STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF HEALTH CARE SERVICES
CALIFORNIA'S DUAL ELIGIBLE DEMONSTRATION
REQUEST FOR SOLUTIONS (RFS)

SACRAMENTO COUNTY
COPY

FEBRUARY 24, 2012

MOLINA® HEALTHCARE

Applicant Name: Molina Healthcare of California Partner Plan, Inc. – Sacramento | Date: February 24, 2012

California Dual Eligible Demonstration Request for Solutions Proposal Checklist

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
1	Applicant has a current Knox Keene License or is a COHS and exempt. See Attachment MQR 1 for Molina's Knox Keene License for Sacramento County.	X	
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter) See Attachment MQR 2 for Molina's Good Financial Standing Letter with HMHC.	X	
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.	X	
3b	Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014.	N/A Please refer to 3a.	
4	Applicant has a current Medi-Cal contract with DHCS.	X	
5	Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.	X	
6	Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.	X	
7a	Applicant has listed all sanctions and penalties taken by Medicare or a state of California government entity in the last five years in an attachment. See Attachment MQR 7a Sanctions and Penalties.	X	
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within		Medicare No sanctions

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
	California.		
7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.	X	
8a	Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements. See Attachment MQR 8a Quality Performance Indicators.	X	
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements. See Attachment MQR-8b for MS-SNP Quality Performance Requirements.	X	
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration. See Attachment CAC 9 Letters of Agreement to work in good faith.	X	
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.	X	
11	Applicant will fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, shall develop a plan to encourage its contracted providers to do the same, and provide an operational	X	

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
	approach to accomplish this as part of the Readiness Review.		
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement. See Attachment MQR-12 for criteria for demonstrating local stakeholder involvement.	X	
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	X	
14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.	X	
15	If Applicant is a limited liability company or limited partnership, it is in "active" standing and qualified to conduct business in California. If not applicable, leave blank.		
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.		
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.	X	
18	Applicant is willing to comply with future Demonstration requirements, requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. Applicant will provide operational plans for achieving those	X	

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
	requirements as part of the Readiness Review.		

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	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	7	
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	X	The Plan reported one significant sanction of $250,000 by DMHC on 12/17/2009 related to a non-routine claims payment audit in 2008, which resulted in a corresponding CAP. However, in 2010, the DMHC conducted a follow-up non-routine claims payment audit, which resulted in no sanctions, and the DMHC accepted Molina's final CAP report and closed its file on 12/11/2011.
3	Do the Plan's three – years of HEDIS results indicate a demonstrable trend toward increasing success?	Yes See Attachment CAC 3 HEDIS 3 Year Trend and Attachment	

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
		CAC 3 HEDIS Reports.	
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	Yes	
5	Has the Plan received NCQA certification for its D-SNP Product?	No	
6	How long has the Plan had a Medi-Cal contract?	Two Plan: Riverside / San Bernardino - April 1996 GMC: Sacramento - October 2000 GMC: San Diego - June 2005	
7	Does the plan propose adding supplemental benefits? If so, which ones?	Yes Dental, vision, non-emergency transportation, home delivered meals, respite coverage for caregivers, home visits by providers and tele-monitoring services.	
8	Did the Plan submit letters from County	No	

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
	officials describing their intent to work together in good faith on the Demonstration Project? From which agencies?		
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	Molina has had preliminary discussions with Sacramento County staff about IHSS services.	
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	Yes Molina is working to renew its MOU with Sacramento County for behavioral services.	
11	Does the Plan express intentions to contract with provider groups that have a track record of providing innovative and high value care to dual eligibles? Which groups?	Yes Please note that the Plan's list of potential new groups is confidential at this time and will be shared as part of the Network Readiness Review.	

#	Project Narrative Criteria	Check Box to certify YES	If no, explain
2.2.1	Applicant will develop a contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1, which stipulates the criteria in the RFS.	X	
2.3.1	Applicant will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.	X	
5.1	Applicant will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU. Sites shall prove compliance during the Readiness Review.	X	
5.2.1	During the readiness review process the Applicant will demonstrate compliance with rigorous standards for accessibility established by DHCS.	X	
5.3.3	Applicant will comply with rigorous requirements established by DHCS and provide the following as part of the Readiness Review. ○ A detailed operational plan for beneficiary outreach and communication. ○ An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs. ○ An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.	X	
5.6.1	Applicant will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU.	X	

6.1.1	Applicant will report monthly on the progress made toward implementation of the timeline.	X	
7.7	Applicants' sub-contractual relationships will not weaken the goal of integrated delivery of benefits for enrolled beneficiaries.	X	
7.8	Applicant will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	X	
7.9	Applicant will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.	X	
8.3	Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available.	X	

Table of Contents

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Section: Executive Summary

The Applicant must provide a two-page executive summary of the Demonstration project. This should serve as a succinct description of the proposed project, including the goals of the project, the proposed geographic coverage area, number of projected dual eligibles to be enrolled, and list of strategic partnerships that will be developed to carry out the project. Write the executive summary so that it is clear, accurate, concise, and without reference to other parts of the Application.

Molina has worked with the State of California for the past thirty-one (31) years to assist the Department of Health Care Services (DHCS) to fulfill its goals and objectives in serving low-income populations. Molina has supplemented its provider network by establishing significant relationships with social service providers, community-based organizations, member advocates and organizations focused on the needs of dual eligible beneficiaries.

At the heart of Molina's Duals Demonstration Project approach is the plan's sophisticated and proven Integrated Care Management Model, which includes:

- Comprehensive member assessments to ensure that care plans meet individual needs;
- Member-centered care principles and practices to achieve better results;
- Patient and family-centric, home-based care options with preferred delivery of services in home and through community-based settings;

- Multi-disciplinary team-based care management systems that focus on coordinating physical, behavioral health care and LTSS, while supporting the Primary Care Physician (PCP) as the facilitator of care;
- Integrated care teams trained to deliver culturally congruent care;
- Accountability for quality metrics;
- Evidenced-based protocols to manage vulnerable populations;
- Network partnerships that expand beyond hospitals to integrate with community-based services, long-term care providers, public and mental health departments and nursing homes;
- Data sharing arrangements to collect, store, integrate and analyze data from multiple sources in a timely manner to improve care coordination and outcomes; and
- Provider payment strategies that reward improvement of quality outcomes and achievement of medical home status.

The geographic coverage area for Sacramento County under the Duals Demonstration Project will include all current DHCS-approved Medi-Cal mandatory enrollment zip codes. This will cover the approximate 45,000 dual eligible beneficiaries in Sacramento County.

Molina has developed essential relationships with the following entities: Service Employees International Union (SEIU); Partners in Care Foundation (PICF); Easter Seals Superior; and Sacramento County Department of Health & Human Services' Low Income Health Program. Molina is developing additional strategic partnerships with organizations experienced and committed to improving care for dual eligibles, such as: Alta California Regional Center; Area 4 Agencies on Aging; Community Based Adult Service providers; Multi-Purpose Senior Services Program; current Medicare Advantage Special Needs Plans in Sacramento County; and innovative healthcare technology companies like Sandata Technologies and Cisco Systems.

Molina is fully committed to working with DHCS to eliminate fragmented, duplicative and inefficient institutional-based care. Molina has sought to collaborate with other Medi-Cal health plans and stakeholders for a Duals Demonstration Project in the county. Molina strongly recommends that DHCS include Sacramento in California's Demonstration Proposal to create a coordinated, integrated program that supports person-centered, self-directed care resulting in increased access to appropriate physical, behavioral health and long-term supportive services.

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Section 1: Program Design

Section 1.1: Program Vision and Goals

The Application must:
Question 1.1.1 Describe the experience serving dually eligible beneficiaries, both under Medi-Cal and through Medicare Advantage Special Needs Plan contracts, if any.

Molina has extensive experience serving dual eligible members and a long-standing commitment in addressing the unique health care needs and challenges faced by low-income and aged populations, and persons with disabilities. Molina Healthcare of California is a Knox-Keene licensed Health Maintenance Organization (HMO) that has an Administrative Services Agreement with Molina Healthcare of California Partner Plan, Inc., its Knox-Keene licensed HMO affiliate. Molina arranges healthcare services for individuals eligible for Medi-Cal, Healthy Families and Medicare Special Needs Plans (D-SNP) in Riverside, San Bernardino, Sacramento, San Diego and Los Angeles counties.

In California, Molina serves over 350,000 members, including 6,400 dual eligibles and over 35,000 Seniors and Persons with Disabilities (SPDs). Molina began serving SPDs in 1980 when it opened its first primary clinic. Molina enrolled SPDs on a voluntary basis under the Primary Care Case Management (PCCM) program in 1985 and expanded the PCCM contract to Riverside County in 1989. Beginning in January 2006, Molina began providing coverage to dual eligible beneficiaries as a D-SNP and ultimately grew to serve members in

Riverside, Los Angeles, Sacramento, San Bernardino and San Diego counties. As of February 2012, Molina serves over 1,500 dual eligible members and 6,900 SPD members in Sacramento County. Additionally, Molina's parent company, Molina Healthcare, Inc., manages ten licensed state health plans nationally that serve approximately 1.7 million members, including 177,000 Aged, Blind and Disabled and over 26,000 dual eligible members, making it one of the ten largest D-SNP plans in the nation.

Since 1996, Molina has been under contract with DHCS as the Commercial Plan in the Two-Plan Managed Care model in Riverside and San Bernardino counties administering services to 100,000 Medi-Cal members within the region. In addition, Molina has participated in the Medi-Cal Geographic Managed Care (GMC) model in Sacramento since 2000 and in San Diego since 2005. Through the GMC model, Molina administers healthcare services to over 105,000 Medi-Cal members in Sacramento and San Diego. In the Two-Plan Medi-Cal Managed Care model in Los Angeles County, Molina serves approximately 108,000 members as a subcontractor to Health Net Community Solutions, Inc.

Question 1.1.2 Explain why this program is a strategic match for the Applicant's overall mission.

Molina's mission and deeply rooted traditions are firmly built upon a distinguished track-record of respecting personal dignity, ethical decision making

and an unwavering commitment to ensuring access to quality healthcare services for vulnerable populations. Molina was founded in 1980 by C. David Molina, M.D. as a primary care clinic serving as a safety net provider under the name Molina Medical Centers. Today, Molina is part of a multi-state managed care company that focuses solely on assisting government agencies in serving low-income and disadvantaged populations. Molina's long-standing goal of providing quality healthcare services to underserved and access-challenged populations stems from an understanding of the complex challenges and disparities faced by vulnerable populations such as dual eligibles. Demonstrating its commitment to ensuring quality healthcare services, nine out of ten eligible health plans, including Molina Healthcare of California, are National Committee for Quality Assurance (NCQA) accredited. The remaining health plan will be eligible for accreditation in early 2014.

Molina's vision and mission align with the Duals Demonstration Project goals to improve access to quality healthcare services to low-income and vulnerable persons. Molina's core values ensure members receive care in the setting of their choice by:

- Removing barriers to quality healthcare services;

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- Being wise and prudent stewards of public funds in government healthcare programs;
- Advocating in the interests of vulnerable populations; and
- Administering health plan services in a respectful and ethical manner.

Molina's core values strongly align with the objectives of the Duals Demonstration Project by seeking to ensure that low-income and access-limited populations receive coordinated care that maintains optimal health and quality of life. This will be achieved through Molina's Integrated Care Management Model which is person-centric and designed to keep dual eligible members in their settings of choice.

In support of the Duals Demonstration Project, Molina will administer a coordinated comprehensive care model that provides seamless access to a full range of covered medical, behavioral health (encompassing both mental health and substance use disorders), social, and long-term care support and services. Molina will be able to draw upon its extensive internal expertise and successful track record of utilizing its integrated care model which has been proven to improve quality and access to care for its dual eligible members.

Question 1.1.3 Explain how the program meets the goals of the Duals Demonstration.

Molina's Integrated Care Model will assist dual eligible beneficiaries obtain services administered by a single entity regardless of payer source to meet the seven goals of the Duals Demonstration Project. Through Molina's Integrated Care Management Model, Molina will ensure that its dual eligible members receive:

- Coordinated benefits and access to care, and improved continuity of care and services;
- Increased ability to remain in their homes and communities with appropriate services and supports in lieu of institutional care;
- More access to desirable home-and community-based alternatives;
- Enhanced ability for consumers to self-direct their care and receive high quality care;
- Improved health processes and satisfaction with care;
- Improved coordination of and timely access to care; and
- More effective use of Medicare, Medi-Cal and other state and county resources.

Molina will partner with the state to meet the goals of the Duals Demonstration Project using the following elements of its Integrated Care Management Model:

- Flexible and innovative care management delivery approaches to integrate physical and mental health service coordination;

- Care coordination that integrates an array of healthcare services designed to improve health outcomes;
- Care transition services that ensure members are educated prior to discharge from a facility;
- Disease management designed to actively engage members self direction in addressing their own health care needs;
- Case management based on risk-stratification of members with complex medical conditions for accurate assessment of needs, interventions and evaluation of outcomes;
- Care access and monitoring to ensure quality, cost-effective and medically necessary services are delivered across the continuum of care;
- Dedicated multilingual Nurse Advice Line services delivered by registered nurses that are available 24 hours per day, seven days per week and most importantly always answered by a live voice to reduce the incidents of hang-ups;
- Scalable information technology systems capable of handling and processing complex data requirements in order to improve care coordination, quality and outcomes; and

- Robust, cost-effective service delivery and provider networks with appropriate oversight and effective utilization practices.

Section 1.2: Comprehensive Program Description

The Application must:
Question 1.2.1 Describe the overall design of the proposed program, including the number of enrollees, proposed partners, geographic coverage area and how you will provide the integrated benefit package described above along with any supplemental benefits you intend to offer. (You may mention items briefly here and reference later sections where you provide more detailed descriptions.)

Molina proposes to create a collaborative, integrated county-wide solution with one set of supplemental benefits for the entire county that would be provided by all participating health plans under the Duals Demonstration Project in Sacramento County. In addition, Molina would collaborate with other participating Duals Demonstration health plans to streamline the administrative barriers by negotiating with the county for the administration of IHSS and behavioral health services and implement a process to share health risk assessment data for individuals who switch between health plans. This collaborative approach would also involve the engagement of other strategic partners and stakeholders in the development and implementation of proposed programs under the Duals Demonstration Project.

Molina will conduct joint meetings and work collaboratively with multiple entities including, but not limited to, the following: Sacramento County Division of Behavioral Health Services; Area 4 Agency on Aging; Sacramento County Department of Health and Human Services and Sacramento County In-Home

Supportive Services Public Authority; Community-Based Adult Services (CBAS) Centers; Long-term care supports and services, including long-term skilled nursing and custodial care and Multi-Purpose Senior Services Program services; Alta California Regional Center; and Sacramento County Public Health.

The geographic coverage area for Sacramento County under the Duals Demonstration Project will include all current DHCS-approved Medi-Cal mandatory enrollment zip codes. This geographic coverage area will cover the approximate 45,000 dual eligible beneficiaries in Sacramento County to enroll in the Duals Demonstration.

Molina will optimize health outcomes for dual eligible members enrolled in the Duals Demonstration Project by drawing upon its knowledge and experience, and leveraging the national experience of its sister health plans in providing comprehensive care management services to dual eligible populations. Through its person-centric Integrated Care Management Model, Molina integrates physical health, behavioral health (mental health and substance use disorders) and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. The Integrated Care Management Model is designed to coordinate services for members based on their specific medical and LTSS needs. The program consists of three programmatic levels: Level 1 - Health Management (for low-risk members); Level 2 - Care Management (for medium-

risk members); and Level 3 - Complex Care Management (for members at highest medical risk). Operating concurrently with these three levels, are Molina's Care Access and Monitoring activities which ensure appropriate and effective utilization of services, and Care Transitions activities which ensure members receive the support they need when moving from one care setting to another. Behavioral health and long-term care services are integrated throughout all aspects of the Integrated Care Management Model. Through continuous process and technology improvements, Molina streamlines interactions between all interdisciplinary care management teams to promote highly effective collaborations that result in optimized member care.

In addition to administering a full range of comprehensive benefits covered under the Duals Demonstration Project, Molina will:

- In Year 1, coordinate services with the Sacramento County Division of Behavioral Health Services to ensure seamless access for patients with serious and persistent mental illness, including incentives for care coordination and performance measures. By Year 3, Molina will subsequently partner with the county agency to integrate coverage for these individuals and make sure the county continues to contribute its clinical expertise to those covered under the Duals Demonstration Project;

- Partner with the Sacramento County Department of Health and Human Services and IHSS/Public Authority in Sacramento County to integrate coverage of IHSS for enrolled dual eligible beneficiaries.
- Provide supplemental benefits, to the extent rates are sufficient, to enrolled dual eligible beneficiaries that include dental, vision, non-emergency transportation, home delivered meals, respite coverage for caregivers, home visits by providers and tele-monitoring services.

Additionally, Molina will negotiate, in good faith, contracts with health plans that have D-SNP membership to ensure continuity of care.

Question 1.2.2 Describe how you will manage the program within an integrated financing model, (i.e. services are not treated as "Medicare" or "Medicaid" paid services.)

Molina is confident in its ability to serve as a single entity responsible for arranging all services and managing the blended funding arrangements for California's dual eligible population. The Duals Demonstration Project will enable Molina to treat individuals' medical, social and behavioral needs, with the beneficiary receiving the advantage of one card, one set of benefits and one responsible entity for all of their care. Given the fragmented care many dual eligibles receive today, Molina believes an integrated care delivery system will lead to optimized health outcomes, an increase in patient satisfaction and a decrease in unnecessary and duplicative services. Under the Duals Demonstration

Project, Molina will actively assess and monitor dual eligible members to ensure that a comprehensive set of services are delivered in a timely and efficient manner.

Specifically, Molina will train its Care Managers to have a comprehensive understanding of all benefits available to the dual eligible members so that they may select the services most appropriate for their needs, regardless of the payment mechanism or historical benefit limitations. Molina will also conduct frequent outreach efforts to members using Community Health Workers and/or Community Connectors to assess timeliness of services, identify unmet needs and general satisfaction with the Molina Integrated Care Management Model. Molina will modify its existing claims payment system to meet Duals Demonstration Project requirements in order to pay claims accurately and timely. Providers will no longer have to bill multiple payers or wait for a response from the primary payer before billing secondary coverage. Molina will coordinate payment so that providers get paid completely with the first billing. This system will be configured to allow payment of Duals Demonstration Project claims that are processed seamlessly to the provider and member. A critical component of Molina's approach is a comprehensive data collection system of health outcomes, payments and members' satisfaction. Molina will routinely review data to ensure the system integrates key clinical indicators specific to the dual eligible population to ensure outcomes are tracked and progress is reported. In addition, all services delivered to the member

will be captured by CPT/HCPCS codes to create reports illustrating surrogate payment values from both Medi-Cal and CMS fee schedules. These reports will illustrate the cost savings from a coordinated approach to members entire continuum of care. Molina will score member satisfaction based on plan surveys.

Question 1.2.3 Describe how the program is evidence-based.

Molina has developed its Integrated Care Management Model and supporting clinical guidelines based on an ongoing review of published research on quality and cost-effectiveness. Molina's Integrated Care Management Model is based on published research demonstrating the value of focused person-centric teams and high-touch member interaction. The literature reviewed included the following key studies: Bodenheimer, T., Berry-Millet, R., *Care Management of patients with complex health care needs*; Robert Wood Johnson Foundation Research Synthesis Report No. 19, December 2009, accessed on March 24, 2011; Meyer, J., Markham-Smith, B., *Chronic Disease Management: Evidence of Predictable Savings*, Health Management Associates, November, 2008; and Musich, S., Paralkar, S., *A comprehensive literature review of studies on care coordination and other health management programs*, Reden & Anders, an Ingenix Company, November 2007, accessed May 2011 from: http://www.ingenixconsulting.com/content/File/PAYER-Care-Coordination.pdf (see appendix for the full listing of literature by area of impact).

Molina believes that industry evidence supports its program's principles of coordinated Managed Care, Integrated Care Management, Transitional Care and Patient-Centered Health Homes. Fully integrated capitated programs in other health plans and states have consistently demonstrated that comprehensive care management services can meet these objectives. The following examples of academic research demonstrate the need for a fully integrated care approach for the dual eligible population. Massachusetts' Senior Care Options program reduced Skilled Nursing Facility admissions by 42% while achieving high satisfaction rates, and in a 2009 survey of Wisconsin Family Care enrollees, more than 80% expressed satisfaction with the program. The Johns Hopkins Guided Care PCMH Model reduced hospitalizations (24%), ER visits (15%) and SNF days (37%). The Transitional Care interventions of Coleman, Naylor and RUSH have each demonstrated significant quality and cost improvements. And Comprehensive Care Coordination models specific to dual eligibles (Care Management Plus, Dorr; Medicare Coordinated Care, Brown; and King County Care Partners, KCCP) have successfully applied these concepts to Molina's target population of frail dual eligibles.

Molina also endeavors to make all clinical decisions using guidance criteria which are based on evidence-based medical data. The Molina Healthcare Medical Policy Department is designed to assist the plan by researching and evaluating

scientific evidence to address both new and existing technologies (e.g., pharmaceuticals, diagnostics, procedures, therapies, medical devices and behavioral health services). A current library of evidence-based coverage decision documents is available to all Molina staff in order to provide optimal services to its dual eligible members.

These processes have been designed in accordance with National Committee on Quality Assurance (NCQA) standards to ensure compliance with requirements for the evidence-based evaluation of new and existing technologies.

Molina's Medical Coverage Guidance Committee is responsible for reviewing the current state of scientific evidence and making final recommendations that guide all coverage determinations. Criteria are outlined to allow coverage for only the safest and most effective services for Molina members. When appropriate, step therapies are factored into the criteria to provide both quality and cost-effective approaches for making medical coverage determinations. Experts associated within a specialty being reviewed evaluate all documents which are subsequently revaluated by the Utilization Management Committee before implementation or changes. This process will help eliminate adverse outcomes and inefficient health care associated with providing coverage for unproven services to Molina's dual eligible members.

InterQual® guidelines provide an important basis for Molina's clinical decision-making process. A panel of independent specialists is consulted when there is a need for guidance interpretation. Molina has also established a working relationship with the McKesson Corporation whereby the Medical Coverage Guidance Committee provides biannual recommendations for changes to established InterQual® criteria based upon an internal review of scientific evidence-based literature. This careful, evidence-based approach will help Molina provide the Duals Demonstration Project members with the most effective and efficient care based on the latest industry research.

Question 1.2.4 Explain how the program will impact the underserved, address health disparities, reduce the effect of multiple co-morbidities, and/or modify risk factors.

Molina's Integrated Care Management Model integrates physical health, behavioral health and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. It is designed to address member health disparities, reduce the effect of multiple co-morbidities and modify actual and potential risk factors by significantly reducing the current fragmentation in care delivery, increasing critical information sharing with multiple care providers, assisting members in taking charge of their own health decisions and supporting members in the least restrictive living environment.

To further reduce the effect of multiple co-morbidities and to modify risk factors, Molina also offers disease management programs for cardiovascular disease, diabetes, asthma, COPD, overweight and obesity management and smoking cessation, all health risks which are more prevalent among low-income underserved populations.

Molina's Integrated Care Management Model includes a high-touch, person-centric care environment where each high risk member has a dedicated Care Manager serving as the single point-of-contact responsible for actively assessing and monitoring dual eligible members as well as developing individual person-centric care plans that effectively address member-specific medical, behavioral health and social needs. The Care Managers work directly with the members face–to-face or telephonically as appropriate based on the members' needs. By acting as the member's patient navigator, the Care Manager works to remove barriers to all appropriate healthcare services and ensure that a comprehensive set of services are delivered to members in a timely and efficient manner.

Whenever possible, Molina Care Managers and members are matched based on cultural congruency. This practice ensures that a member's linguistic needs and cultural traditions, including dietary habits, way of life, cultural beliefs and practices regarding health and illness, are fully accounted for in creating his or her

individual care plan. Care Managers also examine members' respective racial and ethnic backgrounds to help identify possible health disparities among diverse populations predisposed to certain diseases and conditions.

Question 1.2.5 Explain whether/how the program could include a component that qualifies under the federal Health Home Plans SPA.

As authorized in Section 2703 of the Affordable Care Act and further clarified in the State Medicaid Director letter on November 16, 2010 (SMDL# 10-024), there are six (6) services that could be provided by designated health home providers or health teams to qualify for enhanced federal funding:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

Molina believes that most, if not all, of these health home components will qualify for purposes of California's State Plan Amendment.

As requested in an RFI from Mercer several months ago, Molina provided detailed responses to a series of questions designed to specify and describe the services that could be claimed under Section 2703. In fact, several of these services are currently provided under Molina's Integrated Care Management Model to individuals with chronic or complex medical conditions and deemed to be at risk for adverse health outcomes. Molina will provide any and all data that DHCS may require in order to reconcile health home services with CMS in order to receive the enhanced federal reimbursement.

Question 1.2.6 Identify the primary challenges to successful implementation of the program and explain how these anticipated risks will be mitigated.

Based on experience working with populations requiring a complex range of services, Molina has identified the following key areas of challenges and opportunities associated with implementing integrated care for dual eligibles beneficiaries:

Inclusion of LTSS

Molina, along with other Duals Demonstration Project plans, will be assuming responsibility for services that have previously been authorized and reimbursed by other entities and programs. In order to ensure beneficiaries continue to receive all necessary services and avoid care disruption, Molina has already begun discussions with local county agencies and stakeholders about the Duals Demonstration Project and will commit significant resources to ensuring

county contracts, beneficiary communication and outreach efforts and plan administration are addressed prior to readiness reviews.

With regard to IHSS in particular, IHSS county administration in Sacramento County have expressed concern about the future funding sources for the IHSS program when it is integrated in the Duals Demonstration Project. This concern could be challenging for health plans and county IHSS program administration to reach a formal agreement before the program launch. Currently, the IHSS program has a complex funding mechanism where it receives funds from the state and the County. It is unclear at this point if the county funding contribution will be changed because of the full integration of IHSS into the Duals Demonstration Project. Molina is confident that the plans would be able to work productively with the county to integrate IHSS services once the impact of the proposed changes to county funding is first satisfactorily resolved.

Integration of Behavioral Health Services

Molina works closely with its local county mental health agencies to coordinate its current members' care needs. The Duals Demonstration Project will require these existing relationships to be even more coordinated because of the anticipated needs of the population. Molina's Care Managers will need to be able to share and receive timely information from county mental health agencies in order to update the patient's care plan and advise other treating providers

(including county mental health providers) if a critical or urgent change has taken place. Molina will review and, as appropriate, update its existing memorandums of understanding with each county mental health agency to enhance communication while also protecting patient confidentiality. Molina is aware of the challenges that may exist for beneficiaries to receive behavioral health services from the county and we are committed to working together to improve access to care.

Use of Medicare and Medi-Cal fee-for-service data to help early identification and stratification of members health needs

Molina's ability to identify newly enrolling dual eligible beneficiaries with the most critical needs for intervention is made possible by gathering health care information for services that occur prior to enrollment. Given the significant number of dual eligible beneficiaries to be enrolled it is essential to reach out to the most vulnerable as soon as possible.

Similar to the SPD Medi-Cal mandatory enrollment, Molina expects to receive de-identified utilization and pharmacy data for this population, preferably by June 2012. This will provide enough time to assess network adequacy and make necessary adjustments prior to January 2013. Once individuals start to enroll, Molina expects to receive identifiable data to use in conjunction with the results from their health risk assessment to develop an individualized care plan for each member. In addition, there have been regulatory issues that prevented DHCS from

sharing behavioral health and substance use data for the SPD mandatory enrollment. Molina requests that this data be made available for the Duals Demonstration Project as it will assist in the plans' efforts in fully integrating behavioral health into the medical and LTSS system.

Building relationships with new classification of providers and community stakeholders

Medi-cal members are not a homogeneous group. Within each aide code category (TANF, SPD, and Duals), unique providers are required. TANF members require more pediatricians and obstetricians while the SPD members need more internal medicine providers, cardiologists and behavioral health specialists. Molina has developed an expertise in building provider networks tailored to the unique needs of its members. While Molina currently maintains provider networks for its Medicare and Medi-Cal populations, Molina recognizes that there will be additional types and classifications of providers that will need to be included in this integrated program to ensure continuity of care. Molina will contract with an appropriate number and variety of providers to ensure member access, appropriate member service utilization, and the capacity to communicate with members who speak languages other than English, as well as with those who are deaf or hearing impaired. Throughout the term of the Duals Demonstration Project, Molina will assess its provider network to ensure alignment with state and federal eligibility

criteria, reporting requirements and other applicable rules and/or regulations. Molina will also enhance outreach activities with community stakeholders in order to proactively identify and address issues and concerns.

Ensuring Transition and Continuity of Care for Members

After the Duals Demonstration Project begins enrollment, Molina will ensure timely authorizations and coordination of needed services during the critical period of adjustment for newly enrolled members. Members requiring transition of services will be evaluated on a case-by-case basis to determine the length of time transitional care is needed. Molina will work with the members' treating physicians, families and caregivers to develop care transition plans based on the members' unique needs to improve care continuity and member satisfaction.

Inconsistencies between Medicare and Medi-Cal policies on key issues

Molina requests that clear standards and guidance be provided for the Health Risk Assessment form, grievance and appeals, regulatory monitoring and oversight, marketing, outreach, and communication. The plans will mitigate these inconsistencies by developing uniform policies to cover all dual eligible beneficiaries enrolled in the Duals Demonstration Project.

Communicating with providers about the Medical Exemption Request process and continuity of care policy for the Duals Demonstration Project

It has been Molina's experience in serving mandatorily enrolled SPD members that many of these members received care from out-of-network providers

or out-of-service area, and the plans expect a similar experience for the dual eligibles beneficiaries. Molina will work diligently to reach out and contract with these non-contracted providers as they become identified. However, in some cases, providers and members refuse to work within a managed care environment. Therefore, Molina expect that DHCS will clarify and assist in communicating the continuity of care policy and the Medical Exemption Request process to community providers prior to the implementation.

Section 2: Coordination and Integration of LTSS

Section 2.1: LTSS Capacity

The Applicant must:
Question 2.1.1 Describe how you would propose to provide seamless coordination between medical care and LTSS to keep people living in their homes and communities for as long as possible.

To best foster seamless integrated medical care and LTSS coordination for dual eligible members and support members living in their homes and communities for as long as possible, Molina's Integrated Care Management Model includes:

- A person-centered, high-touch approach that ensures members receive comprehensive, integrated services;
- Accurate identification of a member's unique health care needs, with special emphasis on appropriate resource utilization based on the member's physical, behavioral health and social care needs;
- Care management to integrate a wide array of acute care, behavioral health, LTSS and developmental services designed to proactively address member needs and improve outcomes;
- Coordination with PCPs and specialists to provide members with a medical home;
- Utilization of Community Connectors with knowledge and expertise in assisting members in their communities to access needed resources, such as assistance with housing, food and LTSS;

- Care Transition services that ensure members and their families are educated and prepared prior to any change in level of care;
- Health Management designed to empower and activate members to take charge of their health, manage their conditions, engage in preventive care, and reduce inappropriate emergency room use;
- Care Management based on risk-stratification of members with complex conditions for assessment of needs, proactive interventions and evaluation of outcomes;
- Maintenance of a healthy and robust service delivery network to ensure ready access to experienced community and safety net providers; and
- Utilization of a scalable information technology system capable of handling and processing complex data requirements.

Molina's Integrated Care Management teams are regionally based and include physicians, registered nurses, social workers, licensed behavioral health professionals, health educators, pharmacists and other non-clinical staff with experience in care coordination and management who work closely with members, the member's family / caregivers and providers to perform assessments, assist in referrals and coordinate services. These teams collaborate to achieve optimal health outcomes and manage inpatient admissions, readmissions and emergency

room use while ensuring quality of care. Care Managers act as a single point of contact to facilitate interdisciplinary team communications and share information with all providers to allow a comprehensive review of the members' entire spectrum of care with a focus on supporting healthy and effective care settings that enable members to live in their homes and communities.

Once a member is identified for possible integrated care management services, a Molina Care Manager is assigned within 48 hours (or more urgently if necessary) to assess the member's needs. Molina uses multiple and comprehensive evidence-based assessment tools and guidelines based on each member's circumstance and needs to maximize their medical, psychosocial and developmental outcome within Molina's Integrated Care Management Model. This includes the incorporation of state required assessments. An accurate assessment ensures that the Molina Care Manager has the appropriate information required to develop an individualized care management and care coordination plan.

Molina's assessment processes include a comprehensive member evaluation, including, but not limited to: member's health status; clinical history; activities of daily living; mental health status; life planning; cultural and linguistic preferences or limitations; caregiver resources; evaluation of available benefits/community resources; and member self-management plan.

Molina believes this approach will result in an efficient, cohesive, well-managed Duals Demonstration Project that would fully integrate all dual eligible services, including LTSS.

Question 2.1.2 Describe potential contracting relationships with current LTSS providers and how you would develop a reimbursement arrangement.

Molina acknowledges the importance of a robust and stable LTSS network that will provide a dual eligible member the appropriate choice of living environment. Molina is currently seeking the guidance of key stakeholders who are knowledgeable of and involved in the provision and delivery of LTSS within Sacramento County to advise on network expansion needs. Molina's goal is to identify county and private-sector resources that can provide the range of services and benefits that will be required under this Duals Demonstration Project. This inventory of LTSS will be informed by both state fee-for-service claims data, so that Molina identifies current providers, as well as stakeholder recommendations. Once an inventory of current, potential and available resources in Sacramento County has been assembled, Molina will immediately deploy a contracting team to expand its current LTSS network using an array of available reimbursement methodologies including fee-for-service and capitation. Molina will also consider appropriate discharge planning and quality improvement incentives with

contracted nursing facilities. Molina anticipates the expanded LTSS network will include:

- In-Home Supportive Services – To be provided in Sacramento County under an agreement between Molina and the local county unit and the local public authority.
- CBAS – To be provided by state-approved CBAS facilities under direct fee-for-service contracts with Molina;
- Long-Term Custodial Care – To be provided by facilities under direct fee-for-service contracts with Molina; and
- MSSP - To be provided by state-awarded centers under direct fee-for-service contracts with Molina.

Each of these LTSS provider types will be reimbursed at either a state-defined rate or a negotiated fee-for-service visit/case rate.

Question 2.1.3 Describe how you would use Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS.

Molina identifies at-risk members who may benefit from integrated care management through an analysis of all available data which may include encounter forms, claims data, member health risk assessments and pharmacy claims, as well as through internal and external referrals. For high need members, the selection

criteria include one or more of the following: recent utilization for selective chronic conditions; several co-morbidities; high risk maternity; critical changes in living or social support needs; or a history of high service utilization. Selection criteria for members with lower level needs include recent utilization for selective chronic conditions, pharmacy utilization, abnormal lab results, needed preventive services, or other health management needs such as smoking cessation or weight management. These criteria define the trigger lists which are then prioritized using member prospective risk scores from Molina's current predictive modeling tool. Prioritization is further refined to include admission and emergency room visit counts, co-morbidity counts, and high utilization amounts. Molina members benefit from this prioritization process since immediate attention is focused on those who are in greatest need and likely to benefit from intensive care management.

