements with home-based, community and social service programs to address medical, behavioral health and social risks/social needs;
- identification of chronically ill or complex new members who would benefit from program activities through assessments, member/provider/caregiver referrals and during the care/case/health (e.g., disease) management process;
- identification of opportunities linked to continuity and coordination of care through medical record review, practitioner surveys, or any valid methodology;
- coordination of medical and behavioral healthcare and services including information exchange, appropriate diagnosis, treatment and referrals to primary care physicians, management of treatment access, appropriate use of medications, primary/secondary preventive behavioral health program carry out, and special needs of members with severe and persistent mental illness;
- checking of medical records and other data sources to assess continuity and coordination of care delivered to members;
- checking of health (e.g., disease) management processes and indicators related to management of chronic conditions and co-morbidities;
- tracking quality of care issues, including adverse events linked to gaps in continuity and coordination of care;
- tracking program referral and enrollment for timeliness and appropriateness;
- review of member and practitioner satisfaction surveys, grievances and appeals;
- review continuity and coordination issues and implementation of timely action to address findings as necessary;
- promotion and education to members and providers about Advanced Directives; and
- oversight of delegated activities.

Carrying Out Behavioral Health Quality Improvement Activities

Molina carries out and evaluates its behavioral health program in accordance with NCQA standards and regulatory requirements that focus on behavioral health and mental health parity. This program ensures that medical and behavioral health is integrated throughout the health plan so that:

- an adequate and available behavioral health network serves the behavioral health care needs (in alignment with medical and social needs) of all members;
- enrollee access is available so that members receive timely behavioral health services (in alignment with medical and social services as needed);
- an individualized plan or treatment and provision of appropriate level of care is in place for members;
- effective coordination of care is provided between behavioral health providers and the Primary Care Physician;
- follow-up services and continuity of care for behavioral health in alignment with medical and social health and services are appropriate and timely;
- the member's Primary Care Physician is involved in aftercare;
- there are high rates of member satisfaction with the access to and quality of behavioral health services through a review of complaints and appeals and satisfaction survey data;
- utilization of behavioral health services is checked to ensure that members receive appropriate behavioral health services in alignment with medical and social services as applicable;
- screening, assessment, and referral triage services are available, as needed;
- adequate behavioral health care is provided across the continuum of care from widely used outpatient

therapy to inpatient or comprehensive community-based care is available to members as allowed per the benefit structure and available treatment resource options in alignment with behavioral health and social services as needed;
- pharmacy services, medications and supplies are available in accordance with the benefit structure;
- appropriate linkages are made to ancillary support services (e.g., school systems);
- integrated coordination exists within chemical dependency assessment and treatment services per benefits;
- service delivery is checked to make sure that care is available in a timely manner, in appropriate settings and at the appropriate level of care; and
- safe and accessible care delivery process and locations are supplied through checking, tracking, and trending of critical incidents.

Collaborative medical and behavioral health activities are identified through:
- cost containment activities reviewed by Quality Improvement and Health Equity Transformation committees for potential impact on the quality of care delivered;
- evaluation of performance indicators;
- review and evaluation of patient safety activities and initiatives; and
- monitoring for potential over- and under-utilization of behavioral health services.

Quality improvement is fostered through identifying events and/or patterns of care that impact results along with improvement activities that optimize the effectiveness of behavioral health treatment and services.

Reviewing Data to Identify and Address Potential Over- and Under-Utilization

Molina reviews potential over-and under-utilization statistics at least yearly using cross-functional teams and collaboration with the provider network through:
- tracking potential quality of care issues, including adverse events, critical incidents, and sentinel events;
- review of member complaints/grievances and appeals;
- evaluation of utilization management and case management reports;
- review of practitioner medical, pharmacy and utilization data;
- checking of performance measures and rates based on preventive health and clinical practice guidelines; and
- oversight of member satisfaction and utilization by delegated groups (as applicable).

Evaluating Access and Availability of Care and Services

Molina evaluates access and availability of care and service through:

- measurement and evaluation of geographic access for members to primary care physicians, high-volume and high impact specialists, high-volume behavioral health practitioners, hospitals, and other health care services;
- assessment of the cultural, racial, and ethnic, linguistic, and social needs and preferences of Molina's member population (as described in section 7.0);
- evaluation of appointment access and availability for primary care, behavioral health, and high-volume and high-impact specialty care practitioners during normal business hours;
- evaluation of appointment access and availability for primary care and behavioral health practitioners for after-hours care;
- evaluation of Molina Member Services and telephone access including for members who are impaired;
- validation that directs access is available to promote women's health services and transportation is available for all members;
- evaluation of satisfaction measures for availability and access to care, including complaints and appeals; and
- oversight of delegated activities.

Carrying out the Quality Improvement Program through Stakeholder Collaboration

Molina manages the interface with practitioners, providers, members, federal and state Agencies to carry out the Quality Improvement Program. This management includes, but is not limited, to:

- inclusion of contracted medical and behavioral health practitioners and providers in the planning and carry out of clinical programs and activities (e.g., performance improvement projects and quality improvement activities);
- review, approval, and dissemination of preventive health and clinical practice guidelines and measurement of adherence with current recommendations;
- development and adoption of Medical Coverage Guidance documents that address medical, surgical, diagnostic, new technology or other services;
- identification of legislative and benefit changes that enhance health promotion;
- collaboration with the state Medicaid Agency and the External Quality Review Organization (as appropriate) in the development of studies and other care management programs, interventions, and the methodology to evaluate activities;
- performance of targeted and specific training about Medicaid to carry out activities; and
- review of practitioner satisfaction surveys and proposed activities for improvement, on an ongoing basis and at least once a year.

Molina manages the provider network through management of health care practitioner and provider credentialing and recredentialing processes as described in Section 9.0.

Reviewing Clinical Medical Record Data to Address Potential Opportunities

Molina evaluates the medical record review process (as applicable through HEDIS or Potential Quality of Care processes) to make sure that medical records meet standards of structural integrity and contain evidence of appropriate medical practices for quality care by/through:

- review of medical record audit results and corrective actions (HEDIS and PQOC process as applicable);
- checking for provider compliance to assure confidentiality and medical record accuracy;
- checking medical records to ensure that education is provided to patients about Advance Directives and/or Advanced Directives have been completed by members, providers, and Molina staff; and
- education of practitioners.

Collecting and Analyzing Member Satisfaction Data Sources for Quality Improvement

Molina collects, evaluates findings, identifies barriers, and carries out improvement activities that focus on member satisfaction. These strategies include but are not limited to:

- reviewing all sources that impact member satisfaction including, but not limited to findings from the Consumer Assessment of Healthcare Providers and Systems survey; findings from the behavioral health member experience analysis; disenrollment information; and complaints and appeals data;
- ensuring compliance with applicable anti-discrimination laws, including reasons for member disenrollment;
- identifying and addressing barriers and opportunities for improvement;
- designing and evaluating initiatives to improve satisfaction;
- evaluating out-of-network requests, if applicable;
- checking timeliness, accuracy and completeness of the Consumer Assessment of Healthcare Providers and Systems survey submissions;
- reporting survey results and analysis to the National Quality Improvement and Health Equity Transformation Committee as well as to the plan's Quality Improvement and Health Equity Transformation Committee;
- dedicating resources to facilitate and report Consumer Assessment of Healthcare Providers and Systems survey results; and
- analyzing results and determination of the actions to take for improvement based on the survey analysis and evaluation.

Molina takes the following steps to identify the potential opportunities for improvement and needed actions. Molina staff perform quantitative and qualitative reviews of the survey results to determine opportunities for improvement and potential barriers that impact satisfaction. Once the review is completed, Molina defines opportunities for improvement and prioritizes them in order of importance. Molina staff then evaluates current interventions and recommends future interventions to address the identified barriers. Molina staff defines measures to check the progress and establishes performance goals and thresholds to assess the effectiveness of interventions. Ongoing analysis will be carried out to check progress, level of performance and sustained improvement. Molina carries out this process throughout the health plan to support and improve procedures, systems, quality of service, cost, and member satisfaction.

Employing Health Information Systems to Address Quality Improvement Objectives and to Meet Required Reporting

Molina ensures that systems are in place to address Molina's Quality Improvement Program objectives for serving the culturally and linguistically diverse membership. These objectives are described in Section 6.0. Molina employs health information systems with the aim of submitting required reports and data to external organizations, such as federal agencies, state agencies and/or voluntary accreditation organizations. Through these systems, Molina checks the health plan's performance and adherence to written policies and procedures. Molina also employs these systems so that processes can be put into place to submit appropriate data that is required for public review and that informs stakeholders about Molina's performance.

Public data and reports include some or all the following for Medicaid members. The reports and data include, but are not limited to:

- Healthcare Effectiveness Data and Information Set data and state based or federally based performance measures;
- Consumer Assessment of Healthcare Providers and Systems survey data;
- Behavioral health satisfaction data; and
- Long Term Services and Supports/Long Term Care satisfaction survey data, as applicable.

Using Processes to Collect and Report Data

Molina employs health information systems to allow for processes in which Molina staff may submit timely and accurate data that is required for public review that informs stakeholders about Molina's quality performance.

Employing Processes to Collect and Report Data: HEDIS and Quality Performance Reports for Medicaid

Molina performs and/or oversees activities that include, but are not limited to:

- checking NCQA and Medicaid websites and memos for the annual release that specifies the scope of the annual Healthcare Effectiveness Data and Information Set;
- checking timeliness, accuracy, and completeness of submissions;
- devoting dedicated resources who generate and report Healthcare Effectiveness Data and Information Set rates, including the Medicaid Agency required measures that include eligible reporting denominators of 30 or more health plan members;
- housing a dedicated production server for the Healthcare Effectiveness Data and Information Set repository and all relevant data files required for rate generation;
- using licensed National Committee for Quality Assurance® certified software to produce rates;
- compiling Healthcare Effectiveness Data and Information Set data and generating the rates in collaboration with Molina teams;
- conducting quality control with responsibility to conduct abstraction of information found in the member's medical record;
- contracting with a third-party auditor to ensure the accuracy of the annual Healthcare Effectiveness Data and Information Set measurement and reporting through the annual audit;
- taking actions immediately to address any reporting issue(s) to ensure timely and accurate reporting using the National Committee for Quality Assurance's ® Interactive Data Submission System®;
- devoting dedicated resources to compile and report the measures for Molina Medicaid members;
- determining actions for improvement based on annual Healthcare Effectiveness Data and Information Set rates;
- using a systematic approach to develop and initiate actions to improve performance and address gaps and areas of non-compliance; and
- employing key steps to identify actions to take, which include, but are not limited to: 1) conducting quantitative and qualitative barrier analysis to identify the issue (s) that impact the rates and defines priority areas; 2) developing activities and interventions aimed to address the issue(s); 3) defining measures to check progress; 4) establishing standards, performance goals and benchmarks to assess effectiveness; and 5) conducting ongoing analysis to check performance levels and sustained improvement.

Employing Processes to Collect and Report Member Satisfaction and Survey Data to Medicaid Agency (as applicable)

Molina oversees and manages CAHPS and related satisfaction survey data collection and reporting activities for Molina. Molina performs the following activities, including but are not limited to:

- checking NCQA and Medicaid website for annual release specifying scope of annual survey requirements;
- checking timeliness, accuracy, and completeness of the submissions;
- devoting dedicated resources to facilitate and report the CAHPS and other survey results for Molina, managing requirements that include eligible reporting denominators of 500 or more health plan members. The survey is administered according to NCQA required timeframes, and communications with National Committee for Quality Assurance about survey participation, contacts, and vendor selection;
- contracting with a certified approved vendor to conduct the annual CAHPS survey to ensure accuracy of reported data and overall results; and
- determining actions to take based on review of results of annual survey results using a systematic approach to develop and initiate actions to improve performance and address health results.

Molina employs the following steps to identify the actions to take: 1) A qualitative barrier analysis is conducted to identify the issue(s) that impact the rates and to define priority areas; 2) activities and interventions are developed that address the issue(s); 3) measures are defined to check progress; 4) standards, performance goals and benchmarks are established to assess effectiveness; and 5) ongoing analysis is conducted to check performance levels and sustained improvement.

Promoting Health and Wellness with Web-Based and Telephonic Tools

Molina promotes health and wellness by providing members with web-based and telephonic tools to effectively manage health through:

- health appraisals that allow members to assess risks of morbidity and mortality and help them identify how to reduce these risks;
- self-management tools to assess risky and healthy behaviors;
- safety tools to help members identify drug-drug interactions;
- financial tools to assist members with determining cost for medications, surgeries, and treatment;
- access to 24-hour, 7-days-per week Nurse Advice Line; and
- identification of members eligible for wellness programs and ensuring follow-up when appropriate.

Molina also develops and maintains a provider incentives program that is broad and flexible to allow for Molina to carry out innovative market-based incentives and improve the quality and value of care through strategies that provide for increased reimbursement or other market-based incentives that reward quality health care. This program is applicable to providers who serve health plan members in different lines of business, as needed.

Managing Additional Internally Developed Quality Improvement Activities

Molina manages internally developed quality improvement activities that include, but are not limited to:

- activities that support URAC Call Center Accreditation (by Molina's external vendor) to assure members have access to dedicated and experienced personnel to support Molina's integrated care delivery programs. Molina's 24-Hour Nurse Advice Line is accredited by URAC, and Nurse Advice Line senior management oversees compliance with requirements maintained by the external vendor; and
- project management activities, materials, tools, and template reports that support National Committee for Quality Assurance accreditation. Molina plans apply the National Committee for Quality Assurance accreditation format and structure as a framework for all operations. All Molina members benefit from the foundational framework and approaches to improving and supporting health care and services that are delivered to Molina's members in collaboration with network providers.

Managing Additional Externally Required Quality Improvement Activities and Data Collection

Molina manages additional externally required activities focused on measurement, data collection, and quality improvement that address physical health, behavioral health and LTSS services. These activities include but are not limited to:

- initiation of initiatives that are required by the state Medicaid Agency, including but are not limited to quarterly health outcomes and clinical reports, and measures within Agency-approved value-based purchasing contracts;
- implementation of clinical studies and use of HEDIS data and health care Quality measures for our health plan members, including Medicaid-eligible adults (as applicable) described in Section 1139B of the Social Security Act, using data from other similar sources to periodically and regularly assess the Quality and appropriateness of care provided to health plan members (as applicable);
- reporting using the survey tool identified by the Agency for members receiving HCBS services (as applicable);
- procedures used to assess member satisfaction not already defined;
- system implementation to monitor services, including data collection and management for clinical studies, internal quality improvement activities, assessment of special needs populations and other quality improvement activities as required by external regulators;
- monitoring of prescribing patterns of network prescribers to improve quality of care coordination provided to health plan members through strategies such as: (i) identifying medication utilization that deviates from current clinical practice guidelines; (ii) identifying health plan members whose utilization of controlled substances warrants intervention; (iii) providing education, support and technical assistance to providers; and (iv) monitoring prescribing patterns of psychotropic medication to children, including children in foster care (as applicable);
- analysis of the effectiveness of treatment services, employing both standard measures of symptom reduction and management, and measures of functional status;
- monitoring of variations in practice patterns and identify outliers;
- strategies that are designed to promote practice patterns that are consistent with evidence-based clinical practice guidelines through use of education, technical support, and provider incentives (as applicable);
- annual and prospective five-year Quality Improvement Work Plan that sets measurable goals, establishes specific objectives, identifies strategies and activities to be undertaken, monitors results and assesses progress toward the goals; and
- dedicated resources (staffing, data sources and analytical resources) that includes a Quality Improvement and Health Equity Transformation Committee that oversees the quality functions.

Evaluating the Effectiveness of the Quality Improvement Program

Molina evaluates the effectiveness of the Quality Improvement Program in producing measurable improvements in the care and service supplied to Molina members through:

- organization of multi-functional teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results;
- clear documentation of meeting minutes and action items that ensures the accuracy of all Quality Improvement and Health Equity Transformation Committee and subcommittee activities. Committee minutes are contemporaneous and are dated and signed to ensure that the minutes represent the official findings of the committee;
- tracking of progress of Quality Improvement activities through appropriate committee minutes, follow-up of action items, and review and update of the Quality Improvement Work Plan during the year; and
- modification of interventions related to medical, behavioral health, social needs/social risks, health equity as required based on analysis and checking for incorporation at least annually into the Quality Improvement Work Plan.

Organizational Structure Supporting Quality Improvement: Accountability

Board of Directors

The Molina Board of Directors has ultimate authority and responsibility for the quality of care and service delivered by Molina. The Board is responsible for the direction and oversight of the Quality Improvement Program and delegates authority to the Quality Improvement and Health Equity Transformation Committee to the Chief Medical Officer, Plan President, and Quality Lead, unless otherwise specified. The Board of Directors reviews regular health plan reports and the recommendations made by the Quality Improvement and Health Equity Transformation Committee as well as any significant actions taken by the Quality Improvement and Health Equity Transformation Committee or any other committee. The Plan President also serves as a member of the Molina Board of Directors.

Quality Improvement and Health Equity Transformation Committee

The Quality Improvement and Health Equity Transformation Committee is responsible for implementation and ongoing examination of the Quality Improvement Program. Through subcommittees, the Quality Improvement and Health Equity Transformation Committee recommends policy decisions, analyzes, and evaluates the progress and results of all quality improvement activities, institutes needed action and ensures follow up.

The Quality Improvement and Health Equity Transformation Committee sets strategic direction for all Molina health plan quality activities. The committee collects data, feedback, and innovations to develop, monitor, and maintain the overall quality program, implementing process improvements as necessary. The Quality Improvement and Health Equity Transformation Committee receives reports from all Quality Improvement sub-committees, advises and directs the committees on the focus and implementation of the Quality Improvement Program and work plan. The Quality Improvement and Health Equity Transformation Committee reviews data from Quality Improvement activities to ensure that performance meets standard and makes recommendations for improvements to be carried out by sub-committees or by specific departments.

