# 2025 Quality Improvement and Health Equity Transformation Program Description
# Molina Healthcare of CA

**Important Notes:**
**Molina Healthcare of CA** (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 **CA**. 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 **CA**. As reflected in this document, certain quality improvement, quality assurance, and related functions are delegated by the health plan to MHI through a Services Agreement between MHI and the health plan. The health plan submits the form of such a Services Agreement for review when it applies for a health maintenance organization license. Collectively, MHI and its health plans are referenced throughout this plan description as “Molina.”

MOLINA HEALTHCARE

## Table of Contents

| Table of Contents Continued | |
|---|---|
| **Section 5.0 Quality Improvement Strategy (Continued)** | Page(s) |

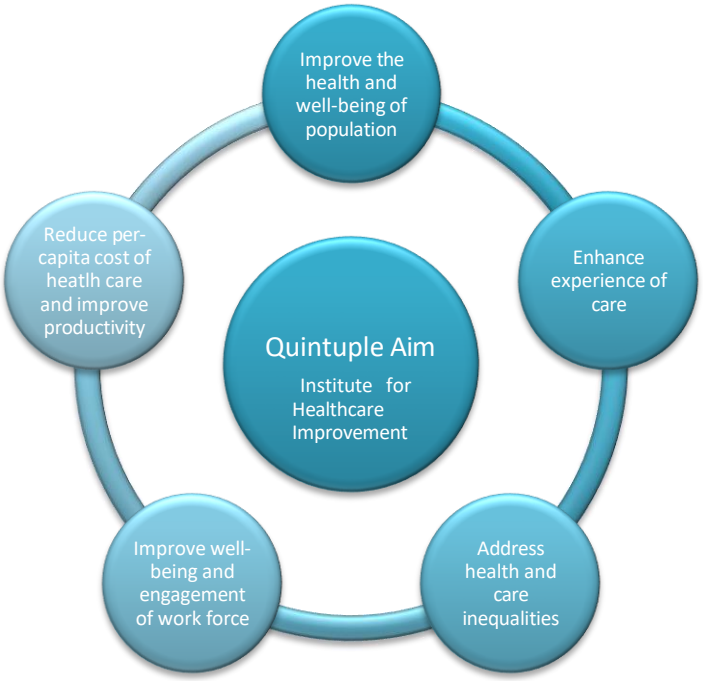
## Table of Contents Continued

## INTRODUCTION

### *Molina's Quality Program - referred to as the Quality Improvement Program and Health Equity Transformation Program- within this document:*

### *Introduction Part A: Achieving Quality Improvement and Health Equity Transformation Goals*

Molina carries out a comprehensive and multi-functional quality improvement program. Through the Program, Molina conducts a wide range of quality improvement activities that focus on how members receive health care and services across the entire health care continuum. The Quality Improvement and Health Equity Transformation Program complements the *Quintuple Aim* goals of the Institute for Healthcare Improvement as described below. Most importantly, Molina helps 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 and Health Equity Transformation Program. Molina drives continuous improvement by using innovative tools for measurement, evaluation, tracking and trending and receiving and incorporating vital feedback from 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:

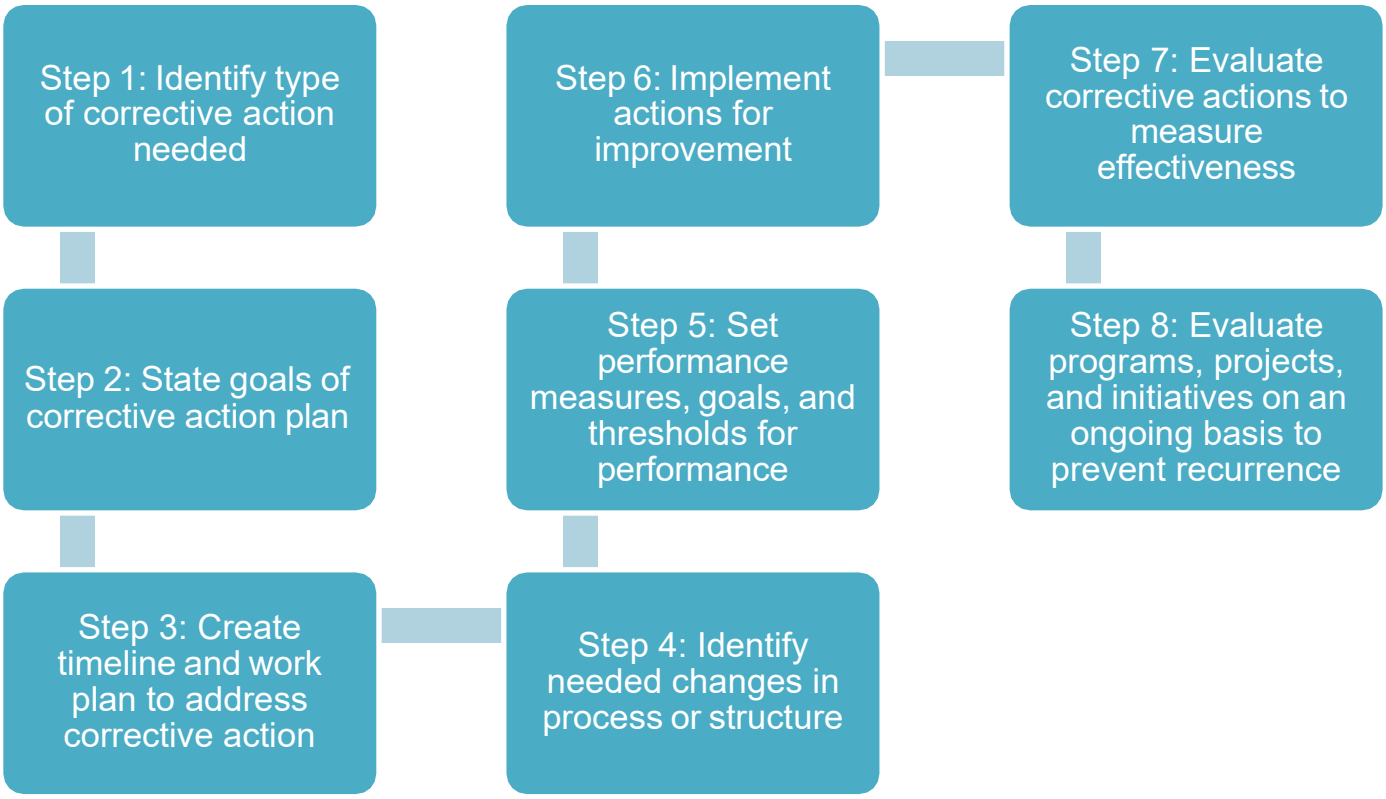
- ensuring health plan Members receive accessible, appropriate, cost-effective, and high-quality health care and services (including physical, behavioral, and oral health as applicable) throughout the care continuum.
- emphasizing the delivery of personalized care so that the doctor or practitioner can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

## *Introduction Part B: Molina's Quality Improvement and Health Equity Transformation Program Key Components: Infrastructure and Framework*

Molina's Quality Improvement and Health Equity Transformation Program provides the infrastructure and framework that allows Molina to fulfill its commitment to quality. Key Quality Improvement and Health Equity Transformation Program components include, but are not limited to, the following examples included in this program.

| **Quality Improvement and Health Equity Transformation Program Components and Aligned Principles** |
|---|
| **Program Component 1:** Molina sets up robust quality improvement structures, processes, plans, and strategies so that Molina can meet internal, program, and external requirements. Molina can then be responsive to the changing needs of stakeholders and to the requirements of the community, federal, and state governing agencies, and voluntary accrediting bodies. |
| **Program Component 2:** Molina contracts with, credentials, and recredentials individual practitioners, provider organizations, facilities, and institutions to deliver health care and services to members, particularly individuals with complex health issues. |
| **Program Component 3:** Molina establishes specific roles that are performed centrally within the national structure (further referenced as "MHI" or national programs within this document) and within the Molina plan. Molina delegates authority to MHI to perform specified health plan functions and services, while maintaining oversight responsibility for delegated and non-delegated activities. |
| **Program Component 4:** Molina specifies detailed Quality Improvement and Health Equity Transformation Program goals and objectives. Goals and objectives are created, reviewed, and updated on an on-going basis and the goals and objectives are formally assessed at least once a year through the combined Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan. The Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan includes specified timelines that will allow Molina to meet highlighted goals and objectives. |
| **Program Component 5:** Molina defines and addresses unique needs of members throughout the Quality Improvement and Health Equity Transformation Program. Molina places additional emphasis on: 1) identifying and stratifying members according to health care utilization and/or potential risk in alignment with member assessment, needs, and preferences 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 primary care physicians, medical and behavioral health, chemical dependency, and substance abuse specialists, and facilities; 4) educating and supporting members and caregivers in managing complex health, pharmacy and behavioral health issues; and 5) incorporating strategies to address the complex issues of members into the Care Management Program. |
| **Program Component 6:** Molina evaluates issues, problems or concerns through causal analysis that are discovered during Quality Improvement Program activities. Molina then develops action plans that are carried out to correct identified problems. (See example on next page) |

## Program Component Example: Molina's Corrective Action and Improvement Process Steps



## Section 1.0 Quality Improvement and Health Equity Transformation 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 health care needs and optimal health outcomes for members who experience a higher burden of chronic conditions (medical and behavioral health, chemical dependency, and substance abuse), members who are frail or disabled, members who come from culturally and linguistically diverse backgrounds, members who have complex and/or unresolved needs, and members who 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 and Health Equity Transformation 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 and health equity transformation through achieving and maintaining the National Committee for Quality Assurance Health Plan Accreditation and maintaining compliance with National Committee for Quality Assurance accreditation standards, federal and state regulations, including those promulgated by the Centers for Medicare & Medicaid Services.
- makes information about the Quality Improvement and Health Equity Transformation Program available to members and providers on the Web site and in hard copy upon request.
- 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.

Molina's Quality Improvement and Health Equity Transformation 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, and that all covered services are provided in a culturally and linguistically appropriate manner.

## Section 2.0 Quality Improvement and Health Equity Transformation Program Goals

Molina has defined key goals for the Quality Improvement and Health Equity Transformation 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). Molina's Quality Improvement and Health Equity Transformation Program goals are described below.

| Molina Quality Improvement and Health Equity Transformation Program Goals |
|---|
| **Structure and Process** |
| Define and demonstrate Molina's commitment to quality and health equity transformation through activities that achieve improvements in quality care and health outcomes, member safety and quality of service. |
| Review, analyze, and understand Molina's member demographic and epidemiological data to identify and address member needs. |
| 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. |
| Plan and maintain programs designed to improve health and health outcomes of health plan members. |
| Conduct ongoing and systematic evaluation to design effective interventions that mitigate barriers to improve Molina's structure, processes, and outcomes. |
| Develop structure and processes to measure and improve member and provider satisfaction with medical and behavioral health care and/or services from providers and practitioners and/or Molina. |
| Use a multidisciplinary committee structure to achieve Quality Improvement and Health Equity Transformation Program goals. |
| Apply sound approaches and methods to develop objective and clearly defined indicators and performance measures using systematic collection of valid and reliable data. |
| Provide 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. |
| Design and implement programs in collaboration with network practitioners, providers and facilities focused on improving health outcomes, reducing hospital readmissions, improving member safety and reducing medical errors, and reducing health and health care disparities. |
| Use value-based arrangements, increased reimbursement, or other market-based member and/or provider incentives to achieve quality improvement goals as applicable. |
| Facilitate collaborative relationships between members, providers, and regulators to promote effective health management, health promotion and wellness education. |
| Align, oversee, and implement activities that meet federal, state, and accreditation requirements. |
| Foster a shared organization-wide approach to protect privacy and security of private member and provider information in line with federal and state regulatory and accreditation requirements. |
| Facilitate 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. |
| **Outcomes** |
| Improve the quality, safety, appropriateness, availability, accessibility, coordination and continuity of health care and services delivered to members. |
| Improve experience for Molina members and network practitioners. |
| Ensure that health plan members receive culturally- and linguistically- appropriate services that facilitate equitable health care and identify and address social determinants of health (including social risks and social needs. |
| Maintain compliance with quality-related federal, state regulatory and accreditation standards. |

## Section 3.0 Quality Improvement and Health Equity Transformation Program Objectives

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

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

Molina reviews and modifies Quality Improvement and Health Equity Transformation 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 combined Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan.

## Section 4.0 Scope of Quality Improvement and Health Equity Transformation Program Activities

Molina carries out a broadly defined Quality Improvement and Health Equity Transformation Program that fully addresses multiple and wide-ranging topics within the scope of quality improvement. Through Molina's Quality Improvement and Hea Program, Molina focuses on activities that encompass the entire health care experience. Molina's scope related to member experience includes the facilitation of equitable, culturally and linguistically appropriate health care and services that address the physical, behavioral health/chemical dependency/substance abuse, social needs, and social risks.

Molina's Quality Improvement and Health Equity Transformation Program scope includes, but is not limited to, medical, behavioral health, chemical dependency, and substance abuse, Long-Term Services and Supports (as applicable), Home-and Community-Based Services (as applicable), health care and services supplied by inpatient facilities, outpatient settings, home care providers, and/or even providers that deliver care in the member's home. The focus of these activities ensures that members receive equitable, culturally and linguistically appropriate health care and services that consider the social needs of the community and social risks of Molina members. Contracted provider groups, primary care and specialty practitioners, facilities and ancillary providers may render these services.

Molina's Quality Improvement and Health Equity Transformation Program focuses 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, geography, language, sex assigned at birth, sexual orientation and gender identity (as available), disease categories, risk status, disability status (as available), health equity (as available), social determinants of health, such as social needs (as available), and by lines of business/product lines, with the aim of better meeting the needs of health plan members.

Molina is fully invested in making sure members receive timely and appropriate behavioral health, chemical dependency, and substance abuse care and services in collaboration with network practitioners and facilities. Through Molina's Quality Improvement and Health Equity Transformation Program, Molina evaluates how well medical and behavioral health, chemical dependency, and substance abuse care and services are coordinated and delivered to health plan Members as designated within Member's assigned benefits. Management of behavioral health, chemical dependency, and substance abuse care and services is evaluated along with any medical issues that may impact the health of members. Molina takes this holistic approach to ensure there is effective coordination between medical and behavioral health, chemical dependency, and substance abuse 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 members are being supported to maintain their health.

## Section 4.0: Scope of Quality Improvement and Health Equity Transformation Program Activities

### *Part A: Continuously Evaluating Important Aspects of Health Care and Services*

Molina continuously monitors important aspects of health care and services to ensure health plan members obtain timely, appropriate, effective, efficient, and safe care in the right setting at the right place. Molina monitors key aspects or activities as shown by the examples listed below.

| Evaluating the Important Aspects of Health Care and Services | |
|---|---|
| **Activity** | **Focus of Activity** |
| Monitor access and availability of services through health risk assessments, appointment scheduling, network composition through monitoring of volumes and type of providers, geographic analysis, and review of member and provider experience data. | Access and Availability of Services and Health Care |
| Collect and analyze data about health care and services about member movement between practitioners, such as between primary care physicians and/or specialists; and member movement across settings of care between primary care providers, specialists, hospitals, Long-Term Services and Supports and Home and Community-Based providers (as applicable), rehabilitation facilities, emergency departments, urgent care centers, and/or skilled nursing facilities. | Continuity and Coordination of Medical Care |
| Monitor and report on activities that focus on: 1) exchange of information between medical and behavioral health, chemical dependency, and substance abuse providers and facilities; 2) collaboration between medical and behavioral health, chemical dependency, and substance abuse providers; 3) diagnosis, treatment and referral of medical and behavioral health, chemical dependency, and substance abuse disorders; 4) appropriate use of psychotropic medications; 5) management of coexisting medical and medical and behavioral health, chemical dependency, and substance abuse conditions; 6) prevention programs for medical and behavioral health, chemical dependency, and substance abuse; and 7) activities for members with severe and persistent mental illness. | Continuity and Coordination of Medical and Behavioral Health, Chemical Dependency, and Substance Abuse Care |
| Monitor Case Management and Health Management activities for compliance with evidence-based guidelines and processes for structured assessment and follow-up. | Case Management and Clinical Programs |
| Evaluate quality and clinical indicator performance as compared to established benchmarks, to identify potential over- and under-utilization and to monitor appropriate use of and compliance with clinical practice guidelines, review of grievance and case review processes and data to determine issues that affect health care provision. | Appropriateness of Care |
| Review grievance and appeal and case review processes and data to determine issues that affect health care provision. | Appropriateness of Care |
| Measure behavioral health/chemical dependency/substance abuse care and services by using and measuring compliance with clinical practice guidelines. | Behavioral health, chemical dependency, and substance abuse utilization<br>Clinical Practice Guidelines |

| | |
|---|---|
| Review utilization and quality data related to Long Term Care and Long-Term Services and Supports (as applicable) | Long-Term Care and Long-Term Services and Supports |
| **Evaluating the Important Aspects of Health Care and Services** | |
| **Activity** | **Focus of Activity** |
| Facilitate the management of chronic conditions and acute care for individuals and evaluate programs and initiatives that focus on these issues. | Chronic Condition Management and Acute Care Provision |
| Evaluate activities related to member safety/medical error reduction/avoidance. | Patient Safety, Medical Error Reduction and Avoidance |
| Review areas of high-risk/high-volume/problem-prone care. | Patient Safety, Medical Error Reduction and Avoidance<br>Hospital Admission Readmission Prevention |
| Measure compliance with clinical practice guidelines to evaluate effectiveness of preventive care provided to health plan members. | Wellness and Health Promotion |
| Manage and evaluate programs and initiatives that focus on members with special health care needs. | Special Health Care Needs |
| Review and evaluate activities for members with complex health needs who may need case management and/or care coordination, including members with co-morbid health problems and complex conditions linked to concurrent/on-going or unresolved medical and behavioral health, chemical dependency, and/or substance abuse issues. | Health Outcomes Improvement<br>Patient Safety, Medical Error Reduction and Avoidance<br>Hospital Readmission Prevention<br>Health and Health Care Disparities Reduction |
| Manage effective coordination of services as identified through clinical programs, adequate transportation, and access to care support, among other services offered. | Health Outcomes Improvement<br>Patient Safety, Medical Error Reduction and Avoidance<br>Hospital Readmission Prevention<br>Health and Health Care Disparities Reduction<br>Wellness and Health Promotion |
| Collect, report and analyze Healthcare Effectiveness Data and Information Set, state required, federally based quality indicators and support activities to address performance gaps. | Health Outcomes Improvement<br>Health and Health Care Disparities Reduction<br>Wellness and Health Promotion |
| Evaluate member and provider satisfaction with medical, behavioral health, chemical dependency, and substance abuse care using Consumer Assessment of Healthcare Providers and Systems surveys, behavioral health assessments, and provider satisfaction surveys. | Member and Provider Experience |
| Implement and manage medical coverage documents and policies. | Medical and Clinical Policies<br>Utilization Management |
| Manage health plan operational processes and service requirements in comparison to key performance indicator goals and thresholds. | Operational Performance |
| Review, investigate, and trend Potential Quality of Care cases, Serious Reportable Adverse Events, Hospital Acquired Conditions, and critical incidents. | Health Outcomes Improvement<br>Patient Safety, Medical Error Reduction and Avoidance |

| | |
|---|---|
| | Hospital Readmission Prevention |

| Evaluating the Important Aspects of Health Care and Services | |
|---|---|
| **Activity** | **Focus of Activity** |
| Implement medication management activities. | Health Outcomes Improvement<br>Patient Safety, Medical Error Reduction and Avoidance<br>Hospital Readmission Prevention<br>Health and Health Care Disparities Reduction |
| Provide timely and appropriate health care and services that meet the needs of members with culturally and linguistically diverse backgrounds. | Health and Health Care Disparities Reduction,<br>Wellness and Health Promotion<br>Health Outcomes Improvement |
| Review and analyze demographic, health status, and utilization data and trends for health plan member populations and within communities served to identify and address the needs and preferences of health plan members. | Health Outcomes Improvement<br>Hospital Readmission Prevention<br>Health and Health Care Disparities Reduction<br>Wellness and Health Promotion |
| Manage and monitor health information systems and data. | Information Systems |
| Implement quality improvement and health equity transformation projects and performance improvement projects internally, and/or in collaboration with other health plans in the market as applicable, that focus on key priority areas identified internally or by external stakeholders to meet state and federal requirements. | Performance Improvement Projects<br>Quality Improvement Projects |
| Collect, report, and analyze applicable and appropriate measures of health outcomes and indices of quality for populations of focus and sub-populations. | Health Outcomes Improvement,<br>Hospital Readmission Prevention<br>Health and Health Care Disparities Reduction<br>Wellness and Health Promotion |
| Identify, analyze, and facilitate activities that address social needs and social risks that are not being met for Molina members. | Person-centered and Whole Person Care<br>Social Determinants of Health |

## *Section 4.0 Scope of Quality Improvement and Health Equity Transformation Program Activities*

### *Part B: Employing Data Sources and Systems to Drive Quality Improvement and Health Equity Transformation*

Molina employs a data-driven process to improve quality and health equity transformation. Molina collects and utilizes many data sources to review, analyze, and evaluate the Quality Improvement and Health Equity Transformation Program and planned actions to address all target populations. Molina uses sound approaches and methods 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, as applicable. Molina builds specific health outcomes and indices of quality specific to Molina's targeted activities and program goals.

Molina applies a rigorous quality methodology as described in Section 5.0: Quality Improvement and Health Equity Transformation Strategy. Molina adopts performance measures and indicators using available published methods; when none are available, Molina conducts tests 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 uses an improvement methodology to outline the approach to take to correct problems that have been revealed through quality improvement activities.

Molina staff then apply the improvement methodology to evaluate the effectiveness of the Quality Improvement and Health Equity Transformation Program annually. This methodology is described in Section 10.0: Quality Improvement and Health Equity Transformation Program Evaluation.

Molina utilizes multiple data sources to monitor, analyze, and evaluate current activities and planned initiatives within the Quality Improvement and Health Equity Transformation Program. Data sources include but are not limited to data and information from claims and encounters, member and provider experience, quality, demographics, and clinical systems. Examples of these data sources are highlighted below.

| Claims and Encounters | Demographics | Clinical |
| --- | --- | --- |
| • Medical and behavioral health, chemical dependency, and substance abuse claims and encounters<br>• Pharmacy<br>• Laboratory data and results, as available | • Statistical, epidemiological, and demographic data as well as data that identifies the cultural, racial, and ethnic and linguistic needs of members<br>• Enrollment and disenrollment data<br>• Social determinants of health data, including social risks and social needs | • Pertinent medical records (minimum necessary)<br>• Utilization reports and case review data and authorization and denial reporting<br>• Case and health (e.g., disease) management program data and health risk assessments<br>• Diagnosis information (laboratory, pathology, and radiography results) |

MOLINA HEALTHCARE

## Quality

- Quality improvement indicators including Healthcare Effectiveness Data and Information Set and other quality measures that are nationally required and state-specific
- Other quality improvement data that have been collected and/or reported focused on medical, behavioral health, pharmacy and lab

## Member and Provider Experience

- Member satisfaction survey results,from surveys, such as Consumer Assessment of Healthcare Providers and Systems surveys
- Internal surveys and feedback mechanisms through voice of the customer surveys, Net Promoter Scores, and committee/focus group input, and through member appeals and grievances received
- Provider satisfaction survey results
- Internal surveys and feedback mechanisms through committee meetings, advisory council meetings, and other provider engagement activities

Molina collects and processes data from all activities through several methods such as electronic software and applications, manual data 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 meet Quality Improvement and Health Equity Transformation Program objectives. Through Molina's health information technology and systems, Molina manages and tracks activities and progress of members throughout the course of care management and other clinical programs. Data, reports, and analysis are made available to state and federal regulatory agencies as requested.

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

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

Maintenance and storage of all 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 Health Insurance Portability and Accountability Act-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 for collecting and integrating data, running analyses, and carrying out quality improvement activities.

## *Section 4.0 Scope of Quality Improvement and Health Equity Transformation Program Activities*

### *Part C: Maintaining Quality Improvement and Health Equity Transformation Program staff and analytical resources to drive quality improvement*

At a minimum, Molina maintains dedicated quality staff and analytical resources to implement the Quality Improvement and Health Equity Transformation Program. Key staff and resources include, but are not limited to the following positions:

- Plan President (oversees the program).
- Chief Medical Officer.
- Quality Lead.
- Additional Directors/Managers, Quality.
- Quality Improvement Program Manager (s), Specialist (s).
- Designated behavioral health practitioner.
- Provider quality and practice transformation staff.
- Analyst(s).

Additional experts in key functional areas oversee key components of the Quality Improvement and Health Equity Transformation Program. These positions may include, but are not limited to teams/staff that focus on:

- utilization management and/or healthcare services.
- care and case management, community engagement, and/or care coordination.
- care model implementation for specific topics/critical areas, such as behavioral health, chemical dependency, and substance abuse and kidney disease management, among others.
- social work, including a focus on social determinants of health.
- Long-Term Care and Long-Term Services and Supports.
- Nurse Advice Line consulting.
- Health (e.g., Disease) Management and population health management.
- pharmacy and medication management.
- Contact Center (e.g., Member Services).
- member outreach.
- medical and healthcare informatics and analysis.
- network management and operations.
- credentialing and recredentialing.
- contract management.
- finance.
- compliance.
- privacy, security, and confidentiality.
- training and development.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

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

Molina employs strategies to improve the health status for health plan members. Molina will include the following issues and activities in a broad-based quality improvement strategy. These issues and activities will include, but may not be limited to: 1) a description of the relevance of the quality improvement strategy for Molina members; 2) performance measures, benchmarks/goals, and thresholds; 3) program goals, timeline and information about barriers and mitigation planning; 4) activities and initiatives to reduce health care disparities, improve health outcomes, focus on member safety and reduce medical errors, prevent hospital readmissions, and address social determinants of health to ensure members receive timely and appropriate care. (Molina publishes the list of activities and methods, timelines, individuals responsible, and set goals within the annual Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan).