Molina's Care Managers utilize a health risk assessment screening process used for the SPD population that was approved by DHCS. The plans risk assessment screening process includes a comprehensive member evaluation, including, but not limited to: member's health status; clinical history; activities of daily living; behavioral health status; life planning; cultural and linguistic preferences or limitations; caregiver resources; evaluation of available benefits/community resources; and member self-management plan to develop

individualized care management and care coordination plans. Within this assessment process, Molina Care Managers will utilize all state required assessment tools to evaluate all services the member is receiving. To support standardization and assist in consolidating assessment tools, Molina will work in partnership with the state, other participating Medi-Cal health plans under the Duals Demonstration Project, and long-term care providers to explore innovative solutions, including cutting edge predictive modeling technology. Using Molina's care management database, which provides a single view of the member's needs, Molina will ensure that all assessments are entered in a timely manner until such time that the state issues a standardized LTSS assessment.

Question 2.1.4 Describe any experience working with the broad network of LTSS providers, ranging from home- and community-based service providers to institutional settings.

Since the mandatory enrollment of seniors and persons with disabilities began in June 2011, Molina has enrolled over 35,000 beneficiaries in its Medi-Cal contract counties. This population requires similar LTSS providers and services that will be further enhanced under the Duals Demonstration Project. For its current SPD population, Molina coordinates transportation, meals and housing with community-based organizations and local agencies. For SPD beneficiaries that are also receiving IHSS services, Molina coordinates with the appropriate county agency as needed. Under the Duals Demonstration Project, many of these

existing relationships and contracts will be enhanced or expanded to broaden the services as well as the coordination between medical, behavioral and social supports. Molina currently conducts in-home Health Risk Assessments that, if necessary, may lead to the provision of additional LTSS in the home such as caregivers, installation of ramps or other environmental modifications, and assistance with adult family home placement. Molina has demonstrated experience in coordinating person-centric care with multiple LTSS partners, including: In-home personal care assistants; Adult Family Homes; Assisted Living and Boarding Homes; Nursing Facility Care; Meals on Wheels; and Lifeline (PERS).

Molina will also work with entities to coordinate appropriate essential home modifications.

Question 2.1.5 Describe your plans for delivering integrated care to individuals living in institutional settings. Institutional settings are appropriate setting for some individuals, but for those able and wanting to leave, how might you transition them into the community? What processes, assurances do you have in place to ensure proper care?

While most individuals would prefer to receive LTSS in their homes and community, skilled nursing facilities and other types of licensed health facilities may also play a role in the care continuum by providing rehabilitative and skilled nursing care for those with exceptional medical needs. Ideally, these services should be provided on a time-limited basis and be focused on improving the

patient's health to a point in which they can safely transition to a lower level of care in their home.

For those who are currently residing in skilled nursing facilities, Molina will enhance the quality of care to dual eligible beneficiaries by providing dedicated physicians, nurse practitioners or other specialists to regularly assess and monitor the beneficiary for medical, social and behavioral needs. The current care provided by the nursing facility will be supplemented by Molina's providers to ensure the beneficiary is frequently assessed and treated in a preventive manner to avoid unnecessary hospitalization or negative health outcomes.

For individuals interested in returning to their home or community, the provider managing their care within the facility will refer them to Molina's Integrated Care Management team. Molina's Integrated Care Management teams will be established within the Duals Demonstration Project sites. Each team will include physicians, pharmacists, registered nurses, social workers and health educators with experience and knowledge in working with complex populations, as well as paraprofessional Community Connectors who will assist members with accessing local community resources including housing, food and LTSS. Molina will also contract with specialists in long-term care and behavioral health to better meet the distinct medical, behavioral and social needs of its culturally diverse members.

All of Molina's Integrated Care Management staff will receive specialized training in integrated care management, assessing long-term care needs and offering LTSS. Detailed processes and workflows have been developed to guide staff in approaching member needs from a holistic standpoint.

Section 2.2: IHSS

The Applicant must:
Question 2.2.1 Certify the intent to develop a contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1. The contract shall stipulate that:

Molina understands and will comply with the requirement to develop a contract with the County to administer IHSS services through individual contracts with the Public Authority and County for IHSS administration in Year 1.

- ***IHSS consumers retain their ability to select, hire, fire, schedule and supervise their IHSS care provider, should participate in the development of their care plan, and select who else participates in their care planning.***

  Molina understands and will ensure that its contract with the County includes a requirement that IHSS consumers be able to retain their ability to select, hire, fire, schedule and supervise their IHSS care provider, should participate in the development of their care plan, and select who else participates in their care planning.

- ***County IHSS social workers will use the Uniform Assessment tool and guided by the Hourly Task Guidelines, authorize IHSS services, and participate actively in local care coordination teams.***

  Molina understands and will ensure that its contract with the County includes a requirement that County IHSS social workers perform assessments using the Uniform Assessment and guided by the Hourly Task Guidelines, authorize IHSS services, and participate actively in local care coordination teams.

- ***Wages and benefits will continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS care providers.***

  Molina understands and will ensure that its contract with the County include a requirement that wages and benefits continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS care providers.

- ***County IHSS programs will continue to utilize procedures according to established federal and state laws and regulations under the Duals Demonstration.***

  Molina understands and will ensure that its contract with the County includes a requirement that County IHSS programs continue to utilize procedures according to established federal and state laws and regulations under the Duals Demonstration.

- ***IHSS providers will continue to be paid through State Controller's CMIPS program.***

  Molina understands and will ensure that its contract with the County includes a requirement that IHSS providers continue to be paid through State Controller's CMIPS program.

- ***A process for working with the County IHSS agency to increase hours of support above what is authorized under current statute that beneficiaries receive to the extent the site has determined additional hours will avoid unnecessary institutionalization.***

  Molina understands and will ensure that its contract with the County includes a requirement stipulating a process for working with the County IHSS

agency to increase hours of support above what is authorized under current statute that beneficiaries receive to the extent the site has determined additional hours will avoid unnecessary institutionalization.

Question 2.2.2 With consideration of the LTSS Framework in Appendix E that emphasizes consumer choice, and in consideration of the approach taken in Year 1 as described above, please describe the interaction with the IHSS program through the evolution of the Demonstration in Years 2 and 3.

Specifically address:

- ***A proposed care coordination model with IHSS, including the referral, assessment, and care coordination process.***

  Molina strongly supports the inclusion of IHSS services in the Duals Demonstration Project and is actively working with organized labor and the public agencies that administer the IHSS program to ensure IHSS care providers are incorporated into the care planning and management of the member. Molina believes IHSS caregivers can play a key and central role in maintaining a quality of life for dual eligible members. Specifically, Molina is in active discussions with SEIU California and its long-term care representatives to collaborate on ways to ensure that IHSS providers are able to assist dual eligible recipients in enrolling and maintaining their eligibility in the Duals Demonstration Project. SEIU, representing nearly 300,000 IHSS providers in California, will be an incredibly powerful influence in educating their members about their role in the success of the Duals Demonstration Project. Molina intends to work closely with SEIU and other

bargaining units to provide greater opportunities and access to professional training throughout the pilot.

Long-term care supports and services (LTSS) will be a vital part of the Duals Demonstration Project by helping individuals to remain in less-costly and more appropriate settings. Molina utilizes a person-centered care model that respects and encourages the member's choice in selecting their health care providers, including their personal care worker. Molina is actively working with the appropriate county IHSS agencies, public authorities and other parties to ensure this benefit is included and coordinated with other services provided under the Duals Demonstration Project. In Sacramento County, the county IHSS agency has expressed concerns about county funding for IHSS services under the Duals Demonstration Project. California's IHSS program is the cornerstone in keeping vulnerable, medically-fragile individuals out of higher-cost care facilities while ensuring their complex medical and social needs are addressed. In Year 1 of the Duals Demonstration Project, Molina will work closely with the county agency and public authority to ensure the IHSS benefit is transitioned appropriately into the benefits Molina already offers. Furthermore, Molina will include an IHSS caregiver in decisions regarding a member's care plan whenever possible.

As the Duals Demonstration Project evolves in Years 2 and 3, Molina believes the county agencies will continue to play a pivotal role in the project's

administration, especially in the assessment and administrative processes of the IHSS benefit. Specifically, Molina envisions county social workers collaborating with Molina's interdisciplinary care staff on member assessments, helping members receive coordinated care from other providers and relaying information to the Molina teams based on direct observations and home visit interaction with members. Molina will also support members receiving IHSS services with local community health workers to ensure linkages to community social programs, cultural activities and non-governmental services.

- ***A vision for professional training for the IHSS worker including how you would incentivize/coordinate training, including with regards to dementia and Alzheimer's disease.***

  IHSS workers will serve as valuable members of the care team due primarily to their proximity and regular interaction with dual eligible members. For dual eligible members with chronic, multiple and serious health and behavioral conditions, an IHSS worker can serve as the first responder to identify problems or complications with the treatment plan, including issues with the member's medication and activities of daily living. Molina will work with county agencies, educational institutions and the public authority to develop and offer training opportunities to IHSS workers that will provide additional education on such topics as: medication management and how to recognize and prevent harmful drug interactions; safely transferring members with limited or no mobility; methods to

reduce healthcare-acquired infections; fall prevention; safe exercise; healthy lifestyle and diet; disease self-management; and how to navigate health plan processes and advocate for members. Molina believes the Duals Demonstration Project represents a unique opportunity to partner with local organizations to develop certified programs for IHSS workers and has engaged in discussions with SEIU and local community colleges.

Within the scope of the Duals Demonstration Project, Molina will work with clinicians and advocacy groups to implement a model of care specifically designed to address the unique needs of dual eligible members with dementia or Alzheimer's disease that will include incorporating the IHSS worker (often a family member) into the diagnostic and treatment planning. Molina will also offer specific educational courses, developed in conjunction with clinical experts, to the family and caregivers of those with these specific conditions.

- ***A plan for coordinating emergency systems for personal attendant coverage.***

  Due to the significant reliance on IHSS services to maintain their independence at home, dual eligible members must be able to contact their plan in case of an emergency and receive personal attendant services if and when their designated IHSS worker is not available. For all dual eligible members enrolled in the Duals Demonstration Project, Molina will contract for and provide temporary

emergency coverage, through a toll-free 24-hour hotline, when a member's IHSS worker cannot perform the designated services. All recipients will be provided this number in multiple formats at the time of assessment and authorization to ensure it is prominently displayed and available to the member. Molina also offers, as part of a limited pilot, a unique Keep in Touch (KIT) phone to eligible members. The KIT phone is free to members and comes preprogrammed with five phone numbers including the plan's Nurse Advise Line.

Section 2.3: Social Support Coordination

Applicants must:
Question 2.3.1 Certify that you will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.

Molina understands and will comply with the requirement to provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.

Question 2.3.2 Describe how you will assess and assist beneficiaries in connecting to community social support programs (such as Meals on Wheels, CalFresh, and others) that support living in the home and in the community.

Under the Duals Demonstration Project, Molina intends to continue its existing efforts at identifying unmet beneficiary needs, locating available community resources and assisting the beneficiary in accessing local programs, such as Meals on Wheels, food banks, transportation and housing assistance. Currently, Molina conducts in-home Health Risk Assessments for its SPD population that, if necessary, assist in the coordination and provision of additional LTSS in the home such as personal care assistants, home modification and assistance with adult family home placement. These coordination activities also include assisting beneficiaries with securing food and housing assistance as available in the community.

Molina's Integrated Care Management Model will serve dual eligible members in the Duals Demonstration Project based on comprehensive integrated

medical/social care management focused on promoting the coordination of social support and medical services across the entire continuum of care. By accurately identifying a member's unique health care needs, with special emphasis on appropriate resource utilization based on the member's clinical, social and behavioral health care concerns, Molina's Integrated Care Management Model supports healthy and effective care settings that allow members to live in their homes and communities.

In addition, Molina's Care Managers will coordinate a member's access to local resources including housing, food and home and-community based services. Molina is currently working with Partners in Care Foundation (PICF) to develop an electronic database of LTSS, state and community organizations, and resources which are specific to Sacramento County and searchable by type of service and geography. Molina also intends to create shared resources and links in the community so that both plans can assist members in accessing these services. The database will be accessible to all providers, caregivers and members.

Question 2.3.3 Describe how you would partner with the local Area Agency on Aging (AAA), Aging and Disability Resource Connection (ADRC), and/or Independent Living Center (ILC).

The mission of local ADRCs has traditionally been to support consumer decision-making, streamline access to appropriate long-term care services and facilitate LTSS. Molina currently partners with ADRCs in counties in which there

are ADRCs on a number of services they provide, including staff training on availability of community resources and advocacy and outreach events. Expansion of this type of collaboration, which could involve Area 4 Agency on Aging, may include contracting to perform face-to-face initial health assessments, hospital discharge planning, transition planning from skilled nursing settings to independent living settings and other assistance identifying physical and/or communication barriers to accessing care. Molina's Care Management team will consult closely with collaborating entities to enhance Molina's existing person-centered model of care and streamline member access to needed social supports.

Molina believes such health and wellness program partnerships with local ADRC-related agencies could help to reduce health disparities in people with multiple chronic and co-morbid conditions.

Molina seeks out and supports partnerships with local independent living centers and/or departments on aging and adult services on an ongoing basis to create new opportunities to improve overall member health by maximizing the strengths of each organization.

Question 2.3.4 Describe how you would partner with housing providers, such as senior housing, residential care facilities, assisted living facilities, and continuing care retirement communities, to arrange for housing or to provide services in the housing facilities for beneficiaries.

Due to their low income, dual eligible beneficiaries are especially at risk for housing instability and may be unnecessarily institutionalized because of the inherent bias in the Medicaid program that pays for room and board in a nursing home, but not in a lower-level care facility. Under the Duals Demonstration Project, Molina intends to use its Community Connectors to initiate and develop relationships with local housing providers and community resources to assist beneficiaries with housing needs.

Molina will coordinate health care provider visits to dual eligible members residing in residential care facilities, assisted living facilities and other similar housing communities in Sacramento County that cannot otherwise be safely or comfortably transported to a provider's office setting or facility. This coordination will reduce unnecessary duplication and ensure that all eligible beneficiaries receive preventive and primary care without requiring multiple physicians to travel to these residential settings on a case-by-case basis. For members residing in these coordinate these provider resources to ensure access and timely referral.

Section 3: Coordination and Integration of Mental Health and Substance Use Services

The Applicant must:
Question 3.1 Describe how you will provide seamless and coordinated access to the full array of mental health and substance use benefits covered by Medicare and Medi-Cal, including how you will:

Molina is committed to integrated care coordination that ensures behavioral health (mental health and substance use disorder) care needs are assessed and managed within the broader context of other medical care management needs, in order to address issues of unidentified or undertreated behavioral health conditions that adversely impact medical outcomes, costs and quality of life. Molina's integrated care approach for the dual eligible population has been used to serve over 200,000 members in Molina Healthcare plans located in New Mexico, Texas and Washington. Since 2005, the Washington Medicaid Integration Partnership (WMIP) program has provided intensive case management and care coordination for the disabled and dual eligible populations by integrating mental health, chemical dependency, long-term care, medical, and pharmacy benefits at the administrative and direct delivery levels. Through this program, Molina Healthcare of Washington has successfully improved quality outcomes, reduced inappropriate inpatient admissions, lengths of stay, readmissions, and emergency room utilization. Molina's care management approach ensures that dual eligible

members receive the full array of mental health and substance use disorder care including the following elements:

Integrated Care Management

- Cross-disciplinary integrated care management teams, comprised of behavioral health professionals and medical nurse case managers adept in identifying and supporting mental health and substance use disorder needs within the broader context of integrated care management of medical and LTSS;
- Utilize validated assessment tools, such as the PHQ9 (Patient Health Questionnaire 9 items) assessment of depression, and the MAST (Michigan Alcoholism Screening Test), DAST (Drug Abuse Screening Test) or AUDIT (Alcohol Use Disorders Identification Test) tools for assessment of substance use disorder treatment needs, to identify needs and monitor progress and treatment response;
- Cross-communication and appropriate linkages among various providers, advocacy groups, community supports and family or other support networks through the exchange of information, support and follow-up monitoring;
- Evidence-based techniques, such as behavioral activation, motivational interviewing or other relevant skills;
- Regularly scheduled caseload consultation with the team psychiatrist or psychiatric advanced registered nurse practitioner and the behavioral health

team, communicate treatment recommendations to the member's PCP or other care specialists in the member's integrated care management teams, and facilitate or monitor medication changes or other treatment plan changes;

- Coordination of admission and discharge planning, treatment objectives and projected lengths of stay with community mental health and substance use disorder treatment center as well as state psychiatric facilities; and
- Appropriate follow-up with behavioral health providers within 24 hours of discharge of an inpatient psychiatric stay to reschedule if the member misses the aftercare appointment.

Effective Member Communication and Education

- Communication techniques to engage members in an effective treatment plan that includes monitoring and documenting progress;
- Member awareness of behavioral health benefits available through both Medicare and Medi-Cal and facilitating member access to these benefits;
- Education for members regarding their behavioral health benefits and ability to self-refer;
- Member education about common mental health and substance use disorders and available treatment options;
- Health coaching to encourage member engagement in their treatment to maximize treatment success, including supporting the member through

initiation of antidepressant medication which often results in early cessation of treatment due to initial side effects and a 4-to-12-week period before positive benefits are experienced; and

- Behavioral Health Hotline services accessible through a toll-free number, automated complaint and inquiry tracking, rapid resolution of problems, trend analysis and management of customer expectations, including contract compliance.

Enhanced Physician Support

- PCP assessment of behavioral health needs by providing assessment tools and associated training;
- Referrals outside the PCP for other clinically indicated services;
- Cross-communication between the member's PCP and behavioral health treatment team;
- Support to the psychiatric prescriber by communicating and documenting side effects as well as effectiveness of the prescribed treatment, and follow up as appropriate; and
- Psychiatric specialist support, such as consultative services for case review, as needed, to PCPs who agree to manage psychotropic medications for members who prefer PCP management.

- ***Incorporate screening, warm hand-offs and follow-up to identify and coordinate treatment for substance use.***

Molina supports innovative mechanisms to identify members in need of substance use treatment. Molina will educate its provider network, including hospitals, primary care physicians and other community providers on mechanisms to incorporate and utilize the Screening, Brief Intervention and Referral to Treatment (SBIRT) approach to dual beneficiaries. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Through this education, Molina's providers will be able to provide opportunities for early intervention with at-risk substance users before more severe consequences occur. SBIRT has been shown to provide significant results: A 2009 article in the journal *Drug and Alcohol Dependence*, for example, found an almost 68-percent reduction in illicit drug use over a 6-month period among people who had received SBIRT services. SBIRT is successful because:

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.

- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

In addition to utilizing SBIRT in its provider network, Molina members are assessed using a general Health Risk Assessment that includes specific questions about substance use that signal the need for a more robust assessment of potential substance use disorder treatment needs. Other members are identified for outreach through utilization data analysis and predictive modeling that includes claims for both psychiatric and substance use disorders. Molina Care Managers use validated tools, such as the MAST, DAST and AUDIT, to assess referral needs and monitor treatment progress. Members are assisted by linkage to a substance use disorder treatment facility or provider that can conduct a full clinical assessment. Subsequent authorization of the appropriate level of care is provided in accordance with the Patient Placement Criteria of the American Society of Addiction Medicine (ASAM).

- ***Incorporate screening, warm hand-offs and follow-up to identify and coordinate treatment for mental illness.***

  Molina Care Managers use validated tools, including the PHQ9 assessment of depression or the Edinburg Post-partum Depression scale, to assess referral needs and monitor treatment progress. Members are given referral assistance in scheduling an appointment with a provider. Molina Care Managers are trained in

accessing help directly while keeping the member on the line if there is an immediate need for intervention. Molina will conduct a warm transfer to a community support service, crisis line or other provider when member safety can be assured. In the event of immediate risk, the Care Manager keeps the member on the phone while emergency services are contacted for intervention and until they arrive.

Question 3.2 Explain how your program would work with a dedicated Mental Health Director, and/or psychiatrist quality assurance (preferably with training in geriatric psychiatry).

Molina will support the Duals Demonstration Project's goal of integrating behavioral health benefits by hiring a dedicated Behavioral Health Director to oversee program development, care coordination activities, and serve as a community liaison with provider groups, members and advocates. In addition, the Behavioral Health Director, who is a board certified physician with behavioral health specialization, will provide senior clinical oversight, case review, inpatient peer reviews and level of care authorization determinations. In the event that a psychiatrist with geriatric training is not available to fill this position, Molina will ensure that a contracted psychiatric gerontologist is available on a consultative basis.

Question 3.3 Explain how your program supports co-location of services and/or multidisciplinary, team-based care coordination.

Molina will leverage the Molina Healthcare of Washington experience with co-location to evaluate expansion of services offered in California to serve dual eligible beneficiaries with behavioral health needs and LTSS. Molina will assess possible co-location within the Molina network. Molina's multidisciplinary Care Management teams are geographically located within each contracted service area to facilitate addressing the full range of members' physical, behavioral and social needs. These regional teams are composed of medical and behavioral health professionals and support specialists experienced in managing members' whole-health needs through the utilization of diverse providers and community support services. Members are assigned to either medical or behavioral health Care Managers depending on their most prominent care need. Medical and behavioral health professionals in the member's care team participate in consultative exchanges on the member's care and may share Care Management functions.

Question 3.4 Describe how you will include consumers and advocates on local advisory committees to oversee the care coordination partnership and progress toward integration.

Molina members in Sacramento County actively participate in quarterly Member Participation Committees (MPC), which provide a forum for member input on access and availability of care and services. Transportation to and from each meeting is provided for members when requested.

The primary functions of the MPCs are to:

- Develop strategies to improve member satisfaction;
- Ensure clear understanding of the grievance and appeals process;
- Provide counsel on the development of new member materials and the availability of materials in alternate formats;
- Express general and specific concerns regarding provider care, including physical and communication access challenges, interpreter services; and
- Act as a focus group to assist with the evaluation of health plan service improvement.

Seniors and Persons with Disabilities (SPD) and dual eligible members who participate in local MPC meetings also have the opportunity to participate in Molina's unique statewide Bridge2Access Advisory (B2A) Committee. The B2A Committee includes individuals from every county that Molina serves, SPDs and dual eligible members, and community organizations that are familiar with the disabilities and chronic conditions of Molina's dual eligible members. The B2A Committee reviews Molina's existing programs and services, providing feedback and recommendations for improvement. As a key forum for topics of concern to Molina's dual eligible and SPD members, the B2A Committee will serve in an advisory capacity to monitor Molina's care coordination partnerships and its progress toward integrating LTSS for dual eligible members.

Bridge2Access members that are based in Sacramento County include:

- Chronic Care Coalition, which is a unique alliance of more than 30 leading consumer health organizations and provider groups that promote the collaborative work of policy makers, industry leaders, providers, and consumers to improve the health of Californians with chronic conditions.
- California Foundation of Independent Living Centers (CFILC), which advocates for barrier-free access and equal opportunity for persons with disabilities to participate in community life by increasing the capacity of Independent Living Centers across California.
- Opportunities for stakeholder collaboration exist through Molina's commitments with other local collaborative as well.

Section 3.2: County Partnerships

Question 3.2.1 Describe in detail how your model will support integrated benefits for individuals severely affected by mental illness and chronic substance use disorders. In preparing the response, keep in mind that your system of care may evolve over time, relying more heavily on the County in Year 1 of the Demonstration. (See Appendix G for technical assistance on coordinating and integrating mental health and substance use services for the seriously affected.)

Working in partnership with county agencies, Molina will assess beneficiaries with serious and persistent mental illness and refer them to a Molina contracted provider or county mental health agency. Transportation to these providers will be offered to ensure beneficiaries are able to attend appointments and receive services. Molina Care Managers will work with the member's primary care and mental health providers to ensure services are coordinated and an integrated treatment plan is utilized. Given that some members may not be capable to participate in their own care coordination, Molina's Care Managers will serve as a primary point of contact with the member, their designated guardian, conservator or other individual participating in the member's care treatment plan. In consultation with the member and their representative, Molina Care Managers will have the responsibility to coordinate appointments and ensure that all care delivery teams are informed and up-to-date on the member's treatment plan and changes. Molina Care Managers will also ensure that the designated IHSS worker and/or family members and caregivers are included in care planning and coordination.

Question 3.2.2 Provide evidence of existing local partnerships and/or describe a plan for a partnership with the County for provision of mental health and substance use services to the seriously and persistently ill that includes measures for shared accountability and progress toward integration in the capitated payment by 2015.

Molina has diligently sought to establish partnerships with the County to ensure seriously and persistently ill members have access to mental health and substance use disorder services. Molina is working on updating its memorandum of understanding (MOU) with Sacramento County Division of Mental Health. Molina fully intends to update and enhance its MOU for the provision of mental health and substance use services. The existing MOU outlines operational protocols for the County and Molina, which include the following areas:

- Scope of services;
- Diagnostic assessment and triage;
- Referrals;
- Service authorizations;
- Mental Health Plan network;
- Fee-for-service mental health services;
- Consultation and training;
- Psychotropic medications and Recommended Drug List;
- Laboratory testing;
- In- and out-of-area emergency room services;

- Nursing facility services;
- Medical transportation;
- Home health services;
- Services for the Developmentally Disabled;
- Inpatient psychiatric history and physicals;
- Confidentiality guidelines for exchange of medical information;
- Notification of referrals from out of plan;
- Provider/member education;
- Grievances and complaints;
- Dispute resolution process;
- Radiological and radioisotope services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental services and California Children's Services (CCS);
- Psychiatric nursing facility services;
- Financial considerations;
- Data/information collection, sharing and confidentiality;
- Provider training;
- Quality Assurance/Quality Improvement;
- Ancillary mental health services;

- Hospital outpatient department services;
- Medical necessity criteria for specialty mental health;
- Physician services; and
- Services excluded from coverage

Starting in Year 1 of the Duals Demonstration Project, Molina will work with its county mental health agency partners to develop care coordination incentives and performance measures in order to target the SPMI populations in greatest need of integrated services. One possible incentive could be the creation of a shared savings pool if the population receives improved care coordination and inappropriate medical care utilization is reduced. These options will be explored and included in the MOU with the county as appropriate. By 2015, Molina intends to contract with each county mental health plan to continue to provide specialty mental health services or inpatient care for members with SPMI.

- ***Describe how you will work with County partners to establish standardized criteria for identifying beneficiaries to target for care coordination.***

As a starting point for initiating standardized criteria, Molina will offer its DHCS-approved Health Risk Assessment and engage with its county partners to ensure members are appropriately identified to receive coordinated treatment for their behavioral and medical needs. Molina's Integrated Care Management team has developed strong working relationships with its County Behavioral Health and

Regional Center contacts. Molina will continue to establish quarterly meetings with these partners to further define each entity's roles and responsibilities to ensure Molina members receive all necessary behavioral health services and to coordinate members' medical, mental health, substance use disorder and social needs. Discussions will include a joint evaluation and development, and creation of shared criteria for identifying members who would benefit from specialized services, such as care coordination and integrated care management.

- ***Describe how you will overcome barriers to exchange information across systems for purposes of care coordination and monitoring.***

  Molina will work with the County, as well as the other participating Duals Demonstration Project plans, to draft and amend existing MOUs to establish clear, consistent assessment criteria as well as referral protocols to overcome information exchange barriers. Molina intends to establish a new behavioral health services MOU with Sacramento County to clarify roles and responsibilities regarding the care of individuals with serious or persistent mental illness and/or substance use disorders.

  Historically, a significant barrier to integrated physical and behavioral health has been the transmission of patient-level data and information regarding treatment and prescribed medication. Molina believes that any new county agreement or contract must allow for this information to be shared in an appropriate and

confidential manner to ensure the member's needs are understood and addressed by the integrated care delivery team. All executed contracts will adhere to the appropriate state and federal laws governing patient confidentiality.

Section 4: Person-Centered Care Coordination

The Applicant must:
Question 4.1 Describe how care coordination would provide a person-centered approach for the wide range of medical conditions, disabilities, functional limitations, intellectual and cognitive abilities among dual eligibles, including those who can self-direct care and also those with dementia and Alzheimer's disease.

Since 2006, Molina has been managing Medi-Cal and Medicare services, and today serves more than 6,400 dual eligible beneficiaries in California, providing integrated care coordination and person-centric care management for members who have multiple or complex conditions. Molina utilizes a person-centered care management approach that considers the wide range of intellectual and cognitive abilities of dual eligible members, including individuals with dementia and Alzheimer's disease, by arranging for a broad spectrum of care that often requires integration of overlapping services, including coordinating acute, mental health, substance use disorders and LTSS.

Molina thoroughly screens dual eligible members for risk stratification to determine the urgency for health care services and performs an in-depth Health Risk Assessment to assign them to basic or complex care management. Members who are assessed as appropriate for high-level interventions are enrolled in Molina's Complex Care Management and are assigned a Care Manager, who will act as the member's primary point-of-contact to ensure consistent and efficient communication between members and their care delivery teams.

In Molina's Integrated Care Management Model, Care Managers manage high-risk members, including working with their PCP, members, families/care givers and other providers, to develop person-centric care plans that establish coordination of comprehensive services such as physician visits, pharmacy, hospital care, skilled nursing care, IHSS and LTSS authorized under Medicaid waivers. For plan members who want to self-direct care, Molina Care Managers will provide them with available resources necessary to help facilitate their ability to access the care to which they are entitled. Where appropriate, the Molina Care Manager will work with the member's authorized patient representative, conservator, public guardian or family member.

Question 4.2 Attach the model of care coordination for dual eligibles as outlined in Appendix C. This will not count against any page limit.

See Attachment 4.2-1 for Molina's 2012 Medicare Model of Care that incorporates tracked changes for serving dual eligible members under the Duals Demonstration Project as outlined in Appendix C.

Question 4.3 Describe the extent to which providers in your network currently participate in care coordination and what steps you will take to train/incentivize/monitor providers who are not experienced in participating in care teams and care coordination.

Molina's contracted providers will be central to the success of the Duals Demonstration Project. In recognition of the additional care management and coordination requirements that will be expected from providers, Molina is

considering a variety of incentives for the enhanced responsibility, including, but not limited to, pay-for-performance and additional reimbursement for specific care coordination activities. Molina's contracted PCPs agree to serve as the clinical focal point of the patient's care team and are assisted in providing comprehensive, integrated benefits by Molina's Care Managers, who coordinate clinical and LTSS for members. Existing network providers are offered ongoing training by Molina's staff using information provided through Molina's online Web Portal, the Provider Manual and "Just the Fax" bulletins. Molina's Care Management and Provider Services teams offer one-on-one training to providers based on provider and member needs.

Molina's Provider Services staff also conduct a new PCP orientation for each newly contracted PCP within ten (10) days of their contract effective date with Molina. This new PCP orientation is performed in-person at the provider's office and includes an overview of Molina's Care Access and Monitoring, and Care Management procedures and tools. Molina supplies a new PCP orientation packet that contains prior authorization and care coordination training materials and resources. Molina's Provider Services staff also conduct similar orientations for specialist and ancillary providers, including newly contracted LTSS providers, on an ongoing, as needed basis.

Additionally, Molina monitors providers and gives feedback through Needed Service Reports, IPA data and care management interactions.

Section 5: Consumer Protections

Applicant must:
Question 5.1 Certify that your organization will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU. Sites shall prove compliance during the Readiness Review.

Molina understands and will comply with the requirement to be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU.

Section 5.1: Consumer Choice

Applicant must:

Question 5.1.1 Describe how beneficiaries will be able to choose their primary provider, specialists and participants on their care team, as needed.

In alignment with DHCS' objective to preserve beneficiary choice, Molina supports members' participation in decisions about their health, including the ability to choose their care providers. Molina provides comprehensive information to beneficiaries and/or their representatives regarding its provider network in advance of initial enrollment to allow for time to review options and select a PCP. The member selects a PCP and other providers, including the locations of any emergency settings and pharmacies in close proximity to where they live, using the Provider Directory, which also includes physical accessibility symbols to help members select a provider that meets their physical accessibility needs. Because patients' trust and comfort level with their PCPs are essential, Molina offers an array of PCPs from which members may select, including linguistically diverse providers representing threshold languages for general practice, family practice, internal medicine and pediatric provider types.

Newly enrolling members must select assignment to a PCP or Molina will assign an appropriate PCP for each defaulted member based on the plan's default auto-assignment criteria, which includes the member's language, geographic location, age and continuity of care. In addition, Molina uses the member's fee-for-

service utilization data or other data sources, in compliance with all federal and state privacy laws, to establish existing provider relationships for the purpose of PCP assignment. Molina utilizes the New Member Welcome Call performed within the first 30 days of enrollment to emphasize the importance of establishing a relationship with a PCP. During the Welcome Call, members are given the opportunity to change their assigned PCP to a PCP of their choice. Members may also contact Member Services through the telephone or TTY service to change their assigned PCP. Molina's ePortal, which members may access to choose a provider and change their PCP, is also available 24/7. After their first 30 days of enrollment, members may change their PCP at any time by contacting Member Services. If a member requests to have a specialist serve as their PCP, and the specialist agrees to function in that role, the plan will work accordingly with the requested specialist.

Members may choose to receive services from a contracted specialist by requesting a referral from their assigned PCP. To access a non-contracted specialist, members may request continuity of care from the plan.

Members always have the right to select the participants on their care team, which can include the member's PCP, rendering specialists, a Molina Care Manager, a caregiver, an authorized representative, a legal guardian or other providers that are involved in their care. The member selects their care team

through the assigned Molina Care Manager, who helps the member develop and maintain a person-centric care plan.

Question 5.1.2 Describe how beneficiaries will be able to self-direct their care and will be provided the necessary support to do so in an effective manner, including whether to participate in care coordination services.

One of Molina's fundamental Care Management principles is to ensure every member has a choice of options and is empowered to achieve or maintain the highest level of self-sufficiency. Molina believes true consumer engagement encourages members to play an active role in their treatment by allowing members to voice their opinions and goals, and participate in the establishment of care plans. Molina's Care Managers utilize a person-centered approach to collaboratively develop a comprehensive plan of care with members that promotes the highest level of functioning in the least restrictive setting. Molina gives the member (or designated representative) choices in managing the activities of their daily living needs, including an option for self-directed services. Molina members will also be offered a self-directed care coordination option as an alternative for those who wish to directly oversee their care.

Section 5.2: Access

Applicant must:
Question 5.2.1 Certify that during the readiness review process you will demonstrate compliance with rigorous standards for accessibility established by DHCS.

Molina understands and will comply with the requirement to demonstrate compliance with rigorous standards for accessibility established by DHCS as part of the Readiness Review.

Question 5.2.2 Discuss how your program will be accessible, while considering: physical accessibility, community accessibility, document/information accessibility, and doctor/provider accessibility.