The Quality Improvement and Health Equity Transformation Committee is co-chaired by the Chief Medical Officer and the Quality Lead. The committee is composed of management of key health plan functional areas, which includes key representatives responsible for operations. A designated Behavioral Health practitioner plays a key advisory role in Molina's Quality Improvement Program and activities. The Quality Improvement and Health Equity Transformation Committee confirms and reports to the Board that plan activities comply with all state and federal regulatory requirements and meet National Committee for Quality Assurance standards. The Quality Improvement and Health Equity Transformation Committee reports any variance from quality performance goals to the Board and the plan to correct the

variance. The Quality Improvement and Health Equity Transformation Committee develops and presents an annual Quality Improvement program description, work plan and prior year evaluation, as well as quarterly summaries to the Board**.**

Quality Improvement Leadership

Plan President

The Plan President is responsible for overseeing the Quality Improvement Program, maintaining the consistency and effectiveness of the Quality Improvement Program, and confirming the Program's compliance with regulatory, contractual and accreditation standards.

Chief Medical Officer (and other Medical Directors, as applicable)

The Chief Medical Officer, who reports to the Plan President, is responsible for providing clinical guidance for the Quality Improvement Program and helps design, carry out and coordinate quality improvement activities. Key responsibilities include, but are not limited to: reporting to the Board with a Medical Affairs update at quarterly meetings; promoting the Quality Improvement Program through communication and practice; reviewing Potential Quality of Care and/or Critical Incident cases to determine outcomes; achieving organizational goals; having direct involvement in Quality Improvement activities to include analysis of Utilization Management and clinical Quality Improvement data; serving as co-chair of Quality Improvement and Health Equity Transformation Committee and the Healthcare Services Committee; facilitating the provision of health care and services including clinical oversight and leadership for utilization management/case management, credentialing, behavioral health and pharmacy; participating on the National Pharmacy and Therapeutics and Professional Review Committees; giving guidance in the development, revision and distribution of clinical practice guidelines, preventive health guidelines and benefit interpretation guidelines; communicating information and decisions to network practitioners and providers, and overseeing corrective action plans about quality of care, member safety, or service.

Designated Behavioral Health Practitioner

A designated behavioral health practitioner who is a doctoral-level practitioner, participates in developing clinical and service activities for behavioral health. The designated behavioral health practitioner key responsibilities include, but are not limited to:

- participating in Quality Improvement and Health Equity Transformation Committee, Healthcare Services and national Pharmacy and Therapeutics Committees (as applicable);
- participating in review and adoption of behavioral health guidelines;
- consulting and recommending strategies related to behavioral health activities, including review of health equity, race and ethnicity, disability status, social risks, and social needs, as applicable;
- providing the behavioral health perspective on identified issues, assessment of potential and confirmed behavioral health quality of care concerns and member safety issues, providing recommendations for further action as it relates to behavioral health; and
- screening member/provider materials to identify and communicate behavioral health needs.

Quality Leadership

The Quality Lead reports to the Plan President and leads quality improvement activities. National staff support the health plan Quality Lead,

Key responsibilities for the quality lead, include, but are not limited to:

- promoting and maintaining quality as a priority and guiding principle throughout Molina;
- identifying and carrying out patient safety activities;
- making administrative support available for resource planning, oversight, and allocation to establish and maintain an organization-wide system of quality improvement;
- serving as a resource for planning, implementing, and evaluating the Quality Improvement Program; providing operational oversight of the Quality Improvement Program and annual work plan, health education, Healthcare Effectiveness Data and Information Set, Health (e.g., Disease) Management, delegation oversight, credentialing, and other clinical measurement processes;
- coordinating health service activities to provide for measurement and analysis and obtaining additional expertise as needed;
- collaborating on National Committee for Quality Assurance accreditation preparation with oversight from the national team;
- assisting with planning, carrying out and evaluating the risk management program (as applicable); and
- managing dedicated quality staff (Managers, Program Managers and Specialists, etc.), as applicable.

National Quality Improvement and Health Equity Transformation Committee

The Quality Improvement and Health Equity Transformation Committee oversees, coordinates, and provides recommendations for Quality Improvement Program activities. The National Quality Improvement and Health Equity Transformation Committee serves as the central advisory body for the national Quality Improvement Program. The National Quality Improvement and Health Equity Transformation Committee works collaboratively with local Molina plans to carry out quality improvement activities. The National Quality Improvement and Health Equity Transformation Committee provides direction related to quality improvement projects.

The National Quality Improvement and Health Equity Transformation Committee is responsible for the following activities, which include, but are not limited to:

- overseeing Molina national quality improvement activities by coordinating implementation, reviewing findings, identifying barriers, and recommending opportunities for improvement;
- recommending quality improvement activity modifications and action plans for improvement based on quality improvement activity findings;
- summarizing quality improvement activity action plans, escalating barriers, and recommending actions;
- providing a multi-functional forum to discuss, review and approve standardized quality improvement and operational policies and procedures, template reports, and processes at least on an annual basis (or more frequently as needed) to ensure regulatory compliance;
- ensuring that summaries of quality improvement activities, policies and procedures, reports, and processes and additional policies focused on critical health care services, that have been approved by the National Quality Improvement and Health Equity Transformation Committee, are distributed to Molina Plans for additional review, discussion, approval and adapted for local use by appropriate health plan Quality Improvement and Health Equity Transformation Committee and subcommittees, as needed; and
- reviewing key performance indicators, including focus on medical, behavioral health, health equity, social needs, and social risks to ensure that Molina Plan Quality Improvement and Health Equity Transformation Committee and subcommittees are operating according to specified timelines and that complete quality improvement documentation is finalized and sent to committees on a timely basis to meet federal and state regulatory requirements and NCQA accreditation standards.

National Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee oversees and coordinates the formulary management activities for Molina. The Pharmacy and Therapeutics Committee approves the scope and activities of formulary management and reviews to influence and improve the quality of drug utilization, evaluate drug utilization for additions, modification, or deletion to/from the drug formulary at least annually, provides effective pharmacy cost management. The National Pharmacy and Therapeutics Committee is responsible for the following activities, which include, but are not limited to:

- reviewing provider utilization patterns;
- reviewing and adopting pharmacy practice consensus and/or national guidelines and criteria from appropriate external organizations at least annually;
- developing and/or reviewing provider education materials; and
- ensuring that members have access to medically necessary drugs via the Drug Formulary or prior authorization request.

National Professional Review Committee

The National Professional Review Committee oversees the credentialing, recredentialing, ongoing monitoring activities, and review of Potential Quality of Care cases (for Levels 3 and 4) for network practitioners and providers. This committee includes regional subcommittees that report up to the National Professional Review Committee. The activities of the National Professional Review Committee will be reported to the National Quality Improvement and Health Equity Transformation Committee at least quarterly.

Standing Quality Improvement and Health Equity Transformation Committee Subcommittees

The Quality Improvement and Health Equity Transformation Committee delegates quality improvement functions to specific subcommittees. Each of these sub-committees is guided by a description that outlines its composition, meeting frequency, standards, and responsibilities. All Molina Quality Improvement and Health Equity Transformation Committee subcommittees meet at least quarterly and keep contemporaneous minutes using a standard format.

Committee Participation and Responsibilities

Committee participation is based on responsibilities and includes key representatives responsible for operations. In general, committee participants are employed by Molina. Some committees may include participation of members and/or contracted providers. In general, individual network providers participate in these committees to give input into the planning, design, implementation, and evaluation of Quality Program activities.

The activities of all quality committees are treated in a confidential manner. The Quality Improvement and Health Equity Transformation Committee and subcommittees are advisory, and recommendations are reviewed. (Please refer to **Appendix A** for the committee structure).

Molina National Quality Improvement and Health Equity Transformation Committee Structure

- National Quality Improvement and Health Equity Transformation Committee. Information from the National Quality Improvement and Health Equity Transformation Committee, including clinical policies and guidelines is reported to the Compliance Committee of the Board of Directors on a quarterly basis or more often as appropriate.
- National Pharmacy and Therapeutics Committee. This committee reports to the National Quality Improvement and Health Equity Transformation Committee.
- National Delegation Oversight Committee. This committee reports to the National Quality Improvement and Health Equity Transformation Committee.
- National Professional Review Committee. This committee reports to the National Quality Improvement and Health Equity Transformation Committee.
- Compliance Committee reports directly to the Board of Directors.

Molina Quality Improvement and Health Equity Transformation Committee Structure

- Quality Improvement and Health Equity Transformation Committee. Information from the Quality Improvement and Health Equity Transformation Committee is reported to the Board of Directors on a quarterly basis or more often as appropriate.
- Healthcare Services Committee. This committee reports to the Quality Improvement and Health Equity Transformation Committee.
- Delegation Oversight Committee. This committee reports to the Quality Improvement and Health Equity Transformation Committee.
- Compliance Committee reports directly to the Board of Directors and has a dotted line relationship to the Quality Improvement and Health Equity Transformation Committee.
- Other subcommittees may include a Member Advisory Committee and the Provider Advisory Board.

The activities of all quality committees are treated in a confidential manner. All quality committees are advisory, and recommendations made nationally are evaluated by local Molina plan committees to ensure for appropriate local oversight. (Please refer to **Appendix A** for the committee structure).

Quality Roles and Responsibilities

The Quality functional area is comprised of appropriately credentialed registered nurses, health professionals, and ancillary personnel. These personnel report to the Quality Lead, and/or MHI Risk and Quality Solutions, respectively. Quality staff coordinate quality improvement policies and planned quality improvement activities. These functional area responsibilities include, but are not limited to:

- coordinating a health plan wide annual evaluation and planning cycle, resulting in an annual Quality Improvement/Healthcare Services Work Plan that outlines quality improvement objectives with action plans, goals, responsibilities, timeframes, and reporting requirements;
- coordinating clinical and service quality measurement and reporting to the Quality Improvement and Health Equity Transformation Committee;
- managing Quality Improvement projects, studies, and interventions;
- preparing and submitting Quality Improvement documents, reports and recommendations to appropriate quality committees and sub-committees;
- identifying opportunities for improvement through monitoring and analysis of clinical, health equity, social risk/social need, and satisfaction data;
- ensuring compliance with Molina and regulatory standards for timely response or resolution of complaints, grievances and appeals, in conjunction with Utilization Management and Contact Center staff;
- checking quality improvement preparation for compliance with quality-related regulatory requirements and for future accreditation;

- ensuring provision of relevant health education programs;
- carrying out the clinical quality of care case review process;
- participating on appropriate Quality Improvement and Health Equity Transformation Committee subcommittees (as applicable);
- maintaining accountability and oversight of delegated administrative functions (as applicable for Molina, that may include credentialing, utilization management, claims, and/or appeals to selected contracted provider groups and vendors;
- maintaining and carrying out quality improvement policies and procedures;
- maintaining necessary quality improvement resources including, but not limited to written materials, software, specialty consultation, analytical and statistical support;
- staffing the Quality Improvement and Health Equity Transformation Committee;
- monitoring medical record documentation;
- assisting departments to identify appropriate metrics that may be based on contractual requirements, national standards, identified key satisfaction drivers, and important clinical and social services and processes; and
- helping departments to identify appropriate data collection methodology, identify relevant opportunities for improvement, develop plans for intervention and evaluate processes for continuing improvement. In addition, quality staff has responsibility for major measurement processes such as Healthcare Effectiveness Data and Information Set data collection, reporting and improvement interventions, Consumer Assessment of Healthcare Providers and Systems, behavioral health member experience analysis and Provider Satisfaction survey data collection, reporting and improvement interventions.

Other Departmental Roles and Responsibilities for Quality Improvement

All departments have a key role in quality improvement. Departments participate in interdepartmental activities and focus on cross-functional opportunities to improve effectiveness or efficiency. All departments participate in one or more of the committees and subcommittees in the quality improvement structure.

The Healthcare Services staff is responsible for:

- developing and maintaining the Healthcare Services Program Description, policies and procedures, annual Quality/Healthcare Services work plan and program evaluation in compliance with National Committee for Quality Assurance, Molina, state, and federal requirements;
- checking for potential over- and under-utilization, coordination, and continuity of care, including access to the nurse advice line;
- documenting potential quality of care/critical incidents, risk management, and member safety issues identified during Utilization Management review;
- overseeing the coordination of care with healthcare delivery organizations (i.e., facilities) and contracted entities, and with groups delegated for Utilization Management functions; and
- carrying out the case management program in collaboration with disease management and prevention programs, including a focus on medical, behavioral health, pharmacy, social risk, and social need priorities.

The Network Management and Operations staff is responsible for:

- checking practitioner, provider and health delivery organization access and availability, including behavioral health, and carrying out of improvement plans, that focus on access and availability, including focus on disability status;
- reviewing practitioner satisfaction survey results, practitioner complaints and other forms of practitioner feedback and carry out of improvement plans;
- disseminating provider education materials as identified including statements of members' rights and responsibilities;
- administering provider inquiry process for payment issues related to post-service claims and/or service denials;
- monitoring trends of member concerns, complaints, appeals, and disenrollment related to dissatisfaction with provider and provider inaccessibility and identifying opportunities for improvement, in conjunction with Member Services staff and quality; and
- carrying out the credentialing and re-credentialing program that includes completion of office site visits (as applicable) to ensure a safe environment for members and appropriate practices.

The Contact Center staff is responsible for:

- administering members' rights and responsibilities;
- checking member access to Molina and compliance with contractual and regulatory standards for timely response or resolution of all issues, in conjunction with Provider Services;
- checking trends of member complaints, grievances, appeals and disenrollment and identification of opportunities for improvement;
- reviewing member satisfaction surveys and other forms of member feedback, identification of opportunities for improvement, and carry out of improvement activities;
- reporting all potential quality of care and risk management issues that are reported by members following policy and procedure;
- administering member complaint and appeal policy, ensuring appropriate timelines are met; and
- generating reports to check the toll-free Helpline for access standards compliance.

For the Contact Center, reports are checked daily, weekly, monthly, and quarterly by the Contact Center leadership. If compliance is not met, corrective actions are taken the following day to ensure compliance. Contact Center leadership will provide Helpline Statistics, grievance and appeal Reports, and Corrective Action Plans to the Plan President. The reports will be submitted to the related Committees and/or subcommittees as requested. The annual summary will be included in the quality improvement analysis to assure identification of opportunities to improve the services supplied by Molina to its enrollees.

Government Contracts staff is responsible for:

- overseeing compliance with all applicable statutory, regulatory, and contractual requirements;
- educating and training Molina staff about contract provisions and new laws/regulations;
- acting as the liaison with the state Agency;
- coordinating contract renewal activities; and
- preparing and reviewing member communications and submission to the state regulatory agency for approval as required, including member handbook, mailings, and all marketing materials.

Compliance staff is responsible for:

- carrying out and validating the Compliance Plan;
- preparing data and reporting relevant issues to the Compliance Committee, which reports to the Board of Directors;
- coordinating regulatory compliance audits;
- overseeing compliance with all applicable statutory, regulatory, and contractual requirements; and
- reviewing draft and final regulations and statutes;
- maintaining approved policies and procedures, ensuring annual review and approval;
- managing and reviewing confidentiality issues and provision of training as needed;
- coordinating organizational compliance for HIPAA (Health Insurance Portability and Accountability Act); and
- monitoring and trending of marketing infractions reported from the State and regulatory agencies.

Pharmacy staff is responsible for:

- identifying key processes to evaluate pharmacy safety and effectiveness;
- maintaining a notification system for drug alerts;
- developing and maintaining operational policy and procedures for effective formulary management, authorization processes and safe practices; and
- overseeing Pharmacy Benefits Manager activities to ensure practices meet Molina's standards.

Role of Participating Providers

Participating practitioners serve on clinical committees, including the Quality Improvement and Health Equity Transformation Committee, Healthcare Services Committee (as applicable), National Pharmacy and Therapeutics Committee, and the Professional Review Committee. Through committee activity, participating providers may:

- review and provide feedback on proposed clinical practice guidelines, preventive health guidelines, clinical protocols, health management programs, quality initiatives, Healthcare Effectiveness Data and Information Set results, new technology and other clinical/social/health equity issues about policies and procedures;
- review proposed Quality Improvement study designs; and
- participate in developing action plans and interventions to improve levels of care and service.

In cases where specific practitioner specialty feedback is needed, community physicians and specialists review cases and provide feedback on proposed interventions or programs. As needed, focus groups of practitioners may be used for assisting with the design or evaluation of specific programs.

Confidentiality

Molina 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, Part 431, Subpart F (Safeguarding Information on Applicants and Recipients), and the Molina Corporate Employee Handbook, Section B. Use of Protected Health Information is outlined in a privacy notice distributed to all members.

All Molina 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 members of the Quality Improvement and Health Equity Transformation Committee and subcommittees 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.

Molina's quality improvement documents are maintained in compliance with all legal requirements and include, but are not limited to, internal reviews, including patient care review studies, quality improvement studies and reports, minutes of committees and administrative (i.e., non-clinical) processes having a direct impact on the provision of care or service. The findings of all Molina Quality Improvement and Health Equity Transformation Committees and Subcommittees are part of the Quality Improvement 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 of Directors assigns the responsibility of managing and reviewing confidentiality concerns to the Government Contracts and/or the Compliance Department. A Compliance Committee has been formed as directed by the Compliance Plan and supports activities of the Quality Improvement Program. The Compliance Committee reports to the Board of Directors.