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part A: Implementing Focused Quality Improvement and Health Equity Transformation Processes, Strategies and Activities*

Molina implements key processes and activities to support Molina's quality improvement and health equity transformation strategy. These processes and activities are described in the table below.

| Molina Quality Improvement and Health Equity Transformation Program Processes, Strategies and Activities. |
|---|
| Molina identifies 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, reducing health and health care disparities and addressing social risks and social needs. |
| Molina addresses topics that were identified through the yearly program evaluation as part of a formal quality improvement projects and/or performance improvement projects and/or activity to address clinical and/or non-clinical or service aspects of care. |
| Molina uses clinical practice and preventive health guidelines to address priority and/or complex health needs associated with high-risk, acute, chronic condition, and social risks/needs and problems faced by plan members. |
| Molina finalizes and formalizes quality improvement project and/or performance improvement project design and implementation based on topic and priority identification with project-specific goals, objectives, and metrics so that results can be monitored against applicable national practice standards and initiating actions to address identified gaps. |
| Molina documents clinical and non-clinical improvement activities in required project templates. |
| Molina evaluates quality improvement project and/or performance improvement project results at baseline and through periodic follow-up and remeasurement cycles to foster sustained improvements. |
| Molina identifies 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. |
| Molina implements 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. |
| Molina employs quality interventions and programs related to preventive health, health education, wellness and health promotion, health (e.g., disease) management, care coordination, case management, and complex case management. |
| Molina identifies and addresses social risks of the community and social needs of members. |
| Molina uses 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, chemical dependency, substance abuse practitioners, as appropriate. |
| Molina oversees delegated processes to make sure delegated groups meet Molina requirements. |

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part B: Employing Data Sources and Systems to Drive Quality Improvement*

Molina staff, health plan Medical Directors, external providers and organizations, members and/or caregivers and other stakeholders may provide priority areas for improvement. Focus areas are prioritized through the Molina National Quality Improvement and Health Equity Transformation Committee, the Molina Healthcare of CA 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.
- availability of scientific research to evaluate the technology.
- service or care found to have a high potential for harm.
- activities or services that are of great importance to members and providers.
- impact on quality of life, functional status, and health and/or social risks/social needs.
- known or suspected overutilization or inappropriate usage.
- other critical topics identified for improvement.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part C: Using Established Methodology to Implement Quality Improvement and Health Equity Transformation Activities*
### *Component 1: Applying a Focused Model for Improvement with Rapid-Cycle Process Improvement and Using Measurement and Analysis Tools*

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

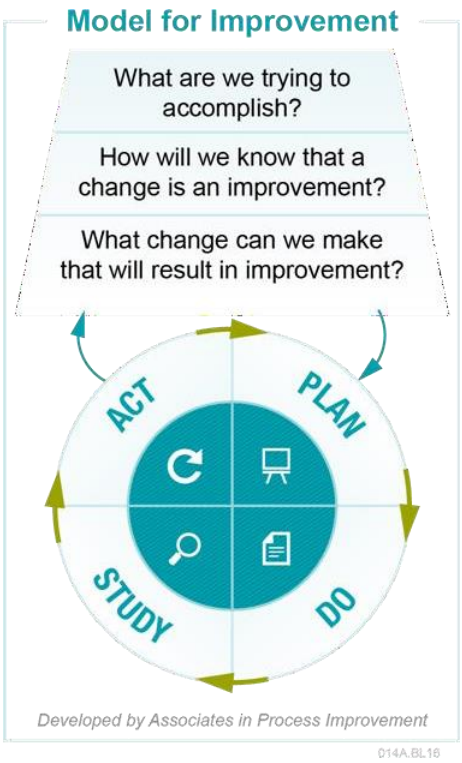
Molina applies the Model for Improvement as developed by the Associates in Process Improvement. As shown on the next page, there are three key steps applied within the Model for Improvement followed by the Plan, Do, Study, Act model. Molina answers the three key questions included in this model prior to the start of a quality improvement activity. These three questions are:

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

These questions help to frame the work that will be carried out during quality improvement activities. Within the Model for Improvement, the second component. is the Plan, Do, Study, Act (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 **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 Molina's Quality Improvement and Health Equity Transformation 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 to programs or initiatives to address potential gaps in performance may include, but are not limited to:

- development, modification or updates related to organizational policies and procedures.
- changes to staffing patterns or personnel, or training requests.
- 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.
- communication of results, changes, and updates internally and externally.
- incorporation member and provider feedback.
- adjustment of existing interventions, initiation or discontinuation of interventions as appropriate.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part C: Using an Established Methodology to Implement Quality Improvement and Health Equity Transformation Activities*

### *Component 2: Using a Continuous Quality Improvement Cycle and Analyzing Performance Measures across Key Focus Areas*

Molina's continuous quality improvement and health equity transformation cycle also includes three major steps, which Molina applies to the measures Molina collects and the outcomes we seek to achieve. As shown below, Molina implements quality metric dashboards as an early warning system to identify and address potential gaps in data; creates feedback mechanisms to receive input from members, providers, and other stakeholders to ensure Molina continually responds to identified issues and innovates, tests, and replicates activities to improve performance based on what works most effectively. Molina evaluates the Quality Improvement and Health Equity Transformation Program and strategies continuously throughout the year, analyzing relevant performance measures and preparing accurate and compliant reports.

# Continuous Quality Improvement Cycle

State-of-the-art quality metrics, dashboards, and reports.

*Molina uses early warning systems to identify and address gaps in data and implement rapid improvement.*

Multi-dimensional and continual responsiveness.

*Molina listens to feedback from members, providers, community members, and stakeholders, like state Agencies. Molina acts on this feedback to meet needs of individual members, and groups or populations of members with specific needs.*

Innovative quality model design and implementation.

*Molina tests and replicates innovative quality models. Through continuous learning, Molina applies what works best for Molina members, providers, and the state*

Molina evaluates the Quality Improvement and Health Equity Transformation Program and strategies continuously throughout the year, analyzing relevant performance measures across multiple dimensions of care and service, and preparing accurate and compliant reports. Examples of focus areas and performance measures evaluated are discussed below.

| | | | | |
|---|---|---|---|---|
| **Accessibility of services and providers** | **Effectiveness of care and services provided** | **Efficiency in managing resources and utilization of services and care** | **Impact of programs on member experience and person-centered care** | **Satisfaction of members, caregivers, providers, and others** |
| Appointment availability | Adult, child and teen preventive care | Plan all-cause readmissions, inpatient admissions, average length of stay | Evaluation of member and caregiver feedback to ensure care goals align with member requests | Provider and member satisfaction survey results |
| Provider ratios | Adult, child, and teen management | Skilled nursing facility admissions and readmissions | Care plan, goals, and assessment | HCBS/LTSS survey results |

| | | | | |
|---|---|---|---|---|
| | of chronic conditions | | completion and frequency | |
| | Adult, child, and teen use of services | Utilization per 1,000 services for outpatient and inpatient services | Health management, case management program member and caregiver experience | Voice of the Customer surveys through performance improvement projects |
| Office wait times | HCBS/LTSS services and care plans (as applicable) | Emergency department visits | | Net Promoter Score |
| After hours access | | LTSS/HCBS transitions from inpatient facilities to community | | Member focus groups |
| Geographic availability | | Child, teen and adult well care visits | | Member and Provider Advisory Committees |
| | | | | Quality Improvement and Health Equity Transformation Committees |
| | | | | Member and provider grievances and appeals |

|  |  |  |
|---|---|---|
| **Health Outcomes and perceived Quality of Life** | **Continuity and Coordination of Care and Services** | **Adequacy of staffing and program resources** |
| Blood Pressure Control | Coordination between medical providers, such as between primary care providers and specialists, specialists to primary care providers, and facilities to other facilities and to primary care providers and specialists | Adequacy of program staffing and resource |
| Hemoglobin A1C Control | Adult, child, and teen management of chronic conditions | Participation in QIHETCs and subcommittees |
| Medicare Health Outcomes Survey results (as applicable) | Diabetes Screening, Diabetes Monitoring, and Cardiovascular Monitoring for people with diabetes or cardiovascular disease with bipolar disorder or schizophrenia | Participation in Member Advisory Committees |

| | | |
|---|---|---|
| Short-Form 12 Quality of Life survey results | Case management evaluation/transition of care management, transitions of care between facilities and care settings | Child, teen and adult well care visits |
| | HCBS/LTSS services and care plans (as applicable) | Utilization per 1,000 services for outpatient and inpatient services |
| | | Emergency department visits |
| | | LTSS/HCBS transitions from inpatient facilities to community |

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part D: Facilitating Patient Safety Improvement Initiatives*
### *Component 1: Collaborating with Network Providers and Educating Molina Members*

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

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

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part D: Facilitating Patient Safety Improvement Initiatives*
### *Component 2: Conducting Medical Management Activities*

Molina conducts medical management activities to ensure that care delivered by network practitioners 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 incidents through oversight by Healthcare Services, and potential fraud, waste, and abuse cases. Serious reportable adverse events are tracked and trended, and adverse occurrences are identified during daily utilization management activities.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part D: Facilitating Patient Safety Improvement Initiatives*
### *Component 3: Identifying and Investigating Potential Quality of Care Cases, Adverse Events, 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 committees. As appropriate, confidential information about quality-of-care issues will be provided to regulatory bodies.

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 annual Quality Improvement Program Evaluation.

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

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

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part D: Facilitating Patient Safety Improvement Initiatives*
### *Component 4: Reviewing and Investigating Potential Pharmacy Management Issues*

Molina also checks for potential pharmacy over- and under-utilization by investigating provider prescribing patterns, assessing provider adherence to clinical practice guidelines, and reviewing 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 health plan members by making sure prescriptions are reviewed as the prescriptions are submitted within the context of the member’s medication history.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part E: Addressing the Needs of Molina's Most Vulnerable Members: Identifying and Evaluating Services Provided*

Molina implements Quality Improvement and Health Equity Transformation Program activities to identify and evaluate the healthcare and services provided 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, members who have many chronic medical and/or behavioral health, chemical dependency, and/or substance abuse conditions, members with End Stage Renal Disease, and/or members who are nearing the end of life through these methods and data analysis.

Molina identifies, stratifies, and monitors the high priority needs of health plan members through data and information gathered through the following methods. These methods include but are not limited to:

- conducting health risk assessments; and/or
- performing home visits; and/or
- using predictive modeling; and/or
- reviewing and analyzing medical, behavioral health/chemical dependency/substance abuse, laboratory and pharmacy claims and encounters data, as applicable; and/or
- implementing care/case/health (e.g., disease) management activities and reviewing social determinants of health; and/or
- facilitating referrals by members/caregivers; and/or
- receiving and tracking member self-referrals through Member Services and Nurse Advice Line; and/or
- receiving and acting on 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 into designated programs. Designated programs include Health (e.g., Disease Management), Care Management, and/or Case Management and/or care coordination. Molina manages the healthcare and services for these members proactively and frequently with consideration for the needs and preferences of individual members. 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 healthcare settings and/or changes in the health status as needed for these members with the goal to improve member outcomes, experience and quality of life.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part F: Managing the Complex Needs of 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 issues; determination of available benefits and resources; and ongoing management through development and implementation of a care plan with performance goals, designated follow-up schedule, progress assessments. This process includes collaboration with the members (and/or authorized caregivers) to incorporate member needs and preferences.

Molina carries out a complex case management program to help members to achieve or maintain optimal 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 Molina's Quality Improvement and Health Equity Transformation Program, as both programs address the members' 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 electronic systems to further support 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's complex case management program and processes include, but are not limited to:

- a population assessment that includes a review and evaluation of member population demographics, relevant subpopulations, children and adolescents, individuals with disabilities, and individuals with serious and persistent mental illness.
- a review of complex case management processes and resources.
- identification of an opportunity for the member and/or authorized caregiver to decline participation or disenrollment from case management programs.
- documentation of timely and appropriate assessments and care plans.
- assessment of member experience, including member feedback, analysis of complaints and appeals, and other member feedback.
- review of social determinants of health, including social risks and social needs.
- assessment of the effectiveness of the program.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part G: Managing Services and Care for Members with Complex or Special Health Care Needs*

Molina facilitates the delivery of effective, quality health care and services for 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.

| ***Managing Services and Care for Members with Complex or Special Health Care Needs Molina:*** |
|---|
| identifies members with special health care needs on a timely basis and subsequent enrollment in complex case management, including behavioral health, chemical dependency, and substance abuse case management, as appropriate. |
| facilitates timely and appropriate continuity and coordination of care for members with special health care needs through case management. |
| enrolls members with chronic conditions in health (e.g., disease) management programs as appropriate. |
| recommends the use of preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs. |
| evaluates performance based on measures related to treatment effectiveness, symptom management, functional status, and health status. |
| distributes 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, among others) and preventive health guidelines to members and practitioners. |
| assists members with finding providers, scheduling appointments, arranging transportation, facilitating community supports, and accessing care related to preventive services, acute care, and management of chronic conditions. |

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part H: Evaluating Timely and Appropriate Continuity and Coordination of Health Care and Services*

Molina evaluates the provision of timely and appropriate continuity and coordination of care and services for health plan members through annual analysis of data.

| ***Through the annual continuity and coordination of care evaluation process, Molina:*** |
|---|
| reviews transition of care processes and effectiveness of internal provider communications for members with complex needs. |
| evaluates documentation that states that the member's approved care representative helped make care or treatment decisions for members with mental or physical incapacities. |
| facilitates arrangements with home-based, community, and/or social service programs to address medical, behavioral health, chemical dependency and substance abuse, social risks and social needs. |
| recognizes new members who are chronically ill or have complex conditions and who would benefit from program activities as identified through assessments, member/provider/caregiver referrals, and during care/case/health (e.g., disease) management. |
| determines opportunities to improve continuity and coordination of care processes as evaluated through medical record review, practitioner survey data collection, or any valid methodology. |
| coordinates medical and behavioral health, chemical dependency, and substance abuse care and services, related to information exchange, appropriate diagnosis, treatment and referrals to primary care physicians, management of treatment access, appropriate use of medications, primary/secondary preventive behavioral health/substance abuse programs, and management of the special needs of members with severe and persistent mental illness. |
| reviews medical records and other data sources to assess continuity and coordination of care delivered to members. |
| monitors health (e.g., disease) management processes and indicators to manage care for members with chronic conditions and co-morbidities. |
| tracks quality of care issues, including adverse events linked to gaps in continuity and coordination of care. |
| monitors program referral and enrollment for timeliness and appropriateness. |
| evaluates member and practitioner input from satisfaction surveys, grievances, and appeals. |
| reviews continuity and coordination issues and taking timely action to address findings. |
| promotes and educates members and providers about Advanced Directives. |
| provides oversight of delegated activities. |

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part I: Carrying Out Behavioral Health, Chemical Dependency, and Substance Abuse-related Quality Improvement and Health Equity Transformation Activities*

Molina carries out and evaluates its behavioral health, chemical dependency, and substance abuse programs in accordance with NCQA standards, federal and state regulatory requirements that focus on behavioral health and mental health parity. This program ensures that medical and behavioral health, chemical dependency, and substance abuse are integrated throughout the health plan.

| ***Molina maintains behavioral health, chemical dependency, and substance abuse quality improvement activities where Molina:*** |
|---|
| maintains available network practitioners in the fields of behavioral health, chemical dependency, and/or substance use disorders who serve the health and social needs of members. |
| ensures that member access to behavioral health, chemical dependency and substance abuse services is available so that members receive timely receipt of behavioral health/substance abuse services (in alignment with medical and social services as needed). |
| puts individualized plans of care or treatment plans in place to facilitate the appropriate level of care for members. |
| coordinates health care and treatment between behavioral health, chemical dependency, and substance abuse providers and primary care physicians and other medical specialists. |
| lines up and make sure follow-up services and continuity of care for behavioral health, chemical dependency, and substance abuse, medical, and social services after transitions of care are appropriate and timely. |
| involves the members' Primary Care Physician in after care. |
| ensures there are high rates of member satisfaction with access to and quality of behavioral health, chemical dependency, and substance abuse services through review of grievances and appeals and satisfaction survey data. |
| monitors utilization of behavioral health, chemical dependency, and substance abuse services to ensure that members receive appropriate services. |
| screens, assesses, and provides referral triage services, as needed. |
| ensures that adequate care is provided across the continuum of care, ranging from widely used outpatient therapy to inpatient care to comprehensive community-based care to members as per the benefit structure and available treatment resource options in alignment with behavioral health, chemical dependency, and substance abuse as needed. |
| makes pharmacy services, medications, and supplies available in accordance with benefit structure. |
| facilitates appropriate linkages to ancillary support services (e.g., school systems). |
| coordinates provision of chemical dependency and substance abuse assessment and treatment per benefit structure. |
| monitors service delivery to make sure that care is available in a timely manner, in appropriate settings and at the appropriate level of care. |
| supplies safe and accessible care delivery across convenient locations through tracking and trending of critical incidents (through Molina's Healthcare Services departments). |

Opportunities for collaborative medical and behavioral health, chemical dependency, and substance abuse activities are identified through:

- reviewing cost containment activities reviewed by the Quality Improvement and Health Equity Transformation Committee for potential impact on the quality of care delivered.
- evaluating performance through key indicators.
- evaluating patient safety activities and initiatives.
- monitoring potential over- and under-utilization of behavioral health services.

Molina fosters quality improvement 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. The goal of these activities is to help health plan members achieve or maintain optimal health, function and quality of life.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part J: Reviewing Data to Identify and Address Potential Over- and Under-Utilization*

Molina reviews potential over-and under-utilization data at least yearly using cross-functional teams and in collaboration with Molina's provider network through:

- tracking of potential quality of care issues, including adverse events, critical incidents, and sentinel events.
- reviewing and trending member complaints/grievances and appeals.
- evaluating utilization management and case management reports.
- reviewing practitioner medical, pharmacy, and utilization data.
- monitoring performance measures and rates based on preventive health and clinical practice guidelines.
- overseeing delegated group member satisfaction and utilization initiatives (as applicable).

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part K: Evaluating Access and Availability of Care and Services*

Molina evaluates access and availability of care and service through:

- measuring and evaluating geographic access for members to receive care from primary care physicians, high-volume and high impact specialists, high-volume behavioral health practitioners, hospitals, and other health care practitioners.
- assessing cultural, racial, ethnic, linguistic, and social needs and preferences of Molina's member population.
- evaluating appointment access and availability for primary care, behavioral health, and high-volume and high-impact specialists during normal business hours.
- evaluating after-hours appointment access and availability for primary care and behavioral health practitioners.
- evaluating Molina Member Services and telephone access, for all members and specifically for members who are impaired.
- validating that direct access is available to promote women's health services and transportation is accessible (as applicable).
- evaluating satisfaction measure results for availability and access to care, including review of grievances and appeals.
- overseeing delegated activities.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part L: Carrying out the Quality Improvement and Health Equity Transformation Program through Stakeholder Collaboration*

Molina coordinates quality improvement and health equity transformation activities with practitioners, providers, members, federal and state Agencies, and additional external stakeholders to implement the Quality Improvement and Health Equity Transformation Program. Molina implements these activities through:

- involving contracted medical and behavioral health practitioners and providers in the planning and implementation of clinical programs and activities (e.g., Performance Improvement Projects and quality improvement activities).
- reviewing, approving, and disseminating preventive health and clinical practice guidelines to network practitioners and measuring adherence with current recommendations to identify areas for quality improvement.
- developing and adopting Medical Coverage Guidance documents that address medical, surgical, diagnostic, new technology or other services.
- identifying legislative and benefit changes that enhance health promotion.
- collaborating 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.
- performing targeted and specific training about Medicaid and other lines of business (as applicable) to implement activities.
- reviewing member and practitioner satisfaction survey results and proposing activities for improvement, on an ongoing basis and at least once a year.

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

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part M: Reviewing Clinical Medical Record Data to Address Potential Opportunities*

Molina evaluates existing medical record review processes (as applicable through Healthcare Effectiveness Data and Information Set and/or Potential Quality of Care reviews) to make sure that medical records meet standards of structural integrity and contain evidence of appropriate medical practices for quality care, as appropriate. Molina conducts this evaluation by:

- reviewing medical record review results and corrective actions through Healthcare Effectiveness Data and Information Set and Potential Quality of Care processes, as applicable.
- monitoring provider compliance to assure confidentiality and medical record accuracy, through existing processes, as applicable.
- monitoring medical records through existing processes to ensure that education is provided to patients about Advance Directives if the directives were not finalized and/or Advanced Directives have been completed by members, providers, and Molina staff, as applicable.
- participating in state and/or External Quality Review Organization medical record audits to support practitioner compliance, as applicable.
- educating practitioners.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

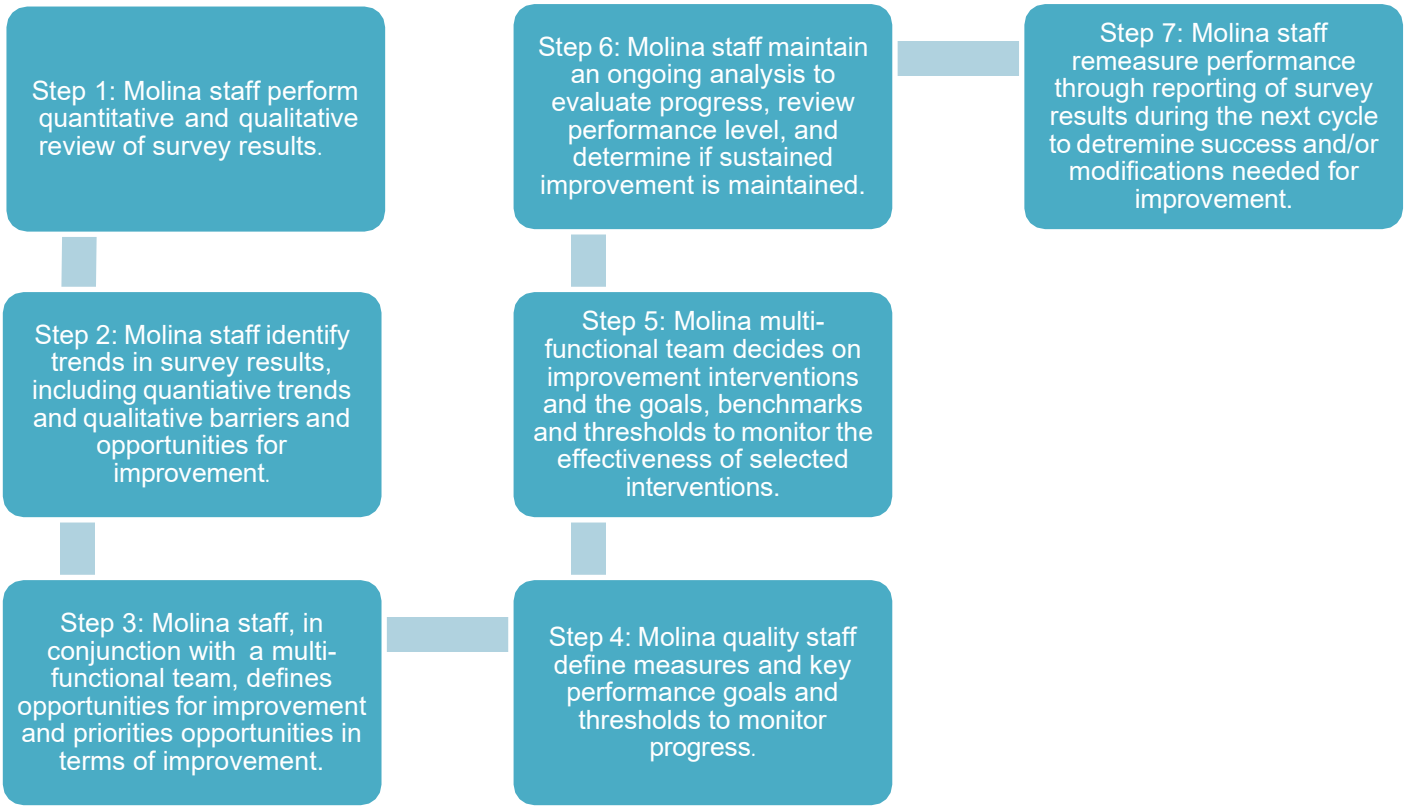
### *Part N: Collecting and Analyzing Member and Provider Satisfaction and Experience Data Sources for Quality Improvement and Health Equity Transformation*

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

- reviewing all sources that impact member and provider satisfaction including, but not limited to, member feedback, provider feedback, Consumer Assessment of Healthcare Providers and Systems survey results, Provider Satisfaction Survey results, findings from behavioral health-member experience analysis, disenrollment information, member grievances and appeals data, and provider grievances and appeals data (as appropriate).
- 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 member and provider satisfaction.
- evaluating out-of-network requests, if applicable.
- monitoring timeliness, accuracy and completeness of Consumer Assessment of Healthcare Providers and Systems survey submissions.
- implementing process for data collection and evaluation of results for Provider Satisfaction Survey.
- reporting member and provider survey results and analysis and other member and provider experience data to the National Quality Improvement and Health Equity Transformation Committee as well as to the health plan Quality Improvement and Health Equity Transformation Committee (and national Quality Improvement and Health Equity Transformation Committee, as appropriate).
- dedicating resources to facilitate and report Consumer Assessment of Healthcare Providers and Systems survey and Provider Satisfaction Survey results and other data related to member and provider experience.
- analyzing results and taking actions for improvement based on survey and experience data analysis and evaluation.

Molina takes the following steps to identify the potential opportunities for improvement and needed actions. Although the example below describes the process used to evaluate effectiveness of programs to improve member and provider satisfaction, Molina implements the process below throughout the health plan to support and improve procedures, systems, quality of service, costs (as applicable), and member and provider satisfaction.

Example: Process used to evaluate member and/or provider satisfaction survey results and act for improvement.




## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part O: Employing Health Information Systems to Address Quality Improvement and Health Equity Transformation Objectives and to Meet Required Reporting*

Molina ensures that systems are in place to address Molina's Quality Improvement and Health Equity Transformation Program objectives. These objectives are described in Section 6.0. Molina employs health information systems with the goal of submitting required reports and data to external organizations, such as federal agencies, state agencies and/or voluntary accreditation organizations. Through these systems, Molina monitors 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.