Molina created the Bridge2Access Program to meet the needs of plan members with disabilities and/or functional limitations. Without a separate product line to identify members with access challenges, there was concern that needs and/or barriers to care would go unrecognized. Molina's Bridge2Access Program makes access to quality health care services its highest priority. Bridge2Access streamlines members' process for obtaining accessible healthcare services, regardless of product line, through the use of member informing materials, online tools and information, one-to-one interaction with a Care Manager, and community outreach. Bridge2Access Program staff serve as a resource to network and external providers for training; policy and procedure development; ensuring appropriate physical and communication accommodations, including ordering qualified ASL interpreters; assistance in obtaining materials in alternate formats; and coordination

of available community resources, such as home modification grants, finding local food banks and obtaining IHSS.

Molina uses the state-approved Facility Site Review (FSR) survey to assess the accessibility of PCP and certain high volume specialists' offices. The survey determines if there is accessible parking, access in and around the building, access in an around the exam room, and if accessible medical equipment is available, such as height adjustable exam tables and wheelchair weight scales. Molina has invested in significant IT resources to ensure this information is available in Molina's online and hardcopy Provider Directory, which enables members to choose a provider based on their accessibility needs. Members can also obtain this information by calling Molina's Member Services.

New and retrofitted Molina Medical Group clinics have universal architectural design modifications that include accessible equipment, such as height adjustable exam tables, wheelchair weight scales, on-site generic medication prescription dispensing, assistive listening devices, and other accommodations, including accessible restrooms, waiting areas, and exam rooms.

While Molina has invested significant effort in identifying PCPs who have modified their offices to meet basic access needs, there remain opportunities to increase the number of PCPs and specialists who can meet the accessibility requirements. Molina's FSR Nurses who perform the survey also make

recommendations to providers on accommodations to consider. Training is provided to PCPs and specialists with a focus on making their offices accessible, and information is provided regarding the tax incentives available for making modifications. Molina will develop strategies to increase the number of accessible provider offices by working with local independent living centers and other disability advocacy organizations.

Molina also ensures that members have access to materials in alternate formats, including Braille, large font, audio and electronic formats. Requests for materials in alternate formats are obtained by Member Services and forwarded to the Disability & Senior Services Access Department. See Attachment 5.2.2-1 Request for Materials in Accessible Formats. Much of the requested information is on-hand and delivered within seven (7) working days. Health Education and other materials are available in large font and audio format on Molina's member website.

Molina includes a plan benefit that enables members in need of a wheelchair or other non-emergent transportation to receive transportation to their medical appointment or to pick up a prescription. In addition, Molina created a resource guide called "Community Connect" for use by Care Management and Member Services staff to find local resources for members. As new resources are identified, in-service trainings are scheduled to educate staff about available benefits and resources that may be useful to members.

Question 5.2.3 Describe how you communicate information about the accessibility levels of providers in your network to beneficiaries.

Molina is committed to ensuring members can choose a provider based on their individual access needs. To prepare for the transition of SPD beneficiaries into managed care, Molina invested significant resources to ensure the increase of provider accessibility information that is presented in a clear and easy-to-understand format in Molina's online and written Provider Directory. Molina utilizes the standardized accessibility symbols required by DHCS to identify providers with "Basic" and "Limited" access, as well as identifying:

- Accessible parking;
- Exterior building access;
- Interior building access;
- Waiting room/reception room access;
- Accessible restrooms;
- Accessible exam rooms;
- Availability of height adjustable exam tables; and
- Availability of a wheelchair weight scale.

See Attachment 5.2.3-1 for the introduction to the Provider Directory, pages 6-7, and Attachment 5.2.3-2 for screen shots of the online and written Provider Directory showing accessibility indicators.

In addition to the information offered to members in the online and written Provider Directory, Molina Member Services and Care Management staff will often assist members in finding an accessible provider during the Welcome Call and Health Risk Assessment process, which is completed within the first month of enrollment.

Section 5.3: Education and Outreach

Applicants must:

Question 5.3.1 Describe how you will ensure effective communication in a range of formats with beneficiaries.

Molina ensures effective member communication by making information available in a variety of formats. All member informing materials and health education materials are written in English at a 6th grade reading level or below. Materials are translated into Molina's threshold languages, including Arabic, Chinese, Hmong, Russian, Spanish and Vietnamese. Materials are also available in accessible formats, such as audio, Braille and large font. Molina's member website is published in English, Chinese, Hmong, Russian, Spanish and Vietnamese. The member website is also Section 508 compliant to ensure accessibility for people with disabilities. Please refer to Attachment 5.3.1-1 Policy and Procedure HE-03 "Communications to Members" for more information on Molina's communication with members.

Question 5.3.2 Explain how your organization currently meets the linguistic and cultural needs to communicate with consumers/beneficiaries in their own language, and any pending improvements in that capability.

Molina develops unique and traditional approaches to oral and written communications to address the diverse cultural and linguistic needs of its members. Members are informed about available written translation and interpreter services through the plan's member handbook/evidence of coverage, which

includes members' rights, and through periodic newsletters, the member website, new member Welcome Calls and Interpreter Request Cards ("I Speak" cards). The wallet-size Interpreter Request Cards provide members and providers with information about the linguistic resources available to Molina members. Members who are limited English proficient (LEP) have access to telephonic interpreter services available 24-hours per day. Face-to-face interpretation, including Sign Language, is also provided for requesting members. TTY/TDD and the California Relay Service (711) are available to members who are deaf, hard of hearing or have a speech impairment.

Additionally, as a Hispanic minority-owned company, Molina has formed the Molina Institute for Cultural Competency, which provides ongoing research, evaluation, consultation, training and support materials, policy and procedure review, and recommendations to improve language and cultural competency.

Please refer to Attachment 5.3.2-1 Policy and Procedure HE-09 "Interpreter Services/Language Access" for more information on how Molina communicates in linguistically and culturally appropriate ways with the plan's membership.

Question 5.3.3 Certify that you will comply with rigorous requirements established by DHCS and provide the following as part of the Readiness Review:

- ***A detailed operational plan for beneficiary outreach and communication.***

Molina understands and will comply with the requirement to provide a detailed operational plan for beneficiary outreach and communication as part of the Readiness Review.

- ***An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs.***

  Molina understands and will comply with the requirement to provide an explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs as part of the Readiness Review.

- ***An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.***

  Molina understands and will comply with the requirement to provide an explanation of its approach to educating counselors and providers to explain the benefit package to beneficiaries in an easily understandable way as part of the Readiness Review.

Section 5.4: Stakeholder Input

The Application must:
Question 5.4.1 Discuss the local stakeholder engagement plan and timeline during 2012 project development/implementation phase, including any stakeholder meetings that have been held during development of the Application.

In 2009, Molina established the Bridge2Access Advisory Committee to provide a forum for structured input on operations and services the plan provides to its growing population of SPDs. The Bridge2Access Advisory Committee includes plan members who are dual eligible beneficiaries and SPDs, advocates and other stakeholders from several disability and senior organizations, including but not limited to Independent Living Centers, Regional Centers, Aging & Adult Services, as well as organizations that serve dual eligible beneficiaries, deaf/hard of hearing and blind/low vision. The committee currently meets biannually with the objectives of:

- Advising plan leadership on developing innovative and unique programs to address the needs of people facing barriers when accessing healthcare; and
- Serving as a key forum for reviewing Molina's existing programs and services in order to provide feedback and recommendations for improvement.

See Attachment 5.4.1-1 for the Bridge2Access Committee Charter and Attachment 5.4.1-2 for the Bridge2Access Committee Roster. In preparation for

the Duals Demonstration Project, Molina staff sought from stakeholders and advocates at the December 8, 2011 Bridge2Access Advisory Committee meeting.

Question 5.4.2 Discuss the stakeholder engagement plan throughout the three-year Demonstration.

Molina's plan for the development of the stakeholder engagement process in 2012 includes the following steps:

First Quarter 2012

- B2A Advisory Committee: Molina has already begun the process of identifying stakeholders that would be appropriate for a subcommittee of the B2A Advisory Committee to provide appropriate and meaningful input regarding the Duals Demonstration Project. Subcommittees will be locally based, and will include at least one member from the Bridge2Access Advisory Committee. Subcommittee members will include representatives from Aging & Adult Services, Independent Living Centers, Department of Behavioral Health, Local Public Authority and IHSS. Molina members who are dual eligible and ages 65 and older, Molina members who are dual eligible and ages 65 and younger, and Molina members who utilizes IHSS will also be included on the subcommittee.
- Member Participation Committee: Molina will receive member input on access and availability of care and services for serving dual eligible beneficiaries.

- County Engagement: Molina has met with the county agency in Sacramento County to initiate discussions about the integration of IHSS services into the comprehensive services.
- Second Quarter 2012
- Molina will begin obtaining commitments from identified stakeholders and schedule meetings for each county.
- Member Participation Committee: Molina will receive member input on access and availability of care and services for serving dual eligible beneficiaries.
- National Advisory Committee: Molina Healthcare, Inc. is in the process of forming a national advisory committee for serving special needs populations, including dual eligible members. The Advisory Committee will represent the broad spectrum of expertise encompassing the clinical care, patient advocacy, LTSS, social and behavioral services and care integration needs of low-income special needs populations such as those dually eligible for Medicare and Medicaid programs. The expertise of each committee member will reflect their personal and professional experience with a special needs population and will contribute to Molina's delivery of care by:
    - Reviewing and providing comment on the appropriate care based on the best available scientific evidence and broad consensus;

- Suggesting methods to reduce inappropriate variation in care practices;
- Providing a more rational basis for referral;
- Promoting independence and diversion from institutionalization; and
- Offering perspective on the complex set of factors that contribute to the medical vulnerability of the populations served by Molina.

Third Quarter 2012

- The first meeting of the Dual Eligible Subcommittee of the Bridge2Access Advisory Committee will be held.
- Molina will finalize and secure contracts with the county agencies for IHSS and behavioral health services.
- Member Participation Committee: Molina will receive member input on access and availability of care and services for serving dual eligible beneficiaries.
- Molina will hold the first National Advisory Committee for Special Needs Populations.

Fourth Quarter 2012

- A report will be prepared by region and entered into the minutes of the biannual Bridge2Access Advisory Committee.

- Member Participation Committee: Molina will receive member input on access and availability of care and services for serving dual eligible beneficiaries.
- Molina will hold its second National Advisory Committee for Special Needs Populations.
- Molina will work with county IHSS and mental health agencies to ensure the readiness reviews are conducted and any implementation issues are addressed.

2013 and Beyond

- The regional Dual Eligible Subcommittee meetings will occur quarterly and reports will be entered into the minutes of the biannual B2A Advisory Committee. Molina anticipates that once regional challenges are identified, there will be opportunities to vet and implement stakeholder recommendations.
- Molina Healthcare Inc. will hold quarterly meetings of the National Advisory Committee for Special Needs Populations and will ensure that the meeting notes and outcomes are shared with its state plan presidents.

Question 5.4.3 Identify and describe the method for meaningfully involving external stakeholders in the development and ongoing operations of the program. Meaningfully means that integrating entities, at a minimum, should develop a process for gathering and incorporating ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.

The Bridge2Access Advisory Committee was designed to include the senior leadership of Molina to ensure its meaningful impact on plan operations. The

Bridge2Access Advisory committee is facilitated by the Chief Medical Officer of Molina. Molina attendees include the Plan President, Vice President of Provider Services, Associate Vice President of Government Contracts, Quality Improvement Director, Director of Member Services and Director of Disability and Senior Access Services. This structure ensures that issues of concern to plan members, including dual eligible members and SPDs, will be heard by leaders in the position to make meaningful changes. During the last two years, the Bridge2Access Advisory Committee has been instrumental in advising Molina about the following:

- Accessible website enhancements;
- Ease of obtaining materials in alternate formats;
- Guidance on policy issues that affect SPDs and dual eligible members, including accessibility of covered services and the plan's member grievance and appeals process;
- Molina Medical Group accessible design standards;
- Development of member informing materials; and
- Development of pilot programs designed to improve the health outcomes of seniors and persons with disabilities.

Molina proposes to create a collaborative involving participating health plans to provide a method for the meaningful involvement of external stakeholders in the development and ongoing operations of the Duals Demonstration Project. This forum would help unit and mobilize organizations to better serve dual eligible beneficiaries, while promoting equal opportunity, independence, and universal access. Health plans and stakeholders would be able to share resources about navigating services and resources from different organizations across the county. This collaboration would also represent a forum for providing ongoing feedback on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections throughout the three (3) year Duals Demonstration Project.

Section 5.5: Enrollment Process

The Applicant must:
Question 5.5.1 Explain how you envision enrollment starting in 2013 and being phased in over the course of the year.

Molina recommends an enrollment model that provides the member (and their legal guardian, representative(s), etc.) a choice of health plans and PCPs with which to enroll. Ideally, the enrollment model should mirror the process used by DHCS to mandatorily enroll SPD beneficiaries, with additional outreach and educational effort by the state, plans, providers, advocates and community organizations. Based on their birth month, dual eligible beneficiaries should be given ninety (90) days to make a health plan and PCP choice. Information regarding each health plan and its respective provider network should be provided to the beneficiary 120 days in advance of initial enrollment. If a beneficiary has not made an enrollment selection within the 90-day period, they should be passively enrolled into a health plan taking into account prior utilization and claims data. For beneficiaries with no clear pattern of prior utilization, those beneficiaries should be assigned on an equal one-to-one basis between contracting plans in the Duals Demonstration Project. In subsequent Duals Demonstration Project years, this default enrollment mechanism should be adjusted based upon quality outcomes.

In order to ensure that a phased-in passive enrollment approach is effective, Molina will collaborate with partners such as SEIU and other organized labor

organizations to educate IHSS providers on making initial contact with dual eligible members to determine transition of care needs, arrange for continuation of services, and communicate with providers and community-based groups to develop a solid collaborative foundation to ensure successful transition into the Duals Demonstration Project.

Question 5.5.2 Describe how your organization will apply lessons learned from the enrollment of SPDs into Medi-Cal managed care.

As a result of SPD enrollment into Medi-Cal managed care, Molina has had the opportunity to learn valuable lessons that can be successfully applied to the Duals Demonstration Project. Many of Molina's successes with enrollment of SPD members have resulted from its ability to quickly adjust staffing levels and create appropriate policies to address member needs. For example, Molina learned that SPD members calling the Member Services call center required additional time in order to resolve member inquiries. Based on this experience, Molina took immediate action to adjust staffing levels to accommodate the volume and length of member calls. Additionally, the complexity of members' needs, such as co-occurring conditions, a high rate of behavioral health issues and multiple social issues, required Molina to adjust clinical staff ratios. Although continuity of care requests were only slightly higher than anticipated, additional time was required to complete them for SPD members. On many occasions, incorrect eligibility

information regarding a member's identified conservator prevented the exchange of member information between Molina and the conservator. To address this issue, Molina developed and implemented a new process to avoid delays in member care.

Through the enrollment of SPD members, Molina learned the value of collaborating closely with Community-Based Organizations (CBOs). Molina realizes that beneficiaries who chose a plan based on their provider, hospital or pharmacy needs were less likely to disenroll or experience other challenges. Consequently, as preparation for the mandatory enrollment of SPDs into Medi-Cal managed care in 2011, Molina reached out extensively to local CBOs and provided them with tools and information for their consumers to assist them in making an educated health plan choice. Molina intends to use this learning experience for the enrollment of the dual eligible members. In addition to continuing to work with CBOs, Molina has entered into discussions with SEIU to collaborate on ways in which their IHSS providers can assist beneficiaries in enrolling and maintaining eligibility in the Duals Demonstration Project. SEIU, representing nearly 300,000 members, will be a powerful influence in educating their members about their role in the success of the Duals Demonstration Project and Molina intends to work closely with SEIU and other bargaining units to develop additional training and access to educational opportunities throughout the pilot.

Other lessons and opportunities for improvement learned from Molina's experience with the mandatory enrollment of SPDs include:

- Initial Health Risk Assessment

  To improve the rate of new members completing the initial health risk assessment, Molina is exploring the possibility of utilizing local Promotoras, ILCs, IHSS providers or other CBOs to conduct face-to-face assessments and provide member education and links to needed LTSS resources. Molina is also considering a pilot that would allow members to complete the Health Risk Assessment online, as members may be less apprehensive about responding to personal questions on the assessment if they are able to complete it independently.

- Consolidation of Assessments

  Molina recognizes the need to develop a simplified, standardized assessment tool that combines multiple assessments covering medical, behavioral health, social and LTSS.

- Availability of Accurate Data

  Molina will work with DHCS to develop strategies to improve the process of obtaining accurate member contact information.

- Risk Stratification

Molina will work with DHCS and stakeholders to upgrade the plan's risk stratification process to more rapidly identify and provide outreach to members who need services.

- Member Communication

  The Bridge2Access brochure was developed to inform members about available health care services. Molina recognizes the need to produce in-depth communications about health resources and ways to access benefits. Molina is considering developing a Bridge2Access magazine that would inform members how they can access their health care services, access local resources and improve their overall health status.

- Provider Education and Communication

  Molina's most successful training with the highest provider turnout has been when continuing education units (CEUs) are offered. Molina also recognizes the opportunity to educate out-of-network providers through state and professional organizations to improve Molina's success rate in bringing more providers into managed care, which will increase access and continuity of care for Molina's members. In recognition that providers have a key role in the success of the Duals Demonstration Project, Molina continues to explore

various methods of disseminating information to providers. Molina is considering a new provider education series in 2012.

Question 5.5.3 Describe what your organization needs to know from DHCS about administrative and network issues that will need to be addressed before the pilot programs begin enrollment.

- Molina requests clarity regarding DHCS's expectations for coordination with local IHSS programs in order for Molina to understand its role in the authorization and payment of these coordinated services. Molina would like to better understand the funding process and how the dollars will flow from the state to the plan to the IHSS program/worker.
- It is the understanding of Molina that DHCS will issue more guidance for Year 2 and Year 3 on integrating IHSS. In order to reach a formal agreement or contract with the county IHSS program before or by January 1, 2013, specific guidance or technical assistance will be needed from DHCS by June 2012.
- The final RFS does not have details requiring program administration, and/or program eligibility for LTSS services. More guidance from DHCS on these issues will facilitate managed care plans' contracting efforts with applicable LTSS program administrators.
- Do CMS and DHCS plan to conduct a joint Readiness Review?
- Molina understands that CMS has stated that they will rely on the state to develop/determine the network adequacy for LTSS. When will the state issue

guidance for LTSS network adequacy? What date will the state require the plans to have all LTSS provider contracts in place?

- Molina requests clarity regarding DHCS's expectations for coordination with local county mental health programs in order for Molina to understand its role in the authorization and payment of these coordinated services. Will DHCS require Molina to refer a dual eligible SPMI member requiring specialty mental health services to utilize a County resource if that resource is unavailable at the time of need? Or, is Molina allowed to refer a dual eligible SPMI member to our contracted behavioral health network if the County is unable to accommodate an urgent care need? Molina would like to better understand the funding process and how the dollars will flow from the state to the plan to a county for behavioral health services.

Additional requests for clarification:

- When will DHCS release the appeals and grievances processes contemplated in section 5.6?
- When will the plans be provided with the state's proposed actuarial sound rates as well as a description of the required funding flows?

Section 5.6: Appeals and Grievances

Applicants must:
Question 5.6.1 Certify that your organization will be in compliance with the appeals and grievances processes for both beneficiaries and providers described in the forthcoming Demonstration Proposal and Federal-State MOU.

Molina understands and will comply with the requirement to be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU.

Section 6: Organizational Capacity

The Applicant must:
Question 6.1 Describe the guiding principles of the organization and record of performance in delivery services to dual eligibles that demonstrate an understanding of the needs of the community or population.

Molina's entire 31-year history has been dedicated to serving the Medi-Cal population. In 2006, Molina began serving dual eligible beneficiaries and gained a deeper understanding of the complex challenges and disparities faced by this population. This knowledge and expertise form the core of Molina's overall guiding principles:

- Taking pride in the plan's responsibility to promote good healthcare through ethical actions and to collaborate with others to effectively shape the systems that serve plan members.
- Understanding the importance of being good stewards of the public's money through the prudent management of financial resources that includes leveraging corporate shared services to ensure cost-effective, quality healthcare.
- Having a singular focus on working with government agencies to serve the low-income, aged and persons with disabilities communities that sets it apart from competitors.

With regard to serving dual eligible beneficiaries, Molina is led by core principles embodied in the plan's Integrated Care Management Model:

- Person-centered healthcare decision-making and service delivery
- Use of empirically validated best practices to achieve improved outcomes
- Coordinated care management and care transition services
- Effective, collaborative partnerships with community groups and providers
- Scalable information technologies capabilities to handle complex care

Molina has a strong track record of managing an integrated delivery system that achieves better health outcomes by administering quality, cost effective and patient-centered care for its members. Molina's performance record in delivery of services to dual eligible members includes:

- Serving over 26,000 dual eligible members nationally, making the Molina family of health plans the 8th largest D-SNP plan in the nation;
- Three (3) year approval by NCQA of Molina's Medicare Model of Care Program;
- Utilizing access to evidence-based healthcare services best practices and continual quality improvements;
- Encouraging avoidance of inappropriate emergency room, hospitalization and clinical variability through a collective effort of effective prevention services, integrated care coordination and disease management programs;

- Providing 24-hour access to registered nurses to address members' health care questions and concerns;
- Improving access to non-emergency transportation to enable medically necessary covered services;
- Providing access to quality providers who offer covered services that meet or exceed NCQA standards; and
- Ensuring efficient utilization of services through culturally sensitive member/family outreach and education campaigns centered on the right care in the right setting at the right time.

Question 6.2 Provide a current organizational chart with names of key leaders.

See Attachment 6.2-1 for Molina Healthcare of California Organizational Chart.

Question 6.3 Describe how the proposed key staff members have relevant skills and leadership ability to successfully carry out the project.

The following Molina key staff members have the skills and leadership ability to successfully lead and carry out the plan's Duals Demonstration Project activities:

Lisa A. Rubino, *Plan President and Senior Vice President, Medicare*

Lisa A. Rubino serves as President for Molina Healthcare of California. Ms. Rubino brings extensive experience in managed care operations management and

leadership, and is responsible for the overall strategic direction and operations for Molina Healthcare California health plan. Prior to joining Molina, Ms. Rubino was part of the Blue Shield of California senior leadership team. With nearly 30 years experience in healthcare operations, Ms. Rubino is widely regarded as an authority on government healthcare products and maintains strong relationships with state administrators at all levels. Ms. Rubino received her Master's of Science in Criminology degree from California State University, Long Beach, where she also received her Bachelor's of Science degree.

Richard Chambers, *Plan President,Molina Healthcare of California*

Richard Chambers will be the Plan President of Molina Healthcare of California in April 2012. Mr. Chambers previously served as the Chief Executive Officer of CalOptima since 2004. He led CalOptima through a period of significant growth, providing direction to develop programs and strategies that meet the needs of the community. Mr. Chambers has extensive experience in health care administration, having spent more than 27 years working for the federal Centers for Medicare & Medicaid Services. He is known as an expert in community-based health care solutions. He shares that knowledge as an adviser on the Congressional Budget Office Panel of Health Advisers and a commissioner on the Medicaid and Children's Health Insurance Payment and Access Commission, two high-level groups that advise Congress on health care policy matters. Mr. Chambers serves on

many other committees, including the Olmstead Advisory Committee, guiding the California Health and Human Services Agency on matters regarding persons with disabilities. He is also part of the state's DHCS Stakeholder Advisory Committee for the Section 1115 Medicaid Waiver Project

Richard Bock, MD, MBA, *Chief Medical Officer*

Richard Bock, MD is responsible for oversight of the medical management functions of Molina Healthcare of California, including utilization management, quality improvement, credentialing, pharmacy, health education, and risk management activities. Prior to joining Molina Healthcare of California, Dr. Bock worked for several healthcare organizations in Southern California including, Prospect Medical Systems, Medeor Systems, Adventist Health System Foundation, and FHP. Dr. Bock obtained his medical degree from the New York Medical College and a Master's in Business Administration degree from University of Redlands in California.

Greg Hamblin, *Chief Financial Officer*

Greg Hamblin is the Chief Financial Officer for Molina Healthcare of California. He has over 28 years experience in financial management with both public and private companies in the managed healthcare industry. Mr. Hamblin is responsible for developing and implementing the company's financial plan. His experience includes Chief Financial Officer positions at UHP Healthcare and

Beech Street/CAPP CARE. He also served in financial management roles at several health plans, including Healthcare USA, Health America and Cigna Health plans. Mr. Hamblin received his Bachelor of Arts degree from Illinois Wesleyan University. He is also a certified public accountant.

Teri Daly Lauenstein, *Vice President of Network Management and Operations*

Teri Daly Lauenstein is the Vice President of Network Management and Operations for Molina Healthcare of California. Previously, Ms. Lauenstein served as the chief executive officer of Community Health Plan (CHP). She is a healthcare executive with more than 25 years of experience in network management and contracting. Ms. Lauenstein was a Senior Director of Network Management for Blue Shield of California with the responsibility for the contracting strategy for the Southern California hospital, physician group and ambulatory surgery center networks. As the Regional Vice President of managed care for Catholic Healthcare West (CHW), she was responsible for the development and execution of the managed care strategy for the Southern California CHW hospitals. Ms. Lauenstein has both Bachelor of Arts and Master of Public Health degrees from the University of California, Los Angeles.

Katherine Davidson Liquin, RN, MBA, *Vice President, Healthcare Services*

Katherine Davidson Liquin is the Vice President of Health Care Services at Molina Healthcare of California. In this role, she partners with Molina's Chief

Medical Officer, to design, implement, and administer operational systems and programs within the company's Health Care Services division. Ms. Davidson Liquin has over 20 years of experience in healthcare including 20 years experience in managed care implementing Medi-Cal, Medicare and commercial lines of business in the areas of Utilization Management, Case Management, Care Coordination, Medical Claim Review, Quality Improvement, Delegation Oversight and Health Education. Prior to joining Molina, Ms. Davidson Liquin held positions at PacifiCare and Health Net as Director of Utilization and Medical Services. Ms. Davidson Liquin received her RN degree from Presbyterian Hospital in Denver, Colorado, her Bachelor of Science in Healthcare Management and Masters in Business Administration from the University of La Verne, California.

Andrew Whitelock, *Associate Vice President of Government Contracts*

Andrew Whitelock is the Associate Vice President of Government Contracts. He serves as Molina Healthcare's primary contact with government agencies and plan partners. Mr. Whitelock works with Molina Healthcare's contractors/plan partners to keep them apprised of new health plan programs and community activities that promote Molina's mission and vision. In addition, he directs the plan's leadership team during the contract renewal process with government agencies and plan partners. Mr. Whitelock develops work plans that ensure the plan develops policies, and procedures to meet both regulatory and

contractual requirements. Mr. Whitelock received his Bachelor of Arts in History and Biology from University of Southern California. In addition, he holds a Master of Science in International Public Administration from University of Southern California and a Masters of Business Administration from Pepperdine University.

Question 6.4 Provide a resume of the Duals Demonstration Project Manager.

Please refer to Attachment 6.4-1 for the resume of Michelle Bentzien-Purrington, Molina's lead project manager for the Duals Demonstration Project.

Question 6.5 Describe the governance, organizational and structural functions that will be in place to implement, monitor, and operate the Demonstration.

Molina's executive team will lead the implementation and operation of its Duals Demonstration Project program. Molina's Board of Directors provides governing oversight of all the plan's activities, which will include the Duals Demonstration Project. Molina's plan president will provide regular updates to the plan's Board of Directors and Molina Healthcare, Inc. on the implementation status and performance of the Duals Demonstration Project. The organizational roles of Molina's executive team are identified in the Molina Healthcare of California Organizational Chart (see Attachment 6.2-1). Molina will utilize the plan's strong functional expertise and capabilities as described in this application to administer quality healthcare services to dual eligible beneficiaries under the Duals Demonstration Project.

To effectively implement, monitor and operate the Duals Demonstration Project, Molina has already or will take actions that include but are not limited to:

- Supporting the creation of a collaborative forum to foster effective communication and feedback with dual eligible beneficiaries, stakeholders, advocates and community-based organizations;
- Establishing standard processes and benefits under the Duals Demonstration Project to simplify the program for dual eligible beneficiaries;
- Establishing an enhanced MOU for behavioral health to ensure appropriate coordination and integration of covered services for dual eligible beneficiaries;
- Building-out the plan's contracted network to effectively administer all covered services under the Duals Demonstration Project;
- Reporting regularly to the plan's accountable oversight committees on the tracking and trending of member grievances and appeals from dual eligible beneficiaries in order to identify potential access to care and other service delivery problems;
- Monitoring on a quarterly basis in the plan's Access & Availability Committee the adequacy of Molina's network to provide all covered services to enrolled members under the Duals Demonstration Project;

- Implementing the plan's operational plan (that will be based upon the contractual standards set forth in the three-way contract between the DHCS, CMS and the plan); and
- Regular reporting to Molina's Board of Directors on the plan's performance in meeting operational requirements in the Duals Demonstration Project.

Section 6.2: Operational Plan

The Applicant must:

Question 6.2.1 Provide a preliminary operational plan that includes a draft work plan showing how it plans to implement in 2013 and ramp up in the first year.

Molina's preliminary operational plan details what actions the plan will accomplish leading up to the launch of the Duals Demonstration Project on January 1, 2013 and the actions that will be taken in 2013 to ensure the success of this project. Molina's preliminary operational plan will be further developed and finalized as more details, guidance and program standards are provided by DHCS and CMS for the Duals Demonstration Project. Molina will implement an operational plan for the Duals Demonstration Project that ensures the plan is ready and prepared to administer quality healthcare services to enrolling dual eligible beneficiaries with the plan as of January 1, 2013.

As part of developing Molina's operational plan, a draft work plan has been created to identify key operational plan activities that will be achieved in 2012 and 2013 to implement and operate the Duals Demonstration Project. Please refer to Attachment 6.2.1-1 – Draft Work Plan for Duals RFS – Molina.

Question 6.2.2 Provide roles and responsibilities of key partners.

Molina will provide seamless access to covered services under the Duals Demonstration Project through the following key partnerships:

- Collaborate with participating health plans to establish standard supplemental benefits, effectively communicate with dual eligible beneficiaries, coordinate IHSS and behavioral health services with county agencies, and work together with advocates, stakeholders and community-based organizations serving dual eligible beneficiaries;
- Contract with Sacramento County Division of Behavioral Health Services to coordinate access to mental health and substance use services for Molina members in Year 1, and work toward fully integrating coverage for all of these covered services by Year 3 of the Duals Demonstration Project;
- Contract with the Sacramento County Department of Health and Human Services and Sacramento County IHSS Public Authority to provide seamless access to IHSS for dual eligible beneficiaries;
- Contract with appropriate service vendors to provide Molina's dual eligible members with the supplemental benefits;
- Enhance the plan's MOU with the Sacramento County Department of Public Health to ensure effective coordination of services for plan members; and
- Contract with additional providers and vendors as necessary to ensure the plan's dual eligible beneficiaries have timely and appropriate access to covered services under the Duals Demonstration Project.

Question 6.2.3 Provide a timeline of major milestones and dates for successfully executing the operational plan.

Please refer to Attachment 6.2.1-1 – Draft Work Plan for Duals RFS – Molina for the plan's draft timeline of milestones and dates for implementing the plan's preliminary Duals Demonstration Project operational plan.

Question 6.2.4 Certify that the Applicant will report monthly on the progress made toward implementation of the timeline. These reports will be posted publicly.

Molina understands and will comply with the requirement to report monthly on the progress made toward implementation of the plan's Duals Demonstration Project operational plan.

Section 7: Network Adequacy

The Applicants must:
Question 7.1 Describe how your organization will ensure that your provider network is adequate for your specific enrollees.

Molina manages its Medicare and Medi-Cal network in California to meet the needs of its members. These networks are reviewed and approved by CMS and the state regulatory agencies in California including the DHCS and the Department of Managed Health Care (DMHC). In order to ensure its provider network is appropriate for the dual eligible population under the Duals Demonstration Project, Molina is currently seeking feedback from its advisory committees, member input and stakeholder comments, including those from providers. Molina is particularly attentive to understanding how the care needs of the dual eligible population are being met today in the fragmented delivery system in order to capture the providers that will be critical in the integration of services. As Molina has done previously in preparing to accept the mandatory enrollment of seniors and persons with disabilities (SPDs), Molina will comply with all network adequacy requirements (both federal and state) and will use the community input to build a solid network of LTSS providers to serve the dual eligible population including the county mental health providers, IHSS providers and CBAS facilities.

Molina has an existing infrastructure and policies and procedures in place to ensure on-going adequacy of the provider network. On a quarterly basis, Molina

evaluates all regional provider networks through the Access and Availability Committee, which reviews member grievance and appeal summaries, updated Geo Access and time/distance reports, nurse advice line reports, provider satisfaction surveys, and summaries of activity with non-contracted providers. Molina utilizes this information to identify potential gaps in its networks, monitor member access to key specialties, and identify all necessary action items. Molina's Quality Improvement staff oversees a provider access study each year, and also conducts random office audits whereby staff calls the provider's office, posing as patients, in order to verify that patients can get appointments scheduled within the state-required timeframes. Any office that does not meet the standards is contacted by the Provider Services Department for focused intervention to effect timely access. Provider education is performed, and the provider must submit a corrective action plan.

Additionally, Molina's contracted primary care providers and specialists, as well as Medical Management and Outreach staff, are encouraged to forward the names of potential providers to approach regarding contracting. Molina's contracting staff works closely with the nurses and care coordinators to ensure that patients are receiving timely access to care. Should the staff involved in daily care management see an increased need for certain types of specialists or ancillary

referrals, they alert the contracting team to begin recruiting additional providers in a local geography.

Question 7.2 Describe the methodologies you plan to use (capitation, Medicare rates, extra payments for care coordination, etc.) to pay providers.

Molina uses several different provider payment structures in its current Medicare and Medi-Cal networks. Primary care providers, including physician practices or community clinics may either have a direct contractual relationship with Molina or be subcontracted through an IPA or multispecialty medical group network. In either instance, these providers are usually capitated for member care. Directly-contracted primary care providers are encouraged to offer member care beyond basic services (allergy testing, basic asthma treatment) under a fee-for-service arrangement to facilitate and incentivize additional care in the PCP setting.

Specialists and ancillary providers may have both a direct relationship with Molina as well as be subcontracted through an IPA or multispecialty medical group network. In either case, specialists are typically reimbursed on a fee-for-service basis for member care.

Specific to the Duals Demonstration Project, Molina will rely on its existing Medicare and Medi-Cal networks as well as contract for services that are not currently covered such as IHSS, CBAS and long-term institutional care in skilled nursing facilities. Molina is also actively working to recruit and contract these

providers in order to offer a comprehensive delivery system at the start of the Duals Demonstration Project. These contracts will utilize capitated, fee-for-service and pay-for-performance payment mechanisms.