Conflict of Interest

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

Implementing a Credentialing Program

Molina maintains a comprehensive and detailed credentialing program designed to assure the network consists of quality practitioners who meet clearly defined criteria and standards. The Credentialing Program has been developed in accordance with National Committee for Quality Assurance standards and regulatory requirements. This program includes, but is not limited to:

- reviewing credentialing and recredentialing policies and procedures including processes to check Opt-Out providers that elect not to provide services to Medicaid members; and
- conducting peer reviews of credentialing and recredentialing decisions; and
- performing peer reviews of investigated quality of care issues and proposed corrective action plans; and
- overseeing delegated credentialing activities; and
- reviewing member Appeals and Grievances.

Policies and procedures within the credentialing program describe the types of practitioners who are under the scope of the credentialing program as well as the process to assure the quality of the practitioners. The policies and procedures are reviewed annually and revised and updated as needed.

The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer practitioners and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

Molina designates the Professional Review (e.g., Credentialing) Committee to make recommendations about credentialing decisions using a peer review process. Molina works with the Professional Review Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina enrollees. A practitioner may not provide care to Molina enrollees until the final decision from the Professional Review Committee is made. In situations of "clean files," network practitioners may not provide care for Molina enrollees until the final decision is made by the Molina Plan Chief Medical Officer.

6.0 Health Equity and Culturally and Linguistically Appropriate (CLAS) Services Program

Molina is committed to reducing healthcare disparities. Tools and needed training are provided to Molina plans to facilitate that high-quality care to members is provided in a culturally competent way and design programs and policies that are culturally congruent with Molina's membership. Molina guides organizational culture to ensure that long-term culturally competent, linguistically appropriate, and equitable healthcare is provided through better decision-making by policy makers and program designers. Molina specializes in practical application of cultural concepts that are employee, provider, and member friendly. These areas of focus include but are not limited to employee training, educational materials, program and policy review guidelines, and consulting.

Health Equity and Cultural Competency Program Objectives

Molina has developed a Health Equity and Cultural Competency Program to ensure the delivery of effective, equitable, understandable, respectful, and culturally competent and linguistically appropriate services and the provision of language access and disability-related access to all enrollees, including limited English Proficiency persons. Our goal is to ensure that we provide culturally and linguistically appropriate and equitable services across the continuum to reduce health disparities and improve health equity and outcomes. The plan is based on guidelines outlined in the National Standards for Culturally and Linguistically Appropriate Services in Health Care, published by the U.S. Department of Health and Human Services, Office of Minority Health. Goals and objectives are listed in the annual work plan and program evaluation and include, but are not limited to, the following:

- Collection and analysis of race, ethnicity, language, gender identity, sexual orientation, and social determinants of health (SDOH) data from eligible individuals to identify significant culturally and linguistically diverse populations within plan's membership and revalidate data at least annually;
- Collection and analysis of race, ethnicity, and language data from practitioners to assess gaps in care annually;
- Collection of data and reporting for the Diversity of Membership Healthcare Effectiveness Data and Information Set measure;
- Determination of threshold languages annually and processes in place to provide members with vital information in threshold languages;
- Identification of specific cultural, linguistic, sexual orientation, gender identity and SDOH-related disparities found within the plan's diverse populations;
- Analysis of Healthcare Effectiveness Data and Information Set measure results for potential cultural, linguistic, sexual orientation, gender identity and SDOH-related, gender and geography disparities that prevent members from obtaining the recommended key chronic and preventive services (includes data stratification of selected HEDIS and CAHPS measures by race, ethnicity, and preferred language);
- Enhancement of current patient-focused Quality Improvement activities, such as prenatal and well-child exam education and/or incentive program, to address specific cultural, linguistic, sexual orientation, gender identity and SDOH barriers using culturally, linguistically focused materials addressing identified critical barriers;
- Provision of a more thorough organizational understanding of the specific reasons behind identified cultural, linguistic, sexual orientation, gender identity and SDOH barriers and priorities. This can be accomplished through focus groups, member feedback forms or surveys, and complaint analyses;
- Selection of critical barrier (s) found through the various cultural, linguistic, sexual orientation, gender identity and SDOH analyses for specific intervention;
- Analysis of interpreter availability;
- Development of educational materials to meet the cultural, linguistic, sexual orientation, gender identity and SDOH needs of the population served as well as those with complex conditions;
- Provision of staff with necessary information, training, and tools to address identified cultural, linguistic, and social barriers;

- Identification, implementation and checking of planned activities related to the Americans with Disabilities Act requirements, such as provider, staff and member training, communication, and assessment of provider compliance;
- Identification, carry out and checking planned activities related to the Americans with Disabilities Act requirements, such as provider, staff and member training, communication, and assessment of provider compliance; Identification and development of initiatives to address the needs of communities within the health plan's service areas, including but not limited to Black, Indigenous and People of Color.
- Continued expansion of the continuous quality improvement process to identify existing disparities related to race, ethnicity, language, gender, geography, and social determinants of health and then implement at least two data-driven activities to reduce disparities related to race, ethnicity and social determinants of health.
- Monitoring of access and utilization of services within communities of color, and individuals with social needs, such as housing insecurity, and others who are at risk due to related disparities.
- Work with community engagement and with external stakeholders to increase equitable access to health care services and treatment for populations identified at risk through new policies or increased collaboratives and through participation on state-health plan joint workgroups.
- Development of enhanced evidence-based approaches and strategies to reduce disparities based on race and ethnicity and for additional specific populations, such LGBTQIA+ population related to service access as available.
- Evaluation of the Culturally and Linguistically Appropriate Services Program to include assessment of completion of planned activities, identification of barriers, opportunities, and interventions to overcome barriers, and overall effectiveness.

Cultural Competency Training

Molina provides training to staff and clinicians with the purpose of educating participants in the complexities of diverse cultures and backgrounds as it relates to care of patients and their families. Cultural beliefs, social structure, and health practices will be discussed in detail with application of practical strategies. Additionally, cultural, and linguistic service principles are integrated into every program to help Molina's practitioners and employees understand how patients' cultural backgrounds affect their approach to healthcare. Areas of training include the changing demographics in the U.S., key components of cultural competency, diversity in different types of medical care, tips on communicating with individuals with different backgrounds, LGBTQIA+ community, social determinants of health, implicit bias, systemic racism, health disparities and equity, geography, language access services and caring for seniors and persons with disabilities.

General cultural competency training is supplied to all employees, while additional training is supplied according to needs determined by each employee's job description, level of interaction with members or providers, and identification of cultural groups being served by the local offices. Training for employees and providers is supplied in modules delivered through a variety of methods including, but not limited to:

- Written materials – Provider Manuals, newsletters, and electronic publications;
- Access to enduring reference materials available through the health plan;
- Integration of cultural competency concepts into provider communications; and
- References for further education and training.

Data Collection for Race, Ethnicity, Language Preferences, Sexual Orientation, Gender Identity and Social Determinants of Health

Molina understands the significance of demographic shifts and conducts ongoing infrastructure assessment to determine whether members' needs are met in the appropriate language and cultural context. As part of this ongoing assessment, Molina has a health information system in place to collect, analyze and evaluate its membership and provider network based on ethnicity, gender, and languages spoken. Additionally, member data is verified whenever the member has contact with the health plan and is regularly updated to reflect demographics and language preferences. Molina also collects member data on sexual orientation, gender identify and social determinants of health.

Many data systems are utilized and analyzed to compare against previous years, available thresholds, and provider distribution. Data analysis each year is conducted through the Quality Improvement Functional Area to understand member demographics based on race, ethnicity, languages spoken, sexual orientation, gender identity and social determinants of health. Data findings are reported to Quality Improvement and Health Equity Transformation Committee and subcommittees to review, approve, and solicit interventions for improvement. Possible interventions may include provider network expansion, increased translation services, and member material enhancement to accommodate changing member demographics.

Data Analysis

Molina conducts periodic needs or population health assessments to identify the needs of the local population, expectations about healthcare, and key drivers of satisfaction related to access and receipt of healthcare within the system and community. This detailed analysis of the community can include stratification of analysis for specific high-volume populations by race, ethnicity and language spoken and high prevalence disease states in a single area. The analysis identifies specific actionable concepts that could be applied to policy and program development to enhance the delivery of high-quality care in the region. It also allows Molina to document sustainable, automated, or near-automated processes that may be applied on an annual basis to enable ongoing tracking and early warning of population and market preference changes in a dynamic population.

Language Services

Molina ensures that members can access language services, such as interpreting and written translation, and programs and services that are congruent with cultural norms. Such congruency with member populations leads to better communication, understanding and member satisfaction. From the time a member joins Molina, Molina's Contact Center begins working directly with members to identify individual considerations about language, culture, and issues of personal importance. Molina has staff within the Contact Center and the Nurse Advice Line who are bilingual in English and Spanish, as well as other languages spoken by members.

7.0 Evidence-Based Clinical Practice and Preventive Health Guidelines

Molina adopts and disseminates clinical practice and preventive health guidelines relevant to health plan members for the provision of preventive, acute or chronic condition management and behavioral healthcare services. The adopted 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 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 and distributed clinical practice guidelines focused on the following key topics that include but may not be limited to:

Physical Health Guidelines	**Behavioral Health Guidelines**
Asthma	Acute Stress and Post-Traumatic Stress Disorder
Children with Special Health Care Needs	Anxiety/Panic Disorder
Chronic Kidney Disease	Attention Deficit and Hyperactivity Disorder
Chronic Obstructive Pulmonary Disease	Autism
Diabetes	Bipolar Disorder
Heart Failure in Adults	Depression
Hypertension	Homelessness – Special Health Care Needs
Obesity	Opioid Management
Perinatal Care	Schizophrenia
Pregnancy Management	Substance Abuse Treatment
Sickle Cell Disease	Suicide Risk
	Trauma-Informed Primary Care

Additionally, to meet the Early and Periodic Screening, Diagnostic, and Treatment Program requirements and adult preventive health recommendations, Molina adopts and disseminates preventive health guidelines based on Bright Futures/American Academy for Pediatrics, the Centers for Disease Control and Prevention, and the U.S. Preventive Services Task Force for children and adults that include but may not be limited to:

- Adult Preventive Services Recommendations;
- Recommendations for Preventive Pediatric Health Care;
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States; and
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States.

The preventive health guidelines focus on care of children and adolescents 18 years and younger and immunizations and preventive services for adults 19 and older.

To evaluate the effectiveness of the guidelines, Molina measures performance of at least two important aspects of the following clinical practice guidelines:

- A clinical practice guideline for an acute or chronic medical condition;
- A second clinical practice guideline for an acute or chronic medical condition;
- A clinical practice guideline for a behavioral health condition;
- A second clinical practice guideline for a behavioral health condition that addresses children and adolescents; and
- Two preventive health guidelines.

The measures assessed must relate to the clinical process of care found within the guidelines that is most likely to affect care. Guideline compliance is monitored through an assessment of Healthcare Effectiveness Data and Information Set performance measurement rates that are collected each year. Topics and effectiveness of clinical practice and preventive health guidelines are reviewed and approved by the Quality Improvement and Health Equity Transformation Committee at least annually, with review of changes occurring at least quarterly to identify new guidelines or changes to existing guidelines.

8.0 Delegation Activities

Molina may delegate credentialing, utilization management, case management, claim processing, and/or appeals to provider groups or Health Delivery Organizations that meet delegation requirements. Prior to delegation, Molina conducts on-site delegation pre-assessments to determine compliance with regulatory and accreditation 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 national and/or health plan Delegation Oversight Committee, which reports to the national or health plan Quality Improvement and Health Equity Transformation Committee. The National or health plan Delegation Oversight Committee requires corrective action of delegates when necessary. The Delegation Oversight lead 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 Quality Improvement and Health Equity Transformation Committee.

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.

9.0 Quality Improvement Program Evaluation

The Quality Improvement Program Description and Work Plan govern the program structure and activities for a period of one calendar year. At least annually, Molina conducts a formal evaluation of the Quality Improvement Program. Molina uses internal Quality Specialists, external survey vendors and analysts to collect, analyze and report on the above data using manual analysis and electronic software. Evaluation of quality activities will include a description of limitations and barriers to improvements.

Molina evaluates Quality Improvement Program activities, identifies program outcomes, and includes, but is not limited to, the following review processes. This evaluation includes:

- review of quality improvement activity implementation during the year and identification of quantifiable improvements in care and service;
- production of a trended indicator report and brief analysis of changes in trends, barriers that impact the rates and improvement actions taken because of trends and to mitigate barriers;
- identification of opportunities to strengthen member safety activities;
- evaluation of resources, training, scope, and content of the program and practitioner participation;
- identification of limitations and barriers and makes recommendations for the upcoming year, including identification of activities that will carry over into next year; and
- evaluation of the overall effectiveness of the Quality Improvement Program.

For the care model evaluation, data analyzed and reported focuses on improved member access to services and benefits; improved health status; adequate service delivery processes; use of evidence based clinical practice guidelines for management of chronic conditions; and satisfaction with Molina's programs. Analysis is also performed of the effectiveness of treatment services, employing both standard measures of symptom reduction/management, and measures of functional status.

Maintenance and storage of all quality improvement evaluation activities are housed in Molina's HIPAA-compliant and secure web-based systems and platform. Molina maintains reasonable and appropriate levels of safeguarding practices to protect electronic and other sensitive member information, to limit incidental uses or disclosures. All electronic information will be used, stored, handled, and transmitted in accordance with all applicable legal, regulatory, contractual, and company policies, standards, and requirements.

Molina determines the actions to take based on the results of quality improvement activities, including the care model measure analysis. A systematic process is used to develop and initiate actions to improve performance. This process is used throughout the organization to support and improve procedures, systems, quality of service, cost, and health results. The process to identify actions to take include but may not be limited to. the following steps:

- conducting qualitative barrier analysis on the measures to identify the issue(s) and define priority areas, defining measures to monitor progress;
- developing activities and interventions aimed to address the issue(s);
- establishing standards, performance goals and benchmarks to assess effectiveness; and
- performing ongoing analysis to monitor performance levels and sustained improvement.

10.0 Governing Body Review and Approval

Molina's Quality Improvement Program activities are reported to the Board of Directors through quarterly and annual reports. The Quality Improvement Program Description and Quality Improvement Work Plan are approved for the coming year. The Quality Improvement Program Evaluation from the previous year is also submitted to the Board of Directors for review and approval. The Board of Directors may act on the Quality Improvement Program evaluation findings and recommend changes and improvements to be made.

11.0 Glossary

HEDIS: Healthcare Effectiveness Data and Information Set

HIPAA: Health Insurance Portability and Accountability Act

NCQA: National Committee for Quality Assurance

PDSA: Plan, Do, Study, Act Improvement Project

Molina Healthcare of California

Quality Improvement and Health Equity Transformation Committee Structure

Molina Healthcare of California:
Quality Improvement Program and Committee Oversight

The Molina Healthcare of California Board of Directors has the ultimate authority and responsibility for the quality of care and services delivered by Molina. The Board is responsible for the direction and oversight of the quality improvement program and delegates authority for Molina Healthcare of California's Quality Improvement and Health Equity Transformation Committee (QIHETC) and quality improvement program oversight to the Plan President, the Chief Medical Officer, Chief Health Equity Officer and the AVP, Quality, unless otherwise specified. The Board of Directors annually approves the Quality Improvement and Health Equity Transformation Program plan, reviews regular health plan reports and recommendations made by the QIHETC as well as significant actions taken by the QIHETC or reporting subcommittee. The Plan President also serves as a member of the Molina Healthcare of California Board of Directors.

Molina Healthcare of California:
Quality Improvement and Health Equity Transformation Committee
Roles, Functions and Responsibilities

Molina Healthcare of California's Quality Improvement and Health Equity Transformation Committee is responsible for implementing and monitoring the health plan's quality improvement program. Molina Healthcare of California's QIHETC recommends and implements policy decisions, evaluates barriers, reviews quality improvement activity progress, institutes needed action, and ensures follow up. The committee also reviews quality improvement activity data and results to ensure that performance meets stated goals, addresses potential barriers, and makes improvement recommendations. The committee is co-chaired by the Chief Medical Officer, Chief Health Equity Officer and the AVP, Quality with participation from health plan leadership and network practitioners.

Four subcommittees also report to Molina Healthcare of California's Quality Improvement and Health Equity Transformation Committee. The subcommittees - the Healthcare Services Committee, Delegation Oversight Committee, the Community Advisory Committee, and the Provider Advisory Committee - provide activity updates to the QIHETC at least quarterly.

Molina Healthcare of California's QIHETC also ensures that quality improvement activities meet state and federal regulatory requirements and National Committee for Quality Assurance standards. On behalf of the QIHETC, the Chief Medical Officer or the AVP, Quality presents the annual quality improvement program description, work plan, prior year quality program evaluation, and quarterly activity summaries to the Board. Additionally, the Chief Medical Officer or the AVP, Quality presents variances from quality improvement goals and recommended action plans to the Board.