Molina reports various data and reports to federal and state agencies and/or members in Medicaid, CHIP, Marketplace, and Medicare, as applicable. The reports and data include, but are not limited to:

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

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part P: Using Systems and Processes to Collect and Report Data*

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

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part Q: Employing Processes to Collect and Report Data*
### *Component 1: Healthcare Effectiveness Data and Information Set and Quality Performance Reports for Additional Performance Reports, as appropriate*

| ***Molina performs and/or oversees activities that include, but are not limited to:*** |
|---|
| monitoring websites and memos for NCQA, Medicaid (and CHIP as applicable) for the annual release of instructions that specify the scope of Healthcare Effectiveness Data and Information Set reporting and additional performance indicators, such as those included in the Medicaid and CHIP Core Sets of Health Care Quality measures. |
| monitoring timeliness, accuracy, and completeness of data and report submissions. |
| devoting dedicated resources to those who generate, and report Healthcare Effectiveness Data and Information Set rates, including Medicaid and other federal Agency-required measures that include eligible reporting denominators of thirty 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 NCQA certified software to produce rates and the required process to report additional performance measures, including indicators in the Medicaid and CHIP Core Set of Health Care Quality measures. |
| compiling Healthcare Effectiveness Data and Information Set measures and other performance measure rates, including Medicaid and CHIP Core Set of Health Care Quality measures, and generating the rates in collaboration with Molina teams. |
| conducting quality control, with assigned responsibility for abstraction of information found in the member's medical record, as applicable. |
| contracting with a third-party auditor to ensure accuracy of annual Healthcare Effectiveness Data and Information Set measurement and reporting through the annual audits, and for additional performance measures as required, including Medicaid and CHIP Core Set of Health Care Quality measures. |
| taking actions immediately to address reporting issues(s) to ensure timely and accurate reporting using the National Committee for Quality Assurance Interactive Data Submission System®. |
| devoting dedicated resources to compile and report measures for Molina members. |
| determining actions for improvement based on annual Healthcare Effectiveness Data and Information Set rates and rates for other performance measures, such as Medicaid and CHIP Core Set of Health Care Quality measures. |
| using a systematic approach to develop and initiate actions to improve performance, address gaps, and areas of non-compliance. |
| employing key steps to identify actions to take, which include, but are not limited to:<br>1) conducting quantitative and qualitative barrier analysis to identify issues that impact rates and define priority areas.<br>2) developing activities and interventions to address key issues.<br>3) defining measures to check progress.<br>4) establishing standards, performance goals, and benchmarks to assess effectiveness.<br>5) conducting ongoing analysis to check performance levels and to maintain sustained improvement. |

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part Q: Employing Processes to Collect and Report Data*
### *Component 2: Member Satisfaction and Survey Data (as applicable) and Provider Satisfaction Survey Data (as applicable).*

Molina manages Consumer Assessment of Healthcare Providers and Systems and related satisfaction survey data collection and reporting activities in addition to Provider Satisfaction Survey data collection and reporting for Molina. Molina performs the following activities, including but are not limited to:

- monitoring the National Committee for Quality Assurance and Centers for Medicare & Medicaid Services websites for release specifying scope of survey requirements.
- checking timeliness, accuracy, and completeness of submissions.
- devoting dedicated resources to facilitating and report Consumer Assessment of Healthcare Providers and Systems survey and other survey results, such as Provider Satisfaction Survey findings (as applicable) for Molina.
- managing requirements that include verifying that there are eligible reporting denominators.
- contracting with a certified approved vendor to conduct the Consumer Assessment of Healthcare Providers and Systems survey (and Provider Satisfaction Survey results, as applicable) to ensure accuracy of reported data and overall results.
- determining actions to take based on review of annual survey results using a systematic approach to develop and initiate actions to improve performance and address results.

Molina employs the following steps to identify improvement actions to take. Molina staff conduct a qualitative barrier analysis to identify the issue(s) that impact the rates and to define priority areas; develop activities and interventions that address the issue(s); define measures to monitor progress; establish standards, performance goals and benchmarks to assess effectiveness; and perform ongoing analysis to check performance levels and maintain sustained improvement.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part R: 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 costs for medications, surgeries, and treatment (as applicable), 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 member and/or provider incentive program (as applicable). This program is broad and flexible to allow Molina to carry out innovative strategies.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy
### *Part S: Managing Additional Internally Developed Quality Improvement and Health Equity Transformation 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, 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 use 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 healthcare and services that are delivered to Molina's members in collaboration with network providers.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part T: Managing Additional Externally Required Quality Improvement and Health Equity Transformation Activities and Data Collection*

Molina manages additional required external activities focused on data collection, data measurement, and quality improvement that address physical health, behavioral health, chemical dependency, and substance abuse, and Long-Term Services and Supports services. These activities include but are not limited to:

- implementing initiatives that are required by the state Medicaid Agency, other regulatory entities and/or the Centers for Medicare & Medicaid Services, including but are not limited to quarterly health outcomes and clinical reports, and measures within Agency-approved value-based purchasing contracts.
- performing quality improvement projects and initiatives, capturing outcomes, and using Healthcare Effectiveness Data and Information Set data and healthcare quality measures for Molina 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.
- using procedures to assess member satisfaction not already defined.
- implementing systems 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 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);
- analyzing the effectiveness of treatment services, employing both standard measures of symptom reduction and management, and measures of functional status.
- monitoring variations in practice patterns and identifying outliers.
- designing strategies to promote practice patterns that are consistent with evidence-based clinical practice guidelines through use of education, technical support, and provider incentives (as applicable).
- implementing and modifying annual and prospective five-year Quality Improvement/Healthcare Services Work Plan that sets measurable goals, establishes specific objectives, identifies strategies and activities, to be undertaken, monitors results, and assesses progress toward the goals.
- using dedicated resources (staffing, data sources, and analytical resources) that includes a Quality Improvement and Health Equity Transformation Committee that oversees quality functions.

## Section 5.0 Quality Improvement and Health Equity Transformation Strategy

### *Part U: Evaluating the Effectiveness of Molina's Quality Improvement and Health Equity Transformation Program*

Molina evaluates the effectiveness of Molina's Quality Improvement and Health Equity Transformation Program in producing measurable improvements in the care and service supplied to Molina members by:

- organizing multi-functional teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
- providing 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 and subcommittee minutes are contemporaneous, dated, and signed to ensure that the minutes represent the official findings of the committee/subcommittees.
- tracking progress of quality improvement activities and interventions through Plan, Do, Study, Act improvement cycle, and documentation of progress through committee minutes, follow-up of action items, and Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan updates.
- initiating, modifying, or discontinuing interventions related to medical, behavioral health, chemical dependency, and substance abuse, social needs/social risks and health equity based on analysis conducted at least annually into the Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan.

## Section 6.0 Organizational Structure Supporting Quality Improvement and Health Equity Transformation: Accountability

### *Part A: Leadership and Accountability for the QIHET Program*

#### *Component 1: Oversight by Board of Directors*

The Molina Board of Directors has ultimate authority and responsibility for the quality of care and services delivered by Molina. The Board is responsible for the direction and oversight of Molina's Quality Improvement and Health Equity Transformation Program. The Board delegates authority for Molina's Quality Improvement and Health Equity Transformation Program to the Chief Medical Officer, Plan President, and Quality Lead unless otherwise specified.

The Board of Directors also delegates the oversight of Molina's Quality Improvement and Health Equity Transformation Program through Molina's committee structure, facilitated through Molina's Quality Improvement and Health Equity Transformation Committee and subcommittees. The Board then reviews regular health plan reports and recommendations made and significant actions taken by the Quality Improvement and Health Equity Transformation Committee or other subcommittees. The Plan President also serves as a member of the Molina Board of Directors. ***See Section 6.0 Part C for detailed Committee structure discussion.***

## Section 6.0 Organizational Structure Supporting Quality Improvement and Health Equity Transformation: Accountability

### *Part A: Leadership and Accountability for the QIHET Program*

#### *Component 2: Quality Improvement Program Leadership*

As stated above, the Molina Board of Directors delegates authority for Molina's Quality Improvement Program to the Chief Medical Officer, Plan President, and Quality Lead unless otherwise specified.

### *Role of the Plan President*

The Plan President oversees Molina's Quality Improvement and Health Equity Transformation Program, maintaining the consistency and effectiveness of Molina's Quality Improvement and Health Equity Transformation 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 Molina's Quality Improvement and Health Equity Transformation Program and helps design, implement, and coordinate quality improvement and health equity transformation activities. Key Chief Medical Officer (and designated Medical Director) responsibilities include but are not limited to:

- reporting to the Board with a Medical Affairs update at quarterly meetings.
- promoting the Quality Improvement and Health Equity Transformation 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 Molina's Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan activities, to include analysis of Utilization Management and clinical data.
- serving as co-chair of Molina's Quality Improvement and Health Equity Transformation Committee and the Healthcare Services Committee.
- facilitating the provision of healthcare and services, including clinical oversight and leadership for utilization management/case management, credentialing, behavioral health, and pharmacy.
- participating in Molina's 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.
- overseeing corrective action plans about quality of care, member safety, or service.

### *Designated Behavioral Health Practitioner*

Molina's designated behavioral health practitioner - at least a doctoral-level practitioner, reports to Molina's Chief Medical Officer and participates in developing clinical and service activities for behavioral health. Designated behavioral health practitioner key responsibilities include, but are not limited to:

- participating in the Molina's Quality Improvement and Health Equity Transformation Committee, Molina's Healthcare Services Committee, and the National Pharmacy and Therapeutics Committees (as applicable).
- participating in review and adoption of behavioral health/chemical dependency/substance abuse 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.
- screening member/provider materials to identify and communicate behavioral health needs.

### *Quality Leadership*

Molina's Quality Lead reports to the Plan President and leads quality improvement and health equity transformation activities. 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 Molina's Quality Improvement and Health Equity Transformation Program; providing operational oversight of Molina's Quality Improvement and Health Equity Transformation 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).
- managing dedicated quality staff (Managers, Program Managers, and Specialists, etc.), as applicable.
- working with the national quality team, as needed.

## Section 6.0 Organizational Structure Supporting Quality Improvement and Health Equity Transformation: Accountability

### *Part A: Leadership and Accountability for the QIHET Program*

### *Component 3: Quality Improvement Functional Area Roles and Responsibilities*

The Quality functional area is comprised of appropriately credentialed registered nurses, health professionals, and ancillary personnel. These personnel report to Molina's Quality Lead and/or the national quality team (MHI Risk and Quality Solutions), respectively. Quality staff coordinate quality improvement policies and procedures, strategies 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 Molina's annual Quality Improvement and Health Equity Transformation/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 Molina's Quality Improvement and Health Equity Transformation Committee.
- managing performance improvement projects and quality improvement and health equity transformation projects and interventions.
- preparing and submitting quality improvement and health equity transformation documents, reports, and recommendations to appropriate quality committees and subcommittees.
- 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.

- preparing quality for compliance with quality-related regulatory requirements and for future accreditation.
- ensuring provision of relevant health education programs.
- implementing clinical quality of care case review process.
- participating in Molina's Quality Improvement and Health Equity Transformation Committee subcommittees (as applicable).
- maintaining accountability and oversight of delegated administrative functions (as applicable for Molina, which may include credentialing, utilization management, claims, and/or appeals to selected contracted provider groups and vendors.
- developing and ensuring compliance with quality improvement policies and procedures.
- maintaining necessary quality improvement resources, including, but not limited to, software, specialty consultation, analytical and statistical support.
- staffing Molina's 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.
- 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 have responsibility for major quality improvement processes such as Healthcare Effectiveness Data and Information Set data collection, reporting and improvement interventions, Consumer Assessment of Healthcare Providers and Systems survey fielding and reporting, behavioral health member experience analysis and provider satisfaction survey data collection, reporting and improvement interventions.

## Section 6.0 Organizational Structure Supporting Quality Improvement and Health Equity Transformation: Accountability

### *Part A: Leadership and Accountability for the QIHET Program*

#### *Component 4: Other Departmental Roles and Responsibilities for Quality Improvement and Health Equity Transformation*

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 Molina's Quality Improvement and Health Equity Transformation Committee and/or subcommittees in the quality improvement structure.

The Healthcare Services staff is responsible for:

- developing and maintaining the Healthcare Services Program Description, policies, and procedures, Molina's Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan, and program evaluation in compliance with National Committee for Quality Assurance, Molina, state, and federal requirements.
- monitoring potential over- and under-utilization, coordination and continuity of care, including access to the nurse advice line.
- documenting critical incidents, risk management, and member safety issues identified during Utilization Management review.

- overseeing the coordination of care related to transitions of care with healthcare delivery organizations (i.e., facilities) and contracted entities, and with groups delegated for Utilization Management functions.
- carrying out the case management program in collaboration with Health (e.g., Disease) management and prevention programs, including a focus on medical, behavioral health/chemical dependency/substance abuse, pharmacy, social risk, and social need priorities.

The Network Management and Operations staff are responsible for:
- monitoring the access and availability of practitioners, providers, and health delivery organizations, including behavioral health/chemical dependency/substance abuse, and implementing 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 implementing improvement plans.
- disseminating provider education materials as identified, including statements of members' rights and responsibilities.
- administering the 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 providers and provider inaccessibility and identifying opportunities for improvement, in conjunction with Contact Center staff and quality.
- implementing 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/Appeals and Grievances staff is responsible for:
- administering members' rights and responsibilities.
- facilitating member access to Molina and ensuring compliance with contractual and regulatory standards for timely response or resolution of all issues, in conjunction with Provider Services.
- monitoring trends of member 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 policies, ensuring appropriate timelines are met.
- 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 Committees and/or subcommittees as requested. The annual summary will be included in the quality improvement program evaluation to assure identification of opportunities to improve the services supplied by Molina to its enrollees.

Government Contracts and Communications staff are responsible for:
- overseeing compliance with all applicable statutory, regulatory, and contractual requirements.
- training Molina staff in contract provisions and new regulations.
- acting as a liaison with the state Agency.
- coordinating contract renewal activities.

- 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:
- implementing 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 Health Insurance Portability and Accountability Act).
- monitoring and trending of marketing infractions reported from the State and regulatory agencies.

Pharmacy staff are responsible for:
- identifying key processes to evaluate pharmacy safety and effectiveness.
- monitoring and addressing trends with pharmacy over and under-utilization and related safety concerns with medication.
- maintaining a notification system for drug alerts.
- developing and maintaining operational policies and procedures for effective formulary management, authorization processes, and safe practices.
- overseeing Pharmacy Benefits Manager activities to ensure practices meet Molina's standards.

## Section 6.0 Organizational Structure Supporting Quality Improvement and Health Equity Transformation: Accountability

### *Part A: Leadership and Accountability for the QIHET Program*

#### *Component 5: Role of Participating Providers*

Participating practitioners serve on various committees and subcommittees, including the Molina Healthcare of CA and Molina's National Quality Improvement and Health Equity Transformation Committee (as applicable), Healthcare Services Committee (as applicable), National Pharmacy and Therapeutics Committee, and the Professional Review Committee. Participating providers may also collaborate with Molina during additional workgroups that focus on critical topics. Through committee activity, participating providers:
- 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.
- Quality Improvement and Health Equity Transformation program, workplan and evaluation.
- review proposed quality improvement study designs.
- 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, participate in committees/workgroups 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.

## Section 6.0 Organizational Structure Supporting Quality Improvement and Health Equity Transformation: Accountability

### *Part A: Leadership and Accountability for the QIHET Program*

#### *Component 6: Molina Healthcare of CA Quality Improvement and Health Equity Transformation Program Leadership and Staffing Resources*

As stated previously in this document, Molina Healthcare of CA is adequately staffed to support the needs of the Quality Improvement and Health Equity Transformation Program. There are local, regional, and national teams that support the Molina Healthcare of CA Quality Improvement and Health Equity Transformation Program. In summary, key quality program staff and resources include, but are not limited to, the following positions and teams that support the Molina Healthcare of CA Quality Improvement and Health Equity Transformation Program.

#### *Molina Healthcare of CA Quality Improvement and Health Equity Transformation Program Leadership and Staffing Resources*

1. The Plan President, based in **CA**, oversees the strategy and work of Quality Improvement and Health Equity Transformation Program.
2. The AVP, Quality & Risk Adjustment, based in **CA**, oversees program strategy and operations. (This individual is considered to be the Quality Lead for the health plan.
3. The Chief Medical Officer, based in **CA**, provides clinical guidance for the program.
4. Medical Director for Behavioral Health, based in **CA**, is the dedicated behavioral health clinical leader for the Quality Program.

The **Quality Improvement department** in **CA** is comprised of the following:

1. AVP, Quality & Risk Adjustment (1)
2. AVP, Risk Adjustment Strategy (1)
   - Manager, Risk Adjustment (1)
   - Analyst, Risk Adjustment (1)
   - Senior Specialist (2)/Specialist (2)
3. Director, Health Plan Quality Improvement (1)
   - Manager, Quality Interventions (1)
     - Senior Specialist, Quality Interventions and QI Compliance (1)
   - Senior Program Manager (1)
   - Senior Specialists, Quality Interventions and QI Compliance (3)
   - Specialist (1)
   - Analyst, Quality Interventions (1)
   - Community Connector (1)
4. Director, Health Plan Quality Improvement (1)
   - Manager, Health Plan Quality Interventions (1)
   - Supervisor, Quality Interventions/QI Compliance (1)
     - Senior Specialists, Provider Quality and Practice Transformation (10)
     - Specialists, Provider Quality and Practice Transformation (7)
5. Director, Health Plan Quality Improvement (1)
   - Manager, Quality Management (1)
     - Supervisor, Quality Interventions/QI Compliance (2)
     - Lead Project Coordinator (2) / Project Coordinator (20)
   - Project Coordinator (1)
6. Director, Health Plan Quality Improvement (1)
   - Manager, Health Plan Quality Interventions (1)

    - Program/Project Coordinators (6)
  - Clinical Services Auditor (7)
  - Facility Site Review Nurse (5)
  - Analyst, Quality Interventions/QI Compliance (1)
7. Director, Health Equity and Cultural Competency
  - Program Manager (1)
  - Program Manager, Health Equity (4)
8. Program Manager (1)
9. Analyst (1)
10. Project Coordinator (1)

## *Component 7: Molina National Staffing Resources in Support of Quality Improvement and Health Equity Transformation Program*

In addition, Molina national Risk and Quality Solutions team supports the Molina Healthcare of **CA** Quality Improvement and Health Equity Transformation Program. Staffing support includes senior leaders, directors, managers, analysts, clinical staff, such as registered nurses, specialists, and support staff. The following teams in Risk and Quality Solutions support the Molina Healthcare of **CA** Quality Improvement and Health Equity Transformation program.

1. Clinical Data Acquisition
   Teams focus on performance measurement operations, data collection, and quality reporting and analysis.
2. Quality Program Management and Performance
   Team focuses on NCQA accreditation operations, member and provider satisfaction survey administration, potential quality of care issue review and investigation, and support of federally-required activities.
3. Member Engagement and Interventions
   The team supports national member engagement interventions in collaboration with local Molina Healthcare of **CA** team.
4. Health Plan Provider Collaboration and Risk Adjustment
   Teams focus on collaborative activities designed to improve quality for Molina Healthcare of **CA**, such as practice transformation with network providers and annual well visits for members.
5. Director, Health Equity and Cultural Competency
   Team oversees national health equity and cultural competency program activities in collaboration with Molina health plans.

## *Section 6.0 Organizational Structure Supporting Quality Improvement and Health Equity Transformation: Accountability*

## *Part B: Leadership and Accountability for the Quality Improvement and Health Equity Transformation Program through Committee Structure*

### *Component 1: Molina Healthcare of CA Quality Improvement and Health Equity Transformation Committee*

Molina's Quality Improvement and Health Equity Transformation Committee is responsible for the implementation and ongoing examination of Molina's Quality Improvement and Health Equity Transformation Program. Through discussion by the committee and 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 improvement activities. The committee collects data, feedback, and innovations to develop, monitor, and maintain Molina's Quality Improvement and Health Equity Transformation Program, implementing process improvements as necessary. The Quality Improvement and Health Equity Transformation Committee receives reports from subcommittees, advises and directs the committee and subcommittees about the focus and implementation of Molina's Quality Improvement and Health Equity Transformation Program and Molina's Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan. Molina's Quality Improvement and Health Equity Transformation Committee reviews data from Molina's Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan to ensure that performance meets standards and makes recommendations for improvements to be carried out by subcommittees or by specific departments.

Molina's Quality Improvement and Health Equity Transformation Committee is co-chaired by the Chief Medical Officer and the Quality Lead. The Quality Improvement and Health Equity Transformation 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.

Molina's Quality Improvement and Health Equity Transformation Committee confirms and reports to the Board through the Quality Lead that plan activities comply with state and federal regulatory requirements and meet National Committee for Quality Assurance standards. Molina's Quality Improvement and Health Equity Transformation Committee reports any variance from quality performance goals to the Board and the plan to correct the variance. Molina's Quality Improvement and Health Equity Transformation Committee develops and presents an annual Quality Improvement and Health Equity Transformation Program description, work plan, and prior- year evaluation, as well as quarterly summaries to the Board**.**

The following subcommittees also report to Molina Healthcare of **CA** Quality Improvement and Health Equity Transformation Committee. The subcommittees - the Healthcare Services Committee, Delegation Oversight Committee, the Member Advisory Committee (Community Advisory Committee), and the Provider Advisory Committee - provide activity updates to the Quality Improvement and Health Equity Transformation Committee at least quarterly.

Topically focused workgroups are also in place as part of the Quality Improvement and Health Equity Transformation Program. Although not part of the formal committee structure, input from these informal workgroups may be brought forward to the committee for review and evaluation.

Molina Healthcare of **CA** Quality Improvement and Health Equity Transformation Committee also ensures that quality improvement activities meet state and federal regulatory requirements and National Committee for Quality Assurance standards. On behalf of the Quality Improvement and Health Equity Transformation Committee, the Chief Medical Officer or the Quality Lead 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 Quality Lead presents variances from quality improvement goals and recommended action plans to the Board.

### *Molina Healthcare of CA's Quality Improvement and Health Equity Transformation Committee Structure*

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

The activities of all quality committees and subcommittees are treated in a confidential manner. All quality committees and subcommittees are advisory, and recommendations made nationally are evaluated by local Molina plan committees to ensure appropriate local oversight.

### *Component 2: Molina's National Quality Improvement and Health Equity Transformation Committee*

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

Molina's National Quality Improvement and Health Equity Transformation Committee is responsible for critical quality improvement 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, recommending actions, and sharing effective practices.
- 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.
- reviewing key performance indicators, including focus on medical, behavioral health, health equity, social needs, and social risks.

These components ensure that Molina's Quality Improvement and Health Equity Transformation Committee and subcommittees operate according to specified timelines. Additionally, quality improvement documentation is finalized and sent to committees/subcommittees on a timely basis to meet federal and state regulatory requirements and NCQA® accreditation standards.

## Molina National Quality Improvement and Health Equity Transformation Committee Structure

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

The National Quality Improvement and Health Equity Transformation Committee members include Chief Medical Officers, Quality Leads, and Vice Presidents, Healthcare Services from all Molina health plans, including Molina Healthcare of CA. 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 National Quality Improvement and Health Equity Transformation Committee from four subcommittees– the National Clinical Policy Committee, National Delegation Oversight Committee, National Professional Review Committee, and National Pharmacy and Therapeutics Committee. Additionally, information from Medicare's national Healthcare Services

Committee and additional Medicare activities are presented to the National Quality Improvement and Health Equity Transformation Committee.

### *Component 3: Molina Committee Participation and Responsibilities*

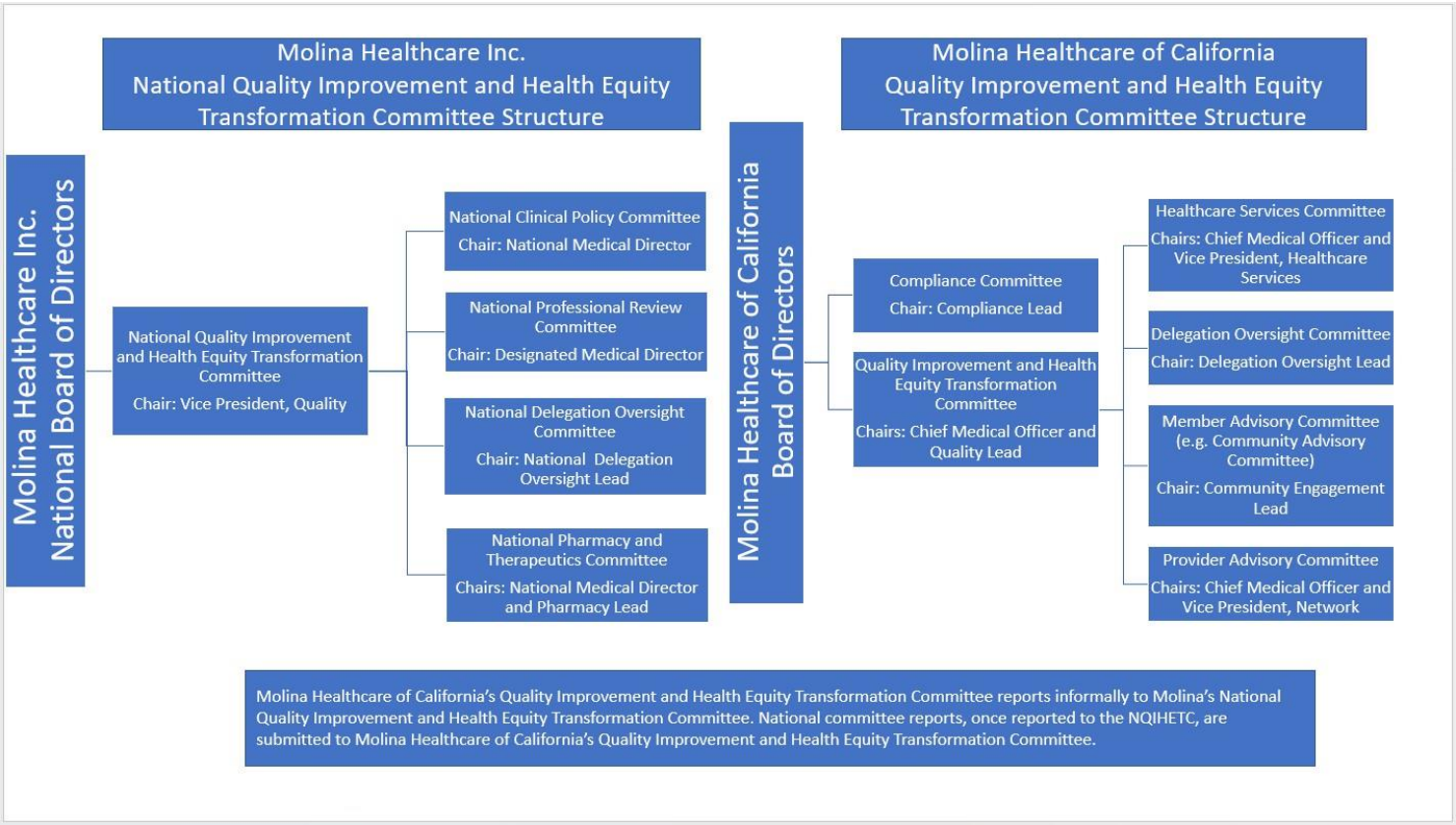
Committee participation is based on responsibilities and includes key representatives responsible for operations. In general, Molina employs committee participants. Some committees may include participation of members and/or contracted providers. In general, individual network providers participate on committees/subcommittees (as applicable) to give input into the planning, design, implementation, and evaluation of Molina's Quality Improvement and Health Equity Transformation Program.

The activities of all quality committees/subcommittees are treated in a confidential manner. Molina's Quality Improvement and Health Equity Transformation Committee and subcommittees are advisory. Committee/subcommittee recommendations are reviewed on an ongoing basis, and at least quarterly.

### *Component 4: Molina Committee Structure Overview and Narrative Description*

**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 CA**
**2025 Quality Improvement and Health Equity Transformation Committee Structure**



## *Molina Healthcare of CA Standing Quality Improvement and Health Equity Transformation Subcommittees Roles, Functions and Responsibilities*

Molina's Quality Improvement and Health Equity Transformation Committee delegates quality improvement functions to specific subcommittees. Each subcommittee 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.