Question 7.3 Describe how your organization would encourage providers who currently do not accept Medi-Cal to participate in the Demonstration project.

Similar to Molina's network review prior to the mandatory enrollment of SPDs in California, Molina is currently reviewing its Medicare and Medi-Cal provider network for serving dual eligible members in the Duals Demonstration Project. Molina is actively recruiting and contracting with additional providers to ensure members, to the greatest extent possible, can choose from a wide selection of providers, including keeping their existing provider relationships after enrollment. Molina has found that it is often the case that low reimbursement rates, payment delays, benefit confusion, and administrative delays are the key reasons providers do not participate in Medi-Cal. Given the fact that Molina will have more financial control and administrative oversight in the Duals Demonstration Project, it can reduce these barriers.

Question 7.4 Describe how you will work with providers to ensure accessibility for beneficiaries with various disabilities.

Accessibility is critical to ensuring dual eligible and special needs populations can be served in a timely and respectful manner. Molina takes access seriously and as discussed previously, Molina and Molina Medical Group invested

significant time and resources to ensure its members were provided maximum accessibility, including construction and retrofitting with universal architectural design modifications that include accessible equipment such as height adjustable exam tables, wheelchair weight scales, and assistive listening devices. Other accommodations include accessible restrooms, waiting areas and exam rooms. All Molina member material is offered in alternative formats.

In addition, Molina works with providers to ensure accessibility for beneficiaries with various disabilities, as several of Molina providers are using its Patient Access Accommodation Requirement form, Attachment 7.4-1. This allows Molina members with disabilities to communicate their specific access requirements to their providers. Providers then have the opportunity to be better prepared for future member appointments.

Molina has coordinated with other Medi-Cal health plans to use one facility site review (FSR) tool. With the advent of SPDs moving into managed care, the FSR tool was expanded to also evaluate the physical accessibility of provider offices. The FSR tool evaluates provider offices from basic attributes (parking, front door, waiting room, bathroom, etc.) to more advanced features such as height adjustable exam tables and wheelchair accessible weight scales. Facility Site Review Nurses offer modification suggestions to providers while they are performing the FSR. (FSR Attachment C can be viewed at:

http://www.molinahealthcare.com/medicaid/providers/ca/manual/Pages/site_review.aspx).

Also, providers are required to participate in physical and behavioral health disabilities awareness and sensitivity training, which includes but is not limited to, in person, web-based and written material. Physical and communication access is a significant part of this training. Molina is committed to working with disability organizations, i.e., independent living centers, areas on aging, consumer centers, etc., to strategize on ways to encourage providers to meet member access needs. Molina is committed to assisting members to understand their benefits and how to arrange for care. Molina looks at this as an opportunity for collaboration/partnership with these community-based organizations to enhance quality of care.

Question 7.5 Describe your plan to engage with providers and encourage them to join your care network, to the extent those providers are working with the Demonstration population and are not in the network.

Similar to the network review prior to the mandatory enrollment of SPDs in California, Molina will be reviewing the Medicare and Medi-Cal providers serving dual eligible patients in the Duals Demonstration Project site and actively recruiting and contracting with these providers to ensure members, to the greatest extent possible, can keep their existing provider relationships after enrollment into the Duals Demonstration Project. Molina will reduce administrative burdens,

provide open communications, and a single funding flow to encourage providers to join the Molina network.

Question 7.6 Describe proposed subcontract arrangements (e.g., contracted provider network, pharmacy benefits management, etc.) in support of the goal of integrated delivery.

Molina has already initiated contact with each of the D-SNP plans currently serving beneficiaries in the Sacramento County region. First and most importantly, Molina intends to negotiate in good faith to subcontract with these D-SNP plans so that beneficiaries will be allowed to remain within their existing network and avoid unnecessary care disruption. Second, Molina's existing subcontracts with provider groups, specialists and health plan partners will be reviewed to ensure providers are able to provide the necessary medical, behavioral and LTSS envisioned by the Duals Demonstration Project. To the extent that additional providers are needed to address an identified need or additional contract requirements must be made with existing providers, Molina will ensure its entire provider network (new and existing) is aware of its Integrated Care Management program and that providers will comply with its care coordination and interdisciplinary approach.

Question 7.7 Certify that the goal of integrated delivery of benefits for enrolled beneficiaries will not be weakened by sub-contractual relationships of the Applicant.

Molina understands and will comply with the requirement that the goal of integrated delivery of benefits for enrolled beneficiaries will not be weakened by Molina's subcontracted relationships.

Question 7.8 Certify that the Plan will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Molina understands and will comply with the requirement to meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate its network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Question 7.9 Certify that the Plan will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.

Molina understands and will comply with the requirement to meet all Medicare Part D requirements (e.g. benefits, network adequacy) and will submit formularies and prescription drug event data.

Section 7.2: Technology

The Applicant must:
Question 7.2.1 Describe how your organization is currently utilizing technology in providing quality care, including efforts of providers in your network to achieve the federal "meaningful use" health information technology (HIT) standards.

Molina utilizes new technologies as an integral part of improving Molina's care management processes. Examples of Molina's activities to incorporate technology for improving care integration and optimize member care include:

- Piloting the use of tablet technology to collect assessment data. Molina Care Management teams working on-site with members will use the technology to instantaneously submit member care data through a portal connected to Molina's core systems. This will expedite the processing of time-sensitive data, increase productivity and eliminate manual processes. By decreasing the time needed for administrative duties, more time becomes available for member care;
- Incorporating Care Access and Monitoring forms and processes into Clinical Care Advance, Molina's case management system, so that all data is located in one place and is easy to locate in Clinical Care Advance. One major benefit of this integration is improved interaction with local Health Information Exchange (HIEs) initiatives. This is intended to optimize Molina's ability to access medical records to help members. Also, it provides Molina with the capability

to access state and hospital run systems in order to gather a broader scope of clinical and care information to facilitate member care; and

- Revamping the plan's e-portal system in order to significantly reduce fax and phone submissions by providers and replace these with an automated authorization process. Members will also have access to the e-portal for health education and other resources. Molina members can request a member ID card, change their PCP, change their demographic information, access their service history, and review the Member Handbook using the e-portal. Providers are able to check member eligibility, submit and authorize claims, and access HEDIS alerts. Improvements in-progress will enable members to review their benefit plan, access health education and Molina incentive programs for staying healthy, and review their personal health history. Other improvements to Molina's e-portal system will allow providers to request and receive automated authorizations, in which services can be automatically authorized through the e-portal system using established criteria. This will decrease the time needed for a service to be reviewed and authorized by a Molina contracted provider.

Question 7.2.2 Describe how your organization intends to utilize care technology in the duals Demonstration for beneficiaries at very high-risk of nursing home admission (such as telehealth, remote health vitals and activity monitoring, care management technologies, medication compliance monitoring, etc.)

Molina is supportive of care technology that can enhance other LTSS services and preserve an individual's ability to live safely at home. This does not replace personal contact by providers, caregivers or care coordinators. Molina is aware of several companies that provide sophisticated monitoring systems for individuals with dementia, or patients at high-risk of falls as well as tele-monitoring systems for medication compliance, blood pressure and other health conditions. Molina currently partners with following companies to utilize care technology applications for the plan's members and particularly with those at high-risk of being institutionalized:

- Sandata Technologies, LLC - Sandata is an industry leader in technology solutions to the home care industry. Sandata provides Electronic Visit Verification (EVV) services for Molina's LTSS programs. Additionally, Molina will create a clinical advisory panel to review these systems and make recommendations as to which devices and systems will provide high-risk beneficiaries with the safest and most effective care technology to allow them to remain at home or in a lower-level care facility.
- Cisco Systems - Cisco provides Molina's data and voice platforms. Molina is presently exploring tools for collaboration and mobile use that will enhance the plan's Care Management processes and increase communication with a

member's care team in various settings including the member's home or other setting.

Question 7.2.3 Describe how technologies will be utilized to meet information exchange and device protocol interoperability standards (if applicable).

Molina, through its clinical advisory panel, will ensure that any care technology acquired, used or otherwise deployed for use with beneficiaries at high-risk of nursing home admission will also be evaluated by its Information Technology department to ensure the technology is compliant with all interoperability standards so that data can be transferred and utilized in the monitoring of Duals Demonstration Project members.

Section 8: Monitoring and Evaluation

The evaluation will examine the quality and cost impacts on specific vital Medicare and Medicaid services, including the integration on IHSS and other home- and community-based LTSS. Therefore, the Applicant must:

Question 8.1 Describe your organization's capacity for tracking and reporting on:

- ***Enrollee satisfaction, self-reported health status, and access to care,***
- ***Uniform encounter data for all covered services, including HCBS and behavioral health services (Part D requirements for reporting PDE will continue to be applied), and***
- ***Condition-specific quality measures.***

Enrollee Satisfaction, Self-reported Health Status and Access to Care

Molina conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS® 4.0H) Survey annually. Member input from the annual satisfaction survey provides a means to assess and improve member satisfaction, accessibility to services and the availability of the provider network. Results are collected and analyzed to track member satisfaction with health plan performance and to identify opportunities for improvement. Molina's quality teams, committees and network providers review annual survey results to assess performance to benchmarks, performance goals, thresholds, and trends to previous performance, to identify gaps and develop quality improvement action plans.

Uniform Encounter Data for all Covered Services including HCBS and Behavioral Health Services (Part D requirements for reporting POE will continue to be applied)

Molina's Management Information System (MIS) department supports application management, development, Electronic Data Interchange, database administration, network management, server/storage administration, data center management, communication systems and disaster recovery. Molina has extensive experience in submitting encounter data to government agencies and private payers with its encounter data systems. These systems support management, reporting and tracking of claims and encounters submitted to the state, and have processes and procedures in place to ensure accurate, timely and complete submission of encounter data for all DHCS covered services and requirements for the California Duals Demonstration Project. Molina adheres to the encounter submission and processing guidelines as outlined by the state's Medicaid/Medicare contract. For encounter data submissions, Molina follows state-specific file types, national industry standards and code sets as published by HIPAA X12N supporting Medical (837P), Institutional (837I) and Dental (837D) form types, National Council for Prescription Drug Programs (NCPDP), and other data standard maintenance organizations.

Condition-specific Quality Measures

Molina uses Healthcare Effectiveness Data and Information Set (HEDIS) reporting measures to document preventive health care and chronic care services that are provided to its members annually. All providers contracted with Molina must submit accurate claims and medical record documentation, when requested, in support of Molina's Quality Improvement Program, which includes HEDIS reporting. An analysis of HEDIS data is presented to Molina's Quality Improvement Committee and subcommittees to identify opportunities for improvement and to monitor action plans for increasing access and provision of preventive health care and chronic care services to Molina members.

To ensure that appropriate systems and processes are in place to support annual reporting of HEDIS results in compliance with NCQA specifications, the plan contracts with Catalyst Technologies Quality Spectrum Insight system, which allows Molina the ability to effectively manage HEDIS data collection and to participate in annual audits by NCQA-certified auditors.

Question 8.2 Describe your organization's capacity for reporting beneficiary outcomes by demographic characteristics (specifically age, English proficiency, disability, ethnicity, race, gender, and sexual identity)

Annually, Molina conducts reporting of beneficiary outcomes by demographic characteristics, in conjunction with an analysis of the top ten diagnoses by age, ethnicity, race, gender, health care setting, and acute and chronic

illness. These outcome reports can be broken down further by using the state defined Aged, Blind and Disabled aid codes, and can also provide language of preference by ethnicity and gender. To further enhance these reports, an annual analysis is conducted of the network providers as compared to the membership for gender, race, ethnicity, age and language.

Question 8.3 Certify that you will work to meet all DHCS evaluation and monitoring requirements, once made available.

Molina understands and will comply with the requirement to work to meet all DHCS evaluation and monitoring requirements, once made available.

Section 9: Budget

The Applicant must, pending further rate development:

Question 9.1 Describe any infrastructure support that could help facilitate integration of LTSS and behavioral health services (i.e. information exchange, capital investments and training to increase accessibility of network providers, technical assistance, etc).

Molina believes the integration of LTSS in the Duals Demonstration Project will require significant resources in education and outreach for beneficiaries and providers. As the SPD enrollment process demonstrated, there are always additional mechanisms that can be employed to help communicate changes to the beneficiary community. Should additional resources be available through the state or federal program, Molina would recommend that they first be targeted toward education and outreach on the Duals Demonstration Project and how beneficiaries and providers will be impacted.

Molina Healthcare

Molina Medicare

Model of Care Program

2012

Review and Approval: *<date>*

Signature_____ Date _____
(Vice President/Medical Director Medicare)

QI Review and Approval: ***xx/xx/11***

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I. Targeted Population

Molina Medicare operates Medicare Dual Eligible Special Needs Plans (SNP) for members who are fully eligible for both Medicare and Medicaid. In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations Molina Medicare has a SNP Model of Care that outlines Molina's efforts to meet the needs of the dual eligible SNP population. This population has a higher burden of multiple chronic illnesses (medical and behavioral health) than other Medicare Managed Care Plan types. The subset includes sub-populations of frail, disabled, culturally diverse, complex or unresolved needs, and requiring coordination between multiple providers, specialists and settings of care.

The Molina Model of Care incorporates and addresses the unique additional needs of Molina's Medicaid subset D-SNP members. These include additional factors in the stratification and identification to manage catastrophic or high risk conditions, coordination of services during healthcare setting transitions to address psychosocial issues, facilitating communication between providers and facilities, educating and supporting members and their care-givers on the management of complex medical, pharmaceutical and behavioral health issues, and incorporating the complex issues of these members into Chronic/Acute Care and Chronic Care Improvement Program (CCIP) and Care Management programs.

Most Molina Medicare Dual Eligible Special Needs Plan members are not institutionalized but instead are mobile members of the community in which they live. As a result Molina Medicare SNP members are not concentrated in any one area but are widely dispersed throughout the Molina Medicare Dual Eligible SNP service areas. The Molina Medicare SNP Provider Networks and Model of Care are designed to provide quality care to this dispersed membership. The Molina Dual Eligible Special Needs Plan Model of Care addresses the needs of all populations and sub-populations found in the Molina Medicare SNP.

II. Care Management Goals

A. Molina Healthcare's Model of Care has established and defined the following goals, in alignment with the Quality Improvement Program, and objectives that support the delivery of care to Molina Medicare and Molina Medicaid subset D-SNP members:

- Design and maintain programs that improve the care and service outcomes within identified member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to members. Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare structure, process, and outcomes.
- Ensure program relevancy through understanding of member demographics and epidemiological data and provide services and interventions that address the diverse cultural, ethnic, racial and linguistic needs of our membership.

1. Molina conducts performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable improvement in aspects of clinical care and non-clinical services. Improvement projects, as defined and described in Appendix A: Molina Medicare Quality Improvement Program Work Plan and Appendix B: Quality Improvement Projects Reporting Schedule and Topics are designed to have a beneficial effect on health outcomes and member satisfaction. Molina continuously monitors performance on a variety of dimensions of care and services for members, identifies its own areas for potential improvement, carries out individual projects to undertake system interventions to improve care, and monitors the effectiveness of those interventions.

   The Model of Care objectives direct personnel, activities, and resources to achieve Molina's goals for the delivery of care to Molina Medicare and Molina Medicaid subset D-SNP members. Written objectives address:
   - Activities planned,
   - Methodology,
   - Persons responsible, and
   - Time frames for meeting each objective

   Objectives are developed and established annually with consideration given to:
   - Important aspects of care and service provided by Molina Healthcare.
   - Objectives identified from ongoing and annual evaluation.
   - Changes in policies, procedures, benefits or product offerings.
   - Changes in member demographics and epidemiological characteristics.

- Recommendations made by regulatory agencies and CMS and Quality Improvement Organizations (QIO); by accreditation organizations such as NCQA, and by practitioners, practitioner groups, and members.
- National, state, and local public health goals.
- Identified "Best Practices".
- Delegated activities and delegates' performance.
- Member and provider satisfaction/data.
- Network changes.
- Ability to achieve meaningful improvement with available resources.

Objectives are reviewed and revised annually or more frequently as needed. Specific activities are identified to support the achievement of the objectives. These activities are outlined, tracked, maintained and are recorded in each respective plan's annual Quality Improvement Work Plan. See Appendix A: Molina Medicare Quality Improvement Program Work Plan.

2. Utilization analysis is conducted to assess Molina Medicare SNP extensive network of primary providers, specialty providers and facilities in addition to services from the Molina Medicare SNP Interdisciplinary Care Team (ICT). Actions to address gaps in performance are designed to improve access and delivery to essential services such as medical, mental health and social services. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external available benchmarks and performance goals:
   a. Molina Medicare GeoAccess reports showing availability of services by geographic area
   b. Number of Molina SNP members utilizing the following services:
      - Primary Care Practitioner (PCP) Services
      - Specialty (including Behavioral Health) Services
      - Inpatient Hospital Services
      - Skilled Nursing Facility Services
      - Home Health Services
      - Mental Health and Chemical Dependency Services
      - Durable Medical Equipment Services
      - Emergency Department Services
      - Supplemental transportation benefits
   c. Healthcare Effectiveness Data and Information Set (HEDIS) Use of Services
   d. Member Access Complaints
   e. Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
   f. Molina Medicare Practitioner Access Survey

Members of the Molina Medicare SNP are full dual eligible for Medicare and Medicaid. For that reason, members are not subject to out of pocket costs or cost sharing for covered

services and have access to quality affordable healthcare. There is no cost share or co-pay for Molina's SNP members for covered services and benefits that include but are not limited to:

- inpatient hospital care
- physician and consultant services
- podiatry
- chiropractor
- behavioral health
- substance abuse
- vision
- dental
- hearing services
- transportation services
- health education materials
- nutritional training
- additional smoking cessation benefits
- select Over The Counter (OTC) medications
- routine screening lab services
- Nurse Advice Line

Molina also ensures member access to information and assistance with billing issues through:

- Information provided to members
- Provider education and communication
- Member reimbursement procedure

B. Molina focuses on delivering high quality care. Molina has an extensive process for credentialing network providers, ongoing monitoring of network providers and peer review for quality of care complaints. Molina maintains recommended clinical practice guidelines that are evidence based and nationally recognized. Molina regularly measures provider adherence to key provisions of its clinical practice guidelines. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external available benchmarks and performance goals:
   1. HEDIS Health Plan Information Practitioner Board Certification
   2. Serious Reportable Adverse Events and Hospital Acquired Conditions
   3. Annual Quality of Care Analysis and Peer Review Activities
   4. Annual PCP Medical Record Review
   5. Clinical Practice Guideline Measurement Report
   6. Provider Monitoring and Licensure Sanction Reports
   7. Medicare/Medicaid Sanction Report Review

C. Members of the Molina Medicare SNP attain improved health outcomes by having access to Molina's network. Molina's network consists of primary care and specialty providers. Additionally members have access to Molina's programs in Care Management Programs including Case Management, Disease Management, Care

Coordination, Nurse Advice Line, Utilization Management Program and Quality Improvement Activities, SNP members have an opportunity to realize improved health outcomes. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external available benchmarks and monitors improvement compared to available benchmarks and performance goals:

1. Medicare Health Outcomes Survey (HOS)
2. Chronic Care Improvement Program Reports
3. HEDIS Effectiveness of Care Measures

D. Molina's established process ensures Members have coordination of care through an identified point of contact. Molina members are assigned a point of contact for through-out their care transitions. According to member need this coordination of care contact point may consist of one of the following Interdisciplinary Care Team (ICT) member; their Molina Network PCP, Molina Care Manager or Molina Case Manager. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external available benchmarks and monitors for
annual improvement:

1. Annual Continuity and Coordination of Care Report
2. Annual HOS
3. Re-admission Within 30-days Report

E. Members of the Molina Medicare SNP are supported through transitions of care across healthcare settings, providers and health services. Molina provides multiple programs designed to facilitate transitions of care. Authorization processes enable Molina staff to become aware of transitions of care due to changes in healthcare status as they occur. Molina care managers and case managers work with members, their caregivers and their providers to assist in care transitions. For elective admissions, Molina includes member notification of service approval, written information regarding how to actively participate
in their care while in the hospital and upon discharge, and provides a Personal Health Record brochure that members may fill out and take with them to the hospital and to follow up visits. In addition Molina has an established program to provide follow-up phone calls to members after hospital discharge to make sure that they received and are following an adequate discharge plan. The purpose of the call is to evaluate if the member is following the prescribed discharge plan, has scheduled a follow up physician appointment, has filled all prescriptions, understands how to administer their medications and is receiving necessary discharge services such as home care or physical therapy. All members experiencing transitions receive either a pre-admit educational letter and health record guide and following a discharge, a post discharge educational letter advising them of benefits and services offered by Molina. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external available benchmarks and monitors for annual improvement toward performance goals:

1. Transition of Care Data

2. Re-admission Within 30 Days Report
3. Provider adherence to notification requirements
4. Provider adherence to provision of the discharge plan

F. Members of the Molina Medicare SNP are offered programs designed to improved access to preventive health services. The Molina SNP expands the Medicare preventive health benefit by providing annual preventive care visits at no cost to all members. This allows PCPs to coordinate preventive care on a regular basis. Molina uses and publicizes nationally recognized preventive health guidelines and schedules to its providers. Molina also makes outreach calls to members to remind them of overdue preventive services and to offer assistance with arranging appointments and providing transportation to preventive care appointments. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external available benchmarks and monitors for annual improvement toward performance goals:
   1. HEDIS Effectiveness of Care Measures
   2. Quality Improvement Project Outcome Measures

G. Members of Molina Medicare SNP benefit from appropriate utilization of healthcare services. Molina utilizes its Utilization Management team to review appropriateness of requests for healthcare services using appropriate Medicare criteria and to assist in members receiving appropriate healthcare services in a timely fashion from the proper provider. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external available benchmarks and monitors for annual improvement toward performance goals:
   1. Molina Over and Under Utilization Reports
   2. HEDIS Use of Service Measures

Molina will know that goals are not met within the timeframe by monitoring program effectiveness through the evaluation of outcomes. Molina also tracks the progress of prior program or procedural changes that were implemented to determine if they are successful and meeting program goals. If measurable outcomes are falling short of goals, the issues and programs will be analyzed again to determine further improvements needed to satisfy requirements.

Molina uses a multidisciplinary committee structure to facilitate the achievement of quality improvement goals (See Appendix D: Molina Medicare Quality Improvement Plan Committees Role/Function and Membership). Molina quality teams and committees consist of Centralized and Plan staff, in conjunction with network providers, who review multiple sources to assess performance to available benchmarks, performance threshold and/or goals. If measurable outcomes are falling short of goals or expected timeframes, the issues and programs will be analyzed again to determine further improvements needed to satisfy requirements. The Corporate Medicare Quality Review Group oversees and coordinates the Centralized aspects of Quality Improvement Program activities for Molina Medicare. Responsibilities of the MQRG consist of the following activities:

- Approve the scope and activities of the Medicare Quality Improvement Program and reviews and evaluates the progress of existing and new quality improvement activities, including activities not required by CMS. Non-CMS required activities may be linked with accreditation requirements such as NCQA Health Plan Standards and Guidelines or URAC Call Center requirements.

- Confirms that organization-wide quality improvement activities are performed and communicated to the Plan Quality Improvement Committees (in states having Medicare and Medicaid subset D-SNP.

- Implements and is accountable to the Plan Quality Improvement Committees which are in turn accountable to their Boards of Directors. The Molina Health Plan's Board of Directors has the overall authority, accountability and responsibility for all areas of the Quality Improvement Program and activities of their Plan Quality Improvement Committees (QIC). The Plan QIC is responsible for the implementation and ongoing monitoring of the Quality Improvement program. Through the Plan Quality Sub-committees, the QIC recommends policy decisions, analyzes and evaluates the progress and outcomes of all quality improvement activities, institutes needed action and ensures follow-up. The QIC reviews data from QI activities to ensure that performance meets standard and makes recommendations for improvements to be carried out by sub-committees or by specific departments. Once the QIC approves the activities, they are included in the QI program evaluation and the next year's QI program work plan. The QI Department will monitor responsible departments for implementation and track activities.

- Integrate quality activities of centralized Molina Medicare functions with activities of the Plan Quality Improvement Committees.

Quantitative analysis is achieved by comparing collected data with internal and external normative and benchmark data and established thresholds and goals. If the comparative analysis indicates performance is under or over the threshold, Molina will monitor and drill into the data at deeper levels. Comparable data may include:

1. Historical plan data that establishes utilization patterns and thresholds;
2. Historical plan data from other comparable Molina products, providers and reports;
3. NCQA Quality Compass;
4. Milliman, Reden & Anders, Certitude, Solucient, APC
5. Comparative data, thresholds and benchmarks provided by associations
6. Evidence-based standards from medical literature and guidelines.

While quantitative reporting is critical, analysis is incomplete without qualitative analysis. Analysts and medical resources collaborate on qualitative analysis drawing conclusions regarding the causes, consequences, and opportunities for management. Methods may include fishbone diagramming or other tools to look for drivers and outcomes like interrelationship digraphs. Molina looks for patterns of that may indicate lack of care and access, inappropriate levels of care, inadequate coordination of care, inefficient use of

services, and potential fraud and abuse. Reports that identify Members who need preventive care or who may benefit from specialized programs such as disease management, care coordination, medical or complex case management are produced. Molina finds all Members who have missed preventive care or standard clinical practice care and also identifies their PCPs and provides them with Member information and education to close the gap in care and prevent future gaps in care. PCP access and availability are also reviewed for improvement opportunities.

See Appendix A: Molina Medicare Quality Improvement Program Work Plan and Appendix B: QIP Reporting Schedule and Topics

III. Staff Structure and Roles

The Molina Medicare SNP has developed its staff structure and roles to meet the needs of dual eligible Special Needs Plan members. Molina Healthcare's background as a provider of Medicaid Managed Care services in the states that it serves allows the plan to have expertise in both the Medicare and Medicaid benefits that members have access to in the Molina Medicare Dual Eligible SNP. Each Molina employee and contracted staff responsible for coordinating care for beneficiaries brings unique qualifications and perspectives to the Model of Care program and its processes. Additionally, Molina's Credentials and Qualifications procedure is designed to ensure employees or contract individuals are not debarred, suspended or otherwise lawfully prohibited from participating. Clinical non-physician professionals are also held to a rigorous review of qualifications and experience. Employees and consultants who work for Molina must meet the license or certification requirements of their profession. All licensed professionals must have a current unrestricted license as designated by their specific position. All licenses are verified with the licensing board/agency upon employment and upon renewal date thereafter. The Human Resources department and hiring management are responsible for ensuring ongoing monitoring is conducted in accordance with state and federal requirements.

Molina has many years experience managing this population of patients within Medicaid to go with its experience of managing the Medicare part of their benefit. Molina Medicare's member advocacy and services philosophy is designed and administered to assure members receive value-added coordination of health care and services that ensures continuity and efficiency and that produces optimal outcomes. Molina Medicare employed staff members are organized in a manner to meet this objective and include:

A. Administrative Functions

1. Member Services Team that serves as a member's initial point of contact with Molina Medicare and main source of information about utilizing the Molina Medicare SNP benefits and is comprised of the following positions:
    a. Member Services Representative-initial point of contact to answer member questions, assist with benefit information and interpretation, provide information on rights and responsibilities, assists with PCP selection, advocates on members' behalf, assists members with interpretive/translation services, inform and educate members on available services and benefits, act as liaison in directing calls to other departments when necessary to assist members.
    b. Member Services Managers/Directors-provide oversight for member services programs, provide and interpret reporting on member services functions, evaluate member services department functions, identify and address opportunities for improvement

2. Appeals and Grievances Team that assists members with information about and processing of appeals and grievances.
    a. Appeals and Grievances Coordinator-provide member with information about appeal and grievance processes, assist members in processing appeals and

grievances, notifies members of appeals and grievance outcomes in compliance with CMS regulations.

b. Appeals and Grievances Manager-provide oversight of appeals and grievance processes assuring that CMS regulations are followed, provide and interpret reporting on A&G functions, evaluate A&G department functions, identify and address opportunities for improvement.

3. Membership Accounting Team-manages member eligibility verification, enrollment/disenrollment issues, PCP assignment processes. Oversight for this team is provided by the Director of Centralized Operations.
4. Claims Examiners- receive, process and adjudicate claims. Oversight is provided by the Director of Medicare Claims Operations.

B. Clinical Functions

1. Integrated Care Management Team forms a main component of the interdisciplinary care team (ICT) and is comprised of the following positions and roles:
   a. Care review Processors – gather clinical information about transitions in care and authorizations for services, authorize services within their scope of training and job parameters based upon predetermined criteria, serve as a resource for nursing staff in collecting existing clinical information to assist nursing assessments and care team coordination.
   b. Care review Clinicians (LPN/RN) – assess, authorize, coordinate, facilitate and evaluate services including those provided by specialists and therapists, in conjunction with the member, providers and other team members based on member's needs, medical necessity and predetermined criteria.
   c. Licensed Clinical Social Workers- Identify and address issues regarding members' behavioral health care and social needs and care plans. Assist in coordination and transitions of care involving behavioral health and social services. Assist and facilitate members' access to community and social service resources
   d. Clinical Case Managers (RN) – assess, authorize, coordinate, triage and evaluate services in conjunction with the member, providers and other team members based on member's needs, medical necessity and predetermined criteria. Assist members, caregivers and providers in member transitions between care settings including facilitation of information retrieval from ancillary providers, consultants, and diagnostic studies for development, implementation and revision of the care plan. Develop, implement, monitor and evaluate care plans in conjunction with members/caregivers, their providers and other team members for members not requiring case management.
   e. Complex Case Managers/Care Coordinators (RN, SW) identify care needs through ongoing clinical assessments of Members identified as high risk or having complex needs. Activities include coordinating services of medical and non-medical care along a continuum rather than episodic care focused on a member's physical health care, behavioral health care, chemical dependency

services, long term care, and social support needs while creating individualized care plans. Conduct health assessments and manage member's medical, psychosocial, physical and spiritual needs – develop, implement, monitor and evaluate care plans in conjunction with members/caregivers, their providers and other team members. Focus is on members with complex medical illness.

2. Behavioral Health Team includes Molina employed clinical behavioral health specialists to assist in behavioral health care issues
   a. Psychologists- Resource for Care Management Teams and providers regarding member's behavioral health care needs and care plans.

3. Community Care Connectors/Health Workers- the Community Care Connectors are community health workers trained by Molina to serve as member navigators and promote health within their own communities by providing education, advocacy and social support. Community Connectors also help members navigate the community resources and decrease identified barriers to care

4. Pharmacy Team includes employed pharmacy professionals that administer the Part D benefit and assist in administration of Part B pharmacy benefits.
   a. Pharmacy Technician-provide authorizations for Part D medications, serve as point of contact for members with questions about medications, pharmacy processes and pharmacy appeals and grievances
   b. Pharmacist-provide oversight of pharmacy technician performance, resource for Care Management Teams, other Molina staff and providers, provide review of post discharge medication changes, review member medication lists and report data to assure adherence and safety, interact with members and providers to discuss medication lists and adherence

5. Consolidated Plan Solutions (CPS) Team is a Molina care team that provides multiple services to Molina Medicare SNP members. CPS provides population based Disease Management Programs in asthma, diabetes, COPD and cardiovascular diseases. CPS also provides a 24/7 Nurse Advice Line for members, outbound post hospital discharge calls and outbound preventive services reminder calls. The CPS team is comprised of the following positions:
   a. Medicare Member Outreach Assistant-make outbound calls related to gathering and giving information regarding Disease Management programs, make outbound calls to review whether member received hospital discharge plan, make referrals to Care/Case Managers when members have questions about their hospital discharge plan, make outbound preventive service reminder calls.
   b. Nurse Advice Line Nurse-receive inbound calls from members and providers with questions about medical care and after-hours issues that need to be addressed, give protocol based medical advice to members, direct after hours transitions in care.

c. Health Educator-develop materials for Disease Management Programs, serve as resource for members and Molina staff members regarding Disease Management Program information, educates members on how to manage their condition.
d. Disease Management Nurse-oversight for development and implementation of Disease Management Programs, resource for providers and staff members with questions or concerns about Disease Management Programs. Provides ongoing contact with members to educate on their condition(s) and self-management techniques, screens high risk members and refers to case management as appropriate.

C. Administrative and Clinical Oversight Function

Molina has a consistent and rigorous process to select, credential, re-credential, and perform ongoing monitoring of medical directors, non-physician clinical and non-clinical employed staff. The rigorous process to select qualified and credentialed staff applies to non-employed reviewers that may be engaged for service. Physician applicants are required to consent to specific pre-employment primary source verification. The Credentialing Department is responsible for ensuring physicians are fully credentialed within ninety days after starting employment.

Clinical non-physician professionals are also held to a rigorous review of qualifications and experience. Employees, consultants and contracted staff who work for Molina must meet the license or certification requirements of their profession. All licensed professionals must have a current unrestricted license as designated by their specific position. All licenses are verified with the licensing board/agency upon employment and upon renewal date thereafter. The Human Resources department and hiring management are responsible for ensuring ongoing monitoring is conducted in accordance with state and federal requirements.

1. Quality Improvement Team that develops, monitors, evaluates and improves the Molina Medicare SNP Quality Improvement Program. QI Team is comprised of the following positions:
   a. QI Specialists-coordinate implementation of QI Program, gather information for QI Program reporting and evaluations, provide analysis of QI Program components.
   b. QI Managers/Directors-development and oversight of QI Program and credentialing program, provide and interpret reporting on QI Program, evaluate QI Program, identify and address opportunities for improvement.
   c. HEDIS Specialist-gather and validate data for HEDIS reporting
   d. HEDIS Manager-oversight and coordination of data gathering and validation for HEDIS reporting, provide and interpret HEDIS reports, provide preventive services missing services report.
   e. Credentialing Specialist-gather data and reporting for provider credentialing processing
2. Medical Director Team has employed board certified physicians

a. Medical Directors and Healthcare Services Program Manager-Responsible for oversight of the development, training and integrity of Molina Medicare SNP Healthcare Services and Quality Improvement programs. Resource for Care Management Teams and providers regarding member's health care needs and care plans. Selects and monitors usage of nationally recognized medical necessity criteria, preventive health guidelines and clinical practice guidelines.
b. Psychiatrist Medical Director- Responsible for oversight of the development and integrity of behavioral health aspects of Molina Medicare SNP Healthcare Services and Quality Improvement programs. Resource for Care Management Teams and providers regarding member's behavioral health care needs and care plans. Develops and monitors usage of behavioral health related medical necessity criteria and clinical practice guidelines.
c. Healthcare analytics team
    i. Healthcare analysts-assist in gathering information, developing reports, providing analysis for health plan to meet CMS reporting requirements, evaluate the model of care and review operations
    ii. Director Healthcare Analytics-develop predictive modeling programs used to assist in identifying members at risk for future utilization, oversight of healthcare reporting and analysis program, oversight of clinical aspects of Part C Quality Reporting, oversight of healthcare analysts.