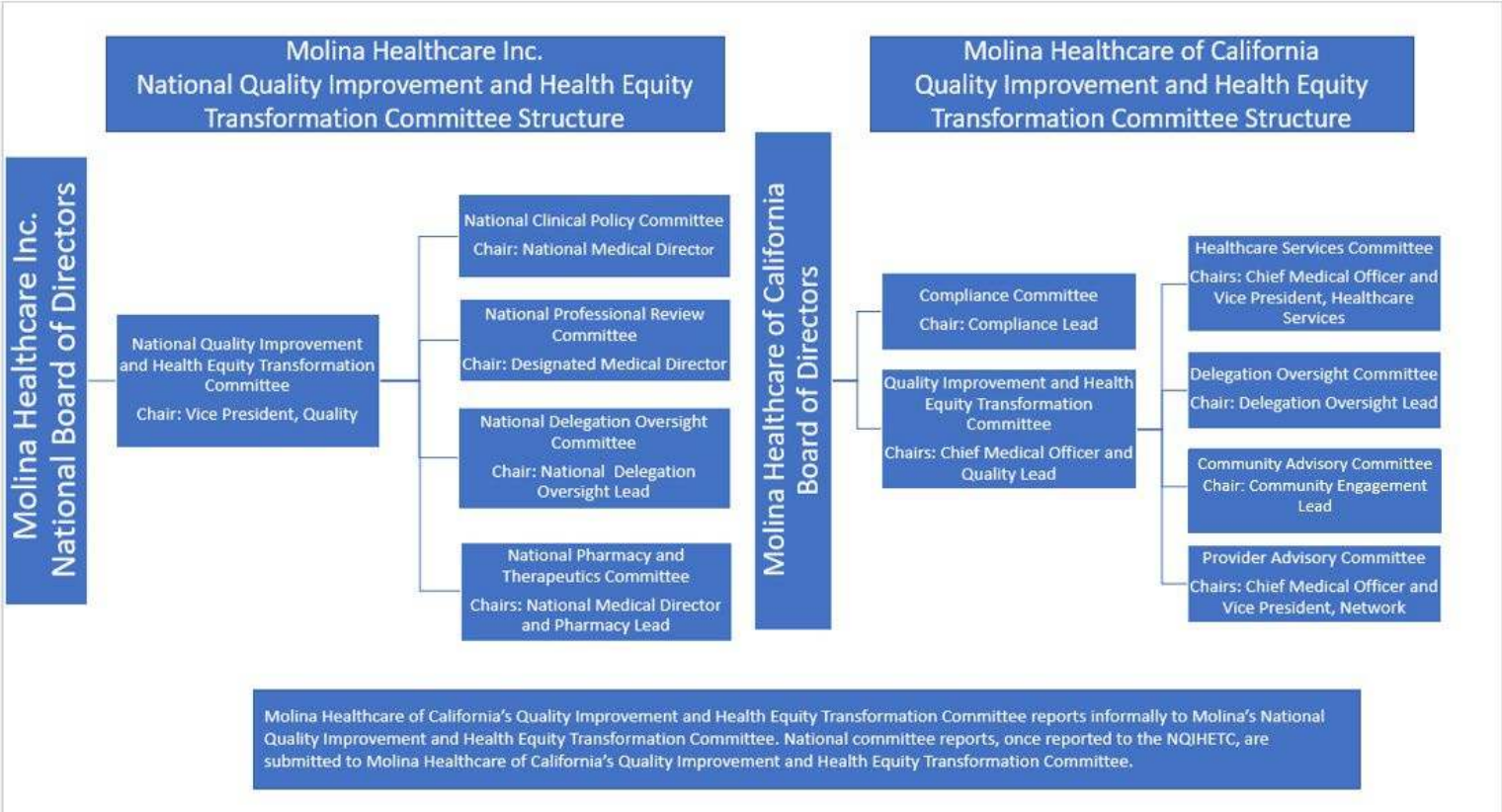
Molina's National Quality Improvement and Health Equity Transformation Committee Roles, Functions and Responsibilities

Molina Healthcare of California's quality program is supported by national activities that are overseen by Molina's National Quality Improvement and Health Equity Transformation Committee (NQIHETC). The NQIHETC oversees and makes recommendations about key quality improvement programs, including the review and adoption of consensus-based clinical practice and preventive health guidelines. The NQIHETC also serves as the central advisory body for national quality activities with representation and participation from Molina plans. The NQIHETC is chaired by the Vice President, Quality. The Molina national Board of Directors oversees Molina's national quality improvement program and NQIHETC activities.

The NQIHETC members include Chief Medical Officers, Quality Leads, and Vice Presidents, Healthcare Services from all Molina health plans, including Molina Healthcare of California. Key national experts from Molina, including behavioral health, pharmacy, clinical, quality, credentialing, and operational leaders actively participate on this committee. Quarterly summaries are presented to the NQIHETC from four subcommittees– the National Clinical Policy Committee, National Delegation Oversight Committee, National Professional Review Committee, and National Pharmacy and Therapeutics Committee.

The visual below provides additional details about the committee structure. The visual describes the committee structure followed by narrative descriptions about critical subcommittee roles and responsibilities.

Molina Healthcare of California
Quality Improvement and Health Equity Transformation Committee Structure



Molina Healthcare of California's QIHETC Subcommittees
Roles, Functions and Responsibilities

Healthcare Services Committee
The Healthcare Services Committee coordinates, directs and monitors the physical health, behavioral health and social/functional components of utilization management, case management, care coordination, Population Health Management, and Transitions of Care programs. The Healthcare Services Program Description and the combined Quality Improvement and Healthcare Services Work Plan govern the activities of this committee. The Healthcare Services Committee reports to the QIHETC.

Delegation Oversight Committee
The Delegation Oversight Committee oversees administrative functions of delegated organizations to ensure that organizations comply with federal and state regulatory requirements and NCQA accreditation standards as applicable. Delegated functions may include, but not limited to credentialing, utilization management, claims, pharmacy, call center, and non-emergency medical transportation. The Delegation Oversight Committee reports to the QIHETC.

Community Advisory Committee
The Community Advisory Committee is designed to receive input from health plan and community members about key Molina quality improvement, clinical, and member experience programs. To receive varied and substantive input, participating members are recruited from across the state of California. Molina incorporates committee member feedback into the design of new or modified current programs and use member input to evaluate the effectiveness of Molina's quality program. The Community Advisory Committee reports to the QIHETC.

Provider Advisory Committee
The Provider Advisory Committee is designed to receive input from network practitioners about key Molina quality improvement, clinical, member and provider experience programs. To receive varied and substantive input, participating network practitioners of different specialties are recruited. Molina incorporates provider feedback into the design of new or modified current programs and use provider input to evaluate the effectiveness of Molina's programs. The Provider Advisory Committee reports to the QIHETC.

Molina's National QIHETC Subcommittees
Roles, Functions and Responsibilities

National Delegation Oversight Committee
Like Molina Healthcare of California's Delegation Oversight Committee, Molina's National Delegation Oversight Committee oversees national delegated organizations to ensure compliance with federal and state regulatory requirements and NCQA accreditation standards. The National Delegation Oversight Committee oversees functions may include, but are not limited to credentialing, utilization management, claims, pharmacy, call center, and non-emergency medical transportation. The National Delegation Oversight Committee, chaired by the delegation oversight lead, reports to Molina's National QIHETC.

National Clinical Policy Committee
The National Clinical Policy Committee, with participation from clinical leadership across Molina, reviews and recommends clinical policy adoption that govern the Utilization Management program at Molina. The committee, chaired by a designated National Medical Director, reports to Molina's National QIHETC.

National Professional Review Committee
The National Professional Review Committee, with participation from medical directors across Molina and external network practitioners from a variety of specialties (e.g., primary care, specialty care, behavioral health, and pharmacy), evaluate credentialing and recredentialing statuses and make decisions for new and current practitioners. The committee, organized into dedicated regions, also review Level 3 and Level 4 (highest level) Potential Quality of Care cases for next steps. CA Facility Site Review program decisions and reporting flows through the Professional Review Committee. The committee, chaired by Molina health plan Chief Medical Officers, reports to Molina's National QIHETC.

National Pharmacy and Therapeutics Committee
The National Pharmacy and Therapeutics Committee includes participation from medical directors and pharmacists across Molina and external network practitioners from a variety of specialties (e.g., primary care, specialty care, behavioral health, and pharmacy). The committee reviews pharmacy policies and procedures, new additions or changes to the health plan formulary, and medication management initiatives. The committee, chaired by a national medical director, reports to Molina's National QIHETC.

Molina's Quality Improvement and Health Equity Transformation Program dedicated leadership and staff *Roles, Functions and Responsibilities*

Molina's Board of Directors, with ultimate authority and responsibility for the quality of care and service delivered by Molina, oversees the direction and oversight of the QIHETP and delegates authority for the Quality Improvement and Health Equity Transformation Committee to the Chief Medical Officer and Plan President. The Board of Directors reviews regular health plan reports and the recommendations made by the Quality Improvement and Health Equity Transformation Committee as well as significant actions taken by the Quality Improvement and Health Equity Transformation Committee or any other committee. The Board of Directors directs necessary modifications t QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards in the DHCS contract and the DHCS Comprehensive Quality Strategy.

The Plan President serves as a member of the Molina Board of Directors and is delegated by Board of Directors to oversee overall quality improvement and health equity transformation program. The Plan President oversees the QIHETP, maintaining the consistency and effectiveness of the Program, and confirming the Program's compliance with regulatory, contractual and accreditation standards.

The Chief Medical Officer, reporting to the Plan President, is responsible for providing clinical guidance for the QIHETP and helps design, carry out and coordinate quality improvement and health equity transformation activities.

The Chief Health Equity Officer, reporting to the Chief Medical Officer, is responsible for providing health equity guidance for the QIHETP and helps design, carry out and coordinate quality improvement and health equity transformation activities.

The dedicated behavioral health practitioner, acts as the designated behavioral health practitioner and participates in developing behavioral health clinical and service activities for behavioral health.

The Quality Lead, reporting to the Plan President leads Quality Improvement and Health Equity Transformation activities. Key responsibilities for this position include promoting and maintaining quality and health equity transformation as a priority and guiding principle; identifying and carrying out patient safety activities; planning, overseeing, and allocating resources to establish and maintain an organization wide system of quality; serving as a resource for planning, implementing, and evaluating the QIHETP; providing operational oversight of the QIHETP and annual work plan, health education, Healthcare Effectiveness Data and Information Set®, Health (e.g., Disease) Management, delegation oversight, credentialing and other clinical measurement processes; coordinating health service activities to provide for measurement and analysis, collaborating on National Committee for Quality Assurance (NCQA) accreditation preparation with oversight from the national team; and managing staff dedicated to quality and health equity transformation activities, such as Managers, Program Managers and Specialists, as applicable.

All departments have a key role in quality improvement and health equity transformation. Departments participate in interdepartmental activities and focus on cross-functional opportunities to improve effectiveness or efficiency. All departments participate in one or more of the committees and subcommittees in the Quality Improvement and Health Equity Transformation structure.

The Quality functional area is comprised of appropriately credentialed registered nurses, health professionals, and ancillary personnel. These personnel report to the AVP, Quality, and/or MHI Risk and

Quality Solutions, respectively. Quality staff coordinate quality improvement and health equity transformation policies and planned quality improvement and health equity transformation activities. These functional area responsibilities include, but are not limited to: coordinating a health plan wide annual evaluation and planning cycle, resulting in an annual Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan that outlines quality improvement and health equity transformation objectives with action plans, goals, responsibilities, timeframes and reporting requirements; coordinating clinical and service quality measurement and reporting to the Quality Improvement and Health Equity Transformation Committee; managing Quality Improvement and Health Equity Transformation projects, studies and interventions; preparing and submitting Quality Improvement and Health Equity Transformation documents, reports and recommendations to appropriate quality committees and sub-committees; identifying opportunities for improvement through monitoring and analysis of clinical, health equity, social risk/social need and satisfaction data; ensuring provision of relevant health education programs; carrying out the potential quality of care case review process; maintaining accountability and oversight of delegated administrative functions (as applicable for Molina, that may include credentialing, utilization management, claims, and/or appeals to selected contracted provider groups and vendors; maintaining and carrying out quality improvement and health equity transformation policies and procedures; maintaining necessary quality improvement and health equity transformation resources including, but not limited to written materials, software, specialty consultation, analytical and statistical support; assisting departments to identify appropriate metrics that may be based on contractual requirements, national standards, identified key satisfaction drivers, and important clinical and social services and processes.

Healthcare Services staff is responsible for developing and maintaining the Healthcare Services Program Description, policies and procedures, annual Quality Improvement and Health Equity Transformation/Healthcare Services work plan and program evaluation; checking for potential over- and under-utilization, coordination, and continuity of care, critical incident reporting, and carrying out the case management program in collaboration, including a focus on medical, behavioral health, pharmacy, social risk and social need priorities.

The Network Management and Operations staff is responsible for checking practitioner, provider and health delivery organization access and availability, including behavioral health, and carrying out of improvement plans, that focus on access and availability, including focus on disability status; reviewing practitioner satisfaction survey results, practitioner complaints and other forms of practitioner feedback and carry out of improvement plans; disseminating provider education materials and carrying out the credentialing and re-credentialing program that includes completion of office site visits (as applicable) to ensure a safe environment for members and appropriate practices.

The Contact Center staff is responsible for administering members' rights and responsibilities; checking trends of member complaints, grievances, appeals and disenrollment and identification of opportunities for improvement; reviewing member satisfaction surveys and other forms of member feedback, identification opportunities for improvement, and carry out of improvement activities; administering member complaint and appeal policy, ensuring appropriate timelines are met; and generating reports to check the toll-free Helpline for access standards compliance.

Government Contracts staff is responsible for overseeing compliance with all applicable statutory, regulatory and contractual requirements; educating and training Molina staff about contract provisions and new laws/regulations; acting as the liaison with the state Agency.

Compliance staff is responsible for carrying out and validating the Compliance Plan; preparing data and reporting relevant issues to the Compliance Committee, which reports to the Board of Directors; coordinating regulatory compliance audits; overseeing compliance with all applicable statutory, regulatory, and contractual requirements.

Pharmacy staff is responsible for identifying key processes to evaluate pharmacy safety and effectiveness; maintaining a notification system for drug alerts; developing and maintaining operational policy and procedures for effective formulary management, authorization processes and safe practices.

Medicare Quality Program Requirements

Molina implements a comprehensive quality improvement program that aligns with Medicare quality requirements. Our quality improvement program for Medicare includes but is not limited to the following components.

An Ongoing Quality Improvement Program

Molina develops and implements quality program activities that are tracked using a comprehensive work plan. This work plan includes a listing of critical activities that occur during the year. Activity objectives are tracked along with timeline, responsible parties, action plan, goals. Once activities are completed, documentation is put together that shows results, whether goals were met, and any identified barriers.

Program monitoring also includes a process to implement plans of correction when issues are identified through internal surveillance, review of member complaints or other mechanisms. The results of corrective actions are brought forward to leadership and committee review as needed.

Molina also implements a committee structure that allows for ongoing monitoring, review, and evaluation of key quality programs. Through the Quality Improvement and Health Equity Transformation Committee, committee members provide input into the status of quality program activities and offer recommendations for improvement.

At least annually, Molina formally evaluates the impact and effectiveness of the quality improvement program. This evaluation allows Molina to measure the progress and success of quality activities, identify barriers, make recommendations for improvement, and then modify programs to re-evaluate success.

A Health Information System to Support the Quality Improvement Program

Molina maintains a health information system that allows Molina to conduct comprehensive quality improvement activities. Using the health information system, Molina collects, analyzes, and integrates data to help implement quality improvement activities. Within the quality improvement program, Molina also ensures that the information received from providers is reliable and complete. Molina also makes information available to the Centers for Medicaid & Medicaid Services as required.

Implementing Chronic Care Improvement Program and Quality Improvement Projects

(42 CFR §422.152(c)–(d)

Molina uses a continuous quality improvement model based on the Plan Do Study Act cycle that is adopted by the Centers of Medicare & Medicaid Services to implement the Chronic Care Improvement Program (and Quality Improvement Projects as needed). Molina uses four steps of the Plan Do Study Act cycle to implement a systematic ongoing approach for quality improvement initiatives. Molina conducts the following activities, including but not limited to:

- using a quality improvement model for the Chronic Care Improvement Program/Quality Improvement Project processes, specifications, and objectives;
- demonstrating progress of program/project implementation and data collection plan;
- analyzing data to determine program/project impact on members and action plans based on findings;
- identifying differences between actual and anticipated program/project results;
- taking specific actions or steps based on current program/project results;
- submitting annual updates for the Do, Study, and Act components of the Plan Do Study Act model to monitor and report ongoing program operations;
- attesting to ongoing plans for the Chronic Care Improvement Program and Quality Improvement Projects (as needed) through the “Quality and Performance” module of the Health Plan Management System;
- ensuring that providers participate in the Centers for Medicare & Medicaid Services and Health and Human Services’ quality improvement initiatives (42 CFR §422.152(a)(3));
- reviewing the process annually to formally evaluate quality program impact and effectiveness (42 CFR §422.152(f)(2));
- implementing internal surveillance, complaints or other mechanisms used to monitor corrective actions as needed (42 CFR §422.152(f)(3));
- fielding the Medicare Consumer Assessment of Healthcare Providers and Systems surveys using an authorized vendor (42 CFR §422.152(b)(5));
- collecting, reporting, implementing and re-evaluating performance measure review using standard measures as required by the Centers for Medicare & Medicaid Services (42 CFR §422.152(e)(i));
- reporting key performance measures to health plan stakeholders, including the Centers for Medicare & Medicaid Services, members, providers, and the public;
- maintaining confidentiality of the doctor-patient relationship with required reporting to the Centers for Medicare & Medicaid Services related to cost of operations, patterns of utilizations of services, and availability, accessibility, and acceptability of Medicare approved and covered services (42 CFR §422.516(a)); and
- submitting a written Quality Improvement Program Plan once a new plan is implemented that outlines the elements of a Quality Improvement Program.

Molina submits an evidence-based Model of Care to the Centers for Medicare & Medicaid Services for evaluation and approval by the National Committee for Quality Assurance in accordance with the Centers for Medicare & Medicaid Services' guidance. 42 CFR §422.101(f) and §422.152(g).

Molina's Model of Care provides the structure for care management processes and systems that will enable Molina to provide coordinated care for special needs individuals. The Model of Care includes a comprehensive description of the Special Needs Population with an overview of the population that addresses the entire continuum of care of current and potential members, in addition to end-of-life needs and considerations, if it is relevant to Special Needs Plan populations.