### 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, and Transitions of Care programs. The Healthcare Services Program Description and the combined Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan govern the activities of this committee. The Healthcare Services Committee reports to the Quality Improvement and Health Equity Transformation Committee.

### Delegation Oversight Committee

The Delegation Oversight Committee oversees the 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 Quality Improvement and Health Equity Transformation Committee.

### Member Advisory Committee (e.g. Community Advisory Committee)

The Member Advisory Committee (Community Advisory Committee) is designed to receive input from health plan members about key Molina quality improvement, clinical, and member experience programs. To receive varied and substantive input, participating health plan members are recruited from across the state. Molina incorporates health plan member feedback into the design of new or modified current programs and uses member input to evaluate the effectiveness of Molina's quality program. The Member Advisory Committee (Community Advisory Committee) reports to the Quality Improvement and Health Equity Transformation Committee.

### 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 Quality Improvement and Health Equity Transformation Committee.

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

## National Delegation Oversight Committee

Like the Molina Healthcare of **CA** 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 Quality Improvement and Health Equity Transformation Committee.

## National Clinical Policy Committee

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

## National Professional Review Committee

Molina's 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 reviewed Level 3 and Level 4 (highest level) Potential Quality of Care cases for next steps. The activities of Molina's National Professional Review Committee are reported to Molina's National Quality Improvement and Health Equity Transformation Committee at least quarterly.

## Molina's National Pharmacy and Therapeutics Committee

Molina's National Pharmacy and Therapeutics Committee oversees and coordinates the formulary management activities for Molina. Molina's National 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, modifications, or deletions to/from the drug formulary at least annually, provides effective pharmacy cost management.

Molina's 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.

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, chaired by a national medical director, reports to Molina's National Quality Improvement and Health Equity Transformation Committee.

### *Molina's Standing Quality Improvement and Health Equity Transformation Committee Subcommittees*

Molina's Quality Improvement and Health Equity Transformation Committee delegates quality improvement functions to specific subcommittees. Each subcommittee 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.

## Section 7.0 Maintaining Confidentiality and Addressing Conflict of Interest within the Quality Improvement and Health Equity Transformation Program

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, a Code of Conduct, and an Employee Handbook Acknowledgment form. The signed documents are on file in the Human Resources Department. In addition, non-Molina staff of Molina's 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 and health equity transformation 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 Molina's Quality Improvement and Health Equity Transformation Committees and subcommittees are part of Molina's Quality Improvement and Health Equity Transformation 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. As directed by the Compliance Plan, a Compliance Committee has been formed and supports activities of the Quality Improvement and Health Equity Transformation Program. The Compliance Committee reports to the Board of Directors.

### *Addressing Conflict of Interest*

Network physicians and practitioners are prohibited from conducting or participating in credentialing and recredentialing reviews related to their own patients, the patients of their practice associates, or cases in which the reviewing physician has a proprietary financial interest in the site providing care.

## Section 8.0 Implementing a Credentialing and Recredentialing Program

Molina maintains a comprehensive credentialing and recredentialing program designed to ensure the network consists of quality practitioners who meet clearly defined criteria and standards. The credentialing and recredentialing program activities meet 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 and CHIP members, as applicable.
- conducting peer reviews of credentialing and recredentialing decisions.
- presenting Potential Quality of Care case summaries as directed by the designed Medical Director and quality staff to the Professional Review Committee for confidential peer review and oversight with the network team for proposed corrective action plans.
- overseeing delegated credentialing activities.
- 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 leadership designates Molina's Professional Review (e.g., Credentialing) Committee, to make recommendations about credentialing decisions using a peer review process. Molina works with Molina's Professional Review Committee 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.

## Section 9.0 Maintaining a Health Equity and Cultural Competency Program

Molina is committed to reducing healthcare disparities. Tools and training are provided to Molina plans to facilitate 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 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 members, including persons with limited English proficiency. The goal for Molina is to provide culturally and linguistically appropriate and equitable services across the healthcare continuum to reduce health disparities and improve health equity, member experience 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.

Molina lists goals and objectives in Molina's annual Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan, program evaluation and include, but are not limited to:

- collecting and analyzing race, ethnicity, language, sexual orientation and gender identity (as available), sex assigned at birth, and social determinants of health data from eligible individuals to identify significant culturally and linguistically diverse populations within the health plan membership and revalidate data at least annually.
- collecting and analyzing race, ethnicity, and language data from contracted practitioners to assess gaps in care annually.
- collecting data for and reporting the Diversity of Membership Healthcare Effectiveness Data and Information Set measure.
- collecting data for and reporting the Language Diversity of Membership Healthcare Effectiveness Data and Information Set measure.
- making determinations about threshold languages annually and implementing processes to provide vital information in threshold languages.
- identifying disparities related to specific demographics, including cultural, linguistic, sexual orientation and gender identity (as available) in addition to sex assigned at birth and social determinants of health and geography within the plan's diverse populations.
- analyzing Healthcare Effectiveness Data and Information Set measure results for potential disparities related to cultural, linguistic, sexual orientation gender identity (as available). sex assigned at birth, social determinants of health, and geography that prevent members from obtaining recommended key chronic and preventive services.
- stratifying data for selected Healthcare Effectiveness Data and Information Set measure rates and Consumer Assessment of Healthcare Providers and Systems survey results by race, ethnicity, gender, and preferred language.
- enhancing quality improvement activities, such as prenatal and well-child visits, to address specific cultural, linguistic, and social determinants of health barriers using culturally and linguistically focused materials addressing identified critical barriers.

- providing a more thorough organizational understanding of the specific reasons behind identified disparities related to cultural, linguistic, sexual orientation and gender identity, sex assigned at birth, and disability status.
- implementing processes for gathering member feedback about health equity and disparities reductions through activities, such as focus groups, direct member feedback through request forms or surveys, and complaint analyses.
- selecting critical barrier (s) found through the various cultural, linguistic, sexual orientation, gender identity, sex assigned at birth, social determinants of health, and geography for specific intervention.
- analyzing interpreter availability and translation requests.
- developing educational materials to meet the needs of Molina members, such as needs related to cultural, linguistic, sexual orientation and gender identity, sex assigned at birth, and social determinants of health as well as those with complex conditions.
- providing staff with necessary information, training, and tools to address identified cultural, linguistic, and social barriers.
- identifying, implementing, and monitoring planned activities related to the Americans with Disabilities Act requirements, such as provider, staff and member training, communication, and assessment of provider compliance.
- Identifying and developing initiatives to address the needs of communities within the health plan's service areas, including but not limited to Black or African American, Indigenous, and People of Color.
- expanding continuous quality improvement to identify and reduce existing disparities related to race, ethnicity, language, sex assigned at birth, 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 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.
- working 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 in state-health plan joint workgroups.
- enhancing evidence-based approaches and strategies to reduce disparities based on race, ethnicity, and specific populations, such Lesbian, Gay, Bisexual, Transgender, Queer, I, A+ population related to service access as available.
- evaluating 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 the care of patients and their families. Cultural beliefs, social structure, and health practices will be discussed in detail with the 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. Molina provides training, which includes but is not limited to:

- cultural competency, with a focus on the changing demographics in the U.S., key components and terminology of cultural competency, components of culture, diversity in different types of experiences in healthcare, healthcare expectations, tips on communicating with individuals with different backgrounds, language access services and caring for seniors and persons with disabilities.

- health equity, with a focus on terminology, social determinants of health, implicit bias, systemic racism, health disparities among different populations (i.e., LGBTQIA+ community) geography, strategies to reduce health disparities and achieve health equity.
- diversity, equity and inclusion, with a focus on terminology, principles, connection, and importance of diversity, equity, and inclusion.

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, such as 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 Preference, Sexual Orientation, Gender Identity and Social Determinants of Health*

Molina understands the significance of demographic shifts and conducts ongoing infrastructure assessments 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 of membership and provider network based on race, ethnicity, sex assigned at birth, 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 collects member data on sexual orientation, gender identity and social determinants of health.

Multiple 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 functional area to understand member demographics, including race, ethnicity, languages spoken, sexual orientation, gender identity, sex assigned at birth, and social determinants of health. Data findings are reported to Molina's Quality Improvement and Health Equity Transformation Committee and subcommittees to review, approve, and solicit interventions for improvement. Interventions may include provider network, expansion, increased interpreter/translation services and member materials enhancement to accommodate changing member demographics of Molina's membership.

### *Data Analysis*

Molina conducts periodic needs or population health assessments at least annually 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 members can access language services, such as interpretation and written translation, and programs and services that are congruent with cultural norms. Such congruency with member populations leads to better communication, understanding, and overall 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.

## Section 10.0 Adopting and Distributing 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/Chemical Dependency/Substance Abuse Guidelines** |
|---|---|
| Asthma | Acute Stress and Post-Traumatic Stress Disorder |
| Children with Special Health Care Needs | Anxiety/Panic Disorder |
| Chronic Kidney Disease | Attention-Deficit Hyperactivity Disorder |
| Chronic Obstructive Pulmonary Disease | Autism Spectrum Disorder |
| Diabetes | Bipolar Disorder |
| Heart Failure in Adults | Depression |
| HIV/AIDS | Homelessness – Special Health Care Needs |
| Hypertension | Opioid Management |
| Obesity | Schizophrenia |
| Perinatal Care | Substance Use Disorder |
| Pregnancy Management | Suicide Risk/Prevention |
| Sickle Cell Disease | 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, and/or state recommendations as applicable. The preventive health guidelines focus on care of children and adolescents 18 years and younger and immunizations and preventive services for adults nineteen and older. The guidelines include but may not be limited to:

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

To evaluate the effectiveness of the guidelines, Molina measures performance of at least two important aspects of 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 at least 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, which are collected annually. Topics and effectiveness of clinical practice and preventive health guidelines are reviewed and approved by Molina's Quality Improvement and Health Equity Transformation Committee at least annually, with review of changes occurring at least quarterly and usually monthly to identify new guidelines or changes to existing guidelines.

## Section 11.0 Delegation Oversight 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 evaluate potential delegate compliance with regulatory and NCQA accreditation requirements. Molina 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 and/or health plan Molina's National and/or local 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, and overseeing the corrective action process, which could include termination of delegation as an option, and summary reporting to Molina's 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.

## Section 12.0 Evaluating the Effectiveness of the Quality Improvement and Health Equity Transformation Program

At least annually, quality staff and staff from other departments conduct a formal evaluation of Molina's Quality Improvement and Health Equity Transformation 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 quality staff evaluate Molina's Quality Improvement and Health Equity Transformation Program activities, identifies program outcomes, implements needed interventions, and conducts re-evaluation as needed. Molina uses the following steps to evaluate the effectiveness of the quality improvement and health equity transformation program, including but not limited to:

- reviewing quality improvement and health equity transformation initiatives and activities implemented during the year and identifying quantifiable improvements in care, services, and outcomes.
- producing trended indicator reports and conducting analysis about changes in trends, barriers that impact rates, and evaluating improvement actions taken to mitigate barriers and address member needs.
- identifying opportunities to strengthen member safety activities.
- evaluating resources, training, scope, and content of the program and practitioner participation.
- identifying limitations and barriers, and making recommendations for the upcoming year, including implementation of activities that will carry over into next year.
- evaluating the overall effectiveness of the Quality Improvement and Health Equity Transformation Program.

For the care model evaluation, Molina staff analyze data and reports to ensure members receive adequate access to services and benefits, improve their health status, have access to adequate service delivery processes that benefit from the use of evidence based clinical practice guidelines to manage chronic conditions, and evaluate satisfaction with Molina's programs. Molina staff also analyze data to measure the effectiveness of treatment services, employing both standard measures of symptom reduction/management, and measures of functional status, among other data sources and strategies.

Molina maintains and stores all quality improvement program evaluation activities in Molina's Health Insurance Portability and Accountability Act-compliant and secure web-based systems and platforms. Molina maintains reasonable and appropriate levels of safeguarding practices to protect electronic and other sensitive member information, to limit incidental uses or disclosures. Molina dedicated staff ensure that all electronic information is 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 and health equity transformation activities, including the care model measure and clinical program analysis. Molina uses a systematic process to develop and initiate actions to improve performance, support and improve procedures, systems, quality of service, cost, and health outcomes. Molina implements the following steps to identify actions that are taken to evaluate quality improvement and health equity transformation program effectiveness that may include, but are not limited to:

- conducting qualitative barrier analysis on measures to identify the issue(s) and define priority areas, defining measures to monitor progress.

- adjusting, discontinuing and/or implementing activities and/or interventions aimed at addressing the issue(s) and improving quality outcomes.
- establishing standards, performance goals and benchmarks to assess effectiveness.
- performing ongoing analysis to monitor performance levels and sustained improvement.

## Section 13.0 Reporting Quality Improvement and Health Equity Transformation Program Activities to the Governing Board

Molina's Quality Improvement and Health Equity Transformation Program activities are reported to the Board of Directors through quarterly and annual reports. Molina's Quality Improvement and Health Equity Transformation Program Description and Molina's Quality Improvement and Health Equity Transformation/Healthcare Services Work Plan are approved for the coming year. Molina's Quality Improvement and Health Equity Transformation 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 Molina's Quality Improvement and Health Equity Transformation Program evaluation findings and recommend changes and improvements to be made.

## Appendix 1: Molina Healthcare of CA State Requirements

Molina Healthcare of CA maintains a fully comprehensive Quality Improvement and Health Equity Transformation Program by meeting and exceeding all requirements that are unique to the state of CA. These Quality Improvement and Health Equity Transformation Program requirements are critical for Molina to be successful; therefore, a dedicated section of this program description outlines the requirements and processes that Molina has in place to meet state requirements. The outline below discusses requirements that are unique for state Medicaid, Marketplace and/or Medicare to the state of CA.

- Molina Healthcare of California (MHC) shall comply with all DHCS Quality related reporting activities as stated in the Medi-Cal Managed Care Plans Contract Exhibit A, Attachment III Section 2.2, Quality Improvement and Health Equity Transformation Program (QIHETP) and Quality-related DHCS All Plan Letters
- 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 Managed Care Plans Contract Exhibit A, Attachment III, Section 2.2.9.
- Medi-Cal Managed Care Plans Contract Exhibit A, Attachment III, Section 2.2.9 (B) MHC shall participate in a minimum of two Performance Improvement Projects (PIPs) as approved and directed by DHCS. At its sole discretion, DHCS may require MHC to conduct or participate in additional PIPs, including statewide PIPs. DHCS may also require MHC to participate in statewide collaborative PIP workgroups.
- Medi-Cal Managed Care Plans Contract Exhibit A, Attachment III, Section 2.2.10, MHC shall maintain a robust program to ensure the provision of all physical, behavioral and oral health services to Members less than 21 years of age. MHC shall also maintain mechanisms to improve on gaps in the quality of and access to care in the following areas: Scope of Services, Utilization Management, Population Health Management and Coordination of Care, Network and Access to Care, Quality and Health Equity, Mental Health and Substance Use Disorder Services, and School-Based Services.
- Medi-Cal Managed Care Plans Contract Exhibit A, Attachment III, Section 2.2.11, MHC shall maintain procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 et. seq.
- 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 Managed Care Plans Contract Exhibit A, Attachment III, Section 2.2.12.
- MHC will conduct site review, site review activities, site review reports, site review corrective actions, data submission, continued oversight and ongoing monitoring as stated in in the Medi-Cal Managed Care Contracts Exhibit A, Attachment III Section 5.2.14 Site Review
- MHC will comply will all Medical Record requirements to include all elements and sub elements listed in the Medi-Cal Managed Care Contracts Exhibit A, Attachment III Section 5.2.14 (G)
- MHC shall ensure provision of an Initial Health Appointment (IHA) in accordance with 22 CCR sections 53851 (b)(1) and 53910.5(a)(1) and the Medi-Cal Managed Care Contracts Exhibit A, Attachment III Section 5.3.3.

# Marketplace Quality Requirements

Molina implements a Marketplace quality improvement program that is designed to improve health care and services that are 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.

***Background of the Marketplace Program.*** The passage of the Patient Protection and Affordable Care Act authorized the creation of Health Insurance Exchanges. Specifically, the U.S. Health and Human Services was authorized to develop quality data collection and reporting tools through four critical programs referenced as "Marketplace Quality Initiatives." Molina takes part in these four programs – the Marketplace Quality Rating System, Qualified Health Plan Enrollee Experience Survey, Quality Improvement Strategy, and Patient Safety Standards.

## *Marketplace Quality Rating System*

***Background.*** The Quality Rating System (QRS) is a quality reporting program that compares the performance of Qualified Health Plans (QHP) offered on Exchanges and accounts for both the quality of supplied healthcare services and the health plan administration. CMS calculates ratings on a 1-to-5 scale (5 is the highest) each year for eligible QHPs in all Exchanges.

The goals of the QRS are to:

- provide comparable and useful information to consumers about the quality of health care services and enrollee experience with QHPs offered through the Exchanges.
- facilitate oversight of QHP issuer compliance with quality reporting standards in the Patient Protection and Affordable Care Act and implemented regulations; and
- provide actionable information that QHP issuers can use to improve quality and performance.

## *Molina's Participation*

Through Molina's Marketplace quality improvement program, Molina collects and reports quality measures that are required through the Marketplace Quality Rating System. As part of Section 1311(c)(3) of the Patient Protection and Affordable Care Act (PPACA), the U.S. Department of Health & Human Services (HHS) Secretary was directed to develop a system that rates Qualified Health Plans s based on relative quality and price. Molina takes part in this program which requires Exchanges to display Qualified Health Plan quality ratings on Exchange websites to assist in consumer selection.

Molina reports on the Quality Rating System measures annually in alignment through the Centers for Medicare & Medicaid Services. Molina collaborates to identify the highest priority areas for quality measurement and quality improvement to assess core quality of care issues. Each year, Molina follows the requirements for Quality Rating System measure reporting which are modified by the Centers for Medicare & Medicaid Services.

In 2025, Molina will report Quality Rating System measures in compliance with the requirement that Qualified Health Plans report audited and validated results if Exchange coverage was offered in the prior year. CMS will calculate quality performance ratings on a 5-star rating scale in 2024 for eligible Molina plans. CMS will apply the rating methodology to clinical measure data (and some of the QHP Enrollee Survey results) that will be discussed in the next section.

In line with the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2025 (September 2024)* document, Molina will meet requirements for 2024 reporting as described in the Final 2024 Call Letter.

Molina will follow national 2025 reporting instructions where there are measures that have been removed from and added to the 2025 Quality Rating System ratings year. Molina will submit new additional measures for Enrollment by Product Line, Social Need Screening and Intervention, and Depression Screening and Follow-Up for Adolescents and Adults as part of the 2025 ratings year. These measures, except for Enrollment by Product Line, will not be scored at least until the 2026 ratings year. Molina will report on the Colorectal Cancer Screening measure using the Electronic Clinical Data System as part of the 2025 ratings year. This measure will be scored beginning with the year 2026 ratings at the earliest.

For the 2025 ratings year, QHP issuers are required to collect and report race and ethnicity stratifications as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity for sixteen measures in the QRS measure set. See Exhibit 11 for a summary of measures finalized for stratified race and ethnicity reporting.

| Implementation Status | Measure |
|---|---|
| **Finalized beginning with the 2023 ratings year[45]** | • *Child and Adolescent Well-Care Visits*<br>• *Colorectal Cancer Screening*<br>• *Controlling High Blood Pressure*<br>• *Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c control (<8.0%)[46]*<br>• *Prenatal and Postpartum Care* |

Molina and other Qualified Health Plans will also be required to collect and report stratified race and ethnicity data for the Eye Exam for Patients with Diabetes, Follow-Up after Hospitalization for Mental Illness, Kidney Health Evaluation for Patients with Diabetes, Childhood Immunization Status (Combination 10), and Cervical Cancer Screening beginning with the 2025 ratings year.

Molina will report on Oral Evaluation, Dental Services, Adult Immunization Status, and Breast Cancer Screening (through the Electronic Clinical Data System), and Glycemic Status Assessment for Patients with Diabetes: Glycemic Status >9.0% measures; these measures will be scored for the first time in the 2025 Quality Rating System.

## *List of Quality Rating System (and Qualified Health Plan) measures that will be reported by Molina in 2025.*

### Exhibit 8. QRS Measure Set

| Measure Title<br>¥ Indicates **measure** not endorsed by **Consensus Based Entity (CBE)**<br>€ Indicates measure with ECDS-only reporting | CBE ID [33] | QRS Measure Type |
|---|---|---|
| Access to Care | 0006[34] | Survey |
| Access to Information ¥ | 0007 | Survey |
| Adult Immunization Status (AIS-E) € | 3620 | Clinical |
| Annual Monitoring for Persons on Long-term Opioid Therapy | 3541 | Clinical |
| Antidepressant Medication Management | 0105 | Clinical |
| Appropriate Treatment for Upper Respiratory Infection | 0069 | Clinical |
| Asthma Medication Ration | 1800 | Clinical |
| Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis | 0058 | Clinical |
| Breast Cancer Screening (BCS-E) € | 2372 | Clinical |
| Care Coordination | 0006 | Survey |
| Cervical Cancer Screening | 0032 | Clinical |
| Child and Adolescent Well-Care Visits ¥ | N/A | Clinical |
| Childhood Immunization Status (Combination 10) | 0038 | Clinical |
| Chlamydia Screening in Women | 0033 | Clinical |
| Colorectal Cancer Screening (COL-E) € | 0034 | Clinical |
| Controlling High Blood Pressure | 0018 | Clinical |
| Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) €, ¥ | 0418 | Clinical |
| Enrollment by Product Line | N/A | Clinical |
| Eye Exam for Patients with Diabetes | 0055 | Clinical |
| Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up) | 0576 | Clinical |

| Measure Title<br>¥ Indicates **measure** not endorsed by **Consensus Based Entity (CBE)**<br>€ Indicates measure with ECDS-only reporting | CBE ID [33] | QRS Measure Type |
|---|---|---|
| Glycemic Status Assessment for Patients with Diabetes: Glycemic Status >9.0% [36] | 0059 | Clinical |
| Immunization for Adolescents (Combination 2) | 1407 | Clinical |
| Initiation and Engagement of Substance Use Disorder Treatment | 0004 | Clinical |
| International Normalized Ratio Monitoring for Individuals on Warfarin | 0555 | Clinical |
| Kidney Health Evaluation for Patients with Diabetes¥ | N/A | Clinical |
| Medical Assistance with Smoking and Tobacco Use Cessation ¥ | 0027 | Survey |
| Oral Evaluation, Dental Services | 2517 | Clinical |
| Plan Administration | 0006 | Survey |
| Plan All-Cause Readmissions ¥ | 1768 | Clinical |
| Prenatal and Postpartum Care ¥[37] | 1517 | Clinical |
| Proportion of Days Covered [38] | 0541 | Clinical |
| Rating of All Health Care | 0006 | Survey |
| Rating of Health Plan | 0006 | Survey |
| Rating of Personal Doctor | 0006 | Survey |
| Rating of Specialist | 0006 | Survey |
| Social Need Screening and Intervention (SNS-E) € | N/A | Clinical |
| Use of Imaging Studies for Low Back Pain ¥ | 0052 | Clinical |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents | 0024 | Clinical |
| Well-Child Visits in the First 30 Months of Life | 1392 | Clinical |

### *Qualified Health Plan Enrollee Experience Survey*

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.

| **QHP Enrollee Survey Topics**<br>***(Asterisk [*] indicates survey questions within this topic are <u>not</u> included in QRS survey measures.)*** |
|---|
| Access to Care |
| Access to Information |
| Care Coordination |
| Cultural Competence * |
| Doctor Communication* |
| Enrollee Experience with Cost* |
| Plan Administration |
| Prevention |

### *Quality Rating System*

For the 2025 Quality Rating System, Molina will report data for thirty-nine measures. CMS will only include thirty-five measures in the calculation of 2024 Quality Rating System scores and ratings. fields and reports on 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.

### *Quality Improvement Strategy*

Molina also implements a focused Quality Improvement Strategy for Marketplace members; the current strategy is focused on diabetes hemoglobin A1C control and 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. Molina conducts the Quality Improvement Strategy that is 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.

Molina eligible plans that have participated in an Exchange for two or more consecutive years will implement and report on a Quality Improvement Strategy, Molina is using incentives by tying payments to measures of performance when providers meet specific quality indicators or enrollees make certain choices or exhibit behaviors associated with improved health.

According to the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2025 (2025 Guidance)* document, Molina will add key new requirements to its Quality Improvement Strategy to make sure that Molina meets federal regulations.

Molina will ensure that Molina's 2025 Marketplace Quality Improvement Strategy is specifically aimed at reducing health and health care disparities. Molina will measure the current strategy using clinical measures related to diabetes to see if there are potential disparities for Marketplace members with diabetes by race and ethnicity, language, gender, and/or geography. If there are identified disparities, an action plan will be implemented to address key interventions needed.

### *Patient Safety Standards*

Molina continues to comply with regulations which require health plans to contract with hospitals that use patient safety evaluation systems and implement comprehensive hospital discharge programs; and requires health plans to contract with health care providers who implement health care quality improvement mechanisms.

Beginning on or after January 1, 2017, to require that a health plan may only contract with a hospital with more than 50 beds if the hospital: (a) works with a Patient Safety Organization; or (b) meets the reasonable exception criteria by implementing an evidence-based initiative to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination. Molina continues to collect information that demonstrates these contracted hospitals implement mechanisms for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient.

# 2025 Medicare Quality Program Requirements Appendix

This Medicare Quality Program Requirements document includes a detailed overview of Medicare quality program requirements. This appendix includes a discussion of quality program requirements in addition to broader Medicare reporting requirements to provide a comprehensive view of all requirements that may impact quality. During 2025, Molina will present and review summaries of these reports during ongoing National Quality Improvement and Health Equity Transformation Committee meetings.

## Table of Contents

### *Background*

In early 2010, the Centers for Medicare & Medicaid Services (CMS) developed a Quality Improvement Strategy for the Medicare Advantage and Prescription Drug Plan Programs based on the 2001 Institute of Medicine report. That strategy was expanded in 2011 to reflect the Department of Health and Human Services National Strategy for Quality Improvement in Health Care.

The Medicare Advantage and Prescription Drug Plan Programs Quality Strategy's vision, mission, core values, and goals collectively drive the quality of healthcare and ongoing quality improvement initiatives for all plans. All Medicare Advantage Organizations are required, as a condition of their contract with CMS, to develop a Quality Improvement program that is based on care coordination for enrollees. The Medicare Advantage and Prescription Drug Plan Programs Quality Strategy supports that requirement by providing a framework for Medicare Advantage and Prescription Drug Plan Programs as they work to improve care and patient health outcomes. The foundation of the Medicare Advantage and Prescription Drug Plan Programs Quality Strategy and the Quality Improvement program is improving care coordination and encouraging provision of health care using evidence-based clinical protocols. (Source: Medicare Managed Care Manual – Chapter 5)

### *An Ongoing Quality Improvement Program 42 CFR§ 422.152*

Medicare Advantage plans that offer one or more MA plans must have an ongoing Quality Improvement program for each of their plans. The purpose of a Quality Improvement program is to ensure that Medicare Advantage Organizations have the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. The requirements for the Quality Improvement program are based in regulation at 42 CFR§ 422.152.