IV. Interdisciplinary Care Team

A. Composition of the Interdisciplinary Care Team

1. The following is a description of the composition of the ICT and how membership on the team is determined. The Molina Medicare SNP Interdisciplinary Care Team (ICT) is the core of Molina's Care Management Program. Molina chooses ICT membership based on those health care professionals who have the most frequent contact with the members and the most ability to implement Model of Care components in the member's care. The ICT is typically composed of the member's assigned PCP and the Molina Integrated Care Management Team (Care Review Clinician, Licensed Clinical Social Worker, and Case Manager). The composition of this team is designed to address all aspects of a member's healthcare including medical, behavioral and social health. Additional members of the ICT may be added on a case by case basis depending on a member's conditions and health status.

   Additional positions that may be included (either temporarily or permanently) to the Molina Medicare SNP ICT caring for members include:
   - Molina Medical Directors
   - Molina Behavioral Health Specialists
   - Molina Pharmacists
   - Molina Care Transition Coaches
   - Molina Community Connectors/Health Workers
   - Network Medical Specialty Providers
   - Network Home Health Providers
   - Network Acute Care Hospital Staff
   - Network Skilled Nursing Facility Staff
   - Network Long Term Acute Care Facility Staff
   - Network Certified Outpatient Rehabilitation Staff
   - Network Behavioral Health Facility Staff
   - Network Renal Dialysis Center Staff
   - Out of Network Providers or Facility Staff (until a member's condition of the state of the Molina Network allows safe transfer to network care)

2. Adding members to the ICT will be considered when:
   a. Member has been stratified to a catastrophic or high risk group in the assessment process
   b. Member is undergoing a transition in healthcare setting
   c. Member sees multiple medical specialists for care on a regular and ongoing basis
   d. Member has significant complex or unresolved medical diagnoses
   e. Member has significant complex or unresolved mental health diagnoses
   f. Member has significant complex or unresolved pharmacy needs

B. Participation of members and caregivers in the ICT

Molina Medicare SNP members and their caregivers participate in the Molina ICT through many mechanisms including:

- Discussions about their health care with their PCP
- Discussions about their health care with medical specialists or ancillary providers who are participating in the member's care as directed by the member's PCP
- Discussions about their health care with facility staff who are participating in the member's care as directed by the member's PCP
- During the assessment process by Molina Staff
- Discussions about their health care with their assigned Molina Care Management Team members
- Discussions with Molina Staff in the course of disease management programs, preventive healthcare outreach and post hospital discharge outreach
- Discussion with Molina Pharmacists about complex medication issues
- Through the appeals and grievance processes
- By invitation during case conferences or regular ICT meetings
- By request of the member or caregiver to participate in regular ICT meetings.

C. ICT Operations and Communication

1. The Molina Medicare SNP member's assigned PCP and the Molina Care Management Team will provide the majority of the care management in the ICT. The member's assigned PCP will be a primary source of assessment information, care plan development and member interaction within the ICT. The PCP will regularly (frequency depends on the member's medical conditions and status) assess the member's medical conditions, develop appropriate care plans, request consultations, evaluations and care from other providers both within and when necessary outside the Molina Network. The Molina Care Management Team will also provide assessments, care plan development and individualized care goals.
2. The Care Management Team will be primarily involved during assessment periods, individualized care plan follow-up, during transitions of care settings, during routine case management follow-up, after referral from other Molina Staff (i.e. Health Management Program staff, Pharmacists), requests for assistance from PCPs and requests for assistance from members/caregivers and during significant changes in the member's health status. Transitions in care and significant changes in health status that need follow-up will be detected when services requiring prior authorization are requested by the member's PCP or other providers (signaling a transition in care or complex medical condition or need). The PCP and Care Management Team will decide when additional ICT members are necessary and invite their participation on an as needed basis as previously documented.
3. The ICT will hold regular case conferences for members with complex healthcare needs and/or complex transition issues. Members will be chosen for case conferences

based on need as identified by the Molina Care Management Team, when referred by their provider or at the request of the member/caregiver. All members of the ICT will be invited to participate in the case conference. Members and /or their caregivers will be invited to participate when feasible. The ICT will keep minutes of the case conferences and will provide a case conference summary for each member case discussed. Case conference summaries will be provided to all ICT members and the involved member/caregiver.

4. Communication between ICT members will be compliant with all applicable HIPAA regulations and will occur in multiple ways including:
    a. Care Management Team to acquire and review member's medical records from providers on the ICT before, during and after transitions in care and during significant changes in the health status of members
    b. Care Management Team to acquire and review member's medical records from provider members of the ICT during authorization process for those medical services that require prior authorization
        i. Care Management Team to acquire and review member's medical records from provider members of the ICT during the course of regular case management activities
        ii. Verbal or written communication between PCP and Care Management Team may occur during PCP participation in ICT Case Conferences on an as needed basis.
        iii. Written copies of assessment documents from Care Management Team to PCP by request and on an as needed basis
        iv. Written copies of individualized care plan from Care Management Team to PCP (and other providers as needed)
        v. Case conference summaries
    c. Member care plans are reviewed at least annually by professional clinical Molina staff members in conjunction with annual Comprehensive Health Risk Assessments. Additional opportunities for review and revision of care plans may exist when Molina Care Management Team members are aware of member transitions in healthcare settings or significant changes in member health care status.

    d. The plan of care is documented, reviewed and revised in the Clinical Care Advance system using template driven data entry to assure accuracy and completeness of care plans.

5. Documentation of the activities of the ICT will occur in 3 primary places; the PCP medical record, Molina's QNXT Information Technology Platform and Molina's Clinical Care Advance Care/Case Management and Disease Management Platform.
    a. The PCP medical record documents PCP assessments, care plans, information related to care transitions (hospital discharge summaries, SNF notes, home health notes), specialty consultations, laboratory testing reports and imaging reports, communications with the Molina Care Management Team.
    b. The Molina QNXT Platform documents member demographics and eligibility, claims activities, call tracking of conversations with

providers/members/caregivers, call tracking of grievances, authorizations for services, preventive services reminder flags,
care management interactions and clinical notes regarding medical services and care transitions.

c. The Molina Clinical Care Advance Platform documents member specific information on assessments, individualized care plans, automated reminders for the Care Management Team, care/case management interventions, care/case management interactions with providers and members/caregivers, Disease Management Program participation and interventions.

V. Provider Network

A. The Molina Medicare SNP maintains a network of providers and facilities that has a special expertise in the care of Dual Eligible Special Needs Plans members. The population served in Dual Eligible Special Needs Plans has a disproportionate share of physical and behavioral health disabilities. Molina's network is designed to provide access to medical care for the Molina Medicare SNP population.

1. The Molina Medicare SNP Network has facilities with special expertise to care for its SNP members including:
    - Acute Care Hospitals
    - Long Term Acute Care Facilities
    - Skilled Nursing Facilities
    - Rehabilitation Facilities (Outpatient and Inpatient)
    - Mental Health/Substance Abuse Inpatient Facilities
    - Mental Health/Substance Abuse Outpatient Facilities
    - Outpatient Surgery Centers (Hospital-based and Freestanding)
    - Laboratory Facilities (Hospital-based and Freestanding)
    - Radiology Imaging Centers (Hospital-based and Freestanding)
    - Renal Dialysis Centers
    - Emergency Departments (Hospital-based)
    - Urgent Care Centers (Hospital-based and Freestanding)
    - Diabetes Education Centers (Hospital-based)

2. The Molina Medicare SNP has a large community based network of medical and ancillary providers with many having special expertise to care for the unique needs of its SNP members including:
    - Primary Care Providers
    - Internal Medicine, Family Medicine, Geriatrics
    - Medical Specialists (all medical specialties) including specifically:
    - Orthopedics, Neurology, Physical Medicine and Rehabilitation, Cardiology, Gastroenterology, Pulmonology, Nephrology, Rheumatology, Radiology, General Surgery
    - Behavioral Health Providers
    - Psychiatry, clinical psychology, Masters or above level licensed clinical social work, certified substance abuse specialist
    - Ancillary providers
    - Physical therapists, occupational therapists, speech/language pathology, chiropractic, podiatry
    - Nursing professionals
    - Registered nurses, nurse practitioners, nurse educators

B. Molina determines provider and facility licensure and competence through the credentialing process. Molina has a rigorous credentialing process for all providers and facilities that must be passed in order to join the Molina Medicare SNP Network. The

Molina Credentialing Team gathers information and performs primary source verification (when appropriate) of training, active licensure, board certification, appropriate facility accreditation (JCAHO or state), malpractice coverage, malpractice history (National Data Bank reports), Medicare opt out status, Medicare/Medicaid sanctions, state licensure sanctions. After credentialing information file is complete and primary source verification obtained the provider or facility is presented to the Molina Professional Review Committee (PRC). The PRC consists of Molina Network physicians who are in active practice as well as Molina Medical Directors. The PRC decides on granting network participation status to providers who have gone through the credentialing process based on criteria including active licensure, board certification (may be waived to assure member access when there is geographic need or access problems), freedom from sanctions and freedom from an excessive malpractice case history. Providers and facilities that have passed initial credentialing must go through a re-credentialing process every 3 years utilizing the same criteria as the initial credentialing process. In addition the PRC performs ongoing monitoring for licensure status, sanctions, Medicare opt out status, member complaint reports and peer review actions on a monthly basis (or quarterly for some reporting).

C. The Molina Medicare SNP member's assigned PCP is primarily responsible for determining what medical services a member needs. For members receiving treatment primarily through specialist physician, the specialist may be primarily responsible for determining needed medical services. The PCP would be assisted by the Molina Care Management Team, medical specialty consultants, ancillary providers, behavioral health providers and members or their caregivers in making these determinations. For members undergoing transitions in healthcare settings, facility staff (hospital, SNF, home health, etc.) may also be involved in making recommendations or assisting with access to needed services. For those services that require prior authorization the Molina Care Management Team will assist providers and members in determining medical necessity, available network resources (and out of network resources where necessary). The Molina Care Management portion of the ICT will assist in finding access when difficulties arise for certain services.

Managing transitions:

1. Molina Medicare will identify that a planned transition is going to happen from the member's usual setting of care to the hospital or from the hospital to the next setting.
    a. Molina Medicare requires notification of a planned transition prior to the transition occurring.
        i. Scheduled admissions-Molina Medicare will provide notice of the review decisions as expeditiously as the member's health requires; no later than 14 calendar days following receipt of the request for service.
        ii. Members receive written notification of approval along with educational material to help support them through the transition from home to hospital and hospital through discharge.
    b. Discharge Planning-Molina Medicare requests from the provider:

i. The discharge plan, and
ii. The discharge review within one business day of discharge to the next setting.

c. Provider compliance with notification requirements and provision of the discharge plan is performed through the use of an attribute on the authorization. The attribute is utilized for tracking and reporting purposes.

2. For planned and unplanned transitions, Molina Medicare will share the plan of care.
   a. The sending Provider is responsible to send the care plan to the receiving setting within one business day of notification of the transition for home health care (HHC), skilled nursing facility (SNF), comprehensive outpatient rehab facility (CORF), behavioral health facility and any other appropriate setting.
   b. A copy of the care plan will be provided to Molina.
3. For planned and unplanned transitions from any setting to any other setting, Molina Medicare notifies the members PCP and/or treating practitioner of the transition by fax, phone or mail within five business day of notification of the transition. Staff will document notification information in the authorization.
   a. Molina Medicare sends any communication received to the PCP, which may include:
      i. Initial notification of admission – demographic and clinical information
      ii. Concurrent review information
      iii. Discharge plan
      iv. Discharge letter
      v. Case Management letter
   b. Following discharge, Molina Medicare sends a copy of the member's Post Discharge Follow Up letter to the PCP.

Supporting Members through Transitions:

1. For planned and unplanned transitions from any setting, Molina Medicare will communicate with the member or responsible party about changes to the member's health status and plan of care.
   a. The member or responsible party will be provided with a copy of their discharge instructions upon discharge from the hospital.
   b. A copy of the discharge instructions/plan will be provided to Molina Medicare within one business day of the member's discharge from any setting.
   c. When feasible, a Molina Medicare clinical staff member (Registered Nurse or Medical Social Worker) will visit the member and/or caregiver in the inpatient facility (hospital, rehabilitation center, skilled nursing facility) prior to discharge. The purpose of the visit is to:
      - Encourage the member to take charge of their own care
      - Discuss the Molina Transitional Care Program
      - Review medications via the medical record or advise the member to request that facility staff review the medication list, clarify new

medications or medications with different dosages, determine if existing medications will be discontinued
- Discuss the importance of understanding prescribed medications and having a system in place to ensure adherence to the regimen
- Discuss the Personal Health Record (PHR)
- Facilitate appointment with either the Primary Care Physician or treating specialist within 5 days of discharge
- Discuss Molina resources (transportation, Nurse Advice Line (NAL) Behavioral health)
- Discuss emergency plan and potential drug reactions
- If facility is able to provide discharge medications upon discharge, the program would be discussed with the member

2. For planned and unplanned transitions from any setting to another, Molina Medicare will notify the member or their responsible party about changes in the member's health status and plan of care.
    a. Following discharge, Molina Medicare will send a Post Discharge Follow-Up letter to the member or their responsible party and a copy to the Primary Care Physician (PCP) within 5 business days of notification of discharge. The discharge letter reminds the member to arrange a post discharge physician appointment and fill all prescriptions. The letter also provides the member with the Molina Healthcare Case Manager's contact information, transportation information, behavioral health information and NAL information
    b. When feasible, a Molina staff member (Registered Nurse or Medical Social Worker) or designee will visit the member in their home within 48-72 hours of discharge from the inpatient facility to evaluate the member's functional abilities, social support, environmental challenges and self-management capabilities and needs. Ideally, the member and caregiver are present during this visit. If a Molina staff member or designee is unable to perform this function, Molina may collaborate with a contracted home care agency to perform the home visit. The following information is discussed during the visit:
        i. Medication Management:
            a) Determine current medications which are recorded in the PHR by the member
            b) Explore if the member has a reliable strategy for administering medications
            c) Encourage the safe storage of expired or non-essential medications
            d) Assist the member in identifying any medication questions
        ii. Personal Health Record:
            a) Discuss the PHR and assist with completion
        iii. Physician Follow-up:
            a) Determine if appointment is scheduled and facilitate appointment and transportation if needed

b) Assist the member with questions for the visit

iv. Red Flags:
   a) Explore member's understanding of signs and symptoms that his/her condition is worsening and how to respond
   b) Discuss NAL

v. If the member is experiencing any clinical issues during the visit including condition instability, depending upon the urgency of the situation, Molina staff or designee may assist the member with arranging an urgent visit with the treating physician, send to an Urgent Care Center or Emergency Department, contact the NAL for further guidance or arrange a home nurse or physician visit. Behavioral health concerns should be directed to the appropriate staff member or delegated vendor.

vi. If the member requires ongoing home support, including intensive education regarding the management of their condition or frequent monitoring, ongoing home support should be arranged via a contracted home health provider or appropriate community agency.

c. A Molina staff member will contact the member within 24-48 hours, 7 days and 14 days of notification of discharge. The timeframes may be adjusted at the discretion of the Molina staff member. If the member is receiving case management services, the Case Manager will contact the member; otherwise another appropriate Molina employee will contact the member.
   i. The post discharge assessment tool in Clinical Care Advance (CCA) will be completed including the three item Care Transition Measure (CTM-3).
   ii. The post discharge home visit will be scheduled during the first call
   iii. The Molina staff member will review medication management, the PHR, follow-up care and red flags.
   iv. The Molina staff member will confirm all medical equipment was delivered (if applicable).
   v. The Molina staff member will confirm that all home care services have begun (if applicable).
   vi. If there are discrepancies in the discharge plan or prescriptions, the appropriate staff will coordinate the services and/or notify the PCP by phone.
   vii. If the member is unable to be reached, a second call will be made the following day, varying the time of the call.
   viii. A third attempt is made within 5 days of discharge.

d. The NAL is available to Molina Medicare members 24 hours a day 7 days a week, after hours, weekends and holidays.

3. For planned and unplanned transitions, Molina Medicare will provide each member who has experienced a transition with the name of a consistent person or unit who is responsible for supporting the member through transitions.

a. It is the responsibility of Molina Medicare's UM Department to authorize inpatient facility transitions. Upon notification of a transition, a Molina Healthcare Case Manager is assigned to the member. The Case Manager performs an initial admission assessment and periodic concurrent review for the purposes of transitional care planning.
b. When an inpatient pre-discharge visit is feasible, the member is provided with the name of the Molina Medicare clinical staff member responsible for supporting the member through the transition. If this is not feasible, this information will be provided during the post discharge telephone call or within 5 business days of notification of the discharge via the Post Discharge Follow-Up letter. Following discharge, Molina Medicare sends a Post Discharge Follow Up letter to the member or responsible party. The letter provides the member with the Molina Healthcare Case Manager's contact information.
c. When a member is accepted into Medical Case Management, a Welcome Letter and the business card of the Case Manager is sent to the member and a copy is sent to the PCP. The letter also provides the member with transportation information and NAL information.

D. A primary way that the Molina Provider Network coordinates with the ICT is via the Molina Medicare SNP Prior Authorization process. The ICT includes the Molina Care Access and Monitoring Team (Care Review Processor, Care Review Clinician, Case Manager, and Case Manager Team) - accountable for receipt, processing, authorization of service requests including referrals and communication of service decisions to all pertinent providers. Molina Medicare SNP Prior Authorization requirements have been designed to identify members who are experiencing transitions in healthcare settings or have complex or unresolved healthcare needs. Molina members undergoing transitions in healthcare settings or experiencing complex or unresolved healthcare issues usually require services that are prior authorized. This allows members of the ICT to be made aware of the need for services and any changes in the member's health status. Part of the process includes obtaining medical records and documenting in QNXT so that the ICT is can track those changes. The provider network will also communicate with the ICT when invited to attend ICT meetings, on an as needed basis by contacting the PCP or the Molina Care Management Team. Molina's electronic fax system allows for the transfer of information from one provider to another during transitions. Hospital inpatient information is provided to the PCP and/or treating practitioner.

The Molina Medicare SNP ICT assures that specialized services are delivered in a timely and effectively through the following activities:

- Assuring services requiring prior authorization are processed and that notification is sent as soon as required by the member's health but no later than timelines outlined in CMS regulations
- Directing care to credentialed network providers when appropriate
- Monitoring access to care reports and grievance reports regarding timely or quality care

Reports on services delivered are maintained by the ICT primarily in the PCP medical record. The Molina Medicare SNP regularly audits the completeness of PCP medical records utilizing the annual PCP Medical Record Review process. The Molina Care Management Team will document relevant clinical notes on services and outcomes in QNXT and Clinical Care Advance platforms as appropriate to document significant changes in the member's healthcare status or healthcare setting and to update care plans. A copy of the care plan will be provided to the PCP.

The Molina Medicare SNP is responsible for coordinating service delivery across care settings and providers. The member's assigned PCP is responsible for initiating most transitions of care settings (i.e. hospital or SNF admissions) and referrals to specialty or ancillary providers. The Molina Care Management Team assists specifically with Prior Authorization, access issues and coordinating movement from one care setting to the next when members experience a change in their health care status (i.e. hospital discharge planning).

E. The Molina Medicare SNP applies nationally recognized, evidence based clinical practice guidelines. Molina Medical Directors will select clinical practice guidelines that are relevant to the SNP population. The clinical practice guidelines are communicated on a regular basis to providers utilizing provider newsletter and the Molina Medicare website. Molina annually measures and assesses provider compliance with important aspects of the clinical practice guidelines and report results to providers. Molina monitors important aspects of the clinical practice guidelines the following data and approaches by comparing against available internal and external available benchmarks and performance goals:
   1. HEDIS Effectiveness of Care Measures
   2. Quality Improvement Projects
   3. Analysis of Utilization Patterns
   4. Medical Record Reviews

VI. Model of Care Training

A. The Molina Medicare SNP provides initial and annual Molina SNP Model of Care training to all employed and contracted personnel. Molina Medicare SNP Model of Care employee training occurs using a variety of training methods including computer self study, webinar and in person training.
All Molina Medicare Providers have access to SNP Model of Care training via the Molina Medicare website. Providers may also participate in webinar or in person training sessions on the Molina SNP Model of Care. Molina Medicare promotes Molina Medicare providers in a written invitation to participate in Model of Care training. The Molina Medicare Dual Eligible SNP has a membership that is widely dispersed in the Molina Medicare services areas and requires a large provider network. Molina's very large community based network includes providers that participate in multiple Medicare SNPs and for that reason Molina promotes all available training modalities to providers.

The Molina Medicare SNP Provider Services Department identifies key groups that have large numbers of Molina Medicare SNP members and will conduct invite these groups to specific in person or webinar trainings. SNP Model of Care training for providers will emphasize the role of providers in the Model of Care and ICT communication.

B. Verification of Medicare employee training is accomplished through attendance logs for in person training or certificate of completion of web based and computer self study training programs.

C. The development of model of care training materials will be the responsibility of a designated Molina Healthcare Services Program Director or Medical Director. Implementation and oversight of completion of training will be the responsibility of a designated Molina Medicare Human Resource Manager (employees) and a designated Molina Medicare Provider Services Manager (providers).

D. Employees will be required to complete training or undergo disciplinary action in accordance with Molina policies on completion of required training.

VII. Health Risk Assessment

A. The Molina Medicare SNP performs initial and annual Comprehensive Health Risk Assessment of all SNP members. Molina uses a general care management assessment tool that is embedded in Molina's electronic care/case/disease management software platform Clinical Care Advance (a Trizetto product). This general care management assessment tool allows assessment of cultural and linguistic needs, medical history, medical utilization history, medications, home health needs and services, preventive health status, cognitive function, activities of daily living, behavioral health problem screening, history, status and needs,
and social needs and concerns.,. There is also access to additional evidenced-based condition specific assessment tools depending on the health risks identified by member's responses (asthma, behavioral health, COPD, diabetes, ESRD, HIV, etc.)

B. A centralized team of professional and support staff, including nurses and specially trained non-clinical staff, conducts initial assessments as soon as possible after member's enrollment in the plan but within 90 days of enrollment. Existing members who have not yet had an initial assessment will have an initial assessment conducted within the calendar year. Annual re-assessments occur within 90 days of the anniversary date of the completion of the initial risk assessment.

   Molina has an established system to collect data for the Comprehensive Initial Health Risk Assessment and annual reassessments for each beneficiary utilizing a number of mechanisms including self reported member data collected via telephone IVR/internet responses, mailed assessment responses, predictive modeling, claims reviews, telephone outreach by trained but non-professional staff, home visits, phone interviews using professional clinical staff. Data collected will be entered into the formatted electronic assessment tools contained within Molina's electronic care/case/disease management data platform (Clinical Care Advance). The combined set of data constitutes the Comprehensive Health Risk Assessment.

C. Once comprehensive health risk assessment data is gathered into the assessment tool Molina's staff of professional R.N. Case Managers, LCSW and R.N. Care Managers will review the information, decide if additional assessment is needed, follow stratification protocols and guide the development and implementation of an individualized care plan for each member. Using a flexible approach in collecting assessment information will allow Molina to focus precious professional clinical resources in analysis of assessment information, development of care plans and ongoing appropriate care/case management activities that provide high quality, effective health care for members rather than routine data gathering.

D. Health risk assessment summaries are sent via fax, mail or email following HIPAA compliant practices to the PCP, relevant specialists and other ICT members without access to Clinical Care Advance. All Molina employee members of the ICT have access to the Clinical Care Advance system. Members will be notified either verbally or in

writing that they can request copies of their Comprehensive Health Risk Assessment results through a request to the Member Services Department.

Molina Medicare SNP Care Management Team members review health risk assessments for accuracy and make updates as they become aware of transitions in healthcare settings or changes in healthcare status of members through mechanisms previously described.

VIII. Individualized Care Plan

A. Molina Medicare SNP professional healthcare staff (care managers, case managers, social workers) use information developed in the assessment process to develop and implement individual care plans for members based on analysis of the data and stratification of the individual member. Molina's care management information system, Clinical CareAdvance provides standardized evidenced based care plans. Care management staff may also document member specific plans to address individual needs not included in standardized plans. In some instances as feasible based on stratification, health status and availability of the member/caregiver, **Molina will seek opportunities to obtain member/caregiver involvement in care plan development. This is particularly critical when member self management goals are judged to be an important part of the care plan.**

B. The plan of care elements may consist of member care preferences, need for utilization of medical, behavioral health and supplemental Medicare benefits, end of life needs, social or community services needs and condition specific educational needs. Care plans may also include home assessments and the provision of laboratory, spirometry and echo services for members requiring more intense management. Care plan elements will be structured in the form of goals (long and short term) and documentation will contain as appropriate identification of barriers, member self management plans, tasks (for ICT members and member/caregivers), interventions and outcomes.

C. Member care plans are reviewed at least annually by professional clinical Molina staff members in conjunction with annual Comprehensive Health Risk Assessments. Additional opportunities for review and revision of care plans may exist when Molina Care Management Team members are aware of member transitions in healthcare settings or significant changes in member health care status.

D. The plan of care is documented, reviewed and revised in the Clinical Care Advance system using template driven data entry to assure accuracy and completeness of care plans.

E. Individual member care plans are sent via fax, mail or email following HIPAA compliant practices to the PCP, relevant specialists and other ICT members without access to Clinical Care Advance upon request. All Molina employee members of the ICT have access to the Clinical Care Advance system. Members and their caregivers, members of the ICT, PCPs and pertinent providers will be notified of any revisions to the individualized care plans and will also be made aware either verbally or in writing that they can request copies of their Individual member care plans through a request to the Member Services Department or assigned CCM or Care Coordinator.

IX. Communication

A. The Molina Medicare SNP monitors and coordinates care for members using an integrated communication system between members/caregivers, the Molina ICT, other Molina staff, providers and CMS.

B. Communications structure includes the following components:
   1. Molina utilizes state of the art telephonic communications systems for telephonic interaction between Molina staff and all other stakeholders with capabilities for call center queues, call center reporting, computer screen sharing (available only to Molina staff) and audio conferencing. Molina maintains member and provider services call centers during CMS mandated business hours and a Nurse Advice Line (after hours) that members and providers may use for communication and inquiries. Interactive voice response systems may be used for member assessment data gathering as well as general healthcare reminders. Electronic fax capability and Molina's ePortal allow for the electronic transmission of data for authorization purposes and transitions between settings. Faxed and electronic information is maintained in the member's Molina record.
   2. For communication of a general nature Molina uses newsletters (provider and member), the Molina Medicare website and blast fax communications (providers only). Molina may also use secure web based interfaces for member assessment, staff training, provider inquiries and provider training.
   3. For communication between members of the ICT, Molina has available audio conferencing and audio video conferencing (Molina staff only). Most regular and ad hoc ICT care management meetings will be held on a face to face basis with PCPs, other providers and member/caregivers joining via audio conferencing as needed.
   4. Written and fax documentation from members and providers (clinical records, appeals, grievances) when received will be routed through secure mail room procedures to appropriate parties for tracking and resolution.
   5. Email communication may be exchanged with providers and CMS.
   6. Direct person to person communication may also occur between various stakeholders and Molina Medicare.
   7. Molina Quality Improvement Committees and Sub-Committees will meet regularly on a face to face basis with members not able to attend in person attending via audio conferencing. Committee composition and reporting responsibility can be found in the Molina Medicare Quality Improvement Program Appendix D: Molina Medicare Quality Improvement Plan Committees Role/Function and Membership and Appendix E: Quality Improvement Program Committee Reporting.

C. Tracking and documentation of communications occurs utilizing the following:
   1. The QNXT call tracking system is designed to document all significant telephonic conversations regarding inquiries from members/caregivers and providers. All telephonically received grievances will be documented in the QNXT call tracking system. QNXT call tracking allows storage of a record of inquiries and grievances, status reporting and outcomes reporting.

2. Communication between ICT members and/or stakeholders is documented in QNXT call tracking, QNXT clinical modules or Clinical Care Advance as appropriate. This documentation allows electronic status tracking and archiving of discussions. Written meeting summaries may be used when issues discussed are not easily documented using the electronic means documented above.
3. Written and faxed communications when received are stored in an electronic document storage solution and archived to preserve the data. Written documents related to appeals and grievances result in a call tracking entry made in QNXT call tracking when they are received allowing electronic tracking of status and resolution.
4. Email communication with stakeholders is archived in the Molina email server.
5. Direct person to person communication results in a QNXT call tracking entry or a written summary depending on the situation
6. Molina maintains contemporaneous, signed and dated Committee meetings minutes which document actions, recommendations and outcomes archived for future reference.

D. A designated Molina Medicare SNP Quality Improvement Director is responsible to oversee, monitor and evaluate the effectiveness of the Molina Medicare SNP Communication Program and is responsible to:

- Promote and ensure the establishment of effective communication program components, actions and results as a priority and guiding principle throughout the organization.
- Serve as a resource for planning, implementation, and evaluation of all quality aspect s of the Model of Care Program.
- Coordinates and communicates health service activities to provide for measurement and analysis, and obtains expertise as needed.
- Evaluate continuity and coordination of care through annual analysis of data, as part of the Model of Care Program. Activities include oversight and monitoring of processes and the effectiveness of inter-provider communications and documentation.
- Provide operational oversight of the Model of Care Communication Program as well as the annual work plan, Health Education, HEDIS, Disease Management and other clinical measurement processes and ensures that results, analyses and actions are accurately communicated to all stakeholders.

X. Care Management for the Most Vulnerable Subpopulations

A. The Molina Medicare SNP identifies vulnerable sub-populations including frail/disabled, multiple chronic conditions, ESRD and those nearing end of life by the following mechanisms:
- Risk assessments
- Home visits
- Predictive modeling
- Claims data
- Pharmacy data
- Care/case/disease management activities
- Self referrals by members/caregivers
- Referrals from Member Services
- Referrals from providers.

B. Specific add-on services of most use to vulnerable sub-populations include:
- Care management
- Case management
- Disease management
- Provider home visits
- Nurse Advice Line
- transportation services
- health education/wellness materials
- nutritional training
- additional smoking cessation benefits
- select OTC medications
- routine screening lab services
- home assessments which may include services such as
  - laboratory services
  - spirometry
  - echocardiograms

The needs of the most vulnerable population are met within the Molina Medicare SNP Model of Care by early identification and higher stratification/priority in Molina programs including Disease Management, Care Management, and Case Management. These members will be managed more aggressively and more frequently by the ICT. This assures that they are receiving all necessary services and that they have
adequate care plans before, during and after transitions in health care settings or changes in healthcare status**.**

XI. Performance and Health Outcomes Measurement

A. Molina employs a cyclic, continuous, systematic process to improve performance, outcomes and identify, address and communicate clinical and service quality issues. This process is used throughout the organization and applies to Medicare and Medicaid subset D-SNP Eligible beneficiaries to support and improve procedures, systems, quality, cost, and outcomes related to their areas of responsibility.

Priority areas for improvement, delineated in the Appendix A: Molina Medicare Quality Improvement Program Work Plan can be submitted by Molina Healthcare staff, plan Medical Directors, or external providers and organizations, members and/or their care givers and CMS. Target areas are prioritized through the Medicare Quality Review Group (MQRG), Plan Quality Committees and Sub-Committees, Medicare Medical Affairs staff, and Medicare Senior Management for development based upon the following information:

- High volume, high cost utilization
- Availability of scientific research to evaluate the technology
- Service or care found to have a high potential for harm
- Activity or service that are of great importance to the membership and providers
- Impact to quality of life and health outcomes
- Known or suspected overutilization or inappropriate usage

The improvement model includes the following steps:

- Establish standards and available benchmarks and performance goals
- Data collection
- Analyze data and determine performance levels
- Identify opportunities for improvement
- Prioritize opportunities
- Design, schedule and implement interventions with timelines
- Measure effectiveness
- Develop follow-up actions and timeframes as need to address performance gap

To evaluate the SNP Model of Care, Molina collects data from multiple sources including:

- Administrative (demographics, call center data)
- Authorizations
- CAHPS
- Call Tracking
- Claims
- Clinical Care Advance (Care/Case/Disease Management Program data)
- Encounters
- HEDIS

- HOS
- Medical record reviews
- Pharmacy
- Provider access survey
- Provider satisfaction survey
- Risk assessments
- Utilization
- SF12v2™ survey results
- Case Management Satisfaction survey

All of Molina Medicare's disease management programs contain robust member and practitioner interventions and will be evaluated rigorously with identified process and outcome measurements. In addition to the standard process and outcome measurements defined for each disease management program, the MTMP will report the following:

Process Measurements

- Number of identified enrollees eligible to participate in the MTMP
- Number of Medicare enrollees participating in the MTMP
- Number of Medicare enrollees disenrolled from the MTMP
- Number of Medicare enrollees who decline to participate in the MTMP
- Total prescription cost per MTMP participant on a PMPM basis
- Other measures as defined by CMS

Outcome Measurements

- Use of high risk medications (drugs to be avoided in the elderly)
- Overall prescription drug cost
- Overall medical costs
- Patient understanding
- Self-management
- Member satisfaction
- Provider satisfaction
- ER utilization

B. Molina Quality Improvement Specialists, External Survey Vendors and Healthcare Analysts collect, analyze and report on the above data using manual analysis, electronic software. Data analyzed and reported demonstrate the following:
    - Improved member access to services and benefits
    - Improved health status
    - Adequate service delivery processes
    - Use of evidence based clinical practice guidelines for management of chronic conditions
    - Participation by members/caregivers and ICT members in care planning
    - Utilization of supplementary benefits

- Beneficiary use of communication mechanisms
- Satisfaction with Molina's Case Management Program

C. Molina Healthcare's improvement methodology is designed to address gaps in performance. Approaches to improve include, and not limited to the following:
    - Develop, modify or update organizational policy and procedures.
    - Address gaps in staffing patterns or personnel, or training needs.
    - Modification in network providers, or scope of services provided
    - 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 modification of existing systems, operations and tools.
        - Communication of results, changes, and updates internally and externally.

In collaboration with CMS' coordinated efforts with designated Quality Improvement Organizations (QIO), Molina provides data to the QIOs as required for quality improvement and monitoring performance. The data may be used for the following limited functions: To enable beneficiaries to compare health coverage options and select among them;

2. To evaluate plan performance;
3. To ensure compliance with plan requirements;
4. To develop payment models; and
5. For other purposes as specified by CMS.

Molina uses a multidisciplinary committee structure to facilitate the achievement of quality improvement goals (See Appendix D: Molina Medicare Quality Improvement Plan Committees Role/Function and Membership). Molina quality teams and committees consist of Centralized and Plan staff, in conjunction with network providers, who review multiple sources to assess performance to available benchmarks, performance threshold and/or goals. If measurable outcomes are falling short of goals or expected timeframes, the issues and programs will be analyzed again to determine further improvements needed to satisfy requirements. The Corporate Medicare Quality Review Group oversees and coordinates the Centralized aspects of Quality Improvement Program activities for Molina Medicare. Responsibilities of the MQRG consist of the following activities:

- Approve the scope and activities of the Medicare Quality Improvement Program and reviews and evaluates the progress of existing and new quality improvement activities, including activities not required by CMS. Non-CMS required activities may be linked with accreditation requirements such as NCQA Health Plan Standards and Guidelines or URAC Call Center requirements.
- Confirms that organization-wide quality improvement activities are performed and communicated to the Plan Quality Improvement Committees (in states having Medicare and Medicaid subset D-SNP.