In Molina's Model of Care, Molina describes the Special Needs Plan population with clear documentation of how Molina staff determines or will determine eligibility of Special Needs Plan members. Molina includes a profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with members in Molina's geographic service area and identifies and describes health conditions that impact members, including characteristics that affect health such as average age, gender, and race and ethnicity. Molina also evaluates potential health disparities associated with specific groups such as language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs and barriers, and caregiver considerations, among other issues.

Within the Model of care, Molina includes a comprehensive description of care coordination process and activities. Molina addresses care coordination activities; defines staff structure, including employed and/or contracted staff that perform clinical functions, employed and/or contracted staff that performs administrative and clinical oversight functions; identifies contingency plan(s) to ensure ongoing monitoring of continuity of critical staff functions; describes process for conducting initial and annual Model of Care training for its employed and contracted staff; and describes how Molina documents and maintains training records as evidence to ensure training is provided to our employed and contracted staff was completed. As applicable, Molina also explains challenges that impact completion of Model of Care training for employed health plan and contracted staff.

Molina also contracts with a comprehensive provider network for our Special Needs Plan population. Molina's provider network has extensive clinical expertise in order to perform extensive medication management, disease management, and behavioral health care and services. In addition, Molina's provider network allows Special Needs Plan members to receive health care and services across the entire care continuum; and obtain extra services and benefits that meet specialized psychosocial, functional, and end-of-life needs of the most vulnerable members as evidenced by measures that are evaluated by Molina.

Molina implements a quality improvement program in line with the Model of Care program goals for Special Needs Plans. Molina's quality improvement program goals include improving Molina's ability to deliver high quality health care and services to our health plan members. As

previously mentioned, we use quality tools to evaluate and improve our health plan's effectiveness and efficiency to drive organizational change. Our quality improvement program is overseen by health plan quality and clinical leadership to the Board of Directors. We evaluate the quality improvement program to measure the current level of performance and determine if health plan systems and processes must be modified based on results.

Molina's Quality Improvement Program describes how Molina provides services to Medicare members; detects whether the Model of Care meets the unique healthcare needs of health plan members; uses the continuous quality improvement cycle to collect, analyze, evaluate and report on quality performance; employs specified data sources, performance and outcome measures to evaluate success; involves leadership, management and other critical staff personnel and stakeholders in the quality improvement process; and integrates Special Needs Plan-specific measurable goals and health outcomes objectives into the overall quality improvement program.

Molina also implements our quality improvement program to achieve measurable goals and health outcomes by identifying, clearly defining, and communicating measurable goals and health outcomes. Molina focuses on program goals that improve access and affordability through effective coordination of care and delivery of services; promote care transitions across all health care settings and providers; monitor appropriate utilization of services for preventive health and chronic conditions; focus on health outcomes; and use methods to assess and track the impact of the Model of Care on health outcomes.

Measuring Member Experience of Care

Molina uses the member satisfaction surveys, like the Consumer Assessment of Healthcare Providers and Systems survey and case management tools, to evaluate Special Need Plan member satisfaction. The results of these surveys are incorporated into the overall Model of Care quality program.

Evaluating the Quality Program

Molina evaluates the Model of Care on an ongoing basis through review of quality indicator results and measures to support ongoing improvement of the Model of Care.

Through multiple feedback mechanisms, such as quality committee discussions, network practitioner meetings, survey results, and complaint and appeal reviews, Molina discusses and evaluates barriers and factors that affect performance. Through this process, Molina uses quality improvement tools to interpret and respond to lessons learned through the Model of Care performance evaluation process.

Molina also documents and presents the results of our quality program evaluation to the Quality Improvement and Health Equity Transformation Committee and the Board of Directors. Molina also shares the evaluation results with providers and internal leadership and key stakeholders, including the Board of Directors.

Molina uses a comprehensive process to communicate and disseminate the results of quality performance to internal leadership and external stakeholders, including the Board of Directors, senior management, key employees, providers, members (and caregivers), the public and regulatory agencies as needed.

Molina reports key performance measures including annual Medicare Healthcare Effectiveness Data and Information Set® measures. During this process, we submit the required audited summary-level data to the National Committee for Quality Assurance. We also report patient-level data to the designated patient-level data contractor. Molina also reports Health Outcomes Survey results in addition to Consumer Assessment of Healthcare Providers and Systems ® survey results annually if our health plan has achieved at least minimum enrollment of 600 eligible members as of July 1st of the previous year.

Marketplace Quality Requirements

Molina implements a quality improvement program for Marketplace that is designed to improve health care and services provided to health plan members. Molina also collaborates with network practitioners to implement a quality program designed to improve health care and services. Molina evaluates the effectiveness of the quality improvement program annually.

Through our Marketplace quality improvement program, Molina collects and reports quality measures that are required through the Marketplace Quality Rating System, including HEDIS measures. Molina also fields and reports the results of the required Qualified Health Plan member satisfaction survey. While customized to Marketplace, the Qualified Health Plan member satisfaction survey is like the Consumer Assessment and Healthcare Providers and System surveys that are fielded for other lines of business, such as Medicaid and Medicare.

Molina also implements a focused Quality Improvement Strategy focused on diabetes hemoglobin A1C control and the receipt of diabetes eye exams. Molina's Quality Improvement Strategy aligns with the requirements described in section 1311(g)(1) of the Patient Protection and Affordable Care Act. The goals of the Quality Improvement Strategy are designed to provide increased reimbursement or other market-based incentives to improve health outcomes, reduce hospital readmissions, improve patient safety, and reduce medical errors, implement wellness and health promotion activities, and/or reduce health and health care disparities. Molina's Quality Improvement Strategy also aligns with the Centers for Medicare & Medicaid Services' Quality Strategy.

Appendix B: State-Specific Program Activities

- Molina Healthcare of California (MHC) shall comply with all DHCS Quality related reporting activities as stated in the Medi-Cal GMC Primary Contracts Exhibit A, Attachment 4 Section 8
- MHC annually or as designated by DHCS shall with an external quality of care review and cooperate with an EQRO as designated by DHCS per the Medi-Cal

  GMC Primary Contracts Exhibit A, Attachment 4 Section 9MHC shall participate in two Quality Improvement Projects (QIPs) approved by DHCS outlined in the Medi-Cal

  GMC Primary Contracts Exhibit A, Attachment 4 Section 9 (D)
- MHC will conduct site review, site review activities, site review reports, site review corrective actions and ongoing monitoring as stated in in the Medi-Cal GMC Primary Contracts Exhibit A, Attachment 4 Section 10
- MHC shall maintain a Disease Management Program as required by the Medi-Cal GMC Primary Contracts Exhibit A, Attachment 4 Section 11
- MHC shall develop, and maintain written policies and procedures that include initial credentialing, re-credentialing, recertification, and reappointment of all healthcare professionals that include all elements as outlined in the Medi-Cal GMC Primary Contracts Exhibit A, Attachment 4 Section 12
- MHC will comply will all Medical Record requirements to include all elements and sub elements listed in Section 13, Attachment 4 Exhibit A of the Medi-Cal GMC Primary Contracts

2022-2023 Population Health Management Strategy

Molina Healthcare of California
Population Health Management Program Strategy
2022-2023

Molina Healthcare Population Health Management Program Strategy is a Working Document and May be Modified During the Year

Molina Healthcare Population Health Management Program Strategy: General Overview
Molina carries out a comprehensive and multi-faceted Population Health Management Program Strategy. Molina's Population Health Management Program Strategy complements the Triple Aim goals from the Institute for Healthcare Improvement. We aim to improve the health of our populations, enhances the experience of care of our members and reduce the cost of health care. Most importantly, we help our members achieve their person-centered social, medical, and behavioral health goals.

Our Population Health Management Program Strategy focuses on four critical areas: keeping members healthy, managing members at emerging risk, patient safety or outcomes across settings and managing members with multiple chronic conditions. Through this strategy, we conduct a wide range of activities that focus on the health care and services that our members receive across the entire health care continuum across all lines of business.

Measurement, improvement, and accountability are three central key concepts that drive Molina's Population Health Management Program Strategy. Molina meets key Program Strategy goals, which include, but are not limited to:

- Making sure that health plan members receive accessible, appropriate, cost-effective, and high-quality health care and services throughout the car continuum;
- Emphasizing the delivery of personalized care so that the provider or practitioner can maintain their pivotal role of managing the unique needs of our members;
- Creating and implementing process and programs that respond to address the culturally and linguistically diverse needs of our members;
- Identification of and focus on removing barriers to care, such as Social Determinants of Health, ensuring health equity, and addressing disparities and making appropriate referrals to community-based organizations for our members;
- Facilitating whole person care through physical health and behavioral health integration.

In this Population Health Management Program Strategy, we discuss the following activities.

- We highlight key member and provider-related programs and initiative, and we have in place, with short descriptions, populations being addressed and goals/measures that are focused on keeping members healthy; managing members with emerging risk; patient safety or outcomes across settings; and managing multiple chronic illnesses.
- We describe how we inform members and providers about how they can find out about, use, and opt in/opt out of interactive Population Health Management programs.
- We highlight how data analytics are in place to support the Population Health Management program.
- We highlight how our systems, processes and information exchange are coordinated within the Population Health Management Program. We discuss how we use multiple data sources to coordinate the program, facilitate timely and appropriate exchange of information, and use systems and processes to coordinate member contacts.
- We discuss how we assess the needs of our populations for Population Health Management and how we evaluate program effectiveness.
- We offer wellness and prevention services, including Health Appraisals and self-management tools.
- We engage our stakeholders in the Population Health Management Program.

Section I: Population Health Management Programs and Initiatives

Multiple member and provider interventions are in place to keep members healthy. Each of the four topic areas listed below are included in our Population Health Management program. The table starting on the next page describes the program goals, populations addressed, programs and services offered; and how members/providers are informed about the programs. Future programs will be included, as needed, to meet the needs of our members.

Keeping members healthy. Molina implements programs that focus on prevention and health education. Health and Wellness activities, based on clinical evidence include but, are not limited to critical topics, such as flu shots, annual health exams, well child and adolescent well care visits, prenatal and postpartum care and women's health.

Managing members with emerging risk. Molina implements risk identification tools to identify members with emerging risk through self-reporting or provider referral. We offer multiple programs focused on critical topics, such as asthma management, diabetes management, depression management and high-risk obstetrical case management.

Patient safety and managing outcomes across multiple settings. Molina implements Transition of Care programs for members with medical and/or behavioral health issues. As appropriate, we place Transition of Care nurses and other members of the care team within high- volume provider facilities to ensure the safety of our members. The care team plans transition of care activities when the member is hospitalized and will be engaged with the member for at least 30 days following a member's discharge.

Managing members with multiple chronic conditions. Molina includes an additional risk level (Level IV, Intensive Needs) to address the frequency and unique nature of high-intensive needs of these members. Level IV includes members who have experienced a critical event or diagnosis that requires extensive use of resources, additional support in navigating the healthcare system, and multiple providers to coordinate.

Key Population Health Management Programs and Initiatives

Population Health Management Program and Initiative #1: Flu Shot Education ***-**Keeping Members Healthy* *-Managing Members with Emerging Risks*
Program Description: According to the Advisory Committee on Immunization Practices, routine annual influenza vaccination is recommended for all individuals ages 6 months of age and older. This program focuses on providing children and adult members with their annual influenza vaccinations.
Program Goal: Increase flu shot rate by two percentage points from current measurement year's reported rate as measured in HEDIS rate. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS or through CAHPS survey distribution. If HEDIS rates reach the 90th national percentile, maintain the 90th percentile. To reduce potential disparities in health care, flu vaccination rates will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points from the current year's reported rate.
Target Population: All Marketplace, Medicaid and Medicare members who are eligible for receiving annual influenza vaccinations.
Program or Services: Molina's Flu Shot Educational Campaign is conducted to encourage members to receive annual flu shots to prevent health issues from developing. Members and providers receive outreach reminders, educational articles about the benefits of the flu shot for members, reminders in provider newsletters, and automated messages.

Population Health Management Program and Initiative #2: Annual Health Exam Reminders and Education
-Keeping Members Healthy
-Managing Members with Emerging Risks

Program Description: This program focuses on keeping our members healthy. Annual checkups allow our members to find problems early to receive timely and appropriate treatment. Annual health exam reminders and education encourage health plan members to receive annual health exams.

Program Goal: Increase Adults' Access to Preventive/Ambulatory Health Services HEDIS rate by two percentage points over the current reported rate based on the most recent measurement year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS.

If HEDIS rates reach the 90th national percentile, maintain the 90th percentile.

To reduce potential disparities in health care, the Adults' Access to Preventive/Ambulatory Health Services HEDIS rate will also be evaluated by race and ethnicity, language, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points from the current year's reported rate.

Target Population: All Medicaid and Marketplace members 20 years and older.

Measure: The percentage of Medicaid and Marketplace members, 20 years of age and older, who had an ambulatory or preventive care visit during the measurement year.

Program or Services: Molina members are informed about the importance of getting annual exams through information placed on the Website and/or member outreach calls and written notification. Providers are encouraged to get patients in for annual health exams through provider engagement visits, incentives, and written materials.

Population Health Management Program and Initiative #3: Diabetes Management
***-**Managing members with emerging risks*

Program Description: According to the Centers for Disease Control and Prevention, more than 34 million people in the U.S- just over 1 in 10- have diabetes and is the 7th leading cause of death in the U.S. This program focuses on helping Molina members with diabetes to manage their health successfully and prevent condition-specific complications.

Program Goal: Increase the diabetes HEDIS rates for Eye Exam, and HbA1c Control (<8%) by two percentage points for each rate. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS.

If HEDIS rates reach the 90th national percentile, maintain the 90th percentile.

To reduce potential disparities in health care, the Comprehensive Diabetes Care Eye Exam, Hemoglobin A1C Testing, and HbA1C Control (<8%) rates will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid, Marketplace and Medicare members aged 18-75 years of age with diabetes (type 1 and type 2) who were identified in the HEDIS eligible population.

Hemoglobin A1C Control for Patients with Diabetes Measure: The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c control (<8.0%)

Eye Exam for Patients with Diabetes Measure: The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had an eye exam (retinal) performed during the measurement year

Program or Services: Molina members are informed about diabetes management programs through outreach calls, member written materials, and member incentives. Providers are encouraged to get members in for diabetes care through provider newsletter articles, provider engagement or provider incentives.

Population Health Management Program and Initiative #4: Medical Assistance with Smoking and Tobacco Use Cessation
-Keeping Members Healthy
-Managing Members with Emerging Risks

Program Description: This program focuses on providing Molina members with tobacco cessation counseling education. Tobacco use is the leading cause for preventable disease, disability, and death in the U.S. Nearly 40 million U.S. adults still smoke cigarettes, and about 4.7 million middle school and high school students use at least one tobacco product, include e-cigarettes. Every day, about 1,600 U.S. youth (<18 years old) smoke their first cigarette. (Centers for Disease Control and Prevention)

Program Goal: Increase outreach to members who are current smokers by advising the member to quit smoking or using tobacco and discussing cessation medications or strategies by two percentage points using the CAHPS reported rates as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in CAHPS.

To reduce potential disparities in health care, the Advising Members to Quit Smoking and Using Tobacco and Discussing Cessation Medications rates will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid and Medicare members who were identified as current smokers.

Program or Services: Molina members are informed about tobacco cessation counseling programs through member materials, use of member incentives and/or provider incentives. Providers are encouraged to counsel members about tobacco cessation.

Population Health Management Program and Initiative #5: Well-Child Visits in the First 30 Months of Life
-Keeping Members Healthy

Program Description: Well-child visits for infants and young children (up to five years) provide opportunities for physicians to screen for medical problems (including psychosocial concerns), to provide anticipatory guidance, and to promote good health. The visits also allow the family physician to establish a relationship with the parents or caregivers. (American Family Physicians). This program focuses on providing Molina members with well-child visit education to encourage children to receive well-child visits.

Program Goal: Increase Well-Child Visits in the First 30 Months of Life HEDIS rate by two percentage points over the current reported rate. The most recent reported rate is based on the most recent calendar year as reported in HEDIS.

If the HEDIS rate reaches the 90th national percentile, maintain the 90th percentile.

To reduce potential disparities in health care, the Well-Child Visits in the First 30 Months of Life HEDIS rate will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid and Marketplace members who were identified for the Well-Child Visits in the First 30 Months of Life HEDIS specifications.

Measure: The percentage of patients who had the following number of well-child visits with a PCP during the last 15 months.

The following rates are reported:
1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.

2. Well-Child Visits for Age 15 Months-30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Program or Services: Molina members are informed about well-child visits through member written materials, information on the Website, member incentives and/or member outreach campaigns. Providers are informed about well-child visits through provider materials, provider engagement and/or provider incentives.

Population Health Management Program and Initiative #6: Child and Adolescent Well Care Visits -*Keeping Members Healthy*

Program Description: Well-child visits for infants and young children (up to five years) provide opportunities for physicians to screen for medical problems (including psychosocial concerns), to provide anticipatory guidance, and to promote good health. The visits also allow the family physician to establish a relationship with the parents or caregivers. (American Family Physicians). This program focuses on providing Molina members with child and adolescent well care visit education to encourage children and adolescents to receive well care visits.

Program Goal: Increase Child and Adolescent Well Care Visits HEDIS rate by two percentage points over the current reported rate. The most recent reported rate is based on the most recent calendar year as reported in HEDIS.

If the HEDIS rate reaches the 90th national percentile, maintain the 90th percentile.

To reduce potential disparities in health care, the Child and Adolescent Well Care Visits HEDIS rate will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid and Marketplace members who were identified for the Child and Adolescent Well Care Visits HEDIS rates by two percentage points.