### *Background: Components of the Ongoing Quality Improvement Program*

For each plan, a Medicare Advantage Organization must:

1. develop and implement a chronic care improvement program 42 CFR §422.152(c).
2. develop and implement a quality improvement project 42 CFR §422.152(d).
3. develop and maintain a health information system (42 CFR §422.152(f)(1)).
4. encourage providers to participate in CMS and HHS Quality Improvement initiatives

   (42 CFR §422.152(a)(3)).
5. implement a program review process for formal evaluation of the impact and effectiveness of the Quality Improvement Program at least annually (42 CFR §422.152(f)(2)).
6. correct all problems that come to its attention through internal surveillance, complaints, or other mechanisms (42 CFR §422.152(f)(3)

7. contract with an approved Medicare Consumer Assessment of Health Providers and Systems (CAHPS®) vendor to conduct the Medicare CAHPS® satisfaction survey of Medicare enrollees (42 CFR §422.152(b)(5)).
8. measure performance under the plan using standard measures required by CMS and report its performance to CMS (42 CFR §422.152(e)(i)).
9. develop, compile, evaluate, and report certain measures and other information to CMS, its enrollees, and the general public; and
10. be responsible for safeguarding the confidentiality of the doctor-patient relationship and report to CMS in the manner required cost of operations, patterns of utilization of services, availability, accessibility, and acceptability of Medicare approved and covered services (42 CFR §422.516(a)).

All Medicare Advantage Organizations, as part of their application to offer new MA products or expand the service area of an existing product, must submit a written Quality Improvement Program Plan (QIPP). The Quality Improvement Program Plan outlines the elements of a Medicare Advantage Organization's QI Program and provides a framework for how a plan will execute each of the QI program requirements stipulated above. Quality Improvement Program Plans are submitted to CMS as part of the contract and Special Needs Plan application processes. Quality Improvement Program Plan templates are included in both the contract and Special Needs Plan applications.

### *Molina's Approach: Implementing a comprehensive Medicare quality program.*

Molina develops and implements quality program activities that are tracked using a comprehensive work plan. This work plan includes a list 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) and Medicare Managed Care Manual Chapter 5, Section 20)*

### *Background*

As required by regulation, each Medicare Advantage Organization must develop and implement a Chronic Care Improvement Program and Quality Improvement Project as part of its required Quality Improvement Program. Medicare Advantage Organizations must conduct the same Chronic Care Improvement Program and Quality Improvement Project for all their non-Special Needs Plan coordinated care plans offered under a specified contract, including employer group plans and Medical Savings Account plans and Private Fee for Service plans that have contracted networks.

Medicare Advantage Organizations must also implement a Chronic Care Improvement Program and Quality Improvement Project specific to each Special Needs Plan offered, including when a Medicare Advantage Organization offers multiple Special Needs Plans of the same type under a contract. Only PFFS plans that do not have contracted networks, section 1833 and 1876 cost plans, and Program of All-Inclusive Care for the Elderly (PACE) plans are exempted from the Chronic Care Improvement Program and Quality Improvement Project requirements.

The quality improvement model adopted by CMS for the Chronic Care Improvement Program/Quality Improvement Projects is based on The Plan-Do-Study-Act (PDSA) quality improvement model. PDSA is an iterative, problem-solving model used for improving a process or carrying out change. The four steps of the PDSA cycle provide a systematic, step-by-step, ongoing approach for quality improvement initiatives.

Components of the PDSA are as follows:

| |
|---|
| ***Plan:*** Describes the processes, specifications, and output objectives used to establish the Chronic Care Improvement Program/Quality Improvement Project. |
| ***Do:*** Describes the progress of the implementation and the data collection plan. |
| ***Study:*** Describes the analysis of data to determine what impact the program has had on members. |
| ***Act:*** Summarizes action plan(s) based on findings; describes, in particular, the differences between actual and anticipated results, and describes specific actions or steps taken or planned based on current results. |

The Medicare Advantage Organization's first step in implementing a Quality Improvement Project or Chronic Care Improvement Program is submitting a complete, standalone "Plan" section of the PDSA model for approval by CMS. Once that Plan is approved and implemented, Medicare Advantage Organizations are required to submit Annual Updates that are comprised of the Do, Study, and Act components of the PDSA model to report on the ongoing operations of that approved Plan.

The Plans and Annual Updates for both Chronic Care Improvement Programs and Quality Improvement Projects are submitted to CMS through the "Quality and Performance" module of the Health Plan Management System (HPMS).

A Chronic Care Improvement Program is a clinically focused initiative designed to improve the health of a specific group of enrollees with chronic conditions. Beginning CY 2012, CMS required that each MA plan conduct, over a 5-year period, a Chronic Care Improvement Program focused on reducing and/or preventing cardiovascular disease.

General summary of the required components of the Chronic Care Improvement Program Plan.

### *Quality Improvement Projects*

Quality Improvement Projects are initiatives focused on one or more clinical and/or non-clinical areas with the aim of improving health outcomes and beneficiary satisfaction. Beginning CY 2012, each Medicare Advantage Organization is required to conduct, over a 3-year period, a Quality Improvement Project focused on reducing 30-day all cause hospital readmission rates.

### *Molina Approach for Chronic Care Improvement Program and Quality Improvement Projects*

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 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 and Quality Improvement Project processes, specifications, and objectives.
- identifying the opportunity/opportunities for improvement and target goal (s).
- implementing specific interventions that are designed to achieve identified goals and members of focus for interventions and expected results.
- demonstrating progress of program/project implementation and data collection plan.
- analyzing data to determine 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.
- attesting to ongoing plans for the Chronic Care Improvement Program and Quality Improvement Projects (as needed) through “Quality and Performance” module of the Health Plan Management System.
- ensuring that providers participate in 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)).

### *Special Needs Plan Model of Care*

Section 1856(f)(7) of the Patient Protection and Affordable Care Act stipulates that all Medicare Advantage Organizations offering Special Needs Plans must submit an evidence-based Model of Care to CMS for NCQA evaluation and approval in accordance with CMS guidance. As provided at 42 CFR §422.101(f) and §422.152(g), Special Needs Plans must develop and implement a Model of Care that provides the structure for care management processes and systems that will enable the health plan to provide coordinated care for special needs individuals. A Medicare Advantage organization must develop separate Model of Care to meet the needs of the targeted population for each Special Needs Plan type it offers. (Section 20.2.1 Model of Care General Medicare Managed Care Manual Chapter 5)

All Special Needs Plans must submit Model of Care Matrix Upload Document, as well as the Model of Care narrative, in HPMS during the MA/Special Needs Plan application timeframe.

The Model of Care narrative must include the following four elements:

1. Description of the Special Needs Plan Population.

2. Care Coordination.

3. Special Needs Plan Provider Network.

4. Model of Care Quality Measurement & Performance Improvement.

### *Molina Approach to Model of Care*

Molina submits an evidence-based Model of Care 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 a 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 and roles and responsibilities for employed and/or contracted staff that perform clinical and administrative functions, staff structure and roles and responsibilities for employed and/or contracted staff that perform administrative and clinical oversight functions; identify 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 the completion of Model of Care training for employed health plan and contracted staff.

To implement Molina's Model of Care:

- Molina implements policies and procedures that describe how the health risk assessment is completed, the health risk assessment is developed and updated, reassessments are completed, and address the detailed plan and rationale for reviewing, analyzing, and stratifying results of the health risk assessment.
- Molina also establishes individualized care plans that meet CMS requirements, including but not limited to: self-management goals and objectives, healthcare preferences, description of services tailored to individual needs, roles of caregiver (s), and identification of goals met or not met; description of process to reassess care plan if goals are not met; explanation of process and staff responsible for care plan development along with involvement of member and caregiver (s), and frequency of care plan review and modification as needs change; care plan documentation and update process, and communication of care plan to member and/or caregiver (s), providers, personnel and other stakeholders, as applicable.
- Molina describes the interdisciplinary care team composition, alignment of expertise and capabilities of the care team with beneficiary needs, contributions to team members to improving health status, participation of beneficiaries and caregivers, use of health risk assessment and care plan to determine care team composition; use of healthcare outcomes to evaluate established processes; identification and explanation of clinical managers, case managers, or others in the interdisciplinary process; description of the communication plan about the care team with clear evidence that the plan is overseen by staff, verification of communications that have taken place, and communications for beneficiaries with hearing impairments, language barriers and/or cognitive deficiencies.
- Molina implements care transitions protocols that describe how beneficiaries are linked to appropriate provider (s), specific staff who are responsible for care transitions and ensuring follow-up services and appointments are scheduled; ensuring care plan is transferred between

healthcare settings, ensuring that beneficiary and/or caregiver has access to and can utilize personal health information to facilitate for communication; education process about health condition to beneficiary and caregiver (s); and process to inform beneficiary and/or caregiver (s) about point of contact through transitions.

- 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 provide 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 explains the process to ensure that network providers use appropriate clinical practice guidelines and nationally recognized protocols, including the use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation; challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines may need modification and ensuring care transitions protocols are used to manage continuity of care.
- Molina explains how initial and annual Model of Care training for network and out-of-network providers is conducted; documentation and maintenance of training records to show evidence of completing training, and explanation of challenges associated with Model of Care training for network providers and description of specific actions to take to address untimely or deficient training.

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 reporting 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 Model of Care Quality Improvement Program (or Plan) describes how Molina makes sure that appropriate services to Medicare beneficiaries and address needs of vulnerable populations; detects whether the Model of Care meets the unique healthcare needs of health plan members; uses a 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 surveys, to evaluate Special Need Plan member satisfaction. The results of these surveys are incorporated into the overall Model of Care quality program and will be addressed through a continuous quality improvement process.

### *Evaluating the Quality Program for the Model of Care*

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 Improvement and Health Equity Transformation 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. Performance measures reported include HEDIS, Health Outcomes Survey, and CAHPS survey and other focus areas that are critical for the Special Needs Plan Model of Care.

## *Medicare Advantage Reporting Requirements for HEDIS, Health Outcomes Survey, and CAHPS. Background*

CMS has authority to collect various types of quality data under section 1852(e) of the Social Security Act (the Act) and use this information to develop and publicly post a 5-star rating system for Medicare Advantage plans based on its authority to disseminate comparative information, including about quality, to beneficiaries under sections 1851(d) and 1860D-1(c) of the Act. As codified at §422.152(b)(3), Medicare health plans are required to report on quality performance data which CMS can use to help beneficiaries compare plans.

Molina collects and reports key performance measures including annual Medicare Healthcare Effectiveness Data and Information Set® measures to the National Committee for Quality Assurance for Measurement Year 2024 by June 13, 2025. We submit the required audited summary-level data to the National Committee for Quality Assurance for all Medicare contracts that were in place as of January 1, 2024 or earlier. Molina contracts with Advent as the CMS and NCQA-approved external audit firm. We also report patient-level data to the designated patient-level data subcontractor. (HEDIS Measurement Year 2024 Volume 2: Technical Specifications for Health Plans.

### *Organization Type and Reporting Requirements*

**Table 1: Organization Type and Quality Measure Reporting Requirements**

| Organization Type | HEDIS | HOS | HOS-M | CAHPS |
|---|---|---|---|---|
| Section 1876 Cost contracts | ✓ | ✓ | ✗ | ✓ |
| Demonstration: Medicare-Medicaid Plans (MMPs) | ✓ | ✓ | ✗ | ✓ |
| HCPP-1833 Cost | ✗ | ✗ | ✗ | ✗ |
| Local Coordinated Care Plans (LCCP) | ✓ | ✓ | ✗ | ✓ |
| Medical Savings Account (MSA) | ✓ | ✓ | ✗ | ✓ |
| Programs of All-Inclusive Care for the Elderly (PACE) | ✗ | ✗ | ✓ | ✗ |
| Private Fee-for-Service (PFFS) | ✓ | ✓ | ✗ | ✓ |
| Employer/Union Only Direct Contract Local CCP | ✓ | ✓ | ✗ | ✓ |
| Employer/Union Direct Contract PFFS | ✓ | ✓ | ✗ | ✓ |
| Regional Coordinated Care Plans (RCCP) | ✓ | ✓ | ✗ | ✓ |

(✗ = Not required to report ✓ = Required to report)

## *Measurement Year 2024 HEDIS Measures Being Reported to CMS*

**Table 2: HEDIS MY 2024 Summary Contract-Level Measures for Reporting[1]**

| ***Effectiveness of Care Measures*** |
|---|
| **PCE –** Pharmacotherapy Management of COPD Exacerbation[2] |
| **CBP –** Controlling High Blood Pressure |
| **PBH –** Persistence of Beta-Blocker Treatment After a Heart Attack[2] |
| **SPC –** Statin Therapy for Patients with Cardiovascular Disease[2] |
| **CRE -** Cardiac Rehabilitation |
| **GSD –** Glycemic Status Assessment for Patients with Diabetes[3] |
| **BPD –** Blood Pressure Control for Patients with Diabetes[3] |
| **EED –** Eye Exam for Patients with Diabetes[3] |
| **KED -** Kidney Health Evaluation for Patients with Diabetes |
| **SPD -** Statin Therapy for Patients with Diabetes[2] |
| **OMW –** Osteoporosis Management in Wsomen Who Had a Fracture |
| **OSW –** Osteoporosis Screening in Older Women |
| **AMM –** Antidepressant Medication Management |
| **FUH -** Follow-Up After Hospitalization for Mental Illness |
| **FUM -** Follow-Up After Emergency Department Visit for Mental Illness |
| **FUA -** Follow-Up After Emergency Department Visit for Substance Use |
| **SAA -** Adherence to Antipsychotic Medications for Individuals with Schizophrenia |
| **TRC -** Transitions of Care[2, 4] |
| **FMC –** Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions |
| **PSA –** Non-Recommended PSA-Based Screening in Older Men |
| **DDE –** Potentially Harmful Drug-Disease Interactions in Older Adults |
| **DAE –** Use of High-Risk Medications in Older Adults |
| **HDO –** Use of Opioids in High Dosage |
| **UOP –** Use of Opioids from Multiple Providers |
| **POD –** Pharmacotherapy for Opioid Use Disorder |

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[1]This does not include any of the HEDIS survey measures such as the measures collected through the HOS.
[2]Section 1876 Cost contracts do not report the following measures: PCE, PBH, SPC, SPD, TRC, PCR, HRF, AHU, EDU, and HPC.
[3]This measure is part of the former Comprehensive Diabetes Care measure set. The measure specifications are the same as in the past.
[4]The Medication Reconciliation Post-Discharge (MRP) measure is still collected as an indicator in the TRC measure.

## *Measurement Year 2024 HEDIS Measures Being Reported to CMS Continued*

| |
|---|
| ***Access/Availability of Care Measures*** |
| **AAP** – Adults' Access to Preventive/Ambulatory Health Services |
| **IET –** Initiation and Engagement of Substance Use Disorder Treatment |
| ***Utilization and Risk-Adjusted Utilization Measures*** |
| **PCR –** Plan All-Cause Readmissions[2] |
| **HFS** – Hospitalization Following Discharge from a Skilled Nursing Facility[2,5] |
| **AHU –** Acute Hospital Utilization[2] |
| **EDU –** Emergency Department Utilization[2] |
| **HPC –** Hospitalization for Potentially Preventable Complications[2] |
| ***Health Plan Descriptive Information*** |
| **LDM –** Language Diversity of Membership |
| **ENP –** Enrollment by Product Line |
| ***Measures Collected Using Electronic Clinical Data Systems*** |
| **BCS-E –** Breast Cancer Screening |
| **DSF-E** – Depression Screening and Follow-Up for Adolescents and Adults |
| **AIS-E –** Adult Immunization Status |
| **SNS-E –** Social Need Screening and Intervention |
| **COL-E –** Colorectal Cancer Screening |
| **DMS-E –** Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults |
| **DRR-E –** Depression Remission or Response for Adolescents and Adults[6] |
| **ASF-E –** Unhealthy Alcohol Use Screening and Follow-Up[6] |

### *Background: MY 2024 Summary Plan Benefit Package-Level Reporting for Coordinated Care Plans with Special Needs Plans (Special Needs Plans) and Medicare-Medicaid Plans*

In 2025, CMS will collect audited summary and Plan Benefit Package-level data from each Plan Benefit Package designated as a Special Needs Plan offered by any Coordinated Care Plan and audited summary Plan Benefit Package -level data for each Medicare-Medicaid Plan Benefit Package. A Special Needs Plan Benefit Package must have had thirty or more members enrolled as listed in the February 2025 Special Needs Plan Comprehensive Report. Special Needs Plan Benefit Packages that meet the enrollment criteria must also exist in both the measurement year and reporting years. Plan Benefit Packages.

A Medicare-Medicaid Plan Benefit Package must have had thirty or more members enrolled as listed in the February 2024 Monthly Enrollment by Plan report. Medicare-Medicaid Plan Benefit Packages that terminated as of December 31, 2024, or after are required to report, if they were in operation for the full 2024 calendar year. If a contract has multiple qualifying Plan Benefit Packages, then each qualifying Plan Benefit Package in the contract must report the measures in a separate submission. Medicare-Medicaid Plans and contracts with Special Needs Plan Benefit Packages do not have to report any additional PLD files. The required HEDIS PLD file submission at the contract level will already include the detailed data about the members in the Special Needs Plan and Medicare-Medicaid Plan Benefit Packages.

Molina will report HEDIS data for required Special Needs Plans and Medicare-Medicaid Program Plans. See table below for Special Needs Plans and Medicare-Medicaid Plans.

**Table 3: HEDIS MY 2024 Measures for Reporting by SNPs and MMP PBPs**

| |
|---|
| ***Effectiveness of Care Measures*** |
| **COA –** Care for Older Adults (SNP- and MMP-only measures)7 |
| **PCE -** Pharmacotherapy Management of COPD Exacerbation |
| **CBP –** Controlling High Blood Pressure |
| **PBH –** Persistence of Beta-Blocker Treatment After a Heart Attack |
| **OMW -** Osteoporosis Management in Women Who Had a Fracture |
| **AMM -** Antidepressant Medication Management |
| **FUH –** Follow-Up After Hospitalization for Mental Illness |
| **DDE –** Potentially Harmful Drug-Disease Interactions in the Elderly |
| **TRC –** Transitions of Care |
| **DAE -** Use of High-Risk Medications in the Elderly |
| ***Utilization and Risk-adjusted Utilization Measure*** |
| **PCR –** Plan All-Cause Readmissions |

### *Background*

All Medicare Advantage Organizations report the Health Outcomes Survey in 2025 with Medicare contracts in effect on or before January 1, 2024. Plans are required to report the Cohort 27 Baseline HOS in 2025 if they have a minimum enrollment of five hundred members in February 2025 as reflected in the March 2025 monthly enrollment file.

In addition, all organizations that reported Cohort 25 Baseline Survey in 2023 are required to administer the Cohort 25 Follow-Up Survey in 2025. In the event of contract consolidations, mergers, or novations, surviving contracts must report Follow-Up HOS for all contracts involved. All eligible members of consolidated, merged, or novated contracts will be resurveyed, and the results will be reported under the surviving contract. In the event of a contract conversion, the contract must report if their new organization type is required to report.

The following organization types are included in the CAHPS survey administration if they have a minimum enrollment of 600 eligible members as of July 1, 2024: All Medicare Advantage Organizations, including all Coordinated Care Plans, PFFS contracts, and MSA contracts; Section 1876 Cost contracts even if they are closed for enrollment; Employer/union only contracts.

Medicare-Medicaid Plans PACE and HCPP 1833 Cost contracts are excluded from the CAHPS administration. Beneficiaries enrolled in I-Special Needs Plans are excluded from sampling.

Organizations are required to contract with an approved MA & PDP CAHPS vendor for the 2025 CAHPS survey administration. All approved CAHPS survey vendors for the 2024 survey administration will be listed on www.MA-PDPCAHPS.org. CMS will issue additional information through HPMS about the CAHPS survey for 2024. As a reminder, for Medicare-Medicaid Plans, failure to adhere to CAHPS reporting requirements may affect quality withhold payments, as articulated in the CMS Core Quality Withhold Technical Notes.

Molina collects and reports the Medicare CAHPS surveys using the CMS- and NCQA-approved survey vendor according to the rules listed by CMS. During Spring 2025, Molina conducts the Medicare CAHPS survey for plans with enrollees of 600 or more enrollees as of July 1, 2024. Molina uses a CMS-approved CAHPS survey vendor to conduct this data collection.

### *Implementing Part C Reporting Requirements for 2025*

CMS has authority to establish reporting requirements for Medicare Advantage Organizations (Medicare Advantage Organizations) as described in 42CFR §422.516 (a). Pursuant to that authority, each Medicare Advantage Organization must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires. Additional regulatory support for the Medicare Part C Reporting Requirements is also found in the Final Rule entitled “Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program” (CMS 4131-F).

Molina complies with Medicare Part C reporting requirements for 2025. These reports address critical areas for CMS submission. Although these reports may not all be completed by the quality functional area, all reports are listed by topic below with background details to demonstrate the comprehensiveness of these requirements. (Medicare Part C Reporting Requirements: Effective January 1, 2025. Centers for Medicare & Medicaid Services)

### *2025 Reporting Requirements by Topic Area*

### *Grievances*

***Background:*** According to the Medicare Modernization Act, all Medicare Advantage organizations must have meaningful procedures for hearing and resolving grievances between enrollees and the organization, including an entity or individual through which the organization provides benefits. A grievance is any complaint or dispute, other than an organization determination or appeal, about any aspect of the operations, activities, or behavior of an MA organization, regardless of any remedial action requested.

### *Molina Reporting*

Molina provides grievance reports to CMS by specific timelines during the year for the following measures:

- Number of Total Grievances
- Number of Total Grievances in which timely notification was given.
- Number of Expedited Grievances
- Number of Expedited Grievances in which timely notifications were given.
- Number of Dismissed Grievances

### *Organization Determinations and Reconsiderations*

***Background:*** Part C organization determinations, reconsiderations, and reopening procedures are included in federal regulations and guidance cited from 42 CFR Part 422, Subpart M, and the Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance. CMS defines organization determinations and reconsiderations for this reporting process. These definitions include but are not limited to the following.

| |
|---|
| A plan's response to a request for coverage (payment or provision) of an item, service, or Part B drug, including auto-adjudicated claims, service authorizations which include prior-authorization (authorization that is issued prior to the services being rendered), concurrent authorization (authorization that is issued at the time the service is being rendered), post authorization (authorization that is issued after the service has been rendered), and requests to continue previously authorized ongoing courses of treatment. An organization determination includes pre-service organization determination requests submitted by the enrollee, enrollee's representative, contract provider on behalf of the enrollee and requests from non-contract providers. It does not include claims payment requests from contract providers that are governed by the contractual arrangement between the Medicare Advantage Organization and its contract providers. |
| Reconsideration is a plan's review of an adverse or partially favorable organization determination as defined in 42 CFR § 422.580. |
| Fully Favorable decision means an item or service was covered in whole. |
| Partially Favorable decision means an item or service was partially covered. For example, if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable. Also, if a pre-service request for ten therapy services was processed, but only five were authorized, this would be considered partially favorable. |
| Adverse decision for reporting purposes means an item or service was denied in whole. |
| Withdrawn organization determination or reconsideration is one that is, upon request, removed from the plan's review process. This category excludes appeals that are dismissed. |
| Dismissal is a decision not to review an organization determination or reconsideration request because it is considered invalid or does not otherwise meet Medicare Advantage requirements. |

| ***Organization Determinations and Reconsiderations Continued*** |
|---|
| Molina provides organization determination and reconsideration reports to CMS by specific timelines during the year for the following measures. |
| Total Number of Organization Determinations and Total Number of Reconsiderations Made in the Reporting Period |
| Number of Organization Determinations and Total Number of Reconsiderations Withdrawn |
| Number of Organization Determinations and Total Number of Reconsiderations Dismissals |
| Number of Organization Determinations and Total Number of Reconsiderations requested by enrollee/representative or provider on behalf of the enrollee (Services) |
| Number of Organization Determinations and Total Number of Reconsiderations submitted by Enrollee/Representative (Claims) |
| Number of Organization Determinations and Number of Reconsiderations requested by Non-Contract Provider (Services) |
| Number of Organization Determinations and Number of Reconsiderations submitted by Non-Contract Provider (Claims) |
| ***Disposition – All Organization Determinations and Reconsiderations*** |
| Number of Organization Determinations and Number of Reconsiderations– Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee |
| Number of Organization Determinations and Number of Reconsiderations -Fully Favorable (Services) Requested by Non-contract Provider |
| Number of Organization Determinations and Number of Reconsiderations – Fully Favorable (Claims) Submitted by enrollee/representative |
| Number of Organization Determinations and Number of Reconsiderations – Fully Favorable (Claims) Submitted by Non-contract Provider |
| Number of Organization Determinations and Number of Reconsiderations – Partially Favorable (Services) Requested by enrollee/representative provider on behalf of the enrollee |
| Number of Organization Determinations and Number of Reconsiderations– Partially Favorable (Services) Requested by Non-contract Provider |
| Number of Organization Determinations and Number of Reconsiderations– Partially Favorable (Claims) Submitted by enrollee/representative |

| *Disposition – All Organization Determinations and Reconsiderations Continued* |
|---|
| Number of Organization Determinations and Number of Reconsiderations– Partially Favorable (Claims) Submitted by Non-contract Provider |
| Number of Organization Determinations and Number of Reconsiderations– Adverse (Services) Requested by enrollee/representative or provider on behalf of the enrollee |
| Number of Organization Determinations and Number of Reconsiderations– Adverse (Services) Requested by Non-contract Provider |
| Number of Organization Determinations and Number of Reconsiderations– Adverse (Claims) Submitted by enrollee/representative |
| Number of Organization Determinations and Number of Reconsiderations– Adverse (Claims) Submitted by Non-contract Provider |

### *Special Needs Plan Care Management*

Molina reports the following to CMS at required timeframes.