- Implements and is accountable to the Plan Quality Improvement Committees which are in turn accountable to their Boards of Directors. The Molina Health Plan's Board of Directors has the overall authority, accountability and responsibility for all areas of the Quality Improvement Program and activities of their Plan Quality Improvement Committees (QIC). The Plan QIC is responsible for the implementation and ongoing monitoring of the Quality Improvement program. Through the Plan Quality Sub-committees, the QIC recommends policy decisions, analyzes and evaluates the progress and outcomes of all quality improvement activities, institutes needed action and ensures follow-up. The QIC reviews data from QI activities to ensure that performance meets standard and makes recommendations for improvements to be carried out by sub-committees or by specific departments. Once the QIC approves the activities, they are included in the QI program evaluation and the next year's QI program work plan. The QI Department will monitor responsible departments for implementation and track activities.
- Integrate quality activities of centralized Molina Medicare functions with activities of the Plan Quality Improvement Committees.

Quantitative analysis is achieved by comparing collected data with internal and external normative and benchmark data and established thresholds and goals. If the comparative analysis indicates performance is under or over the threshold, Molina will monitor and drill into the data at deeper levels. Comparable data may include:

1. Historical plan data that establishes utilization patterns and thresholds;
2. Historical plan data from other comparable Molina products, providers and reports;
3. NCQA Quality Compass;
4. Milliman, Reden & Anders, Certitude, Solucient, APC
5. Comparative data, thresholds and benchmarks provided by associations
6. Evidence-based standards from medical literature and guidelines.

While quantitative reporting is critical, analysis is incomplete without qualitative analysis. Analysts and medical resources collaborate on qualitative analysis drawing conclusions regarding the causes, consequences, and opportunities for management. Methods may include fishbone diagramming or other tools to look for drivers and outcomes like interrelationship digraphs. Molina looks for patterns of that may indicate lack of care and access, inappropriate levels of care, inadequate coordination of care, inefficient use of ervices, and potential fraud and abuse. Reports that identify Members who need preventive care or who may benefit from specialized programs such as disease management, care coordination, medical or complex case management are produced. Molina finds all Members who have missed preventive care or standard clinical practice care and also identifies their PCPs and provides them with Member information and education to close the gap in care and prevent future gaps in care. PCP access and availability are also reviewed for improvement opportunities.

D. The MQRG is responsible to maintain documentation on internal and external quality improvement activities and makes it available to CMS if requested. Maintenance and storage of all quality improvement evaluation activities are housed in Molina's HIPAA compliant and secure web-based systems and platform. Molina maintains reasonable and appropriate levels of safeguarding practices to protect electronic and other sensitive member information, to limit incidental uses or disclosures. All electronic information will be used, stored, handled, and transmitted in accordance with all applicable legal, regulatory, contractual, and company policies, standards, and requirements. All materials and documents are transmitted per CMS protocols and made available on-site as required. Molina adheres to the CMS required public reporting data as outlined in the Appendix A: Molina Medicare Quality Improvement Program Work Plan including:
    - HEDIS Data
    - SNP Structure and Process Measures
    - Health Outcomes Survey
    - CAHPS Survey

E. The Molina Medicare SNP uses the above data collection, analysis and reporting to develop a comprehensive evaluation of the effectiveness of the Molina SNP Model of Care. The evaluation includes the identification of areas for improvement and acting on opportunities to improve the program. A designated Molina Quality Improvement Director and/or Medical Director have responsibility for monitoring and evaluating the effectiveness of the Molina Medicare SNP Model of Care. Molina notifies stakeholders of improvements to the Model of Care by posting the Model of Care Evaluation on its website.

F. Molina communicates improvements to the Model of Care to staff, committees, members/caregivers, and participating practitioners. The communications structure includes the following elements:

    - State of the art telephonic communications systems for telephonic interaction between Molina staff and all other stakeholders with capabilities for call center queues, call center reporting, computer screen sharing (available only to Molina staff) and audio conferencing.
    - Systems to support member and provider services call centers during CMS mandated business hours.
    - Nurse Advice Line (after hours) that members and providers may use for clinical communication and inquiries. Interactive voice response systems may be used for member assessment data gathering as well as general healthcare reminders. Electronic fax capability and Molina's ePortal allow for the electronic transmission of data.
    - Global communications are deployed via newsletters (provider and member), the Molina Medicare website and provider blast fax communications. Molina may also use secure web based interfaces for assessments, staff training, provider inquiries and provider training.
    - For communication between members of the ICT, Molina has available audio conferencing and audio video conferencing (Molina staff only). Most regular

and ad hoc ICT care management meetings are held on a face to face basis with PCPs, other providers and member/caregivers joining via audio conferencing as needed.

- Tracking and documentation of communications occurs utilizing the following systems: QNXT Call Tracking module to document all significant telephonic conversations with members/caregivers and providers. QNXT Call Tracking allows storage of a record of inquiries and grievances, status reporting and outcomes reporting.
- Communication between the Integrated Care Team members and/or stakeholders will be documented in the QNXT Call Tracking and QNXT Clinical Modules, and the Clinical Care Advance platform systems as appropriate. This documentation allows electronic status tracking and archiving of discussions. Written meeting summaries may be used when issues discussed are not easily documented using the electronic means documented above.
- A designated Molina Quality Improvement Director will have responsibility to oversee, monitor and evaluate the effectiveness of the Molina Medicare SNP Communication Program. Communications are made available to CMS as requested and during onsite visits.

APPENDIX A: Quality Improvement Program Workplan

Performance Indicator/Description *Activities Related to Managed Care QI Requirements	**Goal/ Performance Threshold**	**CMS Required Report (Y)**	**CMS Required Activity ***	**Responsible Party**	**Frequency**	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
Plan Demographic Information									
Membership									
Medicare	N/A				Monthly				
Medicaid Subset D-SNP	N/A				Monthly				
QUALITY IMPROVEMENT									
HEDIS (MA + SNP)	75th %ile	Y	Y	MHI & Plans	Annual				
SNP-HEDIS	Submit Timely	Y	Y	MHI & Plans	Annual				
HOS (Baseline and Follow-up) (MA + SNP)	Submit Timely	Y	Y	MHI	Annual				
CAHPS (MA + SNP)	Submit Timely	Y	Y	MHI	Annual				
MOC Staff Training Completed	Meet Schedule		Y	MHI & Plans	Annual				
MOC Provider Training Completed	Meet Schedule		Y	MHI & Plans	Annual				
SNP Structure and Process Measures	≥ 90%	Y	Y	MHI	Annual				
Provider Satisfaction	Plan Std		Y	Plans	Annual				
BH Satisfaction Survey	Plan Std		Y	MHI & Plans	Annual				
DM & CCM Satisfaction Survey	Plan Std		Y	MHI & Plans	Annual				
Pharmacy Medication Therapy Management Program	Submit Timely		Y	MHI	Annual				
Appointment Access/After Hours	Plan Std		Y	Plans	Annual				
Cultural& Linguistic Assessment	Plan Std		Y	Plans	Annual				
Geo-access (Practitioners, Specialists, BH, Hospitals)	CMS Stds		Y	Plans	X2 per year				
Office site Audits	Plan Std		Y	Plans	Annual				
Medical Record Review	Plan Std		Y	Plans	Annual				
Fraud and Abuse Reports	N/A		Y	MHI & Plans	Immediately				
Over- Utilization Report	≥ 90th percentile		Y	MHI & Plans	Annual				
Under- Utilization Report	≤ 10th percentile		Y	MHI & Plans	Annual				
Annual Utilization Management Program Evaluation	Submit Timely		Y	MHI	Annual				
Annual Quality Improvement Program Evaluation	Submit Timely		Y	MHI & Plans	Annual				
CCIP (MA only)	Submit Timely	Y	Y	MHI	Annual				
Quality Improvement Projects (QIP)		*Y*	*Y*	*MHI*	*Annual*				
Medicare Influenza Initiative	Submit Timely	Y	Y	MHI	Annual				

APPENDIX A: Quality Improvement Program Workplan

Performance Indicator/Description *Activities Related to Managed Care QI Requirements	**Goal/ Performance Threshold**	**CMS Required Report (Y)**	**CMS Required Activity ***	**Responsible Party**	**Frequency**	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
Improving BP Control in Members with Hypertension	Submit Timely	Y	Y	MHI	Annual				
Improving Coordination of Care After a Transition	Submit Timely	Y	Y	MHI	Annual				
Reducing High-Risk Medication Use in the Elderly	Submit Timely	Y	Y	MHI	Annual				
Pharmacy Satisfaction	Submit Timely	Y	Y	MHI	Annual				
Glaucoma Screening	Submit Timely	Y	Y	MHI	Annual				
Committee Activity									
Quality Improvement Committee	Meet Schedule		Y	Plans	Quarterly				
Peer Review Committee	Meet Schedule		Y	Plans	Quarterly				
Clinical Quality Improvement Committee	Meet Schedule		Y	Plans	Quarterly				
Utilization Management Committee	Meet Schedule		Y	Plans	Quarterly				
Member & Provider Satisfaction Committee	Meet Schedule		Y	Plans	Quarterly				
Pharmacy & Therapeutics Committee	Meet Schedule		Y	Plans	Quarterly				
Access and Service									
Inpatient Utilization-Acute Care									
Admissions/1000 Members/Yr	2011 QC		Y	MHI	Quarterly				
Bed Days/1000 Members/Yr	2011 QC		Y	MHI	Quarterly				
ALOS	2011 QC		Y	MHI	Quarterly				
% Readmission <15 days	< 30%		Y	MHI	Quarterly				
MedSurg Admissions/1000 Members/Yr	2011 QC		Y	MHI	Quarterly				
ALOS (MedSurg)	2011 QC		Y	MHI	Quarterly				
SNF Admissions/1000/Members/Yr	2011 QC		Y	MHI	Quarterly				
ALOS (SNF)	2011 QC		Y	MHI	Quarterly				
Utilization per Member per Month	2011 QC		Y	MHI	Quarterly				
Top Diagnoses	Meet Schedule		Y	MHI	Annual				
Ambulatory Care									
PCP Utilization	2011 QC		Y	Plans	X2 per year				
Emergency Room Visits/1000 Members/Yr	2011 QC		Y	MHI & Plans	Quarterly				
Emergency Room Visits w/in 30 days of inpt admit	< 30%		Y	MHI & Plans	Quarterly				
OP Ancillary (HH,DME,Hospice,Community) - PTMPY	2011 QC		Y	MHI	Quarterly				
Pharmacy & Therapeutics Reporting			Y						
Drug Safety Reports	Meet Schedule		Y	MHI	X2 per year				

APPENDIX A: Quality Improvement Program Workplan

Performance Indicator/Description *Activities Related to Managed Care QI Requirements	**Goal/ Performance Threshold**	**CMS Required Report (Y)**	**CMS Required Activity ***	**Responsible Party**	**Frequency**	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
Formulary Review	Meet Schedule		Y	MHI	X2 per year				
New Drug Reports	Meet Schedule		Y		X2 per year				
Participation Rate - Medication Therapy Management	>90%		Y	MHI	Quarterly				
Total prescription costs per MTMP - PMPM	2011 QC		Y	MHI	Quarterly				
Behavioral Health			Y						
BH Admissions- PTMPY	2011 QC		Y	MHI & Plans	Quarterly				
BH Days – PTMPY	2011 QC		Y	MHI & Plans	Quarterly				
ALOS (BH)	2011 QC		Y	MHI & Plans	Quarterly				
% BH Readmission <15 days	2011 QC		Y	MHI & Plans	Quarterly				
BH Chemical Dependency Admissions - PTMPY	2011 QC		Y	MHI & Plans	Quarterly				
BH Chemical Dependency - PTMPY	2011 QC		Y	MHI & Plans	Quarterly				
ALOS (CD)	2011 QC		Y	MHI & Plans	Quarterly				
% BH Chemical Dependency Readmission <15 days	2011 QC		Y	MHI & Plans	Quarterly				
Emergency Room Visits/1000 Members/Yr	2011 QC		Y	MHI & Plans	Quarterly				
BH Outpatient Visits/1,000/Yr	2011 QC		Y	MHI & Plans	Quarterly				
UM Authorization									
Timely UM Referral/UM Decision from date of request	> 90%		Y	MHI	Monthly				
Timely Member Notification from receipt of request	> 90%		Y	MHI	Monthly				
Timely Provider Notification from the date of request	> 90%		Y	MHI	Monthly				
Timeliness of Referral-Expedited	> 90%		Y	MHI	Monthly				
Denial Rate	< 5%		Y	MHI	Monthly				
Denial accuracy & timing	> 90%		Y	MHI	Monthly				
UM Inter-Rater Review									
Case Managers	> 90%		Y	MHI	Annual				
Utilization Coordinators	> 90%		Y	MHI	Annual				
Medical Directors (Concordance)	> 90%		Y	MHI	Annual				
Continuity & Coordination of Care									
% of HRAs conducted within 90 days of enrollment	> 90%		Y	MHI	Monthly				
% of annual HRAs conducted	> 90%		Y	MHI	Monthly				
CCM files- % compliant	> 90%		Y	MHI	Monthly				

APPENDIX A: Quality Improvement Program Workplan

Performance Indicator/Description *Activities Related to Managed Care QI Requirements	**Goal/ Performance Threshold**	**CMS Required Report (Y)**	**CMS Required Activity ***	**Responsible Party**	**Frequency**	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
Transition of Care - D/C Plans obtained	> 95%		Y	MHI	Semi-annual				
Transition of Care - D/C Calls completed	> 95%		Y	MHI	Semi-annual				
NAL- Cases Referrals to CM, DM	< 5 days		Y	MHI	Monthly				
NAL Satisfaction Survey	> 90%		Y	MHI	Annual				
DM Program Report	Meet Schedule		Y	MHI	Annual				
CM Program Report	Meet Schedule		Y	MHI	Annual				
Medication Therapy Management Program-# enrolled	N/A	Y	Y	MHI	x2 per year				
MTMP-# of prescriber interventions	N/A	Y	Y	MHI	x2 per year				
MTMP-# of member with change(s) in Therapy	N/A	Y	Y	MHI	x2 per year				
DM Program Outcomes Evaluation	Meet Schedule		Y	MHI	Annual				
Annual Model of Care Performance Evaluation	Meet Schedule		Y	MHI	Annual				
Member Services									
Total Member Calls Received	N/A		Y	MHI	Monthly				
Total Member Calls Answered	N/A		Y	MHI	Monthly				
Total Member Calls Received/1,000	N/A		Y	MHI	Monthly				
Service Level (% of calls answered within 30 seconds)	85%		Y	MHI	Monthly				
ASA (average speed to answer)	≤ 30 seconds		Y	MHI	Monthly				
% Abandoned	≤ 5%		Y	MHI	Monthly				
Member Cultural Needs-access to TTY/TTD	100%		Y	MHI	Annual				
Total Language Line Calls (C&L)	N/A		Y	MHI	Monthly				
Language Line Calls/1,000 Members (C&L)	N/A		Y	MHI	Monthly				
On-line Provider Directory (Usability Analysis)	N/A		N	MHI	Annual				
Total Return Mail (Member)	N/A		Y	MHI & Plans	Monthly				
Grievance/Complaints (Member)									
Total Received/1000 Members/Yr	N/A		Y	MHI	Quarterly				
% Acknowledgment of Receipt ≤ 10 business days	100%		Y	MHI					
% Processed ≤ 30 days	100%		Y	MHI	Quarterly				
Total Volume CTM Received	N/A	Y	Y	MHI	Quarterly				
% Processed within CMS timeframes	100%	Y	Y	MHI	Quarterly				
Member Complaints	3.0 PTMPQ		Y	MHI	Quarterly				
Total potential Quality Of Care (QOC) Events	N/A		Y	MHI	Monthly				
Total Events (SRAE, HAC)	N/A		Y	MHI	Annual				

APPENDIX A: Quality Improvement Program Workplan

Performance Indicator/Description *Activities Related to Managed Care QI Requirements	Goal/ Performance Threshold	CMS Required Report (Y)	CMS Required Activity *	Responsible Party	Frequency	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Validated QOC/1000 Members	N/A		Y	MHI & Plans	Monthly				
PHI Incidents Reported and Referred	N/A		Y	MHI & Plans	Immediately				
Appeals (Member)			Y						
Total Received/1000 Members	N/A		Y	MHI	Quarterly				
Total Reviewed	100%		Y	MHI	Quarterly				
% Upheld	N/A		Y	MHI	Quarterly				
% Overturned (including modified)	N/A		Y	MHI	Quarterly				
% Acknowledgment of Receipt- Expedited	100%		Y	MHI	Quarterly				
% Acknowledgment of Receipt- Standard	> 90 %		Y	MHI	Quarterly				
% Resolved < 15 business days (pre-service)	> 90 %		Y	MHI & Plans	Quarterly				
% Expedited < 24 hours of receipt (pre-service)	100%		Y	MHI & Plans	Quarterly				
% Resolved < 15 business days (post-service)	> 90 %		Y	MHI & Plans	Quarterly				
Independent Review (External Referral)			Y						
Total/1000 Members/Yr	N/A		Y	MHI & Plans	Quarterly				
% Upheld	> 90%		Y	MHI & Plans	Quarterly				
% Overturned (including modified)	N/A		Y	MHI & Plans	Quarterly				
Enrollment									
Member Disenrollment Compliance with CMS Process	100%		Y	MHI & Plans	Quarterly				
Provider Service Calls									
Total Provider Calls Received	N/A		Y	Plans	Quarterly				
Total Provider Calls Answered	N/A		Y	Plans	Quarterly				
Wait time in queue	< 3 min.		Y	Plans	Quarterly				
% calls blocked	< 1%		Y	Plans	Quarterly				
% Abandoned	< 5%		Y	Plans	Quarterly				
PCP/SCP Coverage									
PCP Ratio	Plan Std		Y	Plans	Quarterly				
Women's Health Practitioner Ratio	Plan Std		Y	Plans	Quarterly				
SCP Ratio	Plan Std		Y	Plans	Quarterly				
PCP % with Open Practice	Plan Std		Y	Plans	Quarterly				
Provider Terminations	Plan Std		Y	Plans	Quarterly				
Total Provider Office Meetings Conducted	N/A		Y	Plans	Quarterly				
Total Provider JOM Meetings	N/A		Y	Plans	Quarterly				
Provider Complaints									
Total Received/1000 Members/Yr	N/A		Y	Plans	Quarterly				
% Resolved within timeframes	> 90%		Y	Plans	Quarterly				

APPENDIX A: Quality Improvement Program Workplan

Performance Indicator/Description *Activities Related to Managed Care QI Requirements	**Goal/ Performance Threshold**	**CMS Required Report (Y)**	**CMS Required Activity ***	**Responsible Party**	**Frequency**	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
Provider Claim Appeals			Y		Quarterly				
Total Received/1000 Members/Yr	N/A		Y	Plans	Quarterly				
% Resolved within timeframes	> 90%		Y	Plans	Quarterly				
% Upheld	N/A		Y	Plans	Quarterly				
% Overturned	N/A		Y	Plans	Quarterly				
Marketing									
Review of EOC/Summary of Benefits/Annual Notice	Submit Timely		Y	MHI	Annually				
Marketing Guidelines: Agent Oversight	Meet Schedule		Y	MHI & Plans	Quarterly				
Qualified Providers									
Practitioner Network Credentialing									
PCP , Hospital and Affiliated Specialist File	>99%		Y	MHI & Plans	Monthly				
Provider Affiliation File	>99%		Y	MHI & Plans	Monthly				
Initial Credentialing w/in 180 days	> 99%		Y	MHI & Plans	Monthly				
Recredentialing w/in 3 years	> 99%		Y	MHI & Plans	Monthly				
Initial Credentialing of HDOs w/in 180 days	> 99%		Y	MHI & Plans	Monthly				
Recredentialing w/in 3 years for HDOs	> 99%		Y	MHI & Plans	Monthly				
Facility Site Review Completed (PCP, High Vol SCP)	> 90%		Y	Plans	Monthly				
% Timely Receipt/Approval Actions Plans	> 99%		Y	Plans	Monthly				
Site Visits Follow-up Audits Completed	> 99%		Y	Plans	Monthly				
Delegation Oversight									
UM Delegation Audits Completed	100%		Y	MHI & Plans	Monthly				
% Timely Receipt/Approval Actions Plans	> 80 %		Y	MHI & Plans	Monthly				
Timely Submission of UM Delegated Reports	> 80 %		Y	MHI & Plans	Monthly				
CR Delegation Audits Completed	100%		Y	MHI & Plans	Monthly				
% Timely Receipt/Approval Actions Plans	> 80 %		Y	MHI & Plans	Monthly				
Timely Submission of CR Delegated Reports	> 95 %		Y	MHI & Plans	Monthly				
Claim Delegation Audits Completed	100%		Y	MHI & Plans	Monthly				
% Timely Receipt/Approval Claim Actions Plans	> 80 %		Y	MHI & Plans	Monthly				
Timely Submission of Claims Delegated Reports	> 95 %		Y	MHI & Plans	Monthly				
% Submission of Adequate Encounter Data*	> 90 %		Y	MHI & Plans	Monthly				

2001 QC: 2011 NCQA Quality Compass or equivalent available external benchmark such as Milliman Care Guidelines.

APPENDIX A: Quality Improvement Program Workplan

Performance Indicator/Description	Q1		Q3	Q4	YTD
Member Grievances/Complaints & Appeals - Top 5 Reasons					
Grievances					
1					
2					
3					
Appeals					
1					
2					
3					
Provider Grievances/Complaints & Appeals - Top 5 Reasons					
Grievances					
1					
2					
3					
Appeals					
1					
2					
3					
Grievance/Complaints & Appeals					
Provider Related Complaints					
Mbr Health Ed/DM Complaints					
CCM Complaints					
Access Complaints					
Marketing Complaints					

Q2

APPENDIX B: Quality Improvement (QIP) Reporting Schedule and Topics

Quality Improvement Projects (QIP)
Reporting Schedule and Topics

- Projects must demonstrate significant improvement over baseline before retiring a project
- Projects must initiate before the end of the 2nd contract year and annually thereafter
- Annual project reporting cycle begins July 1st ending June 30th (similar to HEDIS, CAHPS, claims lag)
- All QIP reports due annually to CMS in July, unless otherwise notified or requested by CMS

	2007	2008	2009	2010	2011	2012
QIP						
Influenza	√	√	√	√	√	√
HTN		√	√	√	√	√
Coordination of Care			√	√	√	√
High Risk Medications				√	√	√
Pharmacy Satisfaction					***7/2011***	√
Glaucoma Screening			√			***7/2012***

Requirements	**Summary Rationale**	**Outcome Measures**
QIP		
Influenza	• The objective of the QI Project is aimed to improve the influenza immunization rate and reduce related medical complications. • Molina Medicare beneficiaries consist of members, who generally have multiple chronic conditions, and are often frail, disabled, and have complex needs. The special high risk nature of this population is consistent with the criteria set forth by the CDC. • Annual analysis of Medicare member demographic data showed that nearly 50% of the Molina Medicare population falls into the higher risk group for influenza-related complications based on the CDC criteria. • The inclusion of the entire Medicare	SNP Dual Eligible member rates are generated in addition to non-SNP beneficiaries. • Influenza vaccination rates (CAHPS and utilization data) • Emergency room utilization due to complications from influenza/pneumonia

APPENDIX B: Quality Improvement (QIP) Reporting Schedule and Topics

	population into this project ensures that all members will receive one or more of the planned activities.	

Requirements	Summary Rationale	Outcome Measures
QIP		
HTN	• The objective of the QI Project is aimed to improve members' ability to control their blood pressure and the impact the level of care (risk/acuity). • Blood pressure control rates and as well as members self reported condition management skills rates were below Molina's performance thresholds. • Annual analysis revealed Cardiovascular (hypertension) related clinical events were identified as an important clinical issue using claims/encounters. Cardiovascular (hypertension) related clinical events were identified as a high volume and high risk condition in the Molina membership. • The criteria for inclusion consists of any member enrolled in the hypertension program are identified through claims and encounter data defined by the Disease Management Program.	SNP Dual Eligible member rates are generated in addition to non-SNP beneficiaries. • Rate of blood pressure control in members with hypertension (HEDIS) • Improvement of hypertension control through thiazide type diuretic and pharmaceutical management.
Coordination of Care	• The objective of the QI Project is aimed to improve continuity of care when members are transitioned from one setting to another setting, improving the stability of the member. (i.e. less transitions in care). • Inpatient hospital readmissions as well as ED visits within 30 days of hospital inpatient discharge are indicators of the effectiveness of transitional care activities. • Annual analysis revealed that several Molina Medicare plans' readmission rates and ED visits post discharge rates exceeded Molina Medicare's established performance goals. Coordination of care was identified as a priority area. • The criteria for inclusion consist of any member experiencing a transition of care event. The project is aimed to coordinate services when a member is transitioned from one setting to another.	SNP Dual Eligible member rates are generated in addition to non-SNP beneficiaries. • Timeliness of the Exchange of Information • Member Satisfaction with Coordination of Care/Services

APPENDIX B: Quality Improvement (QIP) Reporting Schedule and Topics

Requirements	Summary Rationale	Outcome Measures
QIP		
High Risk Medications	• The objective of the QI Project is to reduce the use of high-risk medications in the elderly. • Use of harmful medications was identified as an important clinical issue whose relevance was demonstrated based both on the high degree of risk for members and the volume of members affected. Further, use of these medications represents clinical issue where morbidity and adverse events can be managed, have an impact and have measurable results. • Annual Analysis revealed that several Molina Medicare plans' Use of High-Risk Medications Use in the Elderly HEDIS rates exceeded Molina Medicare's established goals. • The target population is any Molina member age 65 years or older during the study period. The numerator is defined as any member age 65 years or older identified as having one or more Harmful Medication during the measurement year. There are no exclusions.	SNP Dual Eligible member rates are generated in addition to non-SNP beneficiaries. • Use of High Risk Medication in the Elderly (One Drug) (HEDIS) • Use of High Risk Medication in the Elderly (Two Drugs) (HEDIS)
Pharmacy Satisfaction	• The objective of the QI Project is aimed to improve member satisfaction with their pharmacy benefit. • Analysis revealed that several Molina Medicare plans could improve member understanding of benefits and how to access. • The target population will be any Molina member during the study period. Molina Medicare beneficiaries consist of members, who generally have multiple chronic conditions, and are often frail, disabled, and have complex needs.	SNP Dual Eligible member rates are generated in addition to non-SNP beneficiaries. • CAHPS – Satisfaction with pharmacy information. • Accuracy of Information Provided
Glaucoma Screening	• The QIP objective is aimed to improve glaucoma screening. • Preliminary findings suggest an opportunity to improve screening rates. The project topic study design will be finalized with the completion of the 2011 HEDIS reported rates. • The target population is any Molina Medicare members aged 67 years or older.	SNP Dual Eligible member rates are generated in addition to non-SNP beneficiaries. • Glaucoma Screening in Older Adults(HEDIS)

APPENDIX C: SNP Structure and Process Measures

SNP Structure and Process Measures

SNP HEDIS Reporting

SNP HEDIS Reporting

Schedule and Submission Requirements

Phase 1 - FY 2008	Phase 2 - FY 2009	Phase 3 - FY 2010	Phase 4 - FY 2011 Submit: February 28, 2011 (New submission date)
SNPs effective as of January 1, 2007	SNPs effective as of January 1, 2008	SNPs effective as of January 1, 2009	SNPs effective as of January 1, 2010 Renewal as of 2011
HEDIS 2008 (13 measures)	HEDIS 2009 (15 measures) ▪ Addition of two 1st year measures: > Care for Older Adults; > Medication Reconciliation Post-Discharge	HEDIS 2010 ▪ Measure development: > Potentially Avoidable Hospitalizations > Inpatient Readmissions > MDS measures (I-SNPs) > Disease-specific measures (C-SNPs)	HEDIS 2011 ▪ New measure: > Plan All-Cause Readmissions ▪ Continue with development of measures: > Potentially Avoidable Hospitalizations > Chronic disease measures
Structure & Process Measures ▪ SNP 1: Complex Case Management ▪ SNP 2: Improving Member Satisfaction ▪ SNP 3: Clinical Quality Improvements	Structure & Process Measures ▪ SNP 1 – 3 ▪ SNP 4: Care Transitions ▪ SNP 5: Institutional SNP Relationship with Facility ▪ SNP 6:Coordination of Medicare & Medicaid	Structure & Process Measures ▪ Refinement of existing S&P measures ▪ Elements changed slightly from previous year, additional requirements for reporting	Structure & Process Measures ▪ Refinement of existing S&P measures, includes the potential development of new elements ▪ Potential development of new measures

Phase 5 - FY 2012	Phase 6 - FY 2013	Phase 7 - FY 2014	Phase 8 - FY 2015
SNPs effective as of (TBD)	SNPs effective as of (TBD)	SNPs effective as of (TBD)	SNPs effective as of (TBD)
HEDIS 2012 (TBD measures)	HEDIS 2013 (TBD measures)	HEDIS 2014 (TBD measures)	HEDIS 2015 (TBD measures)
Structure & Process Measures (TBD measures)	Structure & Process Measures (TBD measures)	Structure & Process Measures (TBD measures)	Structure & Process Measures (TBD measures)

Appendix D: Quality Improvement Program Committee Composition

MOLINA MEDICARE
QUALITY IMPROVEMENT PLAN COMMITTEES
ROLE/ FUNCTION AND MEMBERSHIP

Molina Medicare Plan QICs are responsible for the implementation and ongoing monitoring of the Quality Improvement program. Through the Plan's Quality Sub-committees, the QIC recommends policy decisions, analyzes and evaluates the progress and outcomes of all quality improvement activities, institutes needed action and ensures follow-up.