Measure: The percentage of patients 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Note: The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Program or Services: Molina members are informed about Child and Adolescent Well Care Visits through member written materials, information on the Website, member incentives and/or member outreach campaigns. Providers are informed about Child and Adolescent Well Care Visits through provider materials, provider engagement and/or provider incentives.

Population Health Management Program and Initiative #7: Obesity Management for Children
***-**Keeping Members Healthy*
-Managing Members with Emerging Risk

Program Description: Childhood obesity is a serious health problem in the United States where 1 in 5 children and adolescents are affected. Some groups of children are more affected than others, but all children are at risk of gaining weight that is higher than what is considered healthy.

Obesity is complex. Many factors can contribute to excess weight gain including behavior, genetics and taking certain medications. But societal and community factors also matter: childcare and school environments, neighborhood design, access to healthy, affordable foods and beverages, and access to safe and convenient places for physical activity affect our ability to make healthy choices. (Centers for Disease Control and Prevention).

This program focuses on providing Molina members with education to encourage children and adolescents to maintain appropriate body mass index, nutrition, and physical activity.

Program Goal: Increase Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents HEDIS rates by two percentage points over the current reported rates. The most current reported rates are based on the most recent calendar year as reported in HEDIS.

If the HEDIS rate reaches the 90th national percentile, maintain the 90th percentile.

To reduce potential disparities in health care, the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents HEDIS rates will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: The percentage of patients 3-17 years of age who had an outpatient visit with a PCP or OB/GYN provider.

Measure: The percentage of patients 3-17 years of age who had an outpatient visit with a PCP or OB/GYN provider and who had evidence of the following during the measurement year:
- BMI percentile documentation. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
- Counseling for nutrition documentation or referral for nutrition education.
- Counseling for physical activity documentation or referral for physical activity.

Program or Services: Molina members are informed about Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents through member written materials, information on the Website, member incentives and/or member outreach campaigns. Providers are informed about Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents through provider materials, provider engagement and/or provider incentives.

Population Health Management Program and Initiative #8: Prenatal and Postpartum Care
***-**Keeping Members Healthy*
-Managing Members with Emerging Risk

Program Description: Lack of prenatal care may lead to pregnancy complications and worse birth outcomes. This program focuses on encouraging Molina pregnant women to obtain timely and appropriate prenatal and postpartum care.

Program Goals:
Increase Timeliness of Prenatal Care HEDIS rate by two percentage points over the current reported rate. The most recent reported rate is based on the most recent calendar year as reported in HEDIS.

Increase Postpartum Care HEDIS rate by two percentage points over the current reported rate. The most recent reported rate is based on the most recent calendar year as reported in HEDIS.

If HEDIS rates reach the 90th percentile, maintain the 90th percentile.

To reduce potential disparities in health care, the Timeliness of Prenatal Care and Postpartum Care HEDIS rates will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid and Marketplace members who were identified as eligible for the Prenatal and Postpartum Care HEDIS measures. The women included in these measures are those individuals with deliveries of live births on or between October 8th of the year prior to the measurement year and October 7th of the measurement year.

Measure: Prenatal Care HEDIS rate, measuring the percentage of live birth deliveries on or between October 8th of the year prior to the measurement year and October 7th of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the health plan, with an OB/GYN, other prenatal care practitioner or PCP. T

Measure: Postpartum Visit HEDIS rate, measuring the percentage of live birth deliveries on or between October 8th of the year prior to the measurement year and October 7th of the measurement year that had a postpartum visit with an OB/GYN practitioner or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery.

Any of the following meet criteria:
• A postpartum visit.
• Cervical cytology.
• A bundled service where the organization can identify the date when postpartum care was rendered

Program or Services: Molina members are informed about prenatal and postpartum care programs through written materials, information on the Website, outreach calls as appropriate. Providers are informed through provider materials, provider engagement visits, and/or provider incentives.

Population Health Management Program and Initiative #9: Women's Health
***-**Keeping Members Healthy*
-Managing Members with Emerging Risks

Program Description:
Screening for breast and cervical cancer may help women detect problems early and receive treatment. Recommendations are that women between the ages of 50 and 74 years of age receive screening mammograms every other year. In addition, women between the ages of 21 to 29 years of age receive cervical cancer screening with cervical cytology alone every three years. Women between the ages of 30 and 65 should receive cervical cancer screening every three years with cervical cytology alone, every 5 years with high-risk human papillomavirus testing alone or every 5 years with high-risk human papillomavirus testing combination with cytology. (United States Preventive Services Task Force).

This program focuses on encouraging Molina members to obtain timely and appropriate mammograms and/or cervical cancer screening.

Program Goal: Increase Breast Cancer Screening HEDIS rate and Cervical Cancer Screening HEDIS rates by two percentage points over the current reported rate. The most recent reported rates are based on the most recent calendar year as reported in HEDIS.

If HEDIS rates reach the 90th percentile, maintain the 90th percentile.

To reduce potential disparities in health care, the Breast Cancer Screening and Cervical Cancer Screening HEDIS rates will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population:
For the Breast Cancer Screening measure: All Medicaid, Marketplace, and Medicare members who were identified as eligible for the Breast Cancer Screening HEDIS measure: percentage of women between 50-74 years of age who had at least one mammogram in the past two years.

Measure: Percentage of women between 50-74 years of age who had at least one mammogram in the past two years.

Target Population:
For the Cervical Cancer Screening measure: All Medicaid, Marketplace and Medicare members who were identified as eligible for the Cervical Cancer Screening HEDIS measure: percentage of women 21-64 years of age who had a cervical cytology test performed within the last 3 years, women 30-64 years of age who had cervical high-risk human papillomavirus testing performed within the last 5 years, and women 30-64 years of age who had cervical cytology/high-risk human papillomavirus contesting within the last 5 years.

Measure: Percentage of women 21-64 years of age who had a cervical cytology test performed within the last 3 years, women 30-64 years of age who had cervical high-risk human papillomavirus testing performed within the last 5 years, and women 30-64 years of age who had cervical cytology/high-risk human papillomavirus contesting within the last 5 years.

Program or Services: Members are educated about breast cancer screening and cervical cancer screening through written materials, information on the Website, outreach calls, and/or other programs. Providers may receive provider incentives, HEDIS tip sheets, and provider engagement.

Population Health Management Program and Initiative #10: Asthma Management
***-**Keeping Members Healthy*
-Managing Members with Emerging Risks

Program Description: Asthma is a chronic respiratory disease requiring ongoing medical management. In 2017, asthma resulted in an estimated 1.6 million emergency department (ED) visits and 183,000 hospitalizations in the United States. Asthma has had a considerable economic impact (2) and resulted in a substantial number of missed school days. (Centers for Disease Control and Prevention).

This program focuses on encouraging Molina members with asthma between the ages of 5 and 64 years old to manage their health through appropriate medication management complemented with other activities.

Program Goal: Increase Asthma Medication Ratio HEDIS rates by two percentage points over the current reported rate. The most recent reported rates are based on the most recent calendar year as reported in HEDIS.

If HEDIS rates reach the 90th percentile, maintain the 90th percentile.

To reduce potential disparities in health care, the Asthma Medication Ratio HEDIS rates will also be evaluated by race and ethnicity, gender, language, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid and Marketplace members who were identified as eligible for the Asthma Medication Ratio HEDIS measure: The members included in this measure were members between 5 and 64 years of age who were identified as having persistent asthma.

Measure: Asthma Medication Ratio rate, measuring the percentage of members between 5 and 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Program or Services: Molina members are informed about appropriate asthma management through written materials, information on the Website, and outreach calls as appropriate. Providers are informed through provider materials, provider engagement visits, and/or provider incentives.

Population Health Management Program and Initiative #11: High Blood Pressure Management
***-**Keeping Members Healthy*
-Managing Members with Emerging Risks

Program Description: This program focuses on encouraging Molina members with high blood pressure and heart to manage their health through appropriate medication management complemented with other activities.

Managing asthma is . (United States Preventive Services Task Force).

Program Goal: Increase Controlling Blood Pressure and Statin Therapy for People with Heart Disease HEDIS rates by two percentage points over the current reported rate. The most recent reported rates are based on the most recent calendar year as reported in HEDIS.

If HEDIS rates reach the 90th percentile, maintain the 90th percentile.

To reduce potential disparities in health care, the Asthma Medication Ratio HEDIS rates will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Controlling Blood Pressure
Target Population: All Medicaid and Marketplace members who were identified as eligible for the Controlling Blood Pressure HEDIS measure: percentage of members who were 18 to 85 years of age who had a diagnosis of hypertension.

Measure: The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) mm Hg and a representative diastolic BP of <90 mm Hg.

Statin Therapy for People with Cardiovascular Disease
Target Population
The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD).

Measure
The percentage of males 21-75 years of age and females 40-75 years of age during measurement year, who were identified as having clinical atherosclerotic cardiovascular disease and met the following criteria. Two rates are reported:
1. Received Statin Therapy. Patients were dispensed at least one high or moderate-intensity statin medication during the measurement year.
2. Statin Adherence 80%. Patients remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

Program or Services: Molina members are informed about hypertension management and statin therapy programs through written materials, information on the Website, pharmacy engagement, and/or outreach calls as appropriate. Providers are informed through provider materials, provider engagement visits, and/or provider incentives.

Population Health Management Program and Initiative #12:
High Risk OB Case Management Program
***-**Keeping Members Healthy*
-Managing Members with Emerging Risks

Program Description: This program focuses on encouraging pregnant women enrolled in Molina to receive timely and appropriate prenatal and postpartum care and to reduce potential complications for mothers and/or newborns. Factors such as advanced maternal age, lifestyle choices, maternal health conditions, pregnancy complications, multiple pregnancies, and pregnancy history may put a pregnant woman or baby at risk for health issues.

Program Goal: Reduce Neonatal Intensive Care Unit Rates by one percent as compared to the prior year. The most recent reported rate is based on the most recent calendar year as reported using utilization data on Molina's Executive Dashboard. In addition, as available, low birthweight and infant mortality may be other metrics used to evaluate the goals of this program.

To reduce potential disparities in health care, the Neonatal Intensive Care Unit rate will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid and Marketplace members who were identified as eligible for the High-Risk OB Case Management Program.

Program or Services: Molina members are informed about High-Risk OB Case Management program through written materials, information on the Website, outreach calls as appropriate. Education, case management, reminders, and/or member incentives are in place to pregnant women at high risk for obstetrical complications. Providers are informed through provider materials, provider engagement visits, and/or provider incentives.

Population Health Management Program and Initiative #13:
Level I Case Management: Health Promotion and Disease Prevention
***-**Keeping Members Healthy*
-Managing Members with Emerging Risks

Program Description: Health Promotion and Disease Prevention is designed to achieve member wellness and autonomy through advocacy, communication, education, identification of support resources, and service facilitation. Members usually in this program include members with asthma, hypertension, diabetes and depression with 0 to 1 inpatient admissions in the past 6 months or substance abuse as defined by one positive CAGE AID question and member wants to participate in Case Management.

Program Goal: Reduce admission rate by one percent as compared to the prior year. The most recent reported rate is based on the most recent calendar year as reported using utilization data on Molina's Executive Dashboard.

To reduce potential disparities in health care, the admission rate will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid, Marketplace and Medicare members who were identified as eligible for Level 1 Case Management Program.

Program or Services: Molina members are informed about Level I Case Management program through written materials, information on the Website, outreach calls as appropriate. Providers are informed about the program through provider materials and/or provider engagement visits.

Population Health Management Program and Initiative #14:
Level II Case Management
***-**Managing Members with Emerging Risks*

Program Description: Level II Case Management is designed to help members who are at risk for re-hospitalization post transition of care intervention or with care management needs that warrant triage need more support than Level I and need further evaluation. Level II Case Management is designed to improve the member's health status and reduce the burden of disease through education and assistance with the coordination of care. Case Managers working with Level II members triage the members and step members up to higher levels of case management or step members down to Level I as warranted based on member progress. Members may be assigned to this level based on other clinical needs or provider recommendation for the purpose of self-management and stabilization.

Program Goal: Reduce admission rate by one percent as compared to the prior year. Reduce readmission rate by one percent as compared to the prior year. The most recent reported rates are based on the most recent calendar year as reported using utilization data on Molina's Executive Dashboard.

To reduce potential disparities in health care, the admission and readmission rates will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid, Marketplace and Medicare members who were identified as eligible for Level II Case Management Program.

Program or Services: Molina members are informed about Level II Case Management program through written materials, information on the Website, outreach calls as appropriate. Providers are informed about the program through provider materials and/or provider engagement visits.

Population Health Management Program and Initiative #15:
Level III Case Management
-Managing Members with Multiple Chronic Conditions

Program Description: This program focuses on helping members improve their functional capacity and regain optimal health in an effective and efficient manner. Members usually in this program include members with Alzheimer's Disease, Asthma, Bipolar Disorder, Cancer, Heart Failure, Chronic Kidney Disease, ESRD, COPD, Dementia, Depression, Diabetes, HIV/AIDS, Hypertension, Schizophrenia, Sickle Cell Disease, and Substance Abuse as defined by one positive CAGE AID question and member would like a call back from Case Management; and three or more inpatient admissions in the past 6 months; and 2 or more Emergency Department visits within the past 6 months.

Program Goals:
Reduce admission rate by one percent as compared to the prior year.
Reduce readmission rate by one percent as compared to the prior year.

The most recent reported admission and readmission rates are based on the most recent calendar year as reported using utilization data on Molina's Executive Dashboard.

To reduce potential disparities in health care, the admission and readmission rates will be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid, Marketplace and Medicare members who were identified as eligible for Level III Case Management Program.

Program or Services: Members are made aware of the Level III Complex Case Management Program through outreach calls from Case Managers and Care Coordinators. Case Managers also work with network physicians. Program information is also included in the member handbook, Provider Manual and Website.

Population Health Management Program and Initiative #16:
Level IV Case Management
***-**Managing Members with Multiple Chronic Conditions*

Program Description: Focuses on members with end-stage diagnoses who would otherwise meet criteria for palliative care or hospice services or have other immediate needs requiring urgent intervention and/or referrals. These members are at imminent risk of an emergency department visit, an inpatient admission, or institutionalization related to environmental or social issues and offers high intensity, highly specialized services. Case Managers work with the members to stabilize a member's health, improve the member's ability to copy with severity of condition and improve quality of life.

Program Goals:
Reduce admission rate by one percent as compared to the prior year.
Reduce readmission rate by one percent as compared to the prior year.

The most recent reported admission and readmission rates are based on the most recent calendar year as reported using utilization data on Molina's Executive Dashboard.

To reduce potential disparities in health care, the admission and readmission rates will be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid, Marketplace, and Medicare members who were identified as eligible for Level IV Case Management Program.

Program or Services: Members are made aware of the Level IV Intensive Needs Case Management Program through outreach calls from Case Managers and Care Coordinators. Case Managers also work with network physicians. Program information is also included in the member handbook, Provider Manual and Website.

Population Health Management Program and Initiative #17:
Transition of Care Program
***-**Managing Members with Multiple Chronic Conditions*

Program Description: Transitions of Care Program is designed to improve clinical outcomes and promote member self-determination and satisfaction, while reducing hospital readmissions and emergency department visits by ensuring the member is fully prepared to continue the plan of care throughout the entire transition; engaging the member directly so they have an active role in the implementation of person-centered plan of care; facilitating the five core elements of the program: assessment of health status, medication management, follow-up care, nutrition management, coordination of post discharge services, supporting the member through the transition and coordinating needed services with appropriate providers, and promoting member self-management and encouraging empowerment. Focused program with a minimum of 2 contacts over a 30-day period with initial member contact within 72 hours post discharge.

Program Goals:
Reduce admission rate by one percent as compared to the prior year.
Reduce readmission rate by one percent as compared to the prior year.

The most recent reported admission and readmission rates are based on the most recent calendar year as reported using utilization data on Molina's Executive Dashboard.

To reduce potential disparities in health care, the admission and readmission rates will also be evaluated by race and ethnicity, gender, geography, language, and age. Based on measure review, interventions may be put into place to reduce disparities. The goal going forward will be to reduce identified disparities by two percentage points for each of these rates from the current year's reported rates.

Target Population: All Medicaid, Marketplace, and Medicare members who were identified as eligible for Transition of Care Program.

Program or Services: Members are made aware of the Transition of Care Program through outreach calls from Case Managers and Care Coordinators. Case Managers also work with network physicians. Program information is also included in the member handbook, provider manual and Website.

Population Health Management Program and Initiative #18:
Behavioral Health Transition of Care and Follow-up after Hospitalization Program
***-**Patient Safety and Managing Outcomes Across Multiple Settings*

Program Description: Behavioral Health Transition of Care and Follow-up After Hospitalization Program is designed to improve the likelihood that members will initiate and continue outpatient treatment after an admission. Transition of Care coaches including Behavioral Health clinicians ensure members have initial outpatient appointments within the first seven days of discharge. Transition of Care coaches visit members in the hospital whenever possible and contact members post discharge to facilitate an initial visit within 7 days of discharge and a second follow-up visit within 30 days of discharge.

In conjunction with this Behavioral Health Transition of Care program, Molina's substance abuse disorder model of care includes Substance Abuse Disorder navigators and peer support specialists. These navigators are care managers partner with members to direct and connect members to available community services and to assist members in pursuing their recovery goals.

Population Health Management Program and Initiative #19:
Activities that are not Direct Member Interventions
***-**Provider-based Population Health Management Programs*

Program Description: Provider-Based Population Health Management Programs are being implemented, including but not limited to, missing service lists with providers to allow them to ensure members receive key health tests and exams; value-based payment arrangements related to key quality and population health-based measures; and other key programs.