A. Number of new enrollees due for an Initial Health Risk Assessment

B. Number of enrollees eligible for an annual reassessment HRA

C. Number of initial HRAs performed on new enrollees.

D. Number of initial HRA refusals

E. Number of initial HRAs not performed because Special Needs Plan is unable to reach new enrollees.

F. Number of annual reassessments performed on enrollees eligible for a reassessment.

G. Number of annual reassessment refusals

H. Number of annual reassessments where Special Needs Plan is unable to reach enrollee.

### *Enrollment and Disenrollment*

***Background:*** For Part C reporting, Medicare Advantage Organizations offering MA-only plans (i.e., no Part D benefit) are to report enrollment, disenrollment, and reinstatement activity for these plans in this reporting section. Similarly, 1876 cost plans are to report enrollment, disenrollment, and reinstatement activity for Plan Benefit Packages that do not include a Part D optional supplemental benefit. Enrollment, disenrollment, and reinstatement activity for MA-PD plans and 1876 Cost Plan Benefit Packages that include a Part D optional supplemental benefit must report under the appropriate section in the Part D reporting requirements.

| ***Enrollment*** | ***Disenrollment*** |
|---|---|
| A. The total number of enrollment requests (i.e., requests initiated by the beneficiary or his/her authorized representative) received in the specified time period.<br><br>Do not include auto/facilitated or passive enrollments, rollover transactions, or other enrollments effectuated by CMS. | A. The total number of voluntary disenrollment requests received in the specified time period.<br><br>Do not include disenrollments resulting from an individual's enrollment in another plan. |
| B. Of the total reported in A, the number of enrollment requests completed at the time of initial receipt (i.e., required no additional information from applicant or his/her authorized representative). | B. Of the total reported in A, the number of disenrollment requests completed at the time of initial receipt (i.e., required no additional information from the enrollee or his/her authorized representative. |
| C. Of the total reported in A, the number of enrollment requests for which the sponsor wa required to request additional information from the applicant (or his/her representative). | C. Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason. |
| D. Of the total reported in A, the number of enrollment requests denied due to the sponsor's determination of the applicant's ineligibility to elect the plan (i.e., individual not eligible for an election period). | D. The total number of involuntary disenrollments for failure to pay plan premium in the specified time period. |
| E. Of the total reported in C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and complete within established timeframes. | E. Of the total reported in D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause. |

| *Enrollment* | *Disenrollment* |
|---|---|
| G. Of the total reported in A, the number of paper enrollment requests received. | G. Of the total reported in F, the number of individuals reinstated. |
| H. Of the total reported in A, the number of telephonic enrollment requests received (if sponsor offers this mechanism). | |
| I. Of the total reported in A, the number of electronic enrollment requests received via an electronic device or secure internet website (if sponsor offers this mechanism). | |
| J. Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received. | |

## REWARDS AND INCENTIVES PROGRAMS

Molina reports the following information to CMS on a required timeline.

***Data Element Description***

**A. Do you have a Rewards and Incentives Program(s)? (“Yes” or “No” only;)**

**B. Rewards and Incentive Program Name**

**C. What health related services and/or activities are included in the program?**

**D. What reward(s) may enrollees earn for participation? [Text]**

**E. How do you calculate the value of the reward? [Text]**

**F. How do you track enrollee participation in the program? [Text]**

**G. How many enrollees are currently enrolled in the program? [NUM]**

**H. How many rewards have been awarded so far? [NUM]**

## *PAYMENTS TO PROVIDERS*

### *Background*

HHS developed the four categories of value-based payments: fee-for-service with no link to quality (category 1); fee-for-service with a link to quality (category 2); alternative payment models built on fee-for-service architecture (category 3); and population-based payment (category 4). CMS will collect data from MA organizations about the proportion of their payments made to contracted providers based on these four categories to understand the extent and use of alternate payment models in the MA industry.

Descriptions of the four categories are as follows:

***Category 1*** includes a fee-for-service with no link to quality arrangement to include all arrangements where payments are based on volume of services and not linked to quality of efficiency.

***Category 2*** includes fee-for-service with a link to quality to include all arrangements where at least a portion of payments vary based on the quality or efficiency of health care delivery including hospital value-based purchasing and physician value-based modifiers.

***Category 3*** includes alternative payment models built on fee-for-service architecture to include all arrangements where some payment is linked to the effective management of a population or an episode of care. Payments are still triggered by delivery of services, but there are opportunities for shared savings or 2-sided risk.

***Category 4*** includes population-based payment arrangements to include some payments that are not directly triggered by service delivery so the volume is not linked to 2 Medicare-Medicaid Plans should report for all APMs, not just Medicare APMs. Under these arrangements, clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., greater than a year).

| ***Molina reports the following information to CMS on a required timeline.*** |
|---|
| ***Category 1*** |
| A. Total dollars paid to providers (in and out of network) for Medicare Advantage enrollees in CY 2025 or most recent 12 months. made to contracted providers |
| B. Total paid to providers through legacy payments (including fee-for-service (i.e., payments made for units of service) in CY 2025 or most recent 12 months that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metric (s), Also includes diagnostic-related groups that are not linked to quality and value in CY 2025 or most recent 12 months. |
| ***Category 2*** |
| C. Total dollars paid to providers through fee-for-service plus pay-for-reporting payments (linked to quality) in CY 2025 or most recent 12 months. |

| |
|---|
| ***Category 2 Continued*** |
| D. Total dollars paid to providers through fee-for-service plus pay-for-performance payments (linked to quality) in CY 2025 or most recent 12 months.) |
| E. Dollars paid in foundational spending to improve care (linked to quality) in CY 2025 or most recent 12 months. |
| F. Total dollars paid in Category 2 in CY 2025 or most recent 12 months. |
| ***Category 3*** |
| G. Total dollars paid to providers through traditional shared-savings (linked to quality) payments in CY 2025 or most recent 12 months. |
| H. Total dollars paid to providers through utilization-based shared-savings (linked to quality) payments in CY 2025 or most recent 12 months. |
| I. Total dollars paid to providers through fee-for-service based shared-risk (linked to quality) programs in CY 2025 or most recent 12 months. |
| J. Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) payments in CY 2025 or most recent 12 months. |
| K. Total dollars paid in Category 3 in CY 2025 or most recent 12 months. |
| L. Total Risk-based payments not linked to quality (e.g., 3N in APM definitional framework), |
| ***Category 4*** |
| M. Total dollars paid to providers through condition-specific, population-based payments (linked to quality) in CY 2025 or most recent 12 months. |
| N. Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality) in CY 2025 or most recent 12 months. |
| O. Total dollars paid to providers through population-based payments that are NOT condition-specific (linked to quality) in CY 2025 or most recent 12 months. |
| P. Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) in CY 2025 or most recent 12 months. |
| Q. Total dollars paid to providers through integrated finance and delivery system programs (linked to quality) in CY 2025 or most recent 12 months. |
| R. Total dollars paid in Category 4 in CY 2025 or most recent 12 months. |
| S. Total capitation payment not linked to quality (e.g., 4N in the APM definitional framework). |

Additional reporting focuses on provider data, and primary care physician/primary care group accountable care metrics.

## SUPPLEMENTAL BENEFIT UTILIZATION AND COSTS

The categories listed below show the types of data that must be reported for key supplemental benefits: Plan Benefit Package Category. Molina reports the following information to CMS on a required timeline. NOTE – Molina offers not all these supplemental benefits; this list includes all choices as determined by CMS.

| ***Inpatient Hospital Services*** | ***Preventive and Other Defined Supplemental Services*** |
|---|---|
| Skilled Nursing Facility Services | Dental |
| Cardiac and Pulmonary Rehabilitation Services | Eye Exams/Eyewear |
| Worldwide Emergency/Urgent Coverage | Hearing Exams/Hearing Aids |
| Health Care Professional Services | Medicare covered services offered as POS or VT |
| Outpatient Blood Services | Non-Primarily Health Related Benefits (only available as Special Supplemental Benefits for the Chronically Ill) |
| Transportation Services | Other Supplemental Services |

## *D-SNP ENROLLEE ADVISORY COMMITTEE*

Reporting for SNP Enrollee Advisory Committees focuses on the following data elements.

A. Does the D-SNP share an enrollee advisory committee with other DSNP (s)?
B. Provide the total number of D-SNP EAC meetings held during the measurement year.
C. List the dates during the measurement year when the D-SNP EAC met.
D. Were interpreter services offered for each D-SNP EAC meeting?
E. Were auxiliary aids and services offered for each D-SNP EAC meeting?

## *D-SNP TRANSMISSION OF ADMISSION NOTIFICATIONS*

Reporting focuses on the following data elements.

A, Total number of hospital admissions and skilled nursing facility admissions during 2025 among the high full-benefit dually eligible individuals in the D-SNP.

B. Total number of admission notifications that the D-SNP transmitted to the state or state designated entity during 2025. admissions and skilled nursing facility admissions during the measurement year among the high full-benefit dually eligible individuals in the D-SNP.

## Part D Reporting Requirements

***Background:*** Section 1860D–12(b)(3)(D) of the Act provides broad authority for the Secretary to add terms to the contracts with Part D sponsors, including terms that require the sponsor to provide the Secretary with information as the Secretary may find necessary and appropriate. Pursuant to our statutory authority, we codified these information collection requirements for Part D sponsors in regulation at §423.514. 42 CFR §423.514(a) requires each Part D sponsor to have a procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, statistics indicating the following: 1) The cost of its operations. 2) The patterns of utilization of its services. 3) The availability, accessibility, and acceptability of its services. 4) Information demonstrating that the Part D sponsor has a fiscally sound operation. 5) Pharmacy performance measures. 6) Other matters that CMS may require.

## Enrollment and Disenrollment

***Background:*** Enrollment and disenrollment periods for Medicare Advantage and Part D plan elections are outlined at 42 CFR 422 Subpart B and 42 CFR 423 Subpart B, respectively. CMS will collect data on the elements for these requirements, which are otherwise not available to CMS, to evaluate sponsors' processing of enrollment, disenrollment, and reinstatement requests in accordance with CMS requirements. All enrollment and disenrollment activity involving a Part D benefit (e.g., standalone prescription drug plan, MA prescription drug plan, cost plan with Part D optional supplemental benefit) is reported via the Part D requirements. Medicare Advantage Organizations and 1876 Cost plans report enrollment and disenrollment activity that does not involve a Part D benefit under the Part C reporting requirements.

| ***Enrollment*** | ***Disenrollment*** |
|---|---|
| A. The total number of enrollment requests (initiated by the beneficiary or his/her authorized legal representative) received in the specified time period.<br><br>Do not include auto/facilitated or passive enrollments, rollover transactions, or other enrollments effectuated by CMS. | A. The total number of voluntary disenrollment requests received in the specified time period.<br><br>Do not include disenrollments resulting from an individual's enrollment in another plan. |
| B. Of the total reported in A, the number of enrollment requests completed at the time of initial receipt. | B. Of the total reported in A, the number of disenrollment requests completed at the time of initial receipt. |

| *Enrollment* | *Disenrollment* |
|---|---|
| C. Of the total reported in A, the number of enrollment requests that were not complete at the time of initial receipt and for which the sponsor was required to request additional information from the applicant (or his/her representative). | C. Of the total reported in A, the number of disenrollment requests that were not complete at the time of initial receipt. |
| D. Of the total reported in A, the number of enrollment requests denied due to the sponsor's determination that the applicant was not eligible for an election period. | D. Of the total reported in A, the number of disenrollment requests denied due to the sponsor's determination that the enrollee was not eligible for an election period. |
| E. Of the total reported in C, the number of enrollment requests received that are incomplete upon initial receipt and completed within established timeframes. | E. Of the total reported in C, the number of disenrollment requests received that are incomplete upon initial receipt and completed within established timeframes. |
| F. Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized legal representative not providing the information required to complete the enrollment request within established timeframes. | F. Of the total reported in C, the number of disenrollment requests denied due to the enrollee or his/her authorized legal representative not providing information required to complete the disenrollment request within established timeframes. |
| G. Of the total reported in A, the number of paper enrollment requests received. | G. The total number of involuntary disenrollments for failure to pay plan premium i the specified time period. |
| H. Of the total reported in A, the number of telephonic enrollment requests received (if sponsor offers this mechanism). | H. Of the total reported in G, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause. |
| I. Of the total reported in A, the number of electronic enrollment requests received via an electronic device or secure internet website (if sponsor offers this mechanism). | I. Of the total reported in H, the number of favorable Good Cause determinations. |
| J. Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received. | J. Of the total reported in I, the number of individuals reinstated. |

| *Enrollment* | *Disenrollment* |
|---|---|
| K. Of the total reported in A, the number of enrollment requests received from an applicant through an agent or broker. | |

**Molina reports these data to CMS at the required timeframes.**

### Medication Therapy Management Programs

***Background:*** The requirements stipulating that Part D sponsors provide Medication Therapy Management programs are described in Title I, Part 423, Subpart D, § 423.153. For monitoring purposes, Part D sponsors will be responsible for reporting several data elements related to their Medication Therapy Management program.

**Molina reports the information, including but not limited to CMS at the required timeframe.**

| | |
|---|---|
| Beneficiary identified as cognitively impaired at time of comprehensive medication review | Number of medication therapy problem recommendations made to prescriber. |
| Beneficiary in a long-term care facility at the date of the first comprehensive medication review | Number of medication therapy problem resolutions resulting from recommendations made to beneficiary's prescriber. |
| Targeting criteria met – multiple chronic diseases/multiple Part D drugs/cost threshold/drug management program at-risk beneficiary, both, none. | Number of communications sent to beneficiary regarding safe disposal of medications. |
| The reason participant opted out of the MTM program. | Method of delivery for information regarding safe disposal of medications. |
| Offered annual CMR. | |
| Received annual CMR with written summary in CMS format. | |
| Method of delivery of CMR – in-person, synchronous telehealth, telephone) | |
| Qualified provider who performed initial CMR. | |

### *Grievances*

***Background:*** According to the Medicare Modernization Act, all Medicare Advantage organizations must have meaningful procedures for hearing and resolving grievances between enrollees and the organization, including an entity or individual through which the organization provides benefits. A grievance is any complaint or dispute, other than an organization determination or appeal, about any aspect of the operations, activities, or behavior of an MA organization, regardless of any remedial action requested.

### *Molina Reporting*

Molina provides grievance reports to CMS by specific timelines during the year for the following measures:

- Number of Total Grievances

- Number of Total Grievances in which timely notification was given.
- Number of Expedited Grievances
- Number of Expedited Grievances in which timely notifications were given.
- Number of Dismissed Grievances

### Improving Drug Utilization Review Controls

**Molina will report cumulative Year to Date data by quarter to CMS on the beneficiaries who triggered each of the following opioid safety edits.**

- An opioid care coordination safety edit at 90 morphine milligram equivalent dose per day.
- An optional hard formulary-level, cumulative, opioid daily MME safety edit at 200 MME or more
- A hard opioid naïve days' supply safety edit for initial opioid prescription fills that exceed 7 days for the treatment of acute pain.

### *Coverage Determinations, Redeterminations (including at-risk redeterminations under a Drug Management Program), and Reopenings*

***Background:*** Part D organization determinations, reconsiderations, and reopening procedures are included in federal regulations and guidance cited from 42 CFR Part 423, Subpart M, and the Parts D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance. CMS defines organization determinations and reconsiderations for this reporting process.

<table>
<tr><td colspan="3">Molina provides organization determination and reconsideration reports to CMS by specific timelines during the year for the following measures.</td></tr>
<tr><td colspan="3">Coverage Determinations (including exceptions)</td></tr>
<tr><td>A. Total Number of Coverage Determinations Processed (including exceptions)</td><td>B. Total Number of Withdrawn Coverage Determinations</td><td>C. Total Number of Dismissed Coverage Determinations</td></tr>
<tr><td colspan="3">Disposition – Coverage Determinations (non-exceptions)</td></tr>
<tr><td>D. The total number of fully favorable decisions.</td><td>E. The total number of partially favorable decisions.</td><td>F. The total number of adverse decisions.</td></tr>
<tr><td colspan="3">Disposition – Utilization Management Exceptions</td></tr>
<tr><td>G. The number of utilization management exceptions.</td><td>H. The number of fully favorable decisions.</td><td>I. The number of partially favorable decisions.</td></tr>
<tr><td colspan="3">J. The number of adverse decisions</td></tr>
<tr><td colspan="3">Disposition – Formulary Exceptions</td></tr>
<tr><td>K. The number of formulary exceptions.</td><td>L. The number of fully favorable decisions.</td><td>M. The number of partially favorable decisions.</td></tr>
<tr><td colspan="3">N. The number of adverse decisions.</td></tr>
<tr><td colspan="3">Disposition – Tiering Exceptions</td></tr>
<tr><td>O. The number of tiering exceptions.</td><td>P. The number of fully favorable decisions.</td><td>Q. The number of partially favorable decisions.</td></tr>
<tr><td colspan="3">R. The number of adverse decisions.</td></tr>
</table>

| 2. Redeterminations (including exceptions and at-risk redeterminations) | | |
|---|---|---|
| A. Total Number of Redetermination<br><br>Processed (including exceptions and at risk) | B. Total Number of Withdrawn | C. Total Number of Dismissed |
| **Disposition – Redeterminations (non-exceptions)** | | |
| D. The number of fully favorable decisions. | E. The number of partially favorable decisions. | F. The number of adverse decisions. |
| **Disposition – Utilization Management Exception Redeterminations** | | |
| G. The number of utilization management exceptions. | H. The number of fully favorable decisions. | I. The number of partially favorable decisions. |
| J. The number of adverse decisions. | | |
| **Disposition – Formulary Exception Redeterminations** | | |
| K. The number of formulary exceptions. | L. The number of fully favorable decisions. | M. The number of partially favorable decisions. |
| N. The number of adverse decisions. | | |
| **Disposition – Tiering Exception Redeterminations** | | |
| O. The number of tiering exceptions. | P. The number of fully favorable decisions. | Q. The number of partially favorable decisions. |
| R. The number of adverse decisions. | | |
| **Disposition – At-Risk Redeterminations** | | |
| S. The number of at-risk redeterminations | T. The number of fully favorable decisions. | U. The number of partially favorable decisions. |
| V. The number of adverse decisions. | | |
| **3. Reopenings** | | |
| A. The total number of reopened (revised) decisions, for any reason, in the time period. | | |

### *Medicare Prescription Payment Plan*

The “Medicare Prescription Payment Plan” was established by section 11202 of the Inflation Reduction Act (IRA) of 2022 (P.L. 117-169). Section 1860D-2(b)(2)(E) of the Social Security Act, as added by section 11202 of the IRA, requires all Medicare Part D sponsors to offer their Part D enrollees the option to pay their out-of-pocket (OOP) Part D drug costs through monthly payments over the course of the plan year instead of as upfront payments at the pharmacy point of sale (POS), beginning January 1, 2025.

**Molina** reports to CMS the numbers of individuals who are likely to benefit from the Medicare Prescription Payment Plan and those who submitted an election request to participate.

### *Looking Forward*

***Background:*** CMS is finalizing changes to the Medicare quality program and Medicare Star Ratings in the future. (42 CFE Parts 417, 422, 423, 423, 455, and 460) Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly.

As stated in the final rule for the 2025 contract year, CMS continues to "identify enhancements to the Star Ratings program to ensure it is aligned with the CMS Quality Strategy. CMS continues to state that the Agency is considering including the Universal Foundation of quality measures, which is aligning a core set of measures across CMS programs and across all quality and value-based care programs. Molina continues to collaborate with CMS and health plan stakeholders to work on these issues for improvement.

| ***Medicare Star Rating Changes Discussed in Contract Year 2025 Final Rule and/or the 2026 Advance Notice*** |
|---|
| Continue to implement the Transitions of Care measure in Part C Star Ratings that started in 2024. |
| Continue to implement the Colorectal Cancer Screening measure starting at 50 years of age for 2026 Star Ratings through the 2024 measurement year and. Starting with 2027 Star Ratings and the 2025 measurement year, CMS will include the Colorectal Cancer Screening measure starting at 40 years of age. |
| Move the Care for Older Adults – Functional Status Assessment measure back to 2026 Star Ratings for the 2024 measurement year. This measure being reported includes the updated specification that a functional status assessment must include a notation that Activities of Daily Living were assessed, a notation that Independent Activities of Daily Living were assessed or results of assessment using a standardized functional assessment tool. |
| Add three Part D measures into the 2026 Star Ratings for the 2024 Measurement Year. The three performance measures that will be included in 2026 Star Ratings are: Concurrent Use of Opioids and Benzodiazepines, Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults, and Polypharmacy Use of Multiple Central Nervous System – Active Medication in Older Adults. |
| Add geography (like rural and urban) to the Health Equity Index reward. |
| Retire the following measures potentially from 2026 Star Ratings. These proposed retired measures are: Medication Therapy Management Program Completion Rate for Comprehensive Medication Review, Special Needs Plan Case Management, Care for Older Adults – Pain Assessment (Part C), and Care for Older Adults – Pain Assessment (Part C), |

Care for Older Adults – Medication Review and Care for Older Adults – Functional Status Assessment, Medicare Plan Finder Price Accuracy (Part D), Complaints about the Health and Drug Plan (Part C and D), and Call Center – Foreign Language Interpreter and TTY Availability.

CMS continues to focus on advancing health equity across programs and pursuing a comprehensive approach to advancing health equity for all, including individuals who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. CMS is finalizing regulations to consider specific issues aligned to their needs including those individuals with Limited English Proficiency or reading skills; those individuals of ethnic, cultural, racial or religious minorities; individuals with disabilities; those individuals who identify as lesbian, gay, bisexual or other diverse sexual orientation; those individuals who identify as transgender, non-binary and other diverse gender identifier or people who were born intersect; those individuals who live in rural area and other areas with high levels of deprivation; and those individuals who otherwise are adversely affected by persistent poverty or inequality.

CMS continues to focus on:

- codifying best practice by requiring plans to include providers' cultural and linguistic capability including American Sign Language in provider directories.
- requiring plans to develop and maintain procedures to identify and other digital health education to enrollees with low digital health literacy to assist with accessing medically necessary covered telehealth benefits.
- requiring plans to incorporate one or more activities into their overall quality improvement program that reduces disparities in health and health care among enrollees.
- giving options for plans to conduct quality improvement activities related to improving communication, developing, and using linguistically and culturally appropriate material, hiring bilingual staff, conducting community outreach, or similar activities.
- providing material to enrollees on a standing basis in any non-English language that is the primary language of at least 5 percent of individuals in a plan benefit package service or is in an accessible format upon receiving a request for the material or other leading of the enrollee's primary language and/or need for an accessible format.

Molina will implement key changes impacting quality and related areas as part of the 2025 Medicare Final Rule, including but not limited to:

- including a health equity perspective through participation in the UM Committee and evaluation of policies and procedures.
- conducting an annual health equity analysis of prior authorization requests for members with one or more of the following social risk factors: 1) receipt of the low-income subsidy for

Medicare Part D or being dually eligible for Medicare and Medicaid; or having a disability as reflected in CMS's records regarding the basis for Medicare Part A entitlement.
- revising Medication Therapy Management Program criteria to: 1) add HIV/AIDS to the list of core chronic diseases, with plans adding all ten core chronic diseases to the Medication Therapy Management Program targeting criteria; and 2) include all Part D maintenance drugs in their program as applicable.

Molina monitors and acts on key areas in Medicare Star Ratings based on the changes made by CMS through focused quality improvement interventions. Molina also continues to implement activities to reduce disparities in health care for Medicare members in alignment with CMS's focus on health equity.

### *Aligning with the CMS Quality Goals*

The Centers for Medicare & Medicaid Services (CMS) has launched the CMS National Quality Strategy with the mission to achieve optimal health and well-being for all individuals in 2022. The CMS National Quality Strategy has four priority areas – Equity and Engagement, Outcomes and Alignment, Safety and Resiliency, and Interoperability and Scientific Advancement.

Molina implements multi-faceted quality improvement activities in alignment with the CMS National Quality Strategy. During 2025, Molina will continue focusing Molina's Quality Improvement Program on critical activities to improve quality for Molina Medicare members and for Molina members in other programs, such as Medicaid and Marketplace, that support CMS's efforts.

**Molina Healthcare Population Health Management Program Strategy: General Overview**

Molina implements a comprehensive and multi-faceted **Population Health Management Program Strategy**. Molina's Population Health Management Program Strategy complements the Quintuple Aim goals from the Institute for Healthcare Improvement. We aim to improve the health of our populations, enhance the experience of care for our members, reduce the cost of health care, facilitate the well-being of our care teams and workforce, and advance health equity. Most importantly, we help our members achieve their person-centered social, medical, and behavioral health goals.

Our **Population Health Management Program Strategy** goals focus on keeping members healthy, managing members at emerging risk, addressing patient safety or outcomes across settings and managing members with multiple chronic conditions. Through this strategy, we conduct activities that focus on the health care and services received by our members in all lines of business across the entire health care continuum.

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

- making sure health plan members receive accessible, appropriate, cost-effective, and high-quality health care and services throughout the care continuum;
- emphasizing the delivery of personalized care so that provider or practitioners can maintain their pivotal role of managing the unique needs of our members;
- creating and implementing processes and programs that respond to the culturally and linguistically diverse needs of our members;
- identifying and focusing on removing barriers to care, such as Social Determinants of Health (also referred to as non-medical drivers of health), ensuring health equity, and addressing disparities and making appropriate referrals to community-based organizations for our members; and
- facilitating whole person care through physical health and behavioral health integration.

In our **Population Health Management Program Strategy,** we highlight comprehensive activities that focus on services for our members and collaboration with our providers. We detail how Molina:

- implements key programs focused on keeping members healthy, managing members with emerging risk, addressing patient safety or outcomes across settings, and managing multiple chronic conditions;
- addresses the improvement and disparity-reduction goals, measures, target populations for all programs;
- informs members and providers about how individuals can find out about, use, and opt in and opt out of interactive Population Health Management programs;
- performs data analytics to support the Population Health Management programs;
- coordinates systems, processes, and information exchange within the Population Health Management programs;
- uses multiple data sources to coordinate the programs, facilitates timely and appropriate exchange of information, and implements systems and processes to coordinate member contacts;
- assesses the needs of our populations for Population Health Management programs and how we will evaluate program effectiveness;
- offers wellness and prevention services, including Health Appraisals and self-management tools; and
- engages our stakeholders in Population Health Management programs.

## Section I: Population Health Management programs and Initiatives

Molina implements multiple member and provider interventions to keep our members healthy. Molina's **Population Health Management Strategy** includes all four topics listed below. Starting on the next page, the tables of programs and initiatives describe individual program goals, target populations, programs, and services; and how members/providers are informed about the programs. Additional programs and initiatives may also be implemented to meet unique needs of our members.

**Keeping members healthy.** Molina implements programs that focus on prevention and health education. Health and wellness activities are based on clinical evidence. These programs focus on key topics and may not be limited to 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 with a member who is in an inpatient setting and is in the middle of the discharge and follow up process. The care team will be engaged with the member for at least 30 days following a member's discharge.

**Managing members with multiple chronic condition**s**.** 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 coordination of care across multiple providers.