COMMITTEE	FREQUENCY	ROLE/ FUNCTION	CHAIR	MEMBERS
Board of Directors (BOD)	Annually	• Oversight of QIC • Approves QI program • Approves UM program	Executive VP	CFO Plan President/CEO Corporate Counsel MHI Board members
Quality Improvement Committee (QIC)	Quarterly	• Approve the scope and activities for QI • Review and evaluate the progress of existing and new QI activities • Confirm that QI functions are performed and communicated to the Molina Healthcare Board of Directors (BOD) • Delegate new assignments to its subcommittees • Monitor all policies and procedures for compliance with State and Federal laws governing confidentiality and privacy of health information	Chief Medical Officer	President/CEO State Medicare Director Director, QI Director, Behavioral Health Director, Pharmacy Services Director, Provider Services Director, UM (Health Care Services) Director, Member Services

Appendix D: Quality Improvement Program Committee Composition

COMMITTEE	FREQUENCY	ROLE/ FUNCTION	CHAIR	MEMBERS
Clinical Quality Improvement Committee (CQIC)	Quarterly	• Review the Annual Analysis of member demographics and epidemiology • Provide regular Health Management program and clinical measurement oversight • Evaluate current and new Clinical Practice and Preventive Guidelines for use at least annually • Identify and monitor key quality indicators that measure performance against clinic practice guidelines, external benchmarks and internal targets • Provide oversight of all Disease Management and Health Education programs • Provide oversight of the Clinical Quality of Care process • Assist with development and oversight of all clinical aspects of the Quality Improvement Program and the QI Work plan • Recommend new opportunities or changes in current programs and interventions to improve clinical care and service • Assist with development, review and maintenance of QI policies and procedures	Chief Medical Officer	Director, QI Director, UM (Health Care Services) HEDIS Analyst or Manager, Board Certified Community Practitioners
Member / Provider Satisfaction Committee (MPC)	Quarterly	• Monitor Service Quality Improvement efforts and activities, including but not limited to: Availability of Practitioners, Accessibility of Services & Member Satisfaction • Monitor internal and external customer service by analysis of member, provider and employee satisfaction surveys in an effort to achieve exceptional customer service • Explore new methods to improve satisfaction and identify improvement activities going forward • Review company policies and procedures related to Service Quality Improvement activities (standards listed above) and propose changes or amendments as appropriate	Chief Medical Officer	Director, Provider Services Director, Member Services Director, QI Director, Pharmacy Services HEDIS Manager Human Resources Manager Other Directors/Managers as appropriate

Appendix D: Quality Improvement Program Committee Composition

COMMITTEE	FREQUENCY	ROLE/ FUNCTION	CHAIR	MEMBERS
Utilization Management Committee (UMC)	Quarterly	• Review and approve the Utilization Management Program, Work Plan and the criteria used to review authorization decisions at least annually • Review, assess, and recommend internal utilization management practices used for selected diagnoses or disease classes • Review and analyze data reported on outcomes and trend studies. Recommend additional studies and/or changes in data collection to improve the reports available for review • Conduct under/over utilization monitoring by selected diagnoses, product line and practice type • Assist utilization management staff to set appropriate upper and lower thresholds for over/under utilization trend reports. • Evaluate and recommend new actions based on utilization management reports • Evaluate member and provider satisfaction with the utilization program annually • Make recommendations that assist the staff to improve relationships with members and community providers • Review denial/appeal trends and identify opportunities for improvements • Annually monitor Inter-Rater Reliability studies for each review group; i.e., medical directors, nurses, authorization reviewers, etc. • Monitor compliance with external regulatory and accreditation body requirements • Review utilization information from delegated groups	Chief Medical Officer	Director, UM (Health Care Services) Director, QI Director, Provider Relations Director, Pharmacy Services Community Practitioners

Appendix D: Quality Improvement Program Committee Composition

COMMITTEE	FREQUENCY	ROLE/ FUNCTION	CHAIR	MEMBERS
Professional Review Committee (PRC)	Monthly	• Reviews the credentials of practitioners/providers and renders decisions regarding initial participation and continued participation in the Molina Healthcare network • Evaluates selected quality of care concerns forwarded from Member Service, Provider Services, the QI Department or the Peer Review Panel as they relate to individual practitioners/providers. It renders decisions concerning continued participation • Evaluates member satisfaction concerns and/or complaints forwarded from Member Service, Provider Services or the QI Department as they relate to individual practitioners/providers • Evaluates results of Medical Record Audits, including individual Practitioner corrective action plans • Approves the Molina Healthcare Credentialing Program policies and procedures • Monitors on-going performance of delegated group credentialing activities.	Chief Medical Officer/Medical Director	Community Practitioners, Director, QI Credentialing Specialist
Pharmacy & Therapeutics Committee (P&TC)	Quarterly	• Approve Pharmacy policies and procedures • Oversee Pharmacy QI activities • Manage Formulary development and maintenance • Recommend additions and deletions to the formulary • Oversee communication about Pharmacy and Formulary changes to practitioners • Evaluate drug utilization patterns and develop interventions when appropriate • Develop and implement programs to enhance member and provider satisfaction	Chief Medical Officer	Medical Director(s) Director, Pharmacy Services, Community Practitioners & Pharmacists, Corporate Director, Pharmacy

Appendix E: Quality Improvement Program Committee Reporting

REPORT	DATA SOURCE	DIRECT REPORT COMMITTEE	FREQUENCY OF REPORT
QUALITY IMPROVEMENT COMMITTEE REPORT	QIC MINUTES	BOD	QUARTERLY
PROFESSIONAL REVIEW COMMITTEE REPORT	PRC MINUTES	QIC	QUARTERLY
UTILIZATION MANAGEMENT COMMITTEE REPORT	UMC MINUTES	QIC	QUARTERLY
PROFESSIONAL REVIEW COMMITTEE REPORT	QIC MINUTES	QIC	QUARTERLY
MEMBER + PROVIDER SATISFACTION COMMITTEE REPORT	PRC MINUTES	QIC	QUARTERLY
PHARMACY + THERAPEUTICS COMMITTEE REPORT	UMC MINUTES	QIC	QUARTERLY
CLINICAL QUALITY IMPROVEMENT COMMITTEE REPORT	QIC MINUTES	QIC	QUARTERLY
COMMITTEE CHARTER REVIEW/ APPROVAL- (QIC, CQIC, MPC, PRC, PTC, UMC)	COMMITTEES MINUTES	QIC	YEARLY
QUALITY OF CARE ISSUES	PEER REVIEW	CQIC	MONTHLY
NEW TECHNOLOGY REVIEWS	REPORT	CQIC	MONTHLY
ALL QI SUBCOMMITTEE REPORTS	REPORTS	QIC	QUARTERLY
QUALITY IMPROVEMENT PROGRAM DESCRIPTION	STANDARDS	QIC	YEARLY
QUALITY IMPROVEMENT PROGRAM EVALUATION	QIPD AND REPORTS	QIC	YEARLY
QI WORK PLAN - Annual Review	QIPD AND REPORTS	QIC	QUARTERLY
UTILIZATION MANAGEMENT PROGRAM DESCRIPTION	UMPD AND REPORTS	QIC	YEARLY
UTILIZATION MANAGEMENT PROGRAM EVALUATION	UMPD AND REPORTS	QIC	YEARLY
UTILIZATION MANAGEMENT WORK PLAN - Annual Review	UMPD AND REPORTS	QIC	YEARLY
POLICY REVIEW/ APPROVAL- (QI, UM, MS, PS, CLAIMS, MA)	COMMITTEES MINUTES	QIC	YEARLY
SNP STRUCTURE + PROCESS MEASURES REPORT	ISS REPORT	QIC	YEARLY
CAHPS SURVEY	CMS APPROVED VENDOR	MPSC	YEARLY
HEALTH OUTCOMES SURVEY REPORT	CMS APPROVED VENDOR	MPSC	YEARLY
DISEASE MANAGEMENT PROGRAM OUTCOMES REPORT	CCA/QNXT/HEDIS REORTS	CQIC	SEMI-ANNUALLY
Member Health Education / Disease Management Call Tracking Complaint Report	CALL TRACKING	CQIC	SEMI-ANNUALLY
REPORT	DATA SOURCE	DIRECT REPORT COMMITTEE	FREQUENCY OF REPORT
TOP DIAGNOSIS REPORT / Member Demographics	QNXT	CQIC	YEARLY
HEALTH ED PROGRAM REPORT	Databases AND REPORTS	CQIC	YEARLY
CLINICAL PRACTICE GUIDELINE APPROVAL	NATIONAL GUIDELIN ES	CQIC	YEARLY
PREVENTIVE HEALTH GUIDELINE APPROVAL	NATIONAL GUIDELIN ES	CQIC	YEARLY
HEALTH ED PROGRAM REPORT	databases	CQIC	YEARLY

Appendix E: Quality Improvement Program Committee Reporting

REPORT	DATA SOURCE	DIRECT REPORT COMMITTEE	FREQUENCY OF REPORT
PRIMARY CARE VISITS/UTILIZATION	QNXT	UMC/CQIC	SEMI-ANNUALLY
PREVENTIVE HEALTH SCREENING RATES	databases	CQIC	SEMI-ANNUALLY
DISEASE MANAGEMENT PROGRAM REPORT	databases	CQIC	SEMI-ANNUALLY
Health Education/ Disease Management Call Tracking Complaint Report	CALL TRACKING	CQIC	SEMI-ANNUALLY
HEDIS ANALYSIS	HEDIS SURVEY	CQIC	YEARLY
CLINICAL PRACTICE GUIDELINE MEASUREMENTS	HEDIS REPORTS, Add. MRR	CQIC	YEARLY
PCP Medical Record Review REPORT	CHART REVIEW DATA	CQIC	YEARLY
QUALITY OF CARE COMPLAINT SUMMARY REPORT- 12 MONTHS	CHART REVIEW REPORT	CQIC	YEARLY
CONTINUITY AND COORDINATION REPORT - Behavioral Health	PROVIDER SURVEY,/ Pharmacy	CQIC	YEARLY
CONTINUITY AND COORDINATION REPORT - Co-existing Conditions	MRR, PROVIDER SURVEY	CQIC	YEARLY
MEMBER ACCESS COMPLAINT REPORT	CALL TRACKING	MPSC	YEARLY
MEMBER DEMOGRAPHICS REPORT	QNXT	MPSC	YEARLY
Member Cultural Needs and Preferences Report	QNXT/CENSUS / Call Tracking	MPSC	YEARLY
PRACTITIONER AVAILABILITY (GeoAccess) 1) PCPs and Top Specialists vs. MHU/ MHN standards 2) MEMBER VS PROVIDER LINGUISTIC ANALYSIS 3) MEMBER VS. PROVIDER GENDER ANALYSIS	GEO ACCESS / QNXT	MPSC	YEARLY
PROVIDER SATSIFACTION SURVEY REPORT	3rd PARTY CERTIFIED VENDOR	MPSC	YEARLY
PRACTITIONER ACCESS SURVEY REPORT	ACCESS SURVEY-REPORT	MPSC	YEARLY
DECISION SUPPORT (UM CRITERIA REVIEW)	NATIONAL CRITIERA	CQIC	YEARLY
CONTINUED ACCESS REPORT - Provider Term (QI10)	CASE MANAGEMENT	MPSC	QTRLY/YEARLY
REPORT	DATA SOURCE	DIRECT REPORT COMMITTEE	FREQUENCY OF REPORT
PCP TERMINATION REPORT (QI10)	EXCEL SPREADSHEETS	MPSC	QTRLY/YEARLY
MEMBER CALL TRACKING COMPLAINTS	CALL TRACKING	MPSC	QTRLY/YEARLY
MEMBER MEDICAL APPEALS ANALYSIS	CALL TRACKING / APPEAL FILES	MPSC	QTRLY/YEARLY
MEMBER COMPLAINT PROVIDER RELATED REPORT	CALL TRACKING	MPSC	QTRLY/YEARLY
PROVIDERS COMPLAINT REPORT	CALL TRACKING	MPSC	QTRLY/YEARLY
TELEPHONE SERVICE REPORT	CISCO SYSTEM	MPSC	QTRLY/YEARLY
NEW MEMBER MARKETING SATISFACTION SURVEY	MEDICARE MARKETING TEAM	MPSC	YEARLY
MEMBER DISSENROLLMENT	MEDICARE REPORT	MPSC	QUARTERLY

Appendix E: Quality Improvement Program Committee Reporting

REPORT	DATA SOURCE	DIRECT REPORT COMMITTEE	FREQUENCY OF REPORT
PROVIDER RELATED CATEGORY COMPLAINT REPORT	CALL TRACKING	PRC	QUARTERLY
ADVERSE EVENTS/PEER REVIEW	CQIC	PRC	MONTHLY
MEMBER COMPLAINTS/PEER REVIEW	CQIC	PRC	MONTHLY
LICENSURE SANCTIONS REPORT	STATE WEBSITE	PRC	QUARTERLY
MEDICARE/MEDICAID SANCTIONS REPORT	OIG WEBSITE	PRC	MONTHLY
CREDENTIALS FILES / CLEAN (WATCH STATUS) / APPROVED BY MED. DIR.	CREDENTIALING DATA	PRC	MONTHLY
CREDENTIALS FILES / CLEAN / APPROVED BY MED. DIR.	CREDENTIALING DATA	PRC	MONTHLY
PROVIDER ACCREDITATION REPORT	CREDENTIALING DATA	PRC	MONTHLY
WATCH STATUS REPORT	CREDENTIALING DATA	PRC	MONTHLY
DRUG SAFETY REPORTS	PBM REPORTS	P&T	SEMI-ANNUALLY
FORMULARY REVIEW	PBM REPORTS	P&T	SEMI-ANNUALLY
NEW DRUG REPORTS	PBM REPORTS	P&T	SEMI-ANNUALLY
INTER-RATER RELIABILITY REPORT - PHYSICIANS	REPORTS	UMC	ANNUALLY
INTER-RATER RELIABILITY REPORT - NURSES	REPORTS	UMC	ANNUALLY
HEDIS USE OF SERVICES REPORT	HEDIS	UMC	ANNUALLY
REPORT	DATA SOURCE	DIRECT REPORT COMMITTEE	FREQUENCY OF REPORT
SATISFACTION WITH COMPLEX CASE MANAGEMENT	CCA / MANUAL REPORT	UMC	ANNUALLY
EFFECTIVENESS OF COMPLEX CASE MANAGEMENT	CCA / MANUAL REPORT	UMC	ANNUALLY
OVER AND UNDER UTILIZATION REPORT	MEDICARE	UMC	ANNUALLY
SATISFACTION WITH UM PROCESS	SURVEY	UMC	ANNUALLY
TRANSITION OF CARE DATA REVIEW & ANALYSIS	QNXT	UMC	SEMI-ANNUALLY
UTILIZATION TOTAL PAYMENTS (Medical + BH)	QNXT	UMC	QUARTERLY
UTILIZATION PER MEMBER/MONTH (Medical + BH)	QNXT	UMC	QUARTERLY
PHYSICIAN PROFILING	QNXT	UMC	QUARTERLY
BED DAY AND ALOS (including SNF, home health, facilities)	Corporate Mo Medical Care Rpt	UMC	QUARTERLY
APPEALS TIMELINESS/PROVIDER APPEALS (Medical + BH)	APPEALS FILES	UMC	QUARTERLY
OB REPORT	UM DATA	UMC	QUARTERLY
UM DENIAL REPORT - CLIN INFO/ CRITERIA DENIAL REPORT (VOL/ ACCURACY/ TIMING)	DENIAL FILES	UMC	QUARTERLY
EMERGENCY USAGE (Medical + BH)	UM Report	UMC	QUARTERLY
RE-ADMISSSIONS / SCHEDULED+UNSCHEDULED (Medical + BH)	UM Report	UMC	QUARTERLY

Appendix E: Quality Improvement Program Committee Reporting

REPORT	DATA SOURCE	DIRECT REPORT COMMITTEE	FREQUENCY OF REPORT
HOSPICE REFERRAL	UM Report	UMC	QUARTERLY
HOME HEALTH (Other Services i.e. meal deliver)	UM Report	UMC	QUARTERLY
HOSPITAL (FACILITY) DISCHARGE FOLLOW-UP (Medical + BH)	UM Report	UMC	QUARTERLY
NURSE ADVICE UTILIZATION	NAL UNIT REPORT	UMC	QUARTERLY
ACCESS TO CASE MANAGEMENT	UM Report	UMC	QUARTERLY
COMPLEX CASE MANAGEMENT COMPLAINTS - member and provider	REPORTS	UMC	QUARTERLY
HEALTH RISK ASSESSMENT - Timeliness & Completeness	REPORTS	UMC	QUARTERLY

APPENDIX F
Molina Healthcare Model of Care Program Index

2012 SNP Model of Care Program Index Guide	
Model of Care Elements	**Corresponding Document Page Number/Section**
1. Description of the SNP-specific Target Population	**Document=** Model of Care Page 1
2. Measurable Goals	**Document=** Model of Care Pages 2-8 Appendices C,D & E Pages 49-57
3. Staff Structure and Care Management Roles	**Document=** Model of Care Pages 9-13
4. Interdisciplinary Care Team (ICT)	**Document=** Model of Care Pages 14-17
5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols	**Document=** Model of Care Pages 18-26
6. Model of Care Training for Personnel and Provider Network	**Document=** Model of Care Page 26
7. Health Risk Assessment	**Document=** Model of Care Pages 27-28
8. Individualized Care Plan	**Document=** Model of Care Page 29
9. Communication Network	**Document=** Model of Care Pages 30- 31
10. Care Management for the Most Vulnerable Subpopulations	**Document=** Model of Care Page 32
11. Performance and Health Outcome Measurement	**Document=** Model of Care Pages 33-38 Appendices C,D & E Pages 49 - 57
12. Appendices A-F	**Document=** Model of Care Pages 39 - 57

MOLINA® HEALTHCARE

Request For Materials in Accessible Formats

MSR Name: _____
Extension: _____

To Be Completed by Member Services Representative

MEMBER INFORMATION	
MEMBER'S NAME: (LAST, FIRST)	TELEPHONE:
MEMBER'S ADDRESS	
MEMBER'S EMAIL ADDRESS:	
MEMBER I.D. #	DATE

REQUEST FOR MATERIALS

What Material Needs to be Converted? *(Please attach any un-branded material requests, ie, Medical Procedure instructions, Rx Instructions, physician follow up instructions, etc.)*

☐ **LARGE PRINT:** (Ask member which font size they prefer) ☐ 14pt. ☐ 16pt. ☐ 18pt ☐ Other _____

☐ **AUDIO:** text (Converted to an audio file); ☐ email file or ☐ copy to CD

☐ **BRAILLE:** written text is provided in Braille.

☐ **ELECTRONIC FORMAT:** written material is saved as "plain text" on ☐ CD or ☐ email:

☐ **SPOKEN:** written material is read by Molina Staff or Contracted staff member in-person or over the telephone.

☐ **OTHER** (Please provide explanation):

How would you like us to send you this information?

Please Email Alternate Format Requests to:
Mariana Bidart-MHC Disability & Senior Access Services
Please allow seven (7) working days to receive your material

DSAS Use Only:
Date Received_____ Sent to Member_____Completed by: _____

Introduction

Getting To Know Molina Healthcare

At Molina Healthcare of California, one of our most important activities is to communicate how we operate. This will help us keep you healthy.

Our Provider Directory will help you get started in making decisions about your health care. Here you will find a listing of doctors and hospitals that are available under Molina Healthcare's health plan. You will also learn some helpful tips on how to use Molina Healthcare's services and benefits.

Together, we can be partners for your good health!

What Is The First Step To Good Health?

Your PCP is your Primary Care Physician who treats you when you need medical care.

He or she is your personal doctor who works with you to keep you healthy and guides you through your Medical care.

Think of your PCP's office as your "medical home." Your first step is to choose a doctor from our list of Primary Care Physicians (PCPs).

What Is A Primary Care Doctor?

(Primary Care Physician or "PCP")
A PCP knows you well. A PCP takes care of your health care needs. Call your PCP when you or your child is sick and you do not know what to do. You do not have to go to the emergency room unless you have something that is so serious your life is in danger.

You may think that you should not see your PCP until you are sick. That is not true. Get to know your PCP even when you are well, for yearly checkups and to stay healthy. Go to your PCP for checkups, tests and test results, shots, and – of course – when you are ill. Seeing your PCP for checkups allows problems to be found early. If you or your child needs special care, your PCP will help you get it. Your PCP and you work together to keep you and your child healthy.

If you want to know more about your PCP or other Molina Healthcare doctors, call Molina Healthcare Member Services toll-free at 1 (888) 665-4621. We can give you information about your doctor's qualifications, such as medical school attended, residency completed, and board certification status. We can also tell you which languages your doctor speaks.

Choosing Your Doctor

(Choice of Physician and Providers) To be covered, services must be provided by Molina Healthcare doctors, hospitals, specialists or medical facilities that are assigned to you, except in the case of emergency services, out of area urgent services, or those services listed under "What is a Prior Authorization" in your Member Services Guide.

How do I choose a primary care doctor (PCP)?
Picking the right doctor for you and your family is very important. Molina's Member Services staff can help you choose. They can tell you what the doctor's regular office hours are and how to schedule an office visit.

Call and schedule your first visit to get to know your PCP. If you need help making an appointment, call Molina Healthcare toll free at 1 (888) 665-4621 / TTY: 1-800-479-3310, 711 or other local relay service, Monday through Friday between 7:00 a.m. and 7:00 p.m.

Molina Healthcare can also help you find a PCP that is best for you. Tell us what is important to you in choosing a PCP. We are happy to help you. Call the Member Services Department if you want more information about your Molina Healthcare doctor.

Here are the kinds of PCPs you may select:

- **Family Practice PCP**
  A Family Practice PCP may see the whole family.
- **General Practice PCP**
  A General Practice PCP may also see the entire family.
- **Internal Medicine PCP**
  An Internal Medicine PCP sees adults only (21 years or older).
- **OB/GYN**
  An OB/GYN PCP sees women only. He or she specializes in women's health and maternity care.
- **Pediatrician**
  A Pediatrician sees only children up to age 21.

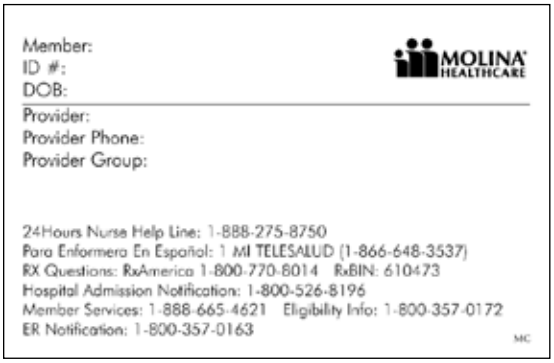
After you decide what kind of doctor you want as a PCP, your next step is to choose the right doctor for you. Here are some helpful tips:

- Choose a doctor in the city where you live.
- Write your doctor's Identification Number (ID) or his/her name on the Medi-Cal Health Plan Choice Form.
- Be sure you fill out the Medi-Cal Health Plan Choice form completely.
- Sign your name on the Medi-Cal Health Plan Choice form.
- Mail your completed Medi-Cal Health Plan Choice Form in our self-addressed stamped envelope included with your packet to Health Care Options.

You may decide you want to receive your health care services from doctors who are under Molina Healthcare's health plan or with our subcontracting health plan, Health Net.

You, your doctor and your health plan will make decisions on where you will get other medical services such as vision, pharmacy, laboratory and hospital care.

For example, if you choose a doctor who is with Molina Healthcare, you will receive all your specialty care and prescriptions through providers and pharmacies that belong to the Molina Healthcare network.


Member:
ID #:
DOB:
MOLINA HEALTHCARE
Provider:
Provider Phone:
Provider Group:
24Hours Nurse Help Line: 1-888-275-8750
Para Enfermera En Español: 1 MI TELESALUD (1-866-648-3537)
RX Questions: RxAmerica 1-800-770-8014 RxBIN: 610473
Hospital Admission Notification: 1-800-526-8196
Member Services: 1-888-665-4621 Eligibility Info: 1-800-357-0172
ER Notification: 1-800-357-0163
MC

Federally Qualified Health Centers and Rural Health Clinics

If you want to get care from a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) you can be assigned to an FQHC or RHC that has a contract with Molina Healthcare. If you see a ▪ next to the name of a clinic in this directory, you will know that it is either an FQHC or RHC.

Teen Friendly Doctors

There are many doctors that like to care for teens. Molina Healthcare supports the care of teens and encourages them to involve themselves in their health care. Enclosed you will find a list of doctors.

Introduction

If there is ▪ next to the doctor's name this means that they are "teen friendly." These doctors and their staff have agreed to be listed as "teen friendly."

What If I Don't Choose A Primary Care Doctor?

Molina Healthcare asks that you select a primary care provider within 30 days of joining Molina Healthcare. However, if you don't choose a PCP, Molina Healthcare will choose one for you.

Changing Your Doctor

What if I want to change my primary care doctor?
You can change your PCP at anytime. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month. Any changes on or after the 26th of the month will be in effect on the first day of the second calendar month. But first visit your doctor. Get to know your PCP before changing. Having a good relationship with your PCP is important to your health care. Call the Member Services Department if you want more information about your Molina Healthcare doctor.

Can my doctor request that I change to a different primary care doctor?
Your doctor may request that you be changed to a different PCP for any of the following reasons:

- You are not following medical instructions (Non-compliant behavior)
- You are being abusive, threatening or have violent behavior
- Doctor patient relationship breakdown

How Do I Choose An OB/GYN?

Women may see an OB/GYN without receiving prior approval from your PCP. You may also choose an OB/GYN in addition to your PCP. But it's very important that you select an OB/GYN who is a member of the same Medical Group (IPA) as your PCP.

If you need help in choosing an OB/GYN, or if you have questions about the PCP and OB/GYN who are a part of your Medical Group (IPA), call Molina Member Services at 1 (888) 665-4621, TTY 1 (800) 479-3310, 711 or other local relay service 7am-7pm Monday through Friday. Our representatives will be happy to help you or answer your questions.

How Does Molina Work With Your Doctor To Keep You Healthy?

Your PCP treats you when you are sick, gives you care to keep you well and prevents you from becoming ill. If you need to go to a hospital, Molina Healthcare will work with your PCP to make sure you get the proper care. When your doctor and Molina Healthcare work together in this way, it is called "Utilization Management." If you need care that can't be given by your doctor, your doctor will refer you to a specialist. We will help your doctor find the right kind of specialist for you.

Your PCP is the doctor who treats you when you need medical care. Think of your PCP's office as your ***"medical home."***

When you need Medical care, contact your PCP unless it is an emergency. If you are experiencing an emergency, dial 911. You also don't need to get a prior authorization from your PCP for a visit to Family Planning Services.

What are My Rights and Responsibilities as a Molina Member?

These rights and responsibilities are posted in doctors' offices and on the Molina Healthcare web site: www.molinahealthcare.com

YOUR RIGHTS

You have the right to:

- Be treated with respect and recognition of your dignity by everyone who works with Molina Healthcare.
- Get information about Molina Healthcare, our providers, our doctors, our services and members' rights and responsibilities.
- Choose your "main" doctor from Molina Healthcare's network (This doctor is called your primary care doctor or personal doctor).
- Be informed about your health. If you have an illness, you have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all your questions about your health answered.
- Help make decisions about your health care. You have the right to refuse medical treatment.
- You have a right to Privacy. We keep your medical records private.*
- See your medical record. You also have the right to get a copy or, correct, your medical record where legally ok.
- Complain about Molina Healthcare or your care. You can call, fax, email or write to Molina Healthcare Member Services.
- Appeal Molina Healthcare's decisions. You have the right to have someone speak for you during your grievance.
- Ask for a State Fair Hearing by calling 1 (800) 952-5253. You also have the right to get information on how to get an expedited State Fair hearing quickly.
- Disenroll from Molina Healthcare (Leave the Molina Health Plan).
- Ask for a second opinion about your health condition.
- Ask for someone outside Molina Healthcare to look into therapies that are experimental or being done as part of exploration.
- Decide in advance how you want to be cared for in case you have a life threatening illness or injury.
- Get interpreter services at no cost to help you talk with your doctor or us if you prefer to speak a language other than English.
- Not be asked to bring a friend or family member with you to act as your interpreter.
- Get information about Molina Healthcare, your providers, or your health in the language you prefer.
- You also have the right to ask for materials in other formats such as, larger size print and Braille.
- Ask for a copy of Molina Healthcare's list of approved drugs (drug formulary).
- Get family planning services, treatment for any sexually transmitted disease, emergency care services, from Federally Qualified Health Centers, and/or Indian Health Services. You do not need to get Molina Healthcare's approval first.
- Get minor consent services.
- Not to be treated poorly by Molina Healthcare, your doctors or the Department of Health Care Services for acting on any of these rights.
- A right to make recommendations regarding the organization's member rights and responsibilities policies.
- To be free from controls or isolation used to pressure, punish or seek revenge.

*Subject to State and Federal laws

Introduction

YOUR RESPONSIBILITIES
You have the responsibility to:

- Learn and ask questions about your health benefits. If you have a question about your benefits, call Member Services at 1 (888) 665-4621.
- Give information to your doctor or Molina Healthcare that is needed to care for you.
- Be active in decisions about your health care.
- Follow the care plans for you that you have agreed on with your doctor(s).
- To keep appointments and be on time. If you are going to be late or can not keep your appointment, call your doctor's office.
- Give your Molina and State card when getting medical care. Do not give your card to others. Let Molina Healthcare or the State know about any fraud or wrongdoing.
- A responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Communication Services

Do you speak a language other than English?
Please tell your doctor or call Molina Healthcare if you are more at ease speaking a language other than English. Many of Molina Healthcare's doctors and staff speak other languages and are familiar with using relay services for our deaf members.

Molina Healthcare can get someone to help you talk with your doctor or us in your language. You can make your needs known and get services without delay. These services may include, but are not limited to, the following:

- Making an appointment
- Talking with your doctor or nurse
- Getting emergency care in a timely manner
- Filing a complaint or grievance
- Getting health education services
- Getting information from the pharmacist about how to take your medicine
- Request face-to-face or telephone interpreter services including **sign language** during discussions of complex medical conditions and accompanying proposed treatment options
- Get documents translated into other languages
- File grievances or complaints if language needs are not met

Tell your doctor or any one working in his or her office if you need an interpreter. If you have problems getting help, please call Molina Healthcare toll-free at **1 (888) 665-4621, TTY: (800) 479-3310, 711 or other local relay service.**

Senior and Disability Access Services

Physical Access is critical. You need to make sure you can get in and around in your doctor's office. We have done a site review on many of your doctor's offices to check accessibility. You will find the words "Basic Access" and "Limited Access" after many of the doctors listed in this directory. Below will explain what Basic and Limited Access means:

Basic Access: Office meets all accessible parking, building, elevator, office, exam room and restroom criteria based on scores of the last site access review.

Limited Access: Office meets some accessible parking, building, elevator, office, exam room and restroom criteria based on scores of the last site access review.

You will also see the following accessibility symbols after many providers in our network: P, EB, IB, W, R, E, T, S. Below will explain what each code means. This data was based on the last site access review. **Please call your provider office to make sure your access needs will be met.**

P=PARKING: There is accessible parking (including Van Accessible). Pathways have ramps and curb cutouts between the parking lot, office and at drop off locations.

EB=EXTERIOR BUILDING: There is an accessible entrance to the building. Curb and other ramps to the building are wide enough for a wheelchair or scooter user. Handrails are provided on ramps longer than six feet. Doorways open wide enough for a wheelchair or scooter user. Door handles are easy to use.

IB=INTERIOR BUILDING: Interior doors open wide enough for a wheelchair or scooter user. Door handles are easy to use. Elevators, stairs and ramps have handrails and are easy to use. The elevator is available for use at all times the building is in use. The elevator has easy to hear sounds and Braille buttons within reach. The elevator has enough room for a wheelchair or scooter to turn around. If there is a platform lift, it can be used without help.

W=WAITING/RECEPTION: The reception and waiting areas have enough room for a wheelchair or scooter user to turn around.

R=RESTROOM: Restroom doors are wide enough for a wheelchair or scooter user and are easy to open. The restroom has enough room for a wheelchair or scooter user to turn around and close the door. There are grab bars on the wall around the toilet. The sink, faucets, soap, and toilet paper are easy to reach and use.

E=EXAM ROOM: The exam room door opens wide enough for a wheelchair or scooter and has a clear path. There is enough room for a wheelchair or scooter user to turn around.

T=EXAM TABLE: The exam table moves up and down to make it easy to get on and off.

S=WHEELCHAIR WEIGHT SCALE: There is a scale with handrails large enough for a wheelchair or scooter user to be weighed.

Accessible Formats

If you would like to get this book in **large print, audio, Braille, email or other format,** please call us. You can call Molina's Member Services Department at 1 (888) 665-4621, TTY 1 (800) 479-3310, 711, or other local relay services, 7am-7pm Monday through Friday.

Molina Will Always Protect Your Privacy

Your privacy is important to us.

You have the right to keep your medical information confidential.

Molina Healthcare needs to use some member information in order to pay claims and prevent fraud, coordinate care, conduct research, fulfill state and federal requirements, and measure quality. We will only give your personal information to people who need it to manage your health. Or, we will give your information to doctors on Molina Healthcare's committees or people from external agencies who need to review your information to ensure that Molina Healthcare is providing quality service.

Introduction

Molina's employees, doctors on Molina Healthcare committees and people from external agencies are required to sign a "confidentiality statement" that requires them to keep your health information strictly confidential.

If Molina Healthcare needs to release your information, we will ask you to give us your permission. When you give us your permission to release your information, you can specify what information may be released, who may have access to it, and ask what purpose the information will be used for. If you give us permission to release your information, we will release it only for these purposes. We will only give information to people you gave us permission to release information to. Release of your information is completely voluntary.

A statement describing Molina Healthcare's Policies and Procedures for keeping the confidentiality of medical records is available. This statement will be given to you if you make a request.

Your Privacy

The privacy of our members is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared.
PHI stands for these words, protected health information. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To share PHI as required or permitted by law

What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways

What must Molina do by law?

- Keep your PHI private.
- Give you written information such as this on our duties and privacy practices about your PHI.
- Follow the terms of the enclosed Notice of Privacy Practices

What can you do if you feel your privacy rights have not been protected?

- Call or write Molina Healthcare and complain.
- Complain to the Department of Health and Human Services.

We will not hold anything against you. Your action would not change your care in any way.
The above is only a summary. Please read the enclosed Notice of Privacy Practices. The Notice has more information about how we use and share your PHI.

We will be happy to answer your questions as a member of Molina Healthcare.

Please call our Member Services Department at 1 (888) 665-4621, TTY 1(800) 479-3310, 711, or use your local relay service, Monday through Friday, 7:00 a.m. to 7:00 p.m.

MOLINA® HEALTHCARE

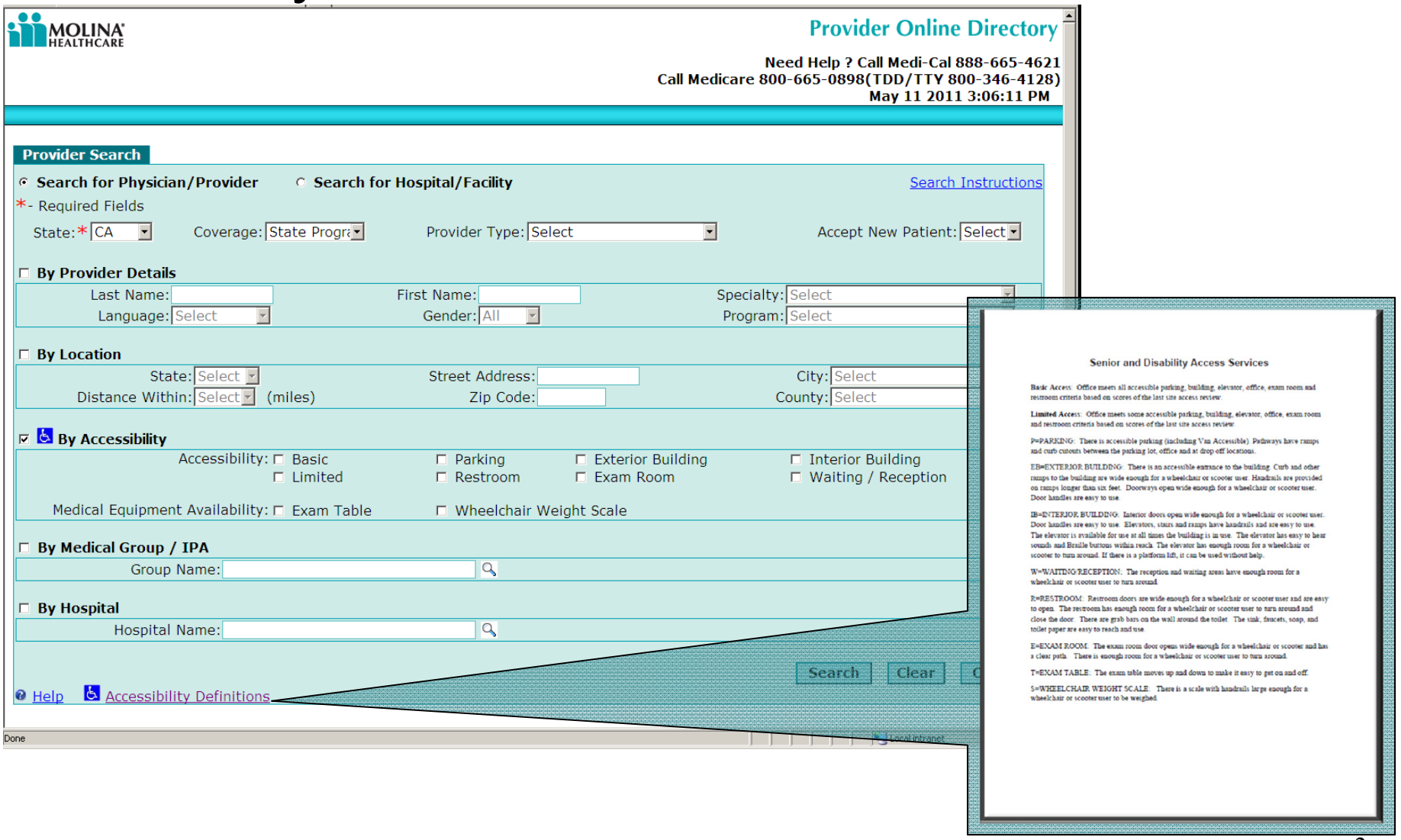
Your Extended Family.

Molina Online and Written Provider Directory with Accessibility Indicators

Accessibility Indicators and Definitions

Indicator	Definition
BASIC ACCESS	Office meets all accessible parking, building, elevator, office, exam room and restroom criteria based on scores of most recent site review.
LIMITED ACCESS	Office meets some accessible parking, building, elevator, office, exam room and restroom criteria based on scores of most recent site review.
P=PARKING	Parking spaces are accessible with ramps and curb cutouts between the parking lot, office and at drop off locations.
EB=EXTERIOR BUILDING	Handrails are provided on both sides of the ramp. Doorways are accessible, open wide enough to accommodate a wheelchair or scooter and have door handles that are easy to use.
IB=INTERIOR BUILDING	The interior doors open wide enough to accommodate a wheelchair or scooter and door handles are easy to use. Elevators, stairs and ramps have handrails and are easy to use. The elevator is available for public/patient use at all times the building is occupied. The elevator has enough room for a wheelchair or scooter to maneuver.
W=WAITING/RECEPTION	The reception and waiting areas have enough room for a wheelchair or scooter to maneuver and turn around.
R=RESTROOM	The restroom is accessible and the doors are wide enough to accommodate a wheelchair or scooter and are easy to open. The restroom has enough room for a wheelchair or scooter to turn around and close the door. There are grab bars which allow easy transfer from wheelchair to toilet. The sink is easy to get to and the faucets, soap, and toilet paper are easy to reach and use.
E=EXAM ROOM	The entrance to the exam room is accessible, with a clear path. The doors open wide enough to accommodate a wheelchair or scooter and are easy to open. The exam room has enough room for a wheelchair or scooter to turn around.
T=EXAM TABLE	The exam table moves up and down to make it easy to get on and off whether standing or using a wheelchair or scooter.
S=WHEELCHAIR WEIGHT SCALE	The scale is able to accommodate a wheelchair or scooter and has handrails.