Target Population: Network practitioners

Informing Members and Providers about Population Health Management Programs

Members are informed about Population Health Management programs through written materials, such as the *Guide to Accessing Quality Health Care*, which is included on Molina's member/prospective member Website. This *Guide* includes information about key programs, including how members become eligible to participate, how members can use the program services, and how members can opt in and opt out of the program. Telephone numbers for these interactive programs are provided so that members can reach out to Molina to participate, opt in, or opt of this program. A mailing is sent to members at least once a year that includes information about what is included in the *Guide* and a link to the Website is provided so members can review the *Guide.* Members also find out about these programs through outreach calls made by Case Managers or Care Coordinators. Molina network providers are informed about the Population Health Management program through multiple sources. These information sources include but are not limited to the provider manual, the provider newsletter, and provider engagement team visits.

Data Analytics to Support Population Health Management Program

Data analytics is the cornerstone to our Population Health Management program. We use data to identify and stratify members for different levels of Population Health Management. Predictive modeling will identify members who are appropriate for the Population Health Management program and initially stratify these members into the Level I to Level IV programs. At the time of enrollment, Molina uses eligibility data, including clinical condition information (e.g., pregnancy), with member demographics and historical medical and pharmacy claims data to appropriately risk-stratify members. As new information is received for our predictive modeling application, we will update risk stratification and take appropriate action. In addition, we will work with members to complete a Health Risk Assessment to adjust the risk stratification as appropriate to make sure our members receive appropriate interventions. Risk stratification levels allow us to conduct a wide range of activities across the care continuum.

Coordinating Systems and Information Exchange within the Population Health Management Program

Using Multiple Data Sources to Coordinate Program

Our Population Health Management program is based on the use of multiple data sources and coordination of services through secure and confidential sharing of data between Molina and network practitioners. We integrate and use data from multiple data sources, such as physical health and behavioral health claims and encounters, pharmacy claims and encounters, laboratory claims and encounters, Health Risk Assessment and Enrollee Needs Assessment results, electronic health records, as available, Health Services programs, such as Health Management, Case Management, Transitions of Care, and medication management initiatives, and advanced data sources, such as health information exchanges, as available.

Facilitating Timely and Appropriate Exchange of Information

Facilitation of timely and appropriate exchange of information allows for the efficient delivery of this strategy. We also facilitate information exchange with providers and members within the Population Health Management program. Our case managers lead these communications with providers through sharing of care plan updates and holding multidisciplinary team meetings as needed. Care managers also monitor missed services and/or appointments and coordinate health care with primary care physicians, specialists, and other providers, and connect members to additional providers and community-based resources.

Communication and information exchange are also enabled through our Provider Portal. Our network practitioners can review HEDIS scores to compare themselves against benchmarks and identify members who are due for key tests and exams. On this provider portal, practitioners are also able to track their performance against their peers and in line with provider incentives as appropriate.

Using Systems and Processes to Coordinate Member Contacts

Molina uses systems and processes to minimize the confusion for our members in potentially duplicative contacts. These systems and processes include but are not limited to:

1) Electronic case management system where Health (e.g., Disease) Management, Level II Case Management, Level III Complex Case Management, Level IV Case Management and Transitions of Care program information and data are entered. Through this system, all member, provider, and external agency contacts, case notes, clinical review, and care plans are tracked. All program staff have access to this system.

   Program staff review the system prior to member outreach attempts in order to understand current health status and to review any other contacts that have been made. In addition, program staff collaborate with network providers to offer information about the participation of their patients in clinical programs. This helps better facilitate programs being implemented.

2) Electronic member contact system used by Contact Center representatives houses all call attempts – inbound and outgoing from our members to Molina. This system allows all Contact Center Staff to view previous contacts and questions that the member had in order to provide the needed context for future calls.

In addition, a team of highly trained Contact Center representatives may make outgoing focused outreach calls to parents and members who are due for key tests and exams and/or visits. These reminder calls are tracked in the member contact system and include information about call resolution and needed follow up. Reports from this outreach team are distributed to Molina Quality team for review and evaluation. Any member who then completes missing services will be removed from future call attempts and from any lists that go out to providers for follow up.

Health Equity and Cultural Competency Plan as Part of Population Health Management

Molina recognizes and reasserts the need to create special programs that educate staff and providers on effective ways to deliver services to members with diverse backgrounds and special needs. Molina works proactively to cultivate an environment that fosters acceptance and respects the unique needs of the Molina membership and potential enrollees.

Molina Healthcare developed a Health Equity and Cultural Competency Plan outlining the delivery of culturally competent services. Our goal is to make sure our members receive culturally and linguistically appropriate services across the care continuum to reduce health disparities and improve health outcomes. Molina is committed to improving health equity and the actions we take to promote health equity in management of member care. This Plan describes how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, religions, genders, geographies as well as those with disabilities, in a manner that recognizes values, affirms, and respects the worth of the individuals, and protects and preserves their dignity.

Since barriers associated with cultural differences can prevent members from accessing services in a timely manner, Molina completes an annual CLAS analysis which provides an overview of completed and ongoing activities for CLAS, assesses the plan's performance on trending of measures, analyzes efforts to reduce disparities and improve the provision of CLAS, including barriers, and evaluates the overall effectiveness of the CLAS program. The CLAS Analysis is included in Molina's Quality Annual Program Evaluation. Molina evaluates its performance on CLAS activities described in the Quality program description and work plan, including all delegated functions. This evaluation includes a description of completed and ongoing CLAS activities for the previous year. Goals and objectives are listed in the annual Quality Improvement work plan and program evaluation and include, but are not limited to, the following:

- Annual collection and analysis of race, ethnicity, language, geography, and gender data from eligible individuals to identify significant culturally and linguistically diverse populations with plan's membership;
- Annual collection and analysis of race, ethnicity, language, geography, and gender data from contracted practitioners to assess gaps;
- Collection of data and reporting for the Diversity of Membership HEDIS measure;
- Determination of threshold languages annually to provide members vital information in threshold languages;
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations;
- Analysis of HEDIS measure results for potential cultural and linguistic disparities and additional disparities based on gender and geography that prevent members from obtaining the recommended key chronic and preventive services (includes data stratification of selected HEDIS and CAHPS measures by race, ethnicity and preferred language);
- Enhancement of current patient-focused Quality Improvement activities, such as prenatal and well-child exam incentive program, to address specific cultural, linguistic, sexual orientation, gender identity and SDOH barriers using culturally, linguistically focused materials addressing identified critical barriers;
- Provision of a more thorough organizational understanding of the specific reasons behind identified cultural, linguistic, sexual orientation, gender identity and SDOH

barriers and priorities. This can be accomplished through focus groups, member feedback forms or surveys, and complaint analyses;

- Selection of critical barrier (s) found through the various cultural, linguistic, sexual orientation, gender identity and SDOH analyses for specific intervention;
- Analysis of interpreter availability;
- Development of educational materials to meet the cultural, linguistic, sexual orientation, gender identity and SDOH needs of the population served as well as those with complex conditions;
- Provision of staff with necessary information, training, and tools to address identified cultural, linguistic, and social barriers;
- Identification, carry out and checking planned activities related to the Americans with Disabilities Act requirements, such as provider, staff and member training, communication, and assessment of provider compliance; Identification and development of initiatives to address the needs of communities within the health plan's service areas, including but not limited to Black, Indigenous and People of Color.
- Continued expansion of the continuous quality improvement process to identify existing disparities related to race, ethnicity, language, gender, geography, and social determinants of health and then implement at least two data-driven activities to reduce disparities related to race, ethnicity and social determinants of health.
- Monitoring of access and utilization of services within communities of color, and individuals with social needs, such as housing insecurity, and others who are at risk due to related disparities.
- Work with community engagement and with the state Agencies to increase equitable access to health care services and treatment for populations identified at risk through new policies or increased collaboratives and through participation on state-health plan joint workgroups.
- Development of enhanced evidence-based approaches and strategies to reduce disparities based on race and ethnicity and for additional specific populations, such LGBTQIA+ population related to service access as available.
- Evaluation of the Culturally and Linguistically Appropriate Services (CLAS) Program to include assessment of completion of planned activities, identification of barriers, opportunities, and interventions to overcome barriers, and overall effectiveness.

Population Assessment and Annual Evaluation

Molina creates an annual population assessment and evaluation that will be provided as a separate document. This population assessment is used as part of the annual Population Health Management program development cycle which will repeated and analyzed each year to ensure our focus areas meet the needs of our health plan, members, and providers. Within the population assessment, the following activities are included, but not limited to:

a. Evaluating the characteristics and needs of our members. In our assessment, we evaluate member demographics, social determinants of health, including the members' eligibility or enrollment in Medicaid; the members' health status including whether members have multiple chronic conditions or severe injuries; the members' racial and ethnic groups and language preferences, and information about access and utilization.

b. Using the assessment to identify and assess the characteristics and needs of our subpopulations. As part of this assessment, we assess the needs of our members who

are between the ages of 2-19 years of age (children and adolescents). We also evaluate the characteristics and needs of members with disabilities and members with serious and persistent mental illnesses to ensure members receive appropriate care especially as related to care coordination and intensive resource use.

c. Reviewing the assessment results to review and update the activities and resources in place that address member needs;
d. Evaluating the assessment results to review the need for community resources to be more integrated into Population Health Management programs; and
e. Monitoring and analyzing the effectiveness of the program through measurement of key measures to determine current barriers and opportunities for improvement.

Wellness and Prevention

Molina implements on-line wellness and prevention tools to help our members identify and manage their health through evidence-based tools that maintain member privacy and explain how Molina uses the information we collect. The tools available to our member on-line include a health appraisal which allows our members to identify their health risks, based on their self-reported health status and health conditions. We also offer evidence-based self-management tools that allow our members to receive information on healthy weight (body mass index) maintenance, smoking and tobacco use cessation, physical activity, healthy eating, stress management, avoiding at-risk drinking, and identifying depression symptoms. These online tools can be accessed by our members through our Website using a secure link and members may also ask to have these tools printed out for them.

The tools available to our member on-line include a health appraisal which allows our members to identify their health risks, based on their self-reported health status and health conditions. We also offer evidence-based self-management tools that allow our members to receive information on healthy weight (body mass index) maintenance, smoking and tobacco use cessation, physical activity, healthy eating, stress management, avoiding at-risk drinking, and identifying depression symptoms. These online tools can be assessed by our members through our Website using a secure link and members may also ask to have these tools printed out for them.
We also use Molina Mobile app to give members access to their personal health information and other resources. Members can also communicate with Case Managers or the Contact Center through the messaging function. Members also have access to Virtual Urgent Care and educational materials.

Stakeholder Engagement

Molina engages stakeholders to obtain input and feedback about our Population Health Management programs through various strategies. We are engaging stakeholders through:

- Quarterly Quality Improvement and Pharmacy and Therapeutics committees which includes participation of behavioral health and medical providers.
- Virtual health care participation of members through the Molina Mobile app or through the member web portals.
- Engagement through provider and member newsletters about key health topics.

Ensuring High Levels of Member Participation

Molina implements multiple strategies to engage our members within the Population Health Management program. For health risk assessments or needs assessments, the lack of assessment completion will be noted in our electronic system. Our Contact Center representatives then explain the benefits of the Health Risk Assessment and will transfer the member to the Population Health Management staff for completion. If members call in for other reasons, this opportunity allows Molina to further engage members in our Population Health Management programs. Through our risk stratification tools, we identify members with priority health conditions or priority populations. We use multiple strategies to then bring these members into the health care system.

These strategies may include but are not limited to:

- Using an internal software tool to allow our internal staff to access multiple phone numbers for our members in one view from varied data sources. Our Contact Center and Population Health Management program staff use this application to access this information quickly to communicate with our members.
- Enlisting a team of Community Connectors to locate members who are difficult to reach and link these members with our care team and community resources.
- Embedding case managers in primary care, specialist practices and at other care sites as needed to provide key interactions with members, identify member needs, and educate members about case management.
- Engaging member's caregivers and other service coordinators to engage members for Population Health Management programs.

All summaries of the measures contained herein are reproduced with permission from HEDIS® Volume 2: Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA).

The information presented herein is for informational and illustrative purposes only. It is not intended, nor is it to be used, to define a standard of care or otherwise substitute for informed medical evaluation, diagnosis and treatment which can be performed by a qualified medical professional. Molina Healthcare, Inc. does not warrant or represent that the information contained herein is accurate or free from defects.

2022- 2023 Health Equity and Cultural Competency Program Description

Background

Healthy People 2030 defines health equity as the 'attainment of the highest level of health for all people. To achieve health equity, 1) communities need to ensure that all people have full and adequate access to opportunities that enable them to lead healthy lives and 2) treat everyone fairly and eliminate avoidable health inequities and health disparities. Health disparities are differences in health outcomes among groups of people, closely linked with social, economic, and/or environmental disadvantages, impacted by numerous factors including race or ethnicity, gender identity, sexual orientation, age, language, disability, socioeconomic status, mental health, and geographic location.

In addition to geographic location, social determinants of health are also impacted by implicit bias. Implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, can be favorable and unfavorable assessments, are activated involuntarily, and without an individual's awareness or intentional control. Implicit bias has been shown to impact decision-making across a wide array of sectors, including employment, health care and education.1 By raising awareness and providing education implicit bias is addressed and part of ongoing dialogue that may lead to reducing and eliminating health disparities. Molina Healthcare is committed to 1) providing equitable access to all members, 2) providing quality health care services and 3) reducing and eliminating health disparities through increasing cultural humility and addressing implicit bias.

Purpose

The Molina Healthcare Health Equity and Cultural Competency Plan outlines the delivery of effective, equitable, understandable, respectful, and culturally competent health care. Our goal is to ensure that we provide culturally and linguistically appropriate services across the continuum to reduce and eliminate health disparities, address social determinants of health, and improve health outcomes. This Plan describes how individuals and systems within the organization will effectively provide services to members regardless of race, ethnicity, culture, religion, age, ability, gender identity, and sexual orientation, in a manner that recognizes values, affirms, and respects the worth of the individuals, and protects and preserves their dignity.

Since barriers associated with cultural differences, systemic racism, implici3t bias, and access to quality resources and opportunities can prevent members from accessing services in a timely manner, Molina recognizes and reasserts the need to create targeted programs and foundationally embed health equity into all services, resources, programs, policies, and initiatives that educate staff and providers on effective ways to deliver services to members with diverse backgrounds and special needs. Molina works proactively to cultivate an environment that fosters acceptance and respects the unique needs of the Molina membership and potential enrollees.

The Health Equity and Cultural Competency Plan is reviewed and updated annually with oversight by Molina's Health Equity and Cultural Competency Workgroup and National

1 *The Ohio State University (2015). State of the Science: Implicit Bias Review*

Quality Improvement Committee. The National Health Equity Officer, VP of Quality, Diversity, Equity and Inclusion lead, and Director of Health Equity and Cultural Competency maintain responsibility for Plan.

Policies and Procedures

Molina creates and maintains policies and procedures to ensure delivery of effective, equitable, understandable, respectful, and culturally competent health care. Policies and Procedures include, but are not limited to:

- Collecting and safely storing race/ethnicity, language, gender identity and sexual orientation data to ensure the delivery of culturally competent services and the provision of linguistic access and disability-related access to all enrollees, including Limited English Proficiency persons.
- Providing members with vital information, including materials and services, in threshold languages.
- Collecting and assessing practitioner network language information to ensure that cultural and linguistic needs of Molina members are met.

Molina's Health Equity and Cultural Competency Plan reflects the guidelines outlined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) (thinkculturalhealth.hhs.gov/clas) in Health and Health Care, published by the U.S. Department of Health and Human Services, Office of Minority Health.

Additionally, Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/state contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency and Members who are deaf, hard of hearing, non-verbal, or have speech or cognitive/intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to members of all cultures, races, ethnic backgrounds and religions, sexual orientation, gender identity, as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services and the Office for Civil Rights. Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability, or sex. This includes gender identity, sexual orientation, pregnancy, and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

To file a discrimination complaint, Molina members can contact the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY/TDD: 711. Members can also email the complaint to civil.rights@molinahealthcare.com or file a complaint online at molinahealthcare.AlertLine.com.

Integrated Quality Improvement – Developing, Tracking, and Monitoring Health Equity Efforts

Molina uses a person-centered approach to effectively reduce disparities, improve health outcomes, and provide equitable healthcare to all members. Initial program designs are presented to the Health Equity and Cultural Competency Workgroup for development, implementation, and evaluation of disparity reduction. Initiatives are revised and improved to increase effectiveness, address new areas of opportunity, and transform systems. Initiatives may include but are not limited to Member, Provider, Community, and Molina Staff interventions. Initiatives are reported to the Quality Improvement Committee for review and feedback is used to enhance the program design. Elements are reported, leveraging the Quality Assessment and Performance Improvement Project template, to capture scope, metrics, outcomes, timelines, milestones, and changes to improve effectiveness.

Integrated Quality Improvement – Ensuring Language Services Access

Molina ensures Member access to language services such as oral interpreting, American Sign Language (ASL), written translation and access to programs, and aids and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with Limited English Proficiency.

Molina develops member material to accommodate the special needs of our members. Materials reflect the guidelines set forth in Plain Language (PlainLanguage.gov). Molina writes content at a 6th grade reading level or lower. Molina offers materials in alternate formats when requested by a member or provider. Alternate formats include large font sizes (20-point font), braille, and audio. Molina's materials are produced in English and Spanish. Molina translates materials into threshold languages designated by health plans. Translation projects are monitored by a Quality Assurance team.