*Notes:*

*This is a working document that may be modified during the year.*

*Molina plans participate in programs and initiatives identified within this strategy. There may be instances where specific Molina plans will not report certain measures or participate in a program. All potential populations included in the program are identified only as applicable to address situations where specific populations (e.g., Marketplace, Medicaid, CHIP, Medicare, Special Needs Plan) are not included in health plan population health management programs and initiatives.*

*Definitions:*

*CAHPS® = Consumer Assessment of Healthcare Providers and Systems survey*

*CLAS = Culturally and Linguistically Appropriate Services*

*HEDIS® = Healthcare Effectiveness Data and Information Set*

*Health-related social needs = (Could be referred to as non-medical drivers of health or social determinants of health)*

| Population Health Management Program and Initiative Number 1 | |
|---|---|
| **Program Title: Flu Shot Education** | |
| **Activity Focus: Keeping Members Healthy and 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 supporting members to receive annual influenza vaccinations. |
| **Program Goal: Improvement** | Increase flu shot rates by achieving a two-percentage-point increase from the current measurement year's reported rate, as measured by the HEDIS rate or CAHPS survey results. The most recent reported rate will be based on the latest calendar year obtained through HEDIS or the CAHPS survey results. If the HEDIS or CAHPS rates reach the 90th percentile, the program goals will be to sustain the 90th percentile. |
| **Program Goal: Reducing Disparities** | Flu shot rates will be evaluated by race, ethnicity, gender, geography, language, and age. Based on the flu shot measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified. The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rate as compared to the year before for the populations identified with disparities and to reduce the gap between the rate of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rate will be compared to the percentile benchmark to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, Marketplace, Medicaid and Medicare members who are eligible to receive annual flu vaccinations. Specifically, the population includes individuals who are eligible and recommended to receive flu shots.<br><br>Note – As applicable, the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan Program members, as applicable. |
| **Measure** | Childhood Immunization Status HEDIS rate: The percentage of children 2 years of age who had at least two influenza vaccinations with different dates of service on or before the child's second birthday.<br><br>Annual Flu Vaccine CAHPS rate. The percent of adult members who received an annual flu vaccination between July 1 of the measurement year and the state when the CAHPS survey was completed. Survey question: Have you received a flu shot since July 1 of the prior year? |
| **Programs or Services Offered** | Molina's Flu Shot Educational Campaign is actively conducted to encourage eligible members to receive annual flu shots, to prevent health issues from developing. Members and providers receive proactive outreach reminders, informative educational articles about the benefits of the flu shot for members, reminders integrated into provider newsletters, and automated messages. |

| Population Health Management Program and Initiative Number 2 | |
|---|---|
| **Program Title: Annual Health Exam Reminders and Education** | |
| **Activity Focus: Keeping Members Healthy and 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. Through annual health exam reminders and education, we actively encourage health plan members to prioritize and schedule their annual health exams, promoting proactive health management. |
| **Program Goal: Improvement** | Increase flu shot rates by achieving a two-percentage-point increase from the current measurement year's reported rate, as measured by the HEDIS rate. The most recent reported rate will be based on the latest calendar year obtained through HEDIS. If the HEDIS rate reaches the 90$^{th}$ percentile, the program goals will be to sustain the 90$^{th}$ percentile. |
| **Program Goal: Reducing Disparities** | Adults' Access to Preventive/Ambulatory Health Services HEDIS rates will be evaluated by race, ethnicity, gender, geography, language, and age. Based on the flu shot measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified. The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rate as compared to the year before for the populations identified with disparities and to reduce the gap between the rate of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rate will be compared to the percentile benchmark to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, all Marketplace, Medicaid, and Medicare members aged 20 years and older.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measure** | The percentage of Marketplace, Medicaid and Medicare members, 20 years and older who had an ambulatory or preventive care visit during the measurement year. |
| **Programs or Services Offered** | Molina members are informed about the importance of getting annual exams through multiple channels, including the website, member outreach calls, and written notifications. Providers are actively encouraged to schedule patients for annual health exams through provider engagement visits, incentives, and written materials. |

| Population Health Management Program and Initiative Number 3 | |
|---|---|
| **Program Title: Diabetes Management** | |
| **Activity Focus: Managing Members with Emerging Risks** | |
| **Program Description** | According to national Diabetes Statistics report from the Centers for Disease Management and Control, more than 38 million people in the U.S. have diabetes. Over 98 million adults in the U.S. also have prediabetes. This program focuses on helping Molina members with diabetes effectively manage their health and proactively prevent condition-specific complications. |
| **Program Goal: Improvement** | Increase the diabetes HEDIS rates for Eye Exams and Hemoglobin A1C Control <8% by achieving a two-percentage-point increase from the current measurement year's reported rate, as measured by the HEDIS rates. The most recent reported rate will be based on the latest calendar year obtained through HEDIS. If the HEDIS rate reaches the 90$^{th}$ percentile, the program goal will be to sustain the 90$^{th}$ percentile. NOTE – the A1C control measure is now called Glycemic Status Assessment for People with Diabetes. |
| **Program Goal: Reducing Disparities** | Diabetes Eye Exam and Hemoglobin A1C Control <8% HEDIS rates will be evaluated by race, ethnicity, gender, geography, language, and age. Based on the diabetes eye exam and Hemoglobin A1C <8% measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to the percentile benchmarks to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, all Marketplace, Medicaid and Medicare members aged 20 years and older.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measure** | The percentage of Marketplace, Medicaid and Medicare members, 20 years and older who had an ambulatory or preventive care visit during the measurement year. |
| **Programs or Services Offered** | Molina members are informed about the importance of getting annual exams through multiple channels, including the website, member outreach calls, and written notifications. Providers are actively encouraged to schedule patients for annual health exams through provider engagement visits, incentives, and written materials. |

| Population Health Management Program and Initiative Number 4 | |
|---|---|
| **Program Title: Medical Assistance with Smoking and Tobacco Cessation** | |
| **Activity Focus: Keeping Members Healthy and Managing Members with Emerging Risks** | |
| **Program Description** | Tobacco use is the leading cause for preventable disease, disability, and death in the U.S. According to the Centers for Disease Control and Prevention, nearly 40 million adults in the U.S. still smoke cigarettes and nearly 5 million middle school and high school students use at least one tobacco product, including e-cigarettes. Every day, about 1,600 U.S. youth less than 18 years of age smoke their first cigarette.<br><br>This program focuses on providing Molina members with tobacco cessation and counseling education. |
| **Program Goal: Improvement** | Achieve a two-percentage-point increase in the current CAHPS reported rate as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in CAHPS. |
| **Program Goal: Reducing Disparities** | Advising Smokers to Quit and Using Tobacco and Discussing Cessation Medications CAHPS rates will be evaluated by race, ethnicity, gender, geography, language, and age (as available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to the percentile benchmarks to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, Marketplace, Medicaid and Medicare members aged 18 years and older. Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measure** | **Advising Smokers and Tobacco Users to Quit:** A rolling average represents the percentage of patients 18 years and older who are current smokers or tobacco users and who received advice to quit during the measurement year.<br>**Discussing Cessation Medications:** A rolling average represents the percentage of patients 18 years and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.<br>**Discussion Cessation Strategies:** A rolling average represents the percentage of patients 18 years and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year. |
| **Programs or Services Offered** | Molina members are informed about tobacco cessation counseling programs through member materials, and/or member incentives (as applicable) and/or provider incentives (as applicable). Providers are actively encouraged to counsel members about tobacco cessation, ensuring a comprehensive approach to support members in their journey towards quitting tobacco use. |

| Population Health Management Program and Initiative Number 5 | |
|---|---|
| **Program Title: Well-Child Visits in the First 30 Months of Life** | |
| **Activity Focus: 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 Academy of Family Physicians). This program focuses on providing Molina members with well-child visit education to encourage children to receive well-child visits. |
| **Program Goal: Improvement** | Achieve a two-percentage-point increase in the current Well-Child Visits in the First 30 Months of Life HEDIS rate as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS. If the HEDIS rate reaches the 90$^{th}$ national percentile, the program aims to sustain the 90$^{th}$ percentile. |
| **Program Goal: Reducing Disparities** | Well-Child Visits in the First 30 Months of Life HEDIS rates will be evaluated by race, ethnicity, gender, geography, language, and age (as available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to the percentile benchmarks to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, Marketplace and Medicaid children who are 30 months or younger.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. |
| **Measure** | Well-Child Visits in the First 15 Months. The percentage of members who turned 15 months old during the measurement year: six or more well-child visits.<br><br>Well-Child Visits for ages 15 to 30 Months of Life. The percentage of members who turned 15 and 30 months of age during the measurement year: two or more well-child visits. |
| **Programs or Services Offered** | Molina members are informed about well-child visits through member-facing written materials, information on the Website, member incentives (as applicable), and/or member outreach campaigns. Providers are informed about well-child visits through provider materials, provider engagement, and/or provider incentives (as applicable). This comprehensive approach ensures that members and providers are well-informed and motivated to prioritize and participate in well-child visits, fostering a collaborative approach to support the holistic health and development of children. |

| Population Health Management Program and Initiative Number 6 | |
|---|---|
| **Program Title: Child and Adolescent Well Care Visits** | |
| **Activity Focus: 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 Academy of Family Physicians).<br><br>This program focuses on providing Molina members with well child and adolescent well care visit education to encourage children and teens to receive well-child visits. |
| **Program Goal: Improvement** | Increase current Child and Adolescent Well Care Visits HEDIS rate by two-percentage points as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS. If the HEDIS rate reaches the 90$^{th}$ national percentile, the program aims to sustain the 90$^{th}$ percentile. |
| **Program Goal: Reducing Disparities** | Child and Adolescent Well Care HEDIS rate will be evaluated by race, ethnicity, gender, geography, language, and age (as available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to the percentile benchmarks to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, Marketplace and Medicaid members who are 3 to 11 years of age.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations as applicable. |
| **Measure** | Child and Adolescent Well Care. The percentage of members 3 to 11 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. |
| **In Programs or Services Offered** | Molina members are informed about child and adolescent well care through member written materials, information on the website, member incentives (as applicable), outreach campaigns. Providers are informed about child and adolescent visits through provider materials, provider engagement, and/or provider incentives (as applicable). This comprehensive approach ensures that members and providers are well-informed and motivated to prioritize and participate in well-child visits, fostering a collaborative approach to support the holistic health and development of children and teens. |

| Population Health Management Program and Initiative Number 7 | |
|---|---|
| **Program Title: Obesity Management for Children** | |
| **Activity Focus: Keeping Members Healthy and Managing Members with Emerging Risk** | |
| **Program Description** | Childhood obesity is a serious health problem in the United States. One in five children and teens is affected. Some groups of children and are more affected than others, but all are at risk of gaining weight that is higher than what is considered healthy.<br><br>Obesity is complex. Many factors can contribute to excess weight gain including behavior, genetics, and taking certain medications. Social 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).<br><br>This program focuses on providing Molina members with education to encourage children and teens to maintain appropriate body mass index, nutrition, and physical activity. |
| **Program Goal: Improvement** | Increase current Weight Assessment and Counseling for Nutrition and Physical Activity HEDIS rates by two-percentage points as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS. If the HEDIS rate reaches the 90$^{th}$ national percentile, the program aims to sustain the 90$^{th}$ percentile. |
| **Program Goal: Reducing Disparities** | The Weight Assessment and Counseling for Nutrition and Physical Activity HEDIS rates will be evaluated by race, ethnicity, gender, geography, language, and age (as available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to the percentile benchmarks to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, Marketplace and Medicaid members between the 3 and 17 years of age who had an outpatient visit with a PCP or OB/GYN practitioner.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. |

| Population Health Management Program and Initiative Number 7 Continued | |
|---|---|
| **Program Title: Obesity Management for Children** | |
| **Activity Focus: Keeping Members Healthy and Managing Members with Emerging Risk** | |
| **Measure** | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents HEDIS rate: The percentage of members 3 to 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:<br><br>BMI percentile documentation. Because BMI norms vary by age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.<br><br>Counseling for nutrition documentation or referral for nutrition education.<br><br>Counseling for physical activity documentation or referral for physical activity. |
| **Programs or Services Offered** | Molina members are informed about weight assessment and counseling through member written materials, information on the website, member incentives (as applicable), outreach campaigns. Providers are informed about weight assessment and counseling through provider materials, provider engagement, and/or provider incentives (as applicable). This comprehensive approach ensures that members and providers are well-informed and motivated to prioritize and participate in appropriate weight management and cone, fostering a collaborative approach to support the holistic health and development of children and teens. |

| Population Health Management Program and Initiative Number 8 | |
|---|---|
| **Program Title: Prenatal and Postpartum Care** | |
| **Activity Focus: Keeping Members Healthy and 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 Goal: Improvement** | Increase current Timeliness of Prenatal Care HEDIS rates by two-percentage points as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS.<br><br>Increase current Postpartum Care HEDIS rates by two-percentage points as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS.<br><br>If the HEDIS rate reaches the 90th national percentile, the program aims to sustain the 90th percentile. |
| **Program Goal: Reducing Disparities** | The Timeliness of Prenatal Care and Postpartum Care HEDIS rates will be evaluated by race, ethnicity, gender, geography, language, and age. Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified. The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of populations with lower rates as compared to the populations with higher rates. Additionally, the current year's rates will be compared to the percentile benchmarks to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, Marketplace and Medicaid members who were eligible for the Prenatal and Postpartum Care HEDIS rates. Specifically, 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.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations as applicable. |

| Population Health Management Program and Initiative Number 8 (Continued) | |
|---|---|
| **Program Title: Prenatal and Postpartum Care** | |
| **Activity Focus: Keeping Members Healthy and Managing Members with Emerging Risk** | |
| **Measure** | **Timeliness of Prenatal Care:** 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 prenatal care visit in the first trimester with an OB/GYN practitioner or other prenatal care practitioner, or PCP.<br>**Postpartum Care:** 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 the criteria: A postpartum visit, cervical cytology, or a bundled service where the organization can identify the date when postpartum care was rendered. |
| **Programs or Services Offered** | Molina members are informed through member written materials, information on the website, member incentives (as applicable), and outreach campaigns, as appropriate. Providers are informed through provider materials, provider engagement, and/or provider incentives (as applicable). Approach ensures that members and providers are motivated to prioritize appropriate prenatal and postpartum care, fostering a collaborative approach. |

| Population Health Management Program and Initiative Number 9 | |
|---|---|
| **Program Title: Women's Health** | |
| **Activity Focus: Keeping Members Healthy and Managing Members with Emerging Risk** | |
| **Program Description** | Screening for breast and cervical cancer may help women detect problems early and receive treatment. (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: Improvement** | Increase current Breast Cancer Screening and Cervical Cancer Screening HEDIS rates by two-percentage points as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS. If the HEDIS rates reach the 90$^{th}$ national percentile, the program aims to sustain the 90$^{th}$ percentile. |
| **Program Goal: Reducing Disparities** | The Breast Cancer Screening and Cervical Cancer Screening HEDIS rates will be evaluated by race, ethnicity, gender, geography, language, and age. Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rates as compared to the populations with higher rates. Additionally, the current year's rates will be compared to the percentile benchmarks to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | **Breast Cancer Screening measure:** As applicable, all Marketplace, Medicaid and Medicare members who were eligible for the Breast Cancer Screening HEDIS measure. Specifically, it focuses on the percentage of women between 50 and 74 years of age who had at least one mammogram in the past two years.<br>**Cervical Cancer Screening measure:** As applicable, all Marketplace and Medicaid members between the ages of 21 and 64 and between 30 to 64 years of age who were eligible for the Cervical Cancer Screening measure.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measures** | **Breast Cancer Screening:** The percentage of women between 50-74 years of age who had at least one mammogram in the past two years.<br>**Cervical Cancer Screening:** The 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. |
| **Programs or Services Offered** | 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 (as applicable), HEDIS tip sheets, and engagement initiatives. |

| Population Health Management Program and Initiative Number 10 | |
|---|---|
| **Program Title: Asthma Management** | |
| **Activity Focus: Keeping Members Healthy and Managing Members with Emerging Risk** | |
| **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: Improvement** | Increase current Asthma Medication Ratio HEDIS rate by two-percentage points as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS.<br><br>If the HEDIS rate reaches the 90$^{th}$ national percentile, the program aims to sustain the 90$^{th}$ percentile. |
| **Program Goal: Reducing Disparities** | The Asthma Medication Ratio HEDIS rate will be evaluated by race, ethnicity, gender, geography, language, and age. Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to the percentile benchmarks to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, all Marketplace and Medicaid members 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.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. |
| **Measure** | Asthma Medication Ratio: The percentage of members between 5 and 64 years of age 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. |
| **Programs or Services Offered** | 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, engagement visits, and/or incentives (as applicable). |

| Population Health Management Program and Initiative Number 11 | |
|---|---|
| **Program Title: Controlling High Blood Pressure and Statin Therapy for Heart Disease** | |
| **Activity Focus: Keeping Members Healthy and Managing Members with Emerging Risk** | |
| **Program Description** | High blood pressure increases the risk for heart disease and stroke, two leading causes of deaths in the U.S. In 2021, hypertension was a primary or contributing cause of nearly 692,000 deaths in the U.S. About half of adults in the U.S. with uncontrolled hypertension have a blood pressure of 140/90 or higher. (Centers for Disease Control and Prevention). Additionally, according to the World Health Organization, nearly 18 million global deaths occurred from heart disease in 2019. 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. |
| **Program Goal: Improvement** | Increase current Controlling High Blood Pressure and Statin Therapy for People with Heart Disease HEDIS rates by two-percentage points as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS.<br><br>If the HEDIS rate reaches the 90$^{th}$ national percentile, the program aims to sustain the 90$^{th}$ percentile. |
| **Program Goal: Reducing Disparities** | The Controlling High Blood Pressure and Statin Therapy for People with Heart Disease HEDIS rates will be evaluated by race, ethnicity, gender, geography, language, and age. Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to the percentile benchmarks to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | **Controlling High Blood Pressure:** As applicable, all Marketplace, Medicaid and Medicare members identified as eligible for the Controlling High Blood Pressure HEDIS measure: percentage of members who were 18 to 85 years of age who had a diagnosis of hypertension.<br><br>**Statin Therapy for People with Cardiovascular Disease:** As applicable, all Marketplace, Medicaid, and Medicare members: males 21-75 years of age and females 40-75 years of age during the measurement year identified as having clinical atherosclerotic cardiovascular disease.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |

| Population Health Management Program and Initiative Number 11 (Continued) | |
|---|---|
| **Program Title: Controlling High Blood Pressure and Statin Therapy for Heart Disease** | |
| **Activity Focus: Keeping Members Healthy and Managing Members with Emerging Risk** | |
| **Measure** | **Controlling High Blood Pressure:** The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was controlled (<140/90) mm Hg and a representative diastolic blood pressure of <90 mm Hg.<br>**Statin Therapy for People with Cardiovascular Disease:** The percentage of males 21-75 years of age and females 40-75 years of age during measurement year, identified as having clinical atherosclerotic cardiovascular disease and met the following criteria. Two rates are reported:<br><br>**1. Received Statin Therapy.** Patients were dispensed at least one high or moderate-intensity statin medication during the measurement year.<br><br>**2. Statin Adherence 80%.** Patients remained on a high or moderate-intensity statin medication for at least 80% of the treatment period. |
| **Programs or Services Offered** | 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, engagement visits, and/or incentives (as applicable). |

| Population Health Management Program and Initiative Number 12 | |
|---|---|
| **Program Title: High Risk OB Case Management Program** | |
| **Activity Focus: Managing Members with Emerging Risk** | |
| **Program Description** | All pregnancies carry risks. The definition of a “high-risk” pregnancy is any pregnancy that carries increased health risks for the pregnant person, fetus or both. People with high-risk pregnancies may need extra care before, during and after delivery. This helps to reduce the possibility of complications. (Cleveland Clinic). 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: Improvement** | Reduce Neonatal Intensive Care Unit rate by achieving a one percent reduction 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 additional metrics that will be used to evaluate the program. As available, benchmarks will be used for comparison. |
| **Program Goal: Reducing Disparities** | The Neonatal Intensive Care Unit rate will be evaluated by race, ethnicity, gender, geography, language, and age (as data is available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program’s goal going forward will be to reduce identified disparities in the admission and readmission rates going forward. In addition, the program’s goal going forward will be to reduce identified disparities in this rate (as available) by achieving an increase in the current year’s reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year’s rates will be compared to identified benchmarks as available to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, all Marketplace and Medicaid and potentially Medicare members identified as eligible for and enrolled in the High-Risk Case Management Program.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |

| Population Health Management Program and Initiative Number 12 (Continued) | |
|---|---|
| **Program Title: High Risk OB Case Management Program** | |
| **Activity Focus: Managing Members with Emerging Risk** | |
| **Measure** | **Neonatal Intensive Care Unit Utilization Rate:** The percentage of members who had live deliveries with Neonatal Intensive Care Unit stays during the measurement period. Additional metrics – low birthweight and infant mortality, will also be used to evaluate this program as available. |
| **Programs or Services Offered** | Molina members are informed about the High-Risk OB Case Management Program through written materials, information on the website, pharmacy engagement, and/or outreach calls as appropriate. Providers are informed through provider materials, engagement visits, and/or incentives. |

| Population Health Management Program and Initiative Number 13 | |
|---|---|
| **Program Title: Level I Case Management: Health Promotion and Disease Prevention** | |
| **Activity Focus: Keeping Members Healthy, Managing Members with Emerging Risk** | |
| **Program Description** | Health Promotion and Disease Prevention Level I Case Management is designed to help members achieve member wellness and autonomy through advocacy, communication, education, identification of support and 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: Improvement** | Reduce admission rates by achieving a one percent reduction 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. As available, benchmarks will be used for comparison. |
| **Program Goal: Reducing Disparities** | The admission rate will be evaluated by race, ethnicity, gender, geography, language, and age (as data is available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in the admission rates going forward. In addition, the program's goal going forward will be to reduce identified disparities in this rate (as available) by achieving an increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to identified benchmarks as available to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, all Marketplace, Medicaid and Medicare members identified as eligible for and enrolled in the Level II Case Management Program.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measure** | **Admission Rates:** The admission rates are for members are for the measurement year being evaluated. |
| **Programs or Services Offered** | Molina members are informed about the Level I Case Management Program through written materials, information on the website, pharmacy engagement, and/or outreach calls from Case Managers and Care Coordinators as appropriate. Providers are informed through provider materials, provider manual and the Website. |

| Population Health Management Program and Initiative Number 14 | |
|---|---|
| **Program Title: Level II Case Management** | |
| **Activity Focus: Managing Members with Emerging Risk** | |
| **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: Improvement** | Reduce admission and readmission rates by achieving a one percent reduction 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. As available, benchmarks will be used for comparison. |
| **Program Goal: Reducing Disparities** | The admission rate will be evaluated by race, ethnicity, gender, geography, language, and age (as data is available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in the admission and readmission rates going forward. In addition, the program's goal going forward will be to reduce identified disparities in this rate (as available) by achieving an increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to identified benchmarks as available to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, all Marketplace, Medicaid and Medicare members identified as eligible for and enrolled in the Level II Case Management Program.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measure** | **Admission and Readmission Rates:** The admission and readmission rates are for members are for the measurement year being evaluated. |
| **Programs or Services Offered** | Molina members are informed about the Level II Case Management Program through written materials, information on the website, pharmacy engagement, and/or outreach calls from Case Managers and Care Coordinators as appropriate. Providers are informed through provider materials, provider manual and the Website. |

| Population Health Management Program and Initiative Number 15 | |
|---|---|
| **Program Title: Level III Case Management** | |
| **Activity Focus: Managing Members with Multiple Chronic Conditions** | |
| **Program Description** | Level III Case Management is designed to help members 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 Goal: Improvement** | Reduce admission and readmission rates by achieving a one percent reduction 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. As available, benchmarks will be used for comparison. |
| **Program Goal: Reducing Disparities** | The admission and readmission rates will be evaluated by race, ethnicity, gender, geography, language, and age (as data is available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in the admission and readmission rates going forward. In addition, the program's goal going forward will be to reduce identified disparities in this rate (as available) by achieving an increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to identified benchmarks as available to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, all Marketplace, Medicaid and Medicare members identified as eligible for and enrolled in the Level III Case Management Program.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measure** | **Admission and Readmission Rates:** The admission and readmission rates are for members are for the measurement year being evaluated. |
| **Programs or Services Offered** | Molina members are informed about the Level III Case Management Program through written materials, information on the website, pharmacy engagement, and/or outreach calls from Case Managers and Care Coordinators as appropriate. Providers are informed through provider materials, provider manual and the Website. |

| Population Health Management Program and Initiative Number 16 | |
|---|---|
| **Program Title: Level IV Case Management: Health Promotion and Disease Prevention** | |
| **Activity Focus: Managing Members with Chronic Conditions** | |
| **Program Description** | This program 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 Goal: Improvement** | Reduce admission and readmission rates by achieving a one percent reduction 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. As available, benchmarks will be used for comparison. |
| **Program Goal: Reducing Disparities** | The admission and readmission rates will be evaluated by race, ethnicity, gender, geography, language, and age (as data is available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in the admission and readmission rates going forward. In addition, the program's goal going forward will be to reduce identified disparities in this rate (as available) by achieving an increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to identified benchmarks as available to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, all Marketplace, Medicaid and Medicare members identified as eligible for and enrolled in the Level IV Case Management Program.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measure** | **Admission and Readmission Rates:** The admission and readmission rates are for members are for the measurement year being evaluated. |
| **Programs or Services Offered** | Molina members are informed about the Level IV Case Management Program through written materials, information on the website, pharmacy engagement, and/or outreach calls from Case Managers and Care Coordinators as appropriate. Providers are informed through provider materials, provider manual and the Website. |

| Population Health Management Program and Initiative Number 17 | |
|---|---|
| **Program Title: Transition of Care** | |
| **Activity Focus: Facilitating Patient Safety and Managing Outcomes across Multiple Settings** | |
| **Program Description** | This 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 Goal: Improvement** | Reduce admission and readmission rates by achieving a one percent reduction 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. As available, benchmarks will be used for comparison. |
| **Program Goal: Reducing Disparities** | The admission and readmission rates will be evaluated by race, ethnicity, gender, geography, language, and age (as data is available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in the admission and readmission rates going forward. In addition, the program's goal going forward will be to reduce identified disparities in this rate (as available) by achieving an increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to identified benchmarks as available to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | As applicable, all Marketplace, Medicaid and Medicare members identified as eligible for and enrolled in the Transition of Care Program.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measure** | **Admission and Readmission Rates:** The admission and readmission rates are for members are for the measurement year being evaluated. |
| **Programs or Services Offered** | Molina members are informed about the Transition of Care Program through written materials, information on the website, pharmacy engagement, and/or outreach calls from Case Managers and Care Coordinators as appropriate. Providers are informed through provider materials, provider manual and the Website. |

| Population Health Management Program and Initiative Number 18 | |
|---|---|
| **Program Title: Behavioral Health Transition of Care and/or Follow-Up after Hospitalization Program** | |
| **Activity Focus: Facilitating Patient Safety and Managing Outcomes Across Multiple Settings** | |
| **Program Description** | This program is designed to improve the likelihood that members will initiate and continue outpatient treatment after admission. Transition of Care coaches and/or Molina clinical staff ensure members have initial outpatient appointments within the first seven days of discharge. Transition of Care coaches and/or Molina clinical staff may 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. |
| **Program Goal: Improvement** | Reduce admission and readmission rates by achieving a one percent reduction 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. As available, benchmarks will be used for comparison. In addition, the Follow-Up after Hospitalization for Mental Illness HEDIS measure will be used to evaluate this program.<br><br>Increase current Follow-Up after Hospitalization for Mental Illness HEDIS rate by two-percentage-points as compared to the prior year. The most recent reported rate would be based on the most recent calendar year as reported in HEDIS.<br><br>If the HEDIS rate reaches the 90$^{th}$ national percentile, the program aims to sustain the 90$^{th}$ percentile. |
| **Program Goal: Reducing Disparities** | The admission and readmission rates and the Follow-Up after Hospitalization for Mental Illness HEDIS rate will be evaluated by race, ethnicity, gender, geography, language, and age (as data is available). Based on the measure review, interventions will be implemented as necessary to mitigate identified disparities in rates across populations identified.<br><br>The program's goal going forward will be to reduce identified disparities in the admission and readmission rates going forward. In addition, the Follow-Up after Hospitalization for Mental Illness rate by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to identified benchmarks as available to determine any improvements made in achieving higher level of performance. |

| Population Health Management Program and Initiative Number 18 Continued | |
|---|---|
| **Program Title: Behavioral Health Transition of Care and/or Follow-Up after Hospitalization Program** | |
| **Activity Focus: Facilitating Patient Safety and Managing Outcomes Across Multiple Settings** | |
| **Target Population (s)** | As applicable, all Marketplace, Medicaid and Medicare members identified as eligible for and enrolled in the Transition of Care Program and/or Follow-Up after Hospitalization for Mental Illness program.<br><br>Note – the Medicaid Line of Business may include Medicaid and/or CHIP populations, as applicable. The Medicare Line of Business may include Medicare, Special Needs Plan members, as applicable. |
| **Measure** | **Admission and Readmission Rates:** The admission and readmission rates are for members are for the measurement year being evaluated. |
| **Programs or Services Offered** | Molina members are informed about the Transition of Care Program through written materials, information on the website, pharmacy engagement, and/or outreach calls from Case Managers and Care Coordinators as appropriate. Providers are informed through provider materials, provider manual and the Website. |

| Population Health Management Program and Initiative Number 19 | |
|---|---|
| **Program Title: Provider-Based Population Health Programs** | |
| **Activity Focus: Activities that are not Direct Member Interventions** | |
| **Program Description** | The provider- based population health management programs include but are not limited to distribution of missing services lists to providers (electronically through the portal, confidential email, or in-person) to allow providers to contact members to receive health tests and exams, implementation of provider value-based programs that focus on quality and population health, provider engagement visits and outreach to support providers in quality and population health, and provider written materials, including HEDIS and CAHPS tip sheets. |
| **Program Goal: Improvement** | Generally, program improvement goals focus on increasing HEDIS and clinical metrics (as applicable). Evaluation will be completed to determine whether providers are helping to improve the health of Molina's members. |
| **Program Goal: Reducing Disparities** | The program's goal going forward will be to reduce identified disparities in relevant HEDIS rates going forward. In addition, the program goals going forward will be to increase relevant HEDIS rates by achieving a two-percentage-point increase in the current year's reported rates as compared to the year before for the populations identified with disparities and to reduce the gap between the rates of the populations with lower rate as compared to the populations with higher rates. Additionally, the current year's rates will be compared to identified benchmarks as available to determine any improvements made in achieving higher level of performance. |
| **Target Population (s)** | Providers who are participating in programs to improve quality. |
| **Measure** | **Relevant HEDIS measures.** HEDIS measure improvements will be evaluated by provider as applicable to determine effectiveness of the provider-directed programs. |