Accessibility Indicators on the Molina Website



https://eportal.molinahealthcare.com/Provider/ProviderSearch?RedirectFrom=MolinaStaticWeb

Accessibility Indicators on the Molina Website

Provider Details

Name	AAZAMI, HESSAM	**Gender**	Male
Language	SPANISH		

Help

Specialty

Primary Specialty	General Practice	**Certification Board**	Not Available

Help

Service Location/Program

This provider renders services at the location(s) below.

Address	22030 SHERMAN WAY STE 101 CANOGA PARK, CA, 91303		
Phone	(818)716-9434	**Fax**	(818)337-2049
Staff Language	ENGLISH		

Program	PCP	Accepting New Patients	Accepted Ages	Gender Restriction	Other Restrictions
Healthy Families - MHC	Y	Y	Upto - 19	N	None
Los Angeles - MHC	Y	Y	Upto - 110	N	None
Riverside - HN	N	N	Not Available	N	None
Riverside - MHC	N	N	Not Available	N	None
Sacramento - MHC	N	N	Not Available	N	None
San Bernardino - HN	N	N	Not Available	N	None
San Bernardino - MHC	N	N	Not Available	N	None

Office Hours	Mon	Tue	Wed	Thu	Fri	Sat	Sun
From:	8:30 AM	8:30 AM	8:30 AM	8:30 AM	8:30 AM	N/A	N/A
To:	6:00 PM	6:00 PM	6:00 PM	6:00 PM	6:00 PM	N/A	N/A

Accessibility: Basic, Parking, Exterior Building, Interior Building, Waiting Room, Restroom, Exam Room

This data was based on the provider's last site review. Please call your provider office to make sure your access needs will be met.

Molina Healthcare makes available telephonic and face-to-face interpretive services to assist you. Please call our Member Services toll-free at 1 (888) 665-4621, TTY 1-800-479-3310, 7am - 7pm Monday through Friday. Tell your doctor or anyone working in his or her office if you need interpretive services. If you need a face to face or sign language interpreter, please call your doctor's office at least 7 days prior to your appointment.

Are you deaf, hard of hearing, have low vision or are blind? Molina Healthcare can help you to talk with your doctor and us. If you are deaf or hard of hearing, call the TTY line toll-free at 1(800) 479-3310 or call the California Relay Service at 711 to contact us. Molina Healthcare can

MOLINA HEALTHCARE

Accessibility Indicators on Printed Directories

Staff Language: Tagalog
Affiliated Hospital(s): Loma Linda University Medical Center, San Gorgonio Memorial Hospital
Board Certified: Yes

SACHS, MICHAEL DO
Family Practice #20A4106
Molina: Inland Valleys IPA
264 N Highland Springs Ave, Ste 3B
Banning, CA 92220
(951)845-7025
Mon-Fri 8:30am-5:30pm
Physician's Language: Spanish
Staff Language: Spanish
Affiliated Hospital(s): Please see list of hospitals on page(s) 60-62
Board Certified: Yes

SMITH, ELLEN DO
Family Practice #20A6168
Molina: La Salle Medical Associates IPA San Bernardino
264 N Highland Springs Ave, Ste 5 - A
Banning, CA 92220
(951)769-0079
Mon-Fri 8am-5pm
Affiliated Hospital(s): Please see list of hospitals on page(s) 60-62
Board Certified: Yes

Thu -Fri 8am-5pm
Physician's Language: Mandarin
Staff Language: Spanish
Affiliated Hospital(s): San Gorgonio Memorial Hospital
Board Certified: Yes

LOERA, ROBERT MD
Internal Medicine #G71491
Molina: Mckinley Medical Group
264 N Highland Springs Ave, Ste 1 - A
Banning, CA 92220
(951)769-7191
Mon-Thu 9am-5pm, Fri 8am-4pm
Physician's Language: Spanish, Tagalog, Visayan
Staff Language: Spanish, Tagalog, Visayan
Affiliated Hospital(s): Hemet Valley Medical Center, San Gorgonio Memorial Hospital
Board Certified: Yes
♿ Accessibility: Basic, P, EB, IB, W, R, E

QAZI, AHSAN MD
Internal Medicine #A38621
Molina: Inland Valleys IPA
264 N Highland Springs Ave, Ste 2 - A
Banning, CA 92220
(951)845-8856
Mon-Fri 8:30am-5pm
Physician's Language: Spanish, Urdu
Staff Language: Spanish, Urdu
Affiliated Hospital(s): San Gorgonio Memorial Hospital
Board Certified: Yes

Banning, CA 92220
(951)849-1543
Mon 1:30pm-5:30pm, Tue -Wed 8am-12pm, Thu -Fri 1:30pm-5:30pm
Staff Language: Spanish
Affiliated Hospital(s): San Gorgonio Memorial Hospital
Board Certified: Yes

■ **SCHWARTZ, STANLEY MD**
Pediatrics #A42271
Practitioners: Derrick Hull NP, Douglas Mc Carthy PA, La Shaun Smith-favors NP
Molina: Mckinley Medical Group
264 N Highland Springs Ave, Ste 1 - A
Banning, CA 92220
(951)769-7191
Mon-Fri 8am-5pm
Physician's Language: Spanish
Staff Language: Spanish
Affiliated Hospital(s): Parkview Community Hospital Medical Center, San Gorgonio Memorial Hospital
Board Certified: Yes
♿ Accessibility: Basic, P, EB, IB, W, R, E

COACHELLA

■ **ACOSTA, JUAN MD**
General Practice #A66595
Molina: Inland Valleys IPA
52 - 565 Harrison St, Ste 104
Coachella, CA 92236
(760)398-0606
Mon-Fri 9am-5pm
Physician's Language: Spanish
Staff Language: Spanish
Affiliated Hospital(s): Please see list of hospitals on page(s) 60-62
Board Certified: Yes
♿ Accessibility: Basic, P, EB, IB, W, R, E

MOSTYN, MICHAEL MD
General Practice #A37252
Molina: Vantage Medical Group
Health Net: Vantage Medical Group
1293 6th Street
Coachella, CA 92236
(760) 391-5151
Mon-Fri 9am-5pm
Physician's Language: Spanish, Tagalog
Staff Language: Spanish, Tagalog
Affiliated Hospital(s): Please see list of hospitals on page(s) 60-62
Board Certified: Yes

❖ *Federally Qualified Health Centers and Rural Health Clinics*
✻ *Physician is currently unavailable to new patients*
■ *Teen Friendly Provider*

Provider availability varies by location.
Please contact member services to verify the availability of selected providers.

Accessibility information subject to change. Please call doctor's office for more information.
♿ *Refer to pages 5 and 6 for a complete definition of accessibility symbols.*

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MOLINA HEALTHCARE of CALIFORNIA

	Policy and Procedure No. HE-03
	Department: Health Education and Cultural/Linguistic Services **Title**: Communications to Members
	Effective Date: 3/1/98
	Reviewed and Revised Date: 3/1/98, 1/7/99, 9/13/2000, 11/26/2003, 12/05/2008, 4/11/11, 7/13/11, 9/13/11
Richard Bock, M.D. **Chief Medical Officer**	**Reviewed Only Date:** 3/04/2002, 1/18/05, 3/30/2007, 5/14/10
Signature: **Date**: 1-9-12	**Supersedes and replaces**: HE-06; Member Health Education Materials Development **Date:**

I PURPOSE

To establish health plan policy for communication to members that improves member comprehension and satisfaction. This policy includes both health education and member informing materials. Health education materials are designed to assist members to modify personal health behaviors, achieve and maintain healthy lifestyles and promote positive health outcomes, including updates on current health conditions, self-care and management of health conditions. Informing materials are vital documents that provide members with essential information about access to and usage of plan services (see Definitions section for examples).

II POLICY

All communications to members are developed or selected using standardized guidelines for cultural/linguistic appropriateness. Auxiliary aids, services and devices are used when ensuring effective communication with individuals with sensory and/or cognitive disabilities including but not limited to qualified sign language interpreters, assistive listening devices, qualified readers, audio recordings, Braille materials, large print materials, captioning and accessible web-sites. All written communication to members are at appropriate readability levels. Communications to members are translated into identified threshold languages as appropriate using a standardized process for ensuring quality. Policy exceptions for readability standards include legal and/or medical terminology required for legal or medical necessity. When such terminology is required, it is accompanied by a definition of the term, worded in as simple terms as is possible. Requirements for reading level and readability formulas are applicable only for written materials produced in English.

III PROCEDURE

A. The initiation of communication to members follows these steps:
   1. Utilize plan's group needs assessment findings or other pertinent plan data sources to determine member needs if appropriate to communication.
   2. Determine objective(s) of communication. Link to specific program goal if this communication is part of a larger program or health initiative.

3. Determine the most appropriate format or formats to meet stated objective(s) such as letter, brochure, postcard, video or audio-tape.

B. Weigh the advantages and disadvantages of purchasing needed communication versus internal development. If a decision is made to purchase a communication product, it must meet all the requirements for review and approval stated in this policy (See C, D & E).

C. Internal development of communication to members follows these steps:
All materials are evaluated, signed and approved by a qualified health educator/health education specialist (see Definitions section for example) using the attached Readability and Suitability Checklist. Molina Healthcare of California was granted a onetime exemption from MMCD to allow health educators hired prior to August 19, 2011 to approve health education materials. The approved health education material and Readability and Suitability Checklist are kept on file by the Plan and made available to the Department of Health Care Services (DHCS) for auditing/monitoring purposes upon request.

1. Review relevant literature and/or current medical guidelines if appropriate.
2. Identify key concepts required to meet specific communication objective and write specific text. (See section B of this policy.)
3. Design the text layout for the desired format (a letter, postcard, newsletter or brochure) or the actual written script for a video or an audiotape. Design for written communications includes at least 25% white space.
4. Develop graphic enhancement if appropriate to communication.
   - Identify illustrations or other graphics to enhance the comprehension of any written communication. Visuals are appropriately placed and represent cultural diversity (or a single-target audience if appropriate). Colors are appealing and draw the reader to the piece.
   - In the case of a video, identify visuals for the various scenes and comprehensive descriptions for all demonstrations and actor movements. Distinguish all desired "live dialogue" from voice-over narration and include captioning.
   - In the case of an audio, identify any desired, sound enhancement (other than scripted narration) and also the type and depth of voice narration desired.
5. Have appropriate content experts, Clinical Staff, Health Educators, Cultural and Linguistic Specialist and the Manager of Senior and Disability Services review draft of communication (any written communication such as a brochure, and the script for a video or audiotape) for accuracy and appropriateness. Simple letter to members does not require this review process as long as Alternate Format tag line is included (Referenced below in Section III.G). Respective departments approve all telephone numbers listed on any communication.
6. Revise draft if indicated.
7. Conduct field-testing with end-users. Field-testing may include but is not limited to: Simple review of health education materials during a Community Advisory Committee (CAC) or other Member event (i.e. Member Participation Committee), key informant interviews with Members and/or community informants, focus groups with targeted Members to determine relevance and effectiveness of more complex education materials and written member surveys.
   - If a health education material is not field tested, an explanation must be included on the Checklist explaining the reason, e.g. material is similar to another that was previously

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Title: Communications to Members	

field tested, material was field tested by another plan, material was produced by the federal government, etc.

8. Obtain required approval signatures before production. (See Exhibit 1. Field-testing and approvals not required for simple letters to members as long as all other standards are met. See section D of this policy.)

D. Develop text (or scripts) within the above communications using the following standardized guidelines for meeting the needs of low literacy populations to achieve plain language. Health Education staff receive training by using the Writing and Designing Print Materials for Beneficiaries: A Guide for State Medicaid Agencies. These guidelines constitute any training activities targeting staff outside of Health Education who develop low-literacy materials:
   1. Use familiar words and avoid technical jargon and acronyms (if required for objective, define adequately).
   2. Limit the number of concepts according to the format chosen (more is not better for persons of low literacy)
   3. Write so that the principal message is evident
   4. Use active voice and keep sentences short and simple. (Limit words to 8 to 10 per sentence.)
   5. Use practical examples.
   6. Organize text using headers, subtitles, etc.
   7. Fulfills objectives for piece
   8. State actions in the positive rather than the negative
   9. Manually calculate the reading level of materials or use software, such as Readability Calculations (includes SMOG, Fry Graph, FOG, Flesch Reading Ease, Dale-Chall) or equivalent software to test the readability that is appropriate for the sample size.
      - Exclude State-mandated legal language in calculating the reading level of health education material.
      - Medical terminology, technical words, and/or multi-syllable words that must be included in the health education material and that cannot be substituted for simpler one or two syllable words may be counted once when testing for reading level (i.e. diabetes).
      - Ensure health education Member materials are written at or below a 6^{th} grade reading level.

E. Translate communications to members into the appropriate threshold languages using the following steps to ensure quality and comprehensibility.

   1. Communications developed in English, are translated into the non-English languages needed in accordance with membership by qualified translators (this includes the text for scripts used in video and audio-tape productions). English words and phrases that do not directly translate into a particular language are translated according to message concept and intent keeping the objective of the communication in mind.
   2. A second, qualified translator (not the original translator) reviews all translated documents.

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3. Translated documents are formatted with graphic design and drafts are developed for field-testing and review (Member letters are exempt from this step). Translated documents include written scripts for video and audio productions.
4. Qualified translator reviews and considers all field-testing (if available) and professional input for possible inclusion in a revision.
5. Final proof for production is developed and approved by a qualified translator who has not been involved in any of the earlier steps of this process.
6. Molina has bilingual internal staff who reviews non-English documents once they have been sent out for translation and are returned to Molina. In addition, Molina has staff that review documents for medical, legal and cultural appropriateness.
7. Written documents are sent to print. Video and audio productions are initiated using quality, vocal interpretation for all narration and dialogue. Video productions also include captioning.

F. Upon member request, translate existing member materials in an alternate format using the following procedure to ensure quality and comprehensibility. If materials are vendor produced and cannot be provided in alternative formats due to copyright laws or other administrative constraints, then the Plan must provide similar educational materials to members in alternative formats.

1. Refer to MS-43 Policy and Procedure on requesting existing member material in an alternate format.

G. Wherever possible, materials will be developed and printed using Arial or other sans serif 14 point font The following tag line will be added to all member communications: *If you need this information in another language or alternate format, ie, large print, Braille, Audio or other electronic format, please contact member services at (888) 665-4621.*

H. Communications to members are evaluated as a component of any comprehensive program and are independently evaluated as appropriate. Revisions are made to communications to members in response to evaluation results and as necessary to maintain medical accuracy (such as when new national guidelines are released).

I. All health education materials not previously approved by MMCD will be reviewed and approved within 12 months of August 19, 2011. Previously approved materials will be reviewed and approved every 3 years to ensure that health and medical information, as well as visual images, remains current and up-to-date.

IV DEFINITIONS

Health Education Materials: Health education materials are designed to assist members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, including updates on current health conditions, self-care and management of health conditions. Topics may include messages about preventive care, health promotion, screenings, disease management, healthy living, and health communications.

Informing Materials: Informing materials are vital documents that provide members with essential information about access to and usage of Plan services. Vital documents may include Evidence of

Coverage (EOC) booklets, enrollment, disenrollment forms, member rights and grievance information, new member welcome packets, provider directories and facility directories.

Health Educator/Health Education Specialist: A qualified Health Educator has one of the following qualifications: Master of Public Health (MPH) degree with a health education or health promotion emphasis; Master's degree in community health with a specialization in health education or health promotion or MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc. The Plan may request a one-time exemption from MMCD for health educators without the required qualifications/credentials who were hired prior to the release of All Plan Letter 11-018 on August 19, 2011. This exemption will "grandfather" currently employed health educators and allow them to approve health education materials. This exemption will be kept on file with the Plan.

Readability:
Readability is the determination of a document's ease of reading by the end-user. Often it is evaluated by reading formulas that assign a grade level to a document. According to C.Doak and L. Doak (low literacy experts), all readability formulas provide a reasonably accurate estimate of the grade level (plus or minus one grade level) required to read a sample of text with a 68% confidence level. Many experts in the field of literacy profess a particular readability formula to be more accurate than another formula. Actually much depends upon the resources including time available for your assessment (computer versus manual) and personal preference. Most common manual readability formulas are the SMOG and the FRY. Smog is quick and consistent but only considers the number of three syllable words or more in its calculations. The FRY, the preferred choice of C. Doak and L. Doak for accuracy, is more time-consuming to calculate, but considers both sentence length and number of syllables in the words. The most common computer software program package included with Microsoft Word contains the Flesch Grade Level Formula, Flesch Reading Ease Formula, and Flesch-Kincaid Grade Level Index. These computer generated formulas are automatically calculated by scanning word processing text and consider the number of words per sentence and the number of syllables per word.

Readability formulas or scales are only one analytical tool available to assess reading levels of text. Other factors such as text format, placement on the page, and illustrative enhancement also contribute greatly to comprehensibility. One should also consider word familiarity not merely number of syllables in writing effectively for low level readers. While nearly all 40 readability formulas give you reasonably accurate estimates of grade level, it is widely accepted that simply writing for a low score from any formula will not, in itself, improve comprehensibility of texts. Readability assessment is merely the starting point. It is an important step to improved comprehensibility given that over 50% of the US adult population reads at or below the eighth grade level.

Threshold Language:
The State of California, Department of Health Care Services designates a threshold language when a specific language reaches a threshold of 3,000 people residing one county or 1,000 beneficiaries in one zip code.

Alternate Formats: an Alternate format is medium and/or methodology that allows people with disabilities to access information in a manner other than how the format was originally delivered. Alternate formatted material is beneficial or useful for people with reduced or no ability to hear or see, or for people with limitations in learning and understanding.

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Audio-formats: Text recorded on tape, disks, and CDs.

Braille: A series of raised dots that can be read with the fingers by people who are blind or whose eyesight is not sufficient for reading printed material.

Large print: Text produced in Arial or other sans Serif Font. Font depends on user needs, consult with the individual.

Electronic text/disk/CD-ROM: Text saved onto a computer disk or CD-ROM. The user gains access to information through a computer connected to a Braille printer, voice output, print monitor or any other system providing access.

Oral Interpreter/Certified Reader: An Interpreter who is able to read and/or interpret competently accurately, and impartially, both receptively and expressively, using specialized terminology for effective communication taking into account a person's language skills.

Captioned films and videos: The spoken word appears in written text on the bottom of the screen as in subtitles. "Open" captions can be seen by everyone while "closed" captions are visible only when activated backup the viewer.

Qualified Sign Language Interpreters: Molina will utilize qualified sign language interpreter who is at minimum RID certified in this complex language that employs signs made with the hands and other movements, including facial expressions and postures of the body (Refer to HE09 – Interpreter Services/Language Access for process to access interpreters)

Assistive Listening Device: Refers to hard-wired or wireless transmitting/receiving devices that transmit sound from the microphone directly to the listener; used primarily by members with hearing loss/hard of hearing. (Refer to HE09 – Interpreter Services/Language Access for process to access an assistive listening device.)

V REFERENCES

C. Doak, L. Doak, and Root (1996), Teaching Patients with Low Literacy Skills.

Policy and Procedure No: HE-03	**Department**: Health Education and Cultural Linguistic Services
Title: Communications to Members	

Exhibit 1

Attachment A: Readability and Suitability Checklist

This Checklist Applies to Health Education Materials Only (See Attachment B for definition)

Title of Material: Main Topic:

Key Message(s):

Target Audience: Date Last Reviewed:

Developed By: Date Developed:

Material Format: ☐ **Flyer** ☐ **Brochure** ☐ **Booklet** ☐ **Poster** ☐ **Other:**

READING LEVEL (6th GRADE READING LEVEL OR LOWER)

Date Assessed: **Reading Level:** **Method Used:**

List medical /technical term(s) that were scored only once:

A. CONTENT ☐ APPROVED

Required: (All required items must be met in order to approve the material.) **Met**

1. Content is accurate and up-to-date ☐
2. Number of concepts/messages is limited to 2-3 per page ☐
3. Sentences are simple ☐
4. Technical terms are defined ☐
5. Material is written in an active voice ☐

Recommended: (Items follow best practice guidelines, but are not required for approval.)

6. Material has a positive tone ☐
7. Material explains how and where to get help or more information ☐

B. LAYOUT ☐ APPROVED

Required: (All required items must be met in order to approve the material.) **Met**

1. Font size is at least 12-point; senior-specific materials are at least 14-point ☐
2. Serif font styles are used for blocks of text ☐
3. All capital letters are used only for headings and when grammatically correct ☐
4. There is an adequate amount of white space (aim for 30%) ☐
5. The layout guides the reader appropriately ☐
6. Headings and subheadings are used to organize and separate ideas ☐
7. Main points are emphasized using bold, italics, boxes or increased font size ☐

Policy and Procedure No: HE-03	**Department**: Health Education and Cultural Linguistic Services
Title: Communications to Members	

8. Bullets or numbers are used for lists ☐
9. There is adequate contrast between the print color and the background color ☐

Recommended: (Items follow best practice guidelines, but are not required for approval.)

10. Left margin is justified (text is aligned on the left) ☐
11. Right margin is unjustified (text is not aligned on the right) ☐

C. VISUALS ☐ APPROVED

Required: (All items in this section must be met in order to approve the material.) **Met**

1. Visuals are relevant to accompanying text ☐
2. Visuals are simple and uncluttered ☐
3. People and activities are representative of the intended audience ☐
4. Phone numbers are bolded if they appear in the text document ☐

Recommended: (Items follow best practice guidelines, but are not required for approval.)

5. Visuals have captions, if needed ☐
6. Graphs and charts only used when absolutely necessary ☐
7. Material is printed on non-glossy paper ☐

D. CULTURAL APPROPRIATENESS ☐ APPROVED

Required: (All required items be met in order to approve the material.) **Met**

1. Visuals are culturally appropriate for the intended audience (material is not offensive, does not reinforce stereotypes, and is inclusive in representation) ☐
2. Content is culturally appropriate for the intended audience (provides culturally meaningful information such as "how to" advice and examples) ☐
3. Topic-specific cultural relevance is reflected where applicable (such as food and exercise habits of the intended audience) ☐
4. Plan-produced materials are available in alternative formats upon request ☐ **N/A** ☐

E. TRANSLATED/NON-ENGLISH MATERIALS ONLY (Complete this section, if applicable.) ☐ APPROVED

This material is available in the following languages, in addition to English:

☐ Arabic	☐ Armenian	☐ Cantonese	☐ Farsi	☐ Hmong
☐ Khmer	☐ Korean	☐ Mandarin	☐ Russian	☐ Spanish
☐ Tagalog	☐ Vietnamese	☐ Other (specify) _____		

Required: (All items in this section must be met in order to approve the material.) **Met**

Policy and Procedure No: HE-03	**Department**: Health Education and Cultural Linguistic Services
Title: Communications to Members	

1. Translation accurately conveys all the information found in the English version ☐
2. Translation is based on meaning (not a literal translation) ☐
3. Word and phrase usage is consistent ☐
4. Material is sensitive to local language (phrases, words, expressions) ☐
5. Translation was reviewed by at least one person in addition to the translator ☐

F. FIELD TESTING (The Plan's health educator will determine field testing methodology and/or whether field testing is needed for this material.) ☐ APPROVED ☐ N/A

Was this material field tested? ☐ Yes ☐ No If no, please explain:

Type of field testing conducted: Total # of participants:_____

☐ Focus Groups: # of Focus Groups: _____ ☐ Individual Member Interviews

☐ Community Advisory Committee (CAC) Review ☐ Other: _____

Brief Summary of Field Testing Results:

G. MEDICAL CONTENT REVIEW (The Plan's health educator will determine whether the material requires clinical review to verify medical accuracy. Check "N/A" if not applicable to material.) ☐ APPROVED ☐ N/A

Required: (All items in this section must be met, unless "N/A" is checked above.) Met

Policy and Procedure No: HE-03	**Department**: Health Education and Cultural Linguistic Services
Title: Communications to Members	

1. Content is medically accurate ☐
2. Content is up-to-date ☐

Primary Medical Content Reviewer:

Reviewed by: ☐ Physician ☐ NP, PA, RN ☐ Pharmacist ☐ Other (describe):

Print Name: Title:

Signature: Date:

Secondary Medical Content Reviewer (optional)

Reviewed by: ☐ Physician ☐ NP, PA, RN ☐ Pharmacist ☐ Other (describe):

Print Name:

Signature:

H. HEALTH EDUCATOR CERTIFICATION & SIGNATURE (Leave blank if submitting to MMCD for approval)

My signature below certifies that this material has been reviewed as stated and, if approved, meets the criteria outlined in MMCD All Plan Letter 11-018. Materials must be reviewed and re-certified every 3 years.

Initial Material Review & Certification ☐ APPROVED

If not approved, describe reason(s): ☐ NOT **APPROVED**

Print Name:

Signature:

Subsequent (3-year) Material Review & Certification ☐ APPROVED

If not approved, describe reason(s): ☐ NO LONGER APPROVED

Print Name:

Signature:

Subsequent (6-year) Material Review & Certification ☐ APPROVED

If not approved, describe reason(s): ☐ NO LONGER APPROVED

Print Name:

Signature:

MOLINA HEALTHCARE of CALIFORNIA

	Policy and Procedure No. HE-09
	Department: Health Education and Cultural/Linguistic Services **Title**: Interpreter Services/Language Access
	Effective Date: 3/1/98
	Reviewed and Revised Date: 3/1/98, 12/14/98, 12/31/98 & 10/1/99, 9/15/2000, 3/4/2002, 1/18/05, 1/03/07, 06/26/2008, 5/14/2010, 4/11/11
Richard Bock, M.D. **Chief Medical Officer**	**Reviewed Only Date:** 11/26/2003, 3/30/2007
Signature: **Date:** 5/31/11	**Supersedes and replaces**: HE-17 (24 Hour Access) and HE-17 (Interpreter Services and HE-(Translated signage) **Date:**

I PURPOSE

To maintain full compliance with Title 6 of the Civil Rights Act, the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, and other regulatory/contract requirements by ensuring limited English proficient (LEP) and members and potential members who are deaf, hard of hearing, or have speech or cognitive/intellectual impairments have equal access to health care services through the provision of high quality interpreter and linguistic services.

II POLICY

Molina provides and maintains 24-hour access to interpreter services for members or potential members whose primary language is not English or for members who are deaf, hard of hearing or have a speech impairment and need sign language. This includes all medical and non-medical points of contact. Molina informs all network practitioners about the language requirements and resources available. Molina provides all network facilities access to translated signage and directs them to post non-English signage in accordance with their membership.

III PROCEDURE

A. Molina identifies the language needs of its members from the California State Department of Health Care Service's database as well as other product intake applications and maintains the information in the Plan's membership database.

B. All members are informed of their right to interpreter services at no cost to them via regular member communications such as the evidence of coverage, compliance mailings, member newsletters, and signage at medical offices.

C. All Molina contracted practitioners are provided information about accessing an available qualified interpreter and identification of language needs through practitioner mailings, provider manual, and practitioner training sessions.
   1. All Molina members and potential members have a right to interpretive services.

Policy and Procedure No: HE-09	**Department**: Health Education and Cultural Linguistic Services
Title: Interpreter Services	

2. Practitioners are informed about the requirement to offer interpreter services to all limited English-proficient patients and patients who are deaf, hard of hearing or have a speech impairment.

3. All member requests for interpretive services should be documented in the member's medical records.
4. Practitioners are reminded that patients should never be asked to bring family members, children or minors to interpret for them. If a patient requests a family member, child or minor to interpret for them (despite knowing about the availability of interpreter services free to them) or refuses interpretive services altogether, this must be documented in the patient's medical record.

D. Requests for face to face interpreter services are initiated through Molina's Member Services Department. Providers and members/potential members may request face to face interpreter services (including Sign Language) by calling our Member Services Department. Providers and members/potential members are instructed to allow at least 3working days notice for the vendor to identify a qualified interpreter.

E. Molina offers telephonic interpreter services to staff, providers, and members/potential members 24 hours a day, 7 days a week.

F. All Molina contracted after-hour providers, and Molina's Nurse Advice Line staff, can access telephonic interpretive services for language needs that cannot be met internally.

G. Molina has a dedicated TTY line (800) 479-3310 for members/potential members who are hard of hearing, deaf or speech impaired. Member services staff utilize TTY, 711 (California Relay Service) and/or other relay services to process sign language interpreter service requests. Notification on how to access 711 California Relay Service or other Relay Services is communicated to network providers via "Just the Fax" communications, Provider Operation Management Meetings, Joint Operation Management Meetings, provider manual and/or provider newsletter.

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

I. Molina identifies and reviews the language capabilities of its employees and the practitioner network, ensuring these reflect the needs of members. Updates are generated quarterly.

J. Molina monitors interpreter services utilization across the Plan and investigates and resolves any service issues/complaints identified by staff or members.

IV DEFINITIONS

Medical points of contact: face-to-face or telephone encounters with practitioners (physicians, physician extenders, registered nurses, pharmacists or other personnel) who provide medical or health care advice to members.

Policy and Procedure No: HE-09	**Department**: Health Education and Cultural Linguistic Services
Title: Interpreter Services	

Non-medical points of contact: membership services, appointment services, member orientation sessions and any committees that members participate in.

Title 6 Civil Rights Act: prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP.

Americans with Disabilities Act and Section 504: Refers to Title III of the Americans with Disabilities Act, 42 U.S.C. § 12181, et seq., and/or Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§ 701, et seq. and/or the regulations promulgated under these statutes.

Qualified Interpreters: a sign language interpreter, oral interpreter, or other interpreter who is able to interpret competently, accurately and impartially, both receptively and expressively, using specialized terminology necessary for effective communication to an individual who is deaf, or hard of hearing or who has a speech impairment, given that individual's language skills.

Assistive Listening Device: Refers to hard-wired or wireless transmitting/receiving devices that transmit sound from the microphone directly to the listener; used primarily by members with hearing loss/hard of hearing.

Molina Healthcare of CA

	Charter Number: HE-18
	Committee: Molina Bridge 2 Access Statewide Advisory Committee (B2A Committee) **Title**: Committee Charter
	Effective Date: 3/23/10
	Reviewed and Revised Date:
Molina Healthcare of California **Richard Bock, MD, MBA** Chief Medical Officer	**Reviewed Only Date:**
Signature: **Date**: 3/23/10	**Supersedes and replaces**: N/A **Date:**

I. PURPOSE OF COMMITTEE

The purpose of the Molina Bridge2Access Statewide Advisory Committee, hereinafter referred to as "B2A Committee" is to provide a forum for structured input from B2A Committee members regarding how Molina Healthcare operations and care networks impact the delivery of care for seniors and persons with disabilities within the plan. B2A Committee representatives will include plan members who are persons with disabilities and/or have activity limitations, disability advocates and community organization representatives who are familiar with the disabilities and chronic conditions that make up the senior and person with disability membership of the Molina Health Plan.

II. SCOPE OF COMMITTEE

The B2A Committee members will advise Molina Healthcare's leadership on developing innovative and unique programs to address the needs of people who face barriers when accessing healthcare. The B2A Committee will also serve as a key forum for reviewing the plan's existing programs and services in order to provide feedback and recommendations for improvement.

III. ROLE AND RESPONSIBILITY OF COMMITTEE MEMBERS

The B2A Committee will evaluate and provide input on topics including, but not limited to:

1. Changes in public policy that affect the healthcare delivery for seniors and persons with disabilities and advise on implementation of those policies;

2. Review Molina Healthcare's outreach and communication process with a focus on the needs of seniors and persons with disabilities;

3. Review health plan policies or procedures as they relate to seniors and persons with disabilities;

Molina Healthcare of California	
Charter No.:	**Committee:** Molina Bridge 2 Access Statewide Advisory Committee (B2A Committee)
Title: B2A Committee Charter	**Effective Date:**

4. Advise on educational and operational issues affecting members who are blind, have low vision or who speak a primary language other than English including American Sign Language;

5. Advise on staff and provider training programs including but not limited to disability cultural competency;

6. Review and provide guidance regarding plan readiness as it relates to emergency/disaster prepardness;

7. Review healthcare policy and plan practices that impacts physical, environmental (path of travel) and communication access for seniors and persons with disabilities.

8. Review and analyze clinical outcome data and evaluate member satisfaction with the program using member and practitioner input.

IV. STRUCTURE

The B2A Committee is delegated by the Molina Healthcare of California (MHC) Plan President to advise the appropriate Molina departments on all issues which impact its senior and disability products and services. The B2A Committee is chaired by the MHC Chief Medical Officer or his appointee.

Membership of the B2A Committee should be comprised of a wide range of community organizations, advocates and Molina members with disabilities and/or activity limitations:

1. The B2A Committee will be comprised of no less than thirteen (13) members

2. The B2A Committee will include but not be limited to the following representatives. Every attempt possible will be made to maintain the ratio of representatives listed below:

- At least three (3) members from MHC who are on Medi-Cal, Medicare or who are dual eligible;
- At least two (2) representatives from advocacy or service organizations that work with members with chronic conditions such as, but not limited to, HIV, Diabetes, Pulmonary or Cardiac conditions;
- At least two (2) representatives from advocacy or service organizations that represent Developmental Disabilities;
- At least two (2) representatives from organizations which represent persons with physical disabilities such as, but not limited to Amputee, Muscular Dystrophy ,Multiple Sclerosis, Spinal Cord Injury(SCI), Spina Bifida or Cerebral Palsy;
- At least one (1) member from an organization representing the deaf and hard of hearing.
- At least one (1) organization representing blind and low vision.
- At least one (1) representative from an Independent Living Center

Molina Healthcare of California	
Charter No.:	**Committee:** Molina Bridge 2 Access Statewide Advisory Committee (B2A Committee)
Title: B2A Committee Charter	**Effective Date:**

- At least one (1) representative from network providers
- Other members as necessary to meet Molina's advisory needs

Mandatory Molina staff participation will consist of:

1. One or more member(s) of the MHC Senior Leadership team (including, but not limited to):
    - Plan President
    - Chief Operations Officer
    - Chief Financial Officer
    - Chief Medical Officer
    - Director, Government Contracts
    - VP, Clinic Operations Molina Medical Group
    - Director, Human Resources
2. Director, Health Education
3. Disability Program Manager
4. Medical Director, Molina Medical Group
5. Director, Member Services
6. Regional Director(s), Provider Services

Optional Molina staff participation:

1. Executive Staff, Molina Healthcare Inc.
2. Director, Community Outreach and Medicare
3. Cultural and Linguistic Specialist
4. Manager, Member Services
5. VP, Clinic