Members or Providers may also request written Member materials in preferred languages and alternate formats, leading to better communication, understanding and Member satisfaction. Online materials found on MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Vital Member information, including Appeals and Grievance forms; notices for denial, reduction, suspension, or termination of services; and vital information from the Member Handbook, are also available in threshold languages on the Molina Member website.

Molina provides oral interpreting to any plan Member who speaks a non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina notifies plan Members of the availability of oral interpreting services upon enrollment and informs them how to access oral interpreting services at no cost to them.

Access to Interpreter Services

Molina provides and maintains access to telephonic interpreter services for members or potential members whose primary language is not English, or for members who are deaf, hard of hearing or speech impaired and need sign language. In many cases, Providers may request interpreters for Members whose primary language is not English by calling Molina's Contact Center. The Representative will immediately connect the Provider and the Member to a language service provider.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. It is never permissible to ask a family member, friend or minor to interpret.

Members can request materials or interpreter services by calling Member Services. Once a member identifies a preferred language other than English, Molina will provide all future materials and communications in the member's preferred language. Members can also request materials in alternate formats.

Molina informs all members of their right to interpreter services at no cost to them, via regular member communications. They include the evidence of coverage or Member Handbook, compliance mailings, member newsletters, and signage at medical offices.

Molina provides contracted practitioners with information about accessing an available qualified interpreter and identifying language needs through practitioner mailings, the Provider Manual, and practitioner training sessions. Molina reminds practitioners that patients should never ask family members, children, or minors to interpret for them. If a member requests a family member, child or minor to interpret for them, or refuses interpreter services after Molina tells them of interpreter services available at no cost to them, the practitioner must document this in the member's medical record. Providers are responsible for supporting access to interpreter services for Members with sensory impairment and/or who have Limited English Proficiency.

Molina Member Services monitors utilization of interpreter services and investigates and resolves any service issues/complaints identified by staff or members. Telephone interpreting calls are live monitored by Quality Assurance team leads and monitors.

Members with Hearing Impairment

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to the Member and Provider Contact Center (M&PCC), Quality, Healthcare Services, and all other health plan functions.

Molina strongly recommends that Provider offices make available assistive listening devices for members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the provider's voice to facilitate a better interaction with the member.

Molina will provide face-to-face service delivery for ASL to support our members with hearing impairment. Face-to-face interpreter services includes Video Remote Interpretation (VRI) and in-person interpretation. Requests should be made five business days in advance of an appointment to ensure availability of the service. In most cases, members will have made this request via Molina Member Services.

Nurse Advice Line

Molina provides twenty-four (24) hours/seven (7) days a week Nurse Advice Services for members. Members may call Molina Healthcare's Nurse Advice Line for assistance in their preferred language. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Data Collection and Analysis
Molina understands the significance of demographic shifts and conducts ongoing infrastructure assessment to determine whether members' needs are met in the appropriate language and cultural context. As part of this ongoing assessment and to comply with National Committee for Quality Assurance (NCQA) standards, Molina has in place a health information system to collect, analyze and evaluate its membership and provider network based on race, ethnicity, gender identity, and languages spoken. The Quality Department in collaboration with other key departments is leading an initiative to conduct the same collection and analysis for sexual orientation data. Additionally, member data is verified whenever the member has contact with the health plan and is regularly updated to reflect demographics and language preferences.

Many data systems are utilized and analyzed to compare against previous years, available thresholds, and provider distribution. The Quality Department analyzes the member demographic based on race, ethnicity, languages spoken, and gender identity annually. To assess disparities, Molina uses HEDIS® and CAHPS® measures aggregated by race, ethnicity, language, and gender identity. Analyses are reported to quality committees to review, approve, and solicit interventions for improvement. Possible interventions include expansion of provider network and translation and/or interpreter services, and enhancement of member materials to accommodate changing member demographics.

Molina conducts periodic needs or population health assessments to identify the needs of the local population, expectations about healthcare, and key drivers of satisfaction related to access and receipt of healthcare within the system and community. This detailed analysis of the community can include stratification of analysis for specific high-volume populations by race, ethnicity, language spoken, gender identity and high prevalence disease states in a single area. The analysis identifies specific actionable concepts that could be applied to policy and program development to enhance the delivery of high-quality care in the region. It also allows Molina to document sustainable, automated or near-automated processes that may be applied on an annual basis to enable ongoing tracking and early warning of population and market preference changes in a dynamic population.

Continuous Quality Improvement – Culturally and Linguistically Appropriate Services Analysis

Molina's National Quality Improvement Committee and Health Equity and Cultural Competency Workgroup oversee and assess the development and implementation of cultural and linguistic accessibility standards and procedures. Molina assesses the cultural, ethnic, racial, gender identity, and linguistic needs and preferences of its members on an ongoing basis. Information gathered during regular monitoring and annual network assessment is used to identify and eliminate cultural and/or linguistic barriers to care through the implementation of programs and interventions. Race/ethnicity, gender identity, and language data is used to assess the existence of disparities and to focus quality improvement efforts towards improving the provision of culturally and linguistically appropriate services (CLAS) and decreasing health care disparities. Molina works to ensure that Limited-English-Proficient members have equal access to quality health care through culturally and linguistically appropriate providers, staff, and written materials.

Molina completes an annual CLAS Analysis which provides an overview of completed and ongoing activities for CLAS, assesses the plan's performance on trending of measures, analyzes efforts to reduce disparities and improve the provision of CLAS, including barriers, and evaluates the overall effectiveness of the CLAS program. The CLAS Analysis is included in Molina's Quality Annual Program Evaluation. Molina annually evaluates its performance on CLAS activities described in the Quality program description and work plan, including all delegated functions. This evaluation includes a description of completed and ongoing CLAS activities for the previous year.

Goals and objectives are listed in the annual Quality Improvement work plan and program evaluation and include, but are not limited to, the following:

- Annual collection and analysis of race, ethnicity, language, gender identity and data from eligible individuals to identify significant culturally and linguistically diverse populations with plan's membership;
- Annual collection and analysis of race, ethnicity and language data from contracted practitioners to assess gaps in care;
- Collection of data and reporting for the Diversity of Membership Healthcare Effectiveness Data and Information Set (HEDIS) measure;
- Determination of threshold languages annually and processes in place to provide members with vital information in threshold languages;
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations;
- Analysis of Healthcare Effectiveness Data and Information Set (HEDIS) measure results for potential cultural and linguistic disparities that prevent members from obtaining the recommended key chronic and preventive services (includes data stratification of selected HEDIS and CAHPS measures by race, ethnicity, preferred language, and gender identity);
- Enhancement of current patient-focused Quality Improvement activities to address specific cultural and linguistic barriers using culturally targeted materials addressing identified critical barriers;
- Provision of a more thorough organizational understanding of the specific reasons behind identified cultural and linguistic barriers and priorities. This can be accomplished through varied forms of direct member input including focus group, member feedback forms or surveys, and complaint analyses;

- Selection of critical barrier(s) found through the various cultural and linguistic analyses for specific intervention;
- Analysis of interpreter availability;
- Development of educational materials to meet the cultural and linguistic needs of the population served as well as those with complex conditions;
- Provision of staff with necessary information, training, and tools to address identified cultural barriers;
- Identification, carry out and checking planned activities related to the American with Disabilities Act requirements, such as provider, staff and member training, communication, and assessment of provider compliance; and
- Evaluation of the Culturally and Linguistically Appropriate Services (CLAS) Program to include assessment of completion of planned activities, identification of barriers, opportunities, and interventions to overcome barriers, and overall effectiveness.

Molina also annually publishes the contracted practitioners' gender (if available), cultural competency training status (if available) and language abilities via the Provider Online Directory (POD).

Molina annually obtains feedback on the CLAS Program and evaluation from various stakeholders through the Quality Improvement Committee, Board of Directors, and member advisory committees. All feedback is reported through the Quality Improvement Committee; the Quality Improvement team is responsible for incorporating stakeholder feedback.

NCQA Activities

Molina strives to maintain NCQA's Multicultural Health Care Distinction. The Multicultural Health Care Distinction recognizes Molina's cultural and linguistic sensitivity, and provision of outstanding services in collecting race/ethnicity and language data, providing language assistance, cultural responsiveness, quality improvement of culturally and linguistically appropriate services, and reduction of healthcare disparities. By achieving Multicultural Health Care Distinction, Molina is considered to meet and even exceed federal Office of Minority Health CLAS standards. Molina is actively collaborating with NCQA to transition successfully to the new Health Equity Accreditation.

Provider Network

Molina strives to create a network of practitioners that reflects the racial and ethnic, cultural, and language preferences of the region. Molina monitors a variety of data sources to determine the language needs and cultural backgrounds of Molina members, including prevalent languages and cultural groups. Provider Contracting uses this data to ensure its network providers closely align with the diversity of the member's cultural, racial, ethnic, and linguistic needs and to ensure appropriate providers are available for member needs. Performance threshold is to assure access to providers who speak languages spoken by >5% of the Molina membership.

Molina publishes the following data for practitioners on the web-based Provider Directories. Also included is a validation of information which includes an explanation of each item, its source, the frequency of validation and limitation with each.

- Name

- Gender
- Specialty
- Hospital Affiliations
- Medical Group Affiliations (if applicable)
- Board Certification with expiration dates
- Acceptance of new patients
- Languages spoken by the practitioner or clinical staff
- Language services available through the practice
- Participation in cultural competency trainings
- Office Locations

Molina members also can call the Member Services Department and request any information listed in the Provider Directories. Molina members are notified of their right to request this information in the member handbook, provider directories, newsletters, and on the Molina Website.

Cultural Competency Training and Resources

Provider Training

Molina works to ensure that our provider network consists of practitioners who understand the cultural norms and primary language or linguistic needs of a diverse membership. Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services or online training modules.

Training modules, delivered through a variety of methods, include:

1. Written materials;
2. On-site cultural competency training;
3. Online cultural competency Provider training; and
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Molina's Building Culturally Competent Health Care: Training for Providers

Cultural Competency can positively impact a patient's health care experience and outcomes. As part of Molina's ongoing commitment to cultural competency, a series of five short Cultural Competency Training videos are available to providers and office staff on the Culturally and Linguistically Appropriate Resources/Disability Resources link under the Health Resources tab at MolinaHealthcare.com. Molina utilizes an online attestation form to track and report on provider participation/completion.

Training topics:

- Video 1: Introduction to Cultural Competency
  - The Need for Cultural Competency
  - How Culture Impacts Health Care
  - Implicit Bias
  - Federal Requirements Related to Cultural Competency (Affordable Care Act, Americans with Disabilities Act)
- Video 2: Health Disparities
  - Examples of Racial Health Disparities and Health Disparities Among Persons with Disabilities
  - Health Equity
  - Social Determinants of Health
- Video 3: Specific Population Focus – Seniors and Persons with Disabilities
  - Social Model of Disability and Accepted Protocol and Language of the Independent Living/Disability Rights Movement
- Video 4: Specific Population Focus – LGBTQ and Immigrants / Refugees
  - Health Disparities Among LGBTQ Population
  - Clear Communication Guidelines for Healthcare Providers Interacting with LGBTQ Patients
  - Disparities Among Immigrant and Refugee Communities
  - Clear Communication Guidelines for Healthcare Providers Interacting with Immigrant and Refugee Patients
- Video 5: Becoming Culturally Competent
  - Perspective-taking
  - Clear Communication Guidelines
  - Tips for Effective Listening
  - Assisting Patients whose Preferred Language is Not English
  - Tips for Working with an Interpreter
  - Teach Back Method
  - Molina's Language Access Services

Training videos range from five to ten minutes each. Viewers may participate in all five training modules, or just one, depending on topics of interest.

Americans with Disabilities Act (ADA) Resources: Provider Education Series:

A series of provider education materials related to disabilities is available to providers and office staff on Molina's website. **Disability Resources consists of the following education**:

Americans with Disabilities Act (ADA)

- Introduction to the ADA and questions and answers for healthcare providers (i.e., which healthcare providers are covered under the ADA; how does one remove communication barriers that are structural in nature; is there money available to assist with ADA compliance costs?).

Members who are Blind or have Low Vision

- How to get information in alternate formats such as braille, large font, audio, or other formats.

Service Animals

- Examples of tasks performed by a service animal; tasks that do not meet the definition of service animal; inquiries you can make regarding service animals; and exclusions, charges, or other specific rules.

Tips for Communicating with People with Disabilities & Seniors

- Communicating with Individuals who Are Blind or Visually Impaired; Deaf or Hard of Hearing; Communicating with Individuals with Mobility Impairments; Speech Impairments; and Communicating with Seniors.

Molina Staff Training

In alignment with the National CLAS Standards, Molina educates and trains governance, leadership, and workforce on culturally and linguistically appropriate policies and practices on an ongoing basis. Molina staff receive Cultural Competency training at least annually through a variety of methods including, but not limited to one or more of the following:

1. Written materials;
2. Employee communications such as Intranet articles;
3. Training and monitoring concurrent with other skills included in the job description of each position;
4. Online self-paced trainings; and
5. On-site cultural competency trainings and discussions.

General cultural competency training is supplied to all employees, while additional training is supplied according to needs determined by each employee's job description, level of interaction with members or providers, and identification of cultural groups being served by the local offices. Molina reports on training completion key performance indicators to the Cultural Competency Workgroup and National Quality Improvement Committee and at Molina Healthcare of Iowa's Quality Improvement Committee. Molina supervisors receive reports on employees' compliance with trainings so that follow-up communication can occur to ensure completion.

Cultural Competency Training Series

Molina Healthcare's **Cultural Competency Staff Training** consists of two trainings:

Part 1: Introduction to Cultural Competency

Description: The web-based training is part of the Molina Healthcare series on cultural competency. Part 1 equips employees with information and tools regarding cultural awareness and the celebration of diversity at Molina. By building awareness of the differences among cultures, and providing tangible ways to improve cultural competency, the course allows employees to improve their interactions with both co-workers and members.

Topics covered: definitions of cultural competency and culture; components of culture; cultural background influences on decision making, perception of time, conflict resolution, communication style and health care expectations; benefits of cultural competency and tips to increase cultural competency.

Objectives:

- Understand the importance of cultural competency and value to Molina
- Define Cultural Competency
- Define culture and how it impacts daily lives
- Learn how culture impacts healthcare and healthcare expectations
- Learn communication and cultural competency tips

Requirements: Required training for all new employees and annual completion of training by all Molina employees.

Part 2: Health Disparities, Health Equity and Social Determinants of Health

Description: The web-based training is part of the Molina Healthcare series on cultural competency. Part 2 focuses on disparate health outcomes between different groups of people. The training explores unconscious biases and identifies meaningful ways to improve communication and positive engagement with all Molina members.

Topics covered: National Standards for Culturally and Linguistically Appropriate Services, health equity, health disparities, social determinants of health, implicit bias, strategies to increase cultural competency, perspective-taking, improving communication skills, teach-back method, and Molina's language access services such as interpreter and translation services.

Objectives:

- Recognize sources of health disparities
- Name several social determinants of health
- Describe how implicit bias affects health outcomes
- Demonstrate strategies that increase understanding between people
- Summarize Molina's available language access resources

Requirements: Required training for all new employees and annual completion of training by all Molina employees.

Molina Healthcare's **Americans with Disabilities Act Staff Training series** consists of two trainings:

Part 1: The Americans with Disabilities Act
Objectives:

- Define "disability" according to ADA
- Explain why the ADA is important and how it has helped Americans with disabilities
- Identify some "reasonable accommodations" in the workplace
- Illustrate how the Olmstead Decision impacted people with disabilities

Part 2: Caring for Seniors and Persons with Disabilities
Objectives:

- Identify types of disabilities and the prevalence of disabilities
- List functional limitations that occur with age
- Identify hidden disabilities
- Describe how culture, and disability intersect
- Explain barriers that may exist for accessing necessary healthcare services
- Use preferred terminology and effective communication with people with disabilities

Molina Staff Resources

Diversity, Equity & Inclusion Commitments

The organization has adopted Diversity Commitments that serve as our guide for an inclusive workplace for all. The Diversity, Equity, and Inclusion team is committed to supporting our Diversity Commitments through planned activities that increase workforce diversity and inclusion at all levels within the organization. One key area is focused on Talent Acquisition and Talent Management focused to improve diverse representation at the director-level and above and create a development path for non-exempt employees to be promoted to exempt roles. The Diversity, Education and Inclusion team has also launched five Employee Resource Groups. These Employee Resource Groups are employee-led groups that focus on groups of people that share similar characteristics, experience, and goals. The current Employee Resource Groups address internal and external gaps that impact the following groups of people: African Americans, Latinx, Women, Veterans, and LGBTQIA+. Employee Resource Groups are essential to helping Molina be more culturally competent and reduce implicit bias by providing insights on what Molina could be doing to support the needs and interest of these work communities. The Diversity, Equity, and Inclusion team uses the Employee Experience Survey to improve inclusion, empowerment, and career development. Additionally, the Diversity, Equity, and Inclusion team implements the required cultural competency trainings for all employees and leaders, creates Diversity, Equity, and Inclusion policies, position statements, program operational guidelines, and Diversity, Equity, and Inclusion results with the purpose to uphold its commitment to diversity and inclusion to all levels within the organization.

Cultural Awareness Campaigns

To increase cultural awareness and reduce implicit bias, the Diversity, Equity, and Inclusion team, leads an enterprise-wide initiative focused on recognition and education campaigns. Every month a different aspect of diversity and inclusion is highlighted on our intranet on a variety of culture and gender equality topics. Including but not limited to; education, accomplishments, language, cuisine, traditions, social behaviors, and other factors supporting our Diversity Commitments. Employees participate and are engaged through testimonials about their cultures and how it has influenced service to others. Employee may also download that months Cultural Awareness Campaign Teams video background cover and utilize it when attending video calls.