## 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 public website which is available to members and prospective members. This *Guide* includes information about key programs, including how members can opt into programs, how members can out opt of programs, and how members can use these services. A mailing is sent to current members at least once a year with information about Guide content and a link to the Website so members can review the Guide. Members also find out about programs through outreach calls made by Case Managers or Care Coordinators. Molina network providers are informed about the Population Health Management programs through multiple sources. These information sources include the provider manual, provider newsletter, and provider engagement team visits.

## Using Data Analytics to Support Population Health Management Programs

Data analytics is the cornerstone to our Population Health Management program. We use data to identify and stratify members for various 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 and 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 intervention. 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 a physical health and behavioral health claims and encounters, pharmacy claims and encounters, laboratory claims and encounters, Health Risk Assessment and member needs assessment results, bidirectional communication through electronic health records as available, clinical programs, such as Heath Management, Case Management, Transitions of Care, 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 the **Population Health Management Program 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 care plan update sharing and 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 enabled through our Provider Portal. Our network practitioners can review HEDIS rates to compare themselves against benchmarks and identify members who are due for key tests and exams. On this provider portal, practitioners can also track their performance against their peers and in line with provider incentives as appropriate.

### Using Systems and Processes to Coordinate Member Contracts

Molina uses systems and processes to minimize the confusion for our members with potentially duplicate contacts. Molina uses an electronic case management system to house Health (e.g., Disease) Management, Level II Case Management, Level III Complex Case Management, Level IV Case Management and transition of care program information and data. All member, provider and external contacts, case notes, clinical review, and care plans are tracked in this electronic case management system. All program staff have access to the system. Program staff review the system prior to member outreach attempts to understand current health status and to review additional contacts that have been made. In addition, program staff collaborate with network providers to offer information about the participation of their patients in local programs. This helps better facilitate program implementation.

In addition, Contact Center representatives use an electronic member contact system that house all call attempts - inbound and inbound from our members to and from Molina. This system allows all Contact Center staff to view previous contacts and questions that the member had to provide needed context for further calls.

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. Reminder calls are tracked in the member contact system and include information about call resolution and needed follow up. The outreach team distributes reports to Molina’s quality team for review and evaluation. The outreach team removes any member who completes missing services from future call attempts and from any lists that go out to providers for follow up.

**Health Equity and Cultural Competency Program 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 with special needs. Molina works proactively to cultivate an environment that fosters acceptance and respect that unique needs of the Molina membership and potential enrollees.

Molina developed a Health Equity and Cultural Competency Program outlining the delivery of culturally competence services. Our goal is to make sure our members receive culturally and linguistically appropriate services across the care continuum. Achieving this goal will help 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 Program describes how individuals and systems within the health plan will effectively provide services to people of all cultures, racial and ethnic backgrounds, religions. genders, different geographic regions, as well as for individuals with disabilities, in a manner that recognizes values, affirms and respects the worth of the individual, 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 analysis of the Health Equity and Cultural Competency Program. This program evaluation includes an overview of completed and ongoing activities that focus on culturally and linguistically appropriate services, assesses the plan's performance on trending of measures, analyzes efforts to reduce disparities and improve the provision of culturally and linguistically appropriate services, including barriers, and evaluates the overall effectiveness of the program. The culturally and linguistically appropriate services analysis is included in Molina's annual quality improvement program evaluation. Molina evaluates its performance on culturally and linguistically appropriate services activities as described in the quality improvement program description and work plan, including a review of delegated functions, as applicable. This evaluation includes a description of completed from the previous year and ongoing activities.

**Program activities include but are not limited to the examples described below.**

| **Examples of Activities that Focus on Culturally and Linguistically Appropriate Services that are Included in the Annual Program Evaluation** |
|---|
| Data collection and analysis of race, ethnicity, language, and geography data from eligible individuals to identify significant culturally and linguistically diverse population with plan's membership. |
| Data collection and analysis of race, ethnicity, language, geography, and gender data from contracted practitioners to assess gaps. |
| Collection of data and reporting of the Race and Language Diversity of Membership HEDIS measures. |
| Identification of specific cultural and linguistic needs found within the plan's diverse populations. |
| Analysis of HEDIS measure results for potential health disparities based on race, ethnicity, gender, and geography that may prevent members from obtaining recommended key chronic condition management and preventive services (includes data stratification of selected HEDIS and CAHPS measures by race, ethnicity, and preferred language). |
| Determination of threshold languages annually to provide members vital information in the identified threshold languages. |
| Enhancement of current patient-focused quality improvement activities. Example includes prenatal and well-child exam incentives and programs that address specific cultural, linguistic, sexual orientation, gender identity and SDOH barriers using culturally, linguistically focused materials that address 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 is 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 within the health plan and at provider offices, as applicable. |
| Development of educational materials to meet 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 monitoring 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. |

| Examples of Activities that Focus on Culturally and Linguistically Appropriate Services that are Included in the Annual Program Evaluation Continued |
|---|
| 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 as the Lesbian, Gay, Bisexual, Queer, Intersex, and Asexual+ population related to service access as available. |
| Evaluation of the 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 as a separate document. This population assessment is part of annual Population Health Management program development cycle which will be repeated and analyzed each year to ensure focus areas meet needs of our health plan, members, and providers. Within the population assessment, the following activities are included but not limited to the examples included in the table below.

| Population Assessment and Annual Evaluation Process Steps |
|---|
| **Step 1:** Evaluate characteristics and needs of our health plan members including review of member demographics, social determinants of health, including member eligibility, member health status including whether members have multiple chronic conditions or severe injuries, member racial and ethnic groups and language preferences, and information about access and utilization. |
| **Step 2:** Identify and assess characteristics and needs of subpopulations using this assessment, specifically for members who are between ages of 2-19 years of age (children and adolescents), members with disabilities and members with serious and persistent mental illnesses, and other populations as applicable to ensure members receive appropriate care as related to care coordination and intensive resource use. |
| **Step 3:** Review population assessment results to review and update activities and resources in place that address member needs. |
| **Step 4:** Evaluate assessment results to review need for community resources to be more integrated into Population Health Management programs. |
| **Step 5:** Monitor and analyze 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 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 members on-line include a health appraisal which allows members to identify health risks, based on self-reported health status and health conditions. We also offer evidence-based self-management tools that allow 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 members on-line include a health appraisal which allows members to identify health risks, based on self-reported health status and health conditions. We also offer evidence-based self-management tools that allow 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 members through the Website using a secure link and members may also ask to have these tools printed out for them. We also use the Molina Mobile app to give members access to personal health information and other resources. Members can also communicate with Case Managers or Contact Center through messaging function. Members also have access to Virtual Urgent Care and educational materials.

## Stakeholder Engagement

Molina engages stakeholders to obtain input and feedback about the Population Health Management programs through various strategies. We engage stakeholders through:

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

## Ensuring High Levels of Member Participation

| **Molina implements multiple strategies to engage members within Population Health Management program.** |
|---|
| For health risk assessments, assessment completion is included in the electronic system. Contact Center representatives then explain the benefits of the Health Risk Assessment and will transfer the member to 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 not limited to enlisting a team of Community Connectors to locate members who are difficult to reach and link members with our care team and community resources. embedding case managers in primary care, specialist practices and at other care sites 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. |

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# 2025 Health Equity and Cultural Competency Program Description

## *Program Description Components and Table of Contents*

## *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, such as transportation, housing, and food insecurity, are 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 or unfavorable, activated involuntarily, and care acted upon without an individual's awareness or intentional control. Implicit bias impacts decision-making across many sectors, including employment, health care and education.[1] Through awareness and education, implicit bias can be addressed and may lead to reducing and eliminating health disparities.

## *Overview of Molina's Health Equity and Cultural Competency Program Description*

Molina is committed to facilitating health care and services for our health plan members that respect diverse perspectives and cultures to maintain health equity. Molina's Health Equity and Cultural Competency Program Description outlines how our health plans facilitate the provision and delivery of effective, equitable, understandable, respectful, and culturally competent health care and services to our health plan members in collaboration with our network practitioners. This document describes how individuals, health care practitioners, and health care systems will provide services and health care effectively to health plan members regardless of the member's race, ethnicity, culture, religion, age, ability, gender identity and sexual orientation, and disability status in a manner that recognizes values, affirms, and respects the worth of the individuals, and protects and preserves their dignity.

Barriers associated with cultural differences, systemic racism, implicit bias, and access to quality resources and opportunities exist. These barriers may prevent health plan members from accessing services in a timely and appropriate manner. Molina recognizes and reasserts the need for our health plans in collaboration with our network providers and other external partners to create focused programs where health equity is embedded into all services, resources, programs, policies, and initiatives. We are also educating health plan staff and network providers about effective ways they can work with our members to offer health care and services to members with diverse backgrounds and special needs.

The Health Equity and Cultural Competency Program Description is reviewed and updated annually with oversight by the National Quality Improvement Health Equity Transformation Committee. The Chief Health Equity Officer, VP of Quality, Diversity, Equity and Inclusion lead, and Director of Health Equity and Cultural Competency maintain responsibility for reviewing and updating this Program Description.

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

### *Molina's Purpose Statement, Goals, and Objectives in Serving a Diverse Population*

Molina's stated overall objectives for serving a culturally and linguistically diverse population are as follows. Molina:

- ensures that our health plan members receive culturally and linguistically appropriate and equitable services no matter where they receive health care and services.
- works with network providers to deliver culturally competent and equitable care to their patients;
- trains all employees in our workforce about cultural competency, implicit bias, and cultural humility.
- makes certain that our employees interact respectfully with individuals in Molina's workforce and interact with health plan members.
- identifies, addresses, and reduces potential health disparities and foster equitable health outcomes through focused quality improvement interventions.

### *How Molina's Health Equity and Cultural Competency Program is Organized to Meet Program Objectives*

Molina's Health Equity and Cultural Competency Program is fully organized to meet the program objectives listed above. As stated throughout this document, Molina's Health Equity and Cultural Competency Program components are comprehensive in scope.

Molina implements the Health Equity and Cultural Competency Program by:

- maintaining an effective governance structure.
- integrating quality improvement with health equity.
- ensuring access to language access, written materials, interpreter services, and clinical services for Molina members.
- using data collection and analysis and continuous quality improvement to evaluate culturally and linguistically appropriate services.
- evaluating the cultural responsiveness of Molina's provider network through analysis.
- using data collection and analysis to identify and meet the unique needs of members.
- evaluating the effectiveness of the Program using continuous quality improvement.
- training providers and staff about cultural competency.
- facilitating cultural competency to staff through diversity, equity, and inclusion resources and activities.
- maintaining oversight of the Program through defined roles and responsibilities.

Through the comprehensive Program scope, Molina ensures that Molina's meets critical Program objectives. Molina's Program is organized effectively to ensure that: Molina health plan members can receive equitable and high quality services and care; Molina providers remain culturally responsive to the needs of their patients and Molina members; Molina workforce is trained on critical competency topics and therefore, interact respectfully with Molina employees and Molina members; and Molina identifies, addresses, and reduces potential health disparities through focused quality improvement interventions.

### *Maintaining an Effective Governance Structure: Implementation of 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 focus on topics that include, but are not limited to:

- Collecting and safely storing race, ethnicity, language, sex assigned at birth, gender identity, sexual orientation, social needs and social risks data to ensure the delivery of culturally competent services and the provision of linguistic access and disability-related access to all enrollees, including persons with Limited English Proficiency.
- 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.

### *Maintaining an Effective Governance Structure: Alignment with National Standards and Regulatory Requirements*

Molina's Health Equity and Cultural Competency Program Description 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 and intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to members of all cultures, racial and 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.

### *Maintaining an Effective Governance Structure: Nondiscrimination in Healthcare Delivery*

Molina complies with the guidance set forth in the final rule for Section 1557 of the Patient Protection and Affordable Care Act, 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.

### *Integrating Quality Improvement with Health Equity– Developing, Tracking, and Monitoring Cultural Competency and Health Equity Efforts*

Molina uses a continuous quality improvement approach to identify, address, and reduce disparities, improve health outcomes, and facilitate the delivery of equitable healthcare for health plan members. Quality improvement initiatives designed to reduce disparities are presented to the Health Equity and Cultural Competency SMEs for development, implementation, and evaluation of disparity reduction. Initiatives are revised and improved to improve effectiveness, address new areas of opportunity, and transform systems. Initiatives may include but are not limited to member, provider, community, and Molina organization-wide interventions. Initiatives are reported to the National Quality Improvement and Health Equity Transformation Committee for review. Feedback from the committee 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.

### *Ensuring Access to Language Services and Critical Written Materials in Alternate Languages*

Molina ensures that health plan members can access language services such as oral interpreting, American Sign Language, 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 written materials to accommodate the special needs of our members. Materials reflect the guidelines set forth in Plain Language (PlainLanguage.gov). Molina writes content at a sixth grade reading level or lower to meet literacy needs. 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 staff produce materials in English and Spanish and translates materials into threshold languages designated by health plans. A quality assurance team monitors translation projects.

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.

### *Ensuring Access to Interpreter Services*

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.

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 providers with information about accessing an available qualified interpreter and identifying language needs through provider mailings, the Provider Manual, and provider training sessions. Molina reminds providers 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.

### *Ensuring Access to Services for 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, 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 to support our members with hearing impairment. Face-to-face interpreter services includes Video Remote Interpretation 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.

### *Ensuring Access to Clinical Services: Nurse Advice Line*

Molina provides nurse advice services twenty-four hours/seven days a week for members. Members may call Molina Healthcare's Nurse Advice Line for assistance in their preferred languages. The Nurse Advice Line staff also use the TTY/TDD 711 line to provide access to members with hearing impairment. The Nurse Advice Line telephone numbers are also printed on membership cards.

### *Using Data Collection and Analysis to Identify and Meet Unique Needs of Members*

Molina understands the significance of demographic shifts and conducts ongoing assessments 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 standards and to meet federal and state regulatory requirements, Molina has a health information system in place to collect, analyze and evaluate its membership and provider network based on race, ethnicity, sex assigned at birth, and languages spoken, geography and disability status. The quality functional area in collaboration with other key leaders is leading an initiative to conduct the same collection and analysis for sexual orientation and gender identity 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 functional area analyzes the member demographics based on race, ethnicity, languages spoken, sex assigned at birth, and geography annually. To assess disparities, Molina uses Healthcare Effectiveness Data and Information Set measures and Consumer Assessment of Healthcare Providers and Systems survey results to identify potential disparities based on race, ethnicity, language, sex assigned at birth, and geography. Analyses are reported to the national and health plan Quality Improvement and Health Equity Transformation Committees to review, approve, and solicit interventions for improvement.

Interventions may 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, sex assigned at birth 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.

### *Using Continuous Quality Improvement to Evaluate Culturally and Linguistically Appropriate Services*

Molina's National Quality Improvement and Health Equity Transformation Committee oversees and assesses the development and implementation of cultural and linguistic accessibility standards and procedures. Molina quality staff assess the cultural, racial, ethnic, sex assigned at birth, 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, language, and geography 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 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.

### *Evaluating the Effectiveness of the Health Equity and Cultural Competency Program*

Molina completes an annual analysis of culturally and linguistically appropriate services to evaluate the effectiveness of the Heath Equity and Cultural Competency Program. The analysis includes an overview of completed and ongoing activities, assessment of the plan's performance on trending of measures, analysis of efforts to reduce disparities and improve the provision of culturally and linguistically appropriate services, including barriers, and evaluation of the overall effectiveness of the program. The analysis is included in Molina's Annual Quality Program Evaluation. Molina annually evaluates its performance on the activities described in the Quality program description and work plan, including all delegated functions, however, health equity is not delegated to external groups. This evaluation includes a description of completed and ongoing activities for the previous year.

### *Evaluating the Effectiveness of the Health Equity and Cultural Competency Program: Using Measurable Goals and Objectives*

Measurable goals and objectives are listed in the combined annual Quality Improvement and Healthcare Services Work Plan that is included as an attachment to the Quality Improvement Program Description. The Quality Improvement Program Description and program evaluation focus on, but are not limited to:

- Collection and analysis of race, ethnicity, language, gender identity, sexual orientation, sex assigned at birth, and social determinants of health data from eligible individuals to identify significant culturally and linguistically diverse populations with plan's membership and revalidate data at least annually.
- Collection and analysis of race, ethnicity, and language data from contracted practitioners to assess gaps in care annually.
- Collection of data and reporting for the Diversity of Membership Healthcare Effectiveness Data and Information Set measure.
- Collection of data and reporting for the Language 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, sex assigned at birth, 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, sex assigned at birth, and SDOH-related, and geography disparities that prevent members from obtaining the recommended key chronic and preventive services (includes data stratification of selected measures by race, ethnicity, 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, sex assigned at birth, 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, sex assigned at birth, and SDOH 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, linguistic, sexual orientation, gender identity, sex assigned at birth, and SDOH analyses for specific intervention;
- Analysis of interpreter availability and translation requests.
- Development of educational materials to meet the cultural, linguistic, sexual orientation, gender identity, sex assigned at birth, 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 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.
- Identification and development of initiatives to address the needs of communities within the health plan's service areas, including but not limited to Black or African American, Indigenous, and People of Color.

- Continued expansion of the continuous quality improvement process to identify existing disparities related to race, ethnicity, language, sex assigned at birth, 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 Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual + population related to service access as available.
- Evaluation of the Health Equity and Cultural Competency Program to include assessment of completion of planned activities, identification of barriers, opportunities, and interventions to overcome barriers, and overall effectiveness.

Molina also receives feedback annually on the Program and evaluation from various stakeholders through the National Quality Improvement and Health Equity Transformation Committee, Board of Directors, and member advisory committees. All feedback is reported through the National Quality Improvement and Health Equity Transformation Committee.

### *Evaluating the Cultural Responsiveness of the Provider Network*

Molina strives to create a network of practitioners that reflects the racial, ethnic, cultural, language preferences of the geographic area. 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
- Sex Assigned at Birth
- 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.

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

### *Offering Cultural Competency Training and Resources to Providers: Provider Training Overview*

Molina works to ensure that our provider network consists of practitioners and facilities 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 training reinforced annually through Provider Services or online training modules.

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

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

### *Training Providers: Advancing Culturally Competent Health Care*

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 is 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.

### *Training Providers: 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.

### *Training Molina Staff about Cultural Competency: Molina Staff Training Overview*

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 of more of the following: written materials; employee communications such as Intranet articles; training and monitoring concurrent with other skills included in the job description of each position; online self-paced trainings; and on-site cultural competency trainings and discussions.

Molina requires all employees take general cultural competency training, 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 National Quality Improvement and Health Equity Transformation Committee and at the local health plan Quality Improvement and Health Equity Transformation Committee. Molina supervisors receive reports on employee compliance with training so that follow-up communication can occur to ensure completion.

## *Training Molina Staff about Cultural Competency: Cultural Competency Training Series*

### Cultural Competency

Molina Healthcare's Cultural Competency web-based training equips employees with information and tools regarding cultural awareness, health equity, and diversity, equity, and inclusion. By building awareness of the differences among cultures, understanding root causes of health inequities, and the importance of diversity, equity, and inclusion the course provides tangible ways to improve cultural competency to achieve health equity. The course provides strategies for employees to improve their interactions with both co-workers and members.

### Training Topics:

**Cultural Competency**: the changing demographics in the U.S., key components and terminology of cultural competency, component of culture, diversity in different types of experiences in healthcare, healthcare expectations, tips on communicating with individuals with different backgrounds, language access services and caring for seniors and persons with disabilities.

### Objectives

- Increase cultural competency with members and employees.
- Identify several effective strategies to enhance cross-cultural communication with members and employees.
- Be able to understand Molina's commitment to Culturally and Linguistically Appropriate Services (CLAS) to increase member and employee satisfaction.
- Gain understanding on culturally competent services and their importance.

**Health Equity**: terminology, social determinants of health, implicit bias, systemic racism, health disparities among different populations (i.e., LGBTQIA+ community), geography, strategies to reduce health disparities and achieve health equity.

### Objectives

- Define health equity and health disparity;
- Name several social determinants of health and understand their impact on health equity;
- Understand the root causes of health inequities; and
- Recognize strategies you can take to promote health equity in your work at Molina.

**Diversity, Equity, and Inclusion**: terminology, principles, connection, and importance of diversity, equity, and inclusion.

### Objectives

- Understand the connection between health equity and diversity, equity, and inclusion;
- Learn the principles of diversity, equity, and inclusion; and
- Understand the importance of diversity, equity, and inclusion at Molina.

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

### *Training Molina Staff about Cultural Competency: Americans with Disabilities Act Staff Training Series*

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; and
- 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; and
- Use preferred terminology and effective communication with people with disabilities.

### *Promoting Molina Staff Resources*: *Diversity, Equity & Inclusion Commitments*

Molina has adopted Diversity Commitments that guide Molina's inclusive workplace for all. Molina's 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 of focus for Talent Acquisition and Talent Management is to increase diverse representation at the director-level and above and create a development path for non- exempt employees to be promoted to exempt roles.

Molina's Diversity, Education and Inclusion team has also launched six Employee Resource Groups. These Employee Resource Groups are employee-led groups that focus on groups of people with shared similar characteristics, lived experience, and goals. The current Employee Resource Groups address internal and external gaps that impact the following groups of people: Black or African Americans, Latinos, Women, Veterans, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual+, and employees with disabilities. Employee Resource Groups are essential so employees can become 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 utilizes 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.

### *Promoting Cultural Competency for Staff: Cultural Awareness Campaigns for Employees*

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, Molina highlights a different aspect of diversity and inclusion on our Intranet related to culture and gender equality topics. These topics include but are 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.

### *Maintaining Oversight of Molina's Health Equity and Cultural Competency Program: Oversight and Roles and Responsibilities of Functional Areas*

Under the guidance of Molina's Chief Health Equity Officer and Director, Health Equity and Cultural Competency, Molina maintains the national oversight mechanism for the Health Equity and Cultural Competency Program and associated initiatives. The Chief Health Equity Officer, reporting to Molina's Chief Medical Officer, guides the strategic direction of Molina's health equity work. The Director, Health Equity and Cultural Competency, reporting to the Vice President, Quality, guides the quality-related activities, continuous quality improvement efforts, and oversees the evaluation of the program. The results of the program, including evaluation and review of ongoing initiatives and programs, are brought forward to the National Quality Improvement and Health Equity Transformation Committee for review, analysis, and recommendations for action. All Molina plans have representation on the National Quality Improvement and Health Equity Transformation Committee, including the Chief Medical Officers, Vice Presidents of Healthcare Services, and Quality Leads for all Molina Plans.

Reports, activity summaries, and program evaluations are then distributed to the quality leads at all Molina plans. The local Quality Improvement and Health Equity Transformation Committee presents the documented activities and analysis to committee participants, including network practitioners and leadership from across the health plan. The local plan also reviews plan-specific data and reports that lead to the identification of improvement opportunities and actions that will be taken. The Quality Lead at the health plan reports to health plan leadership and acts as the link to the national quality and health equity-led activities.

Molina national and local quality teams continue to collaborate on future recommendations for action. These activities are all in alignment with NCQA Health Equity Accreditation and related regulatory requirements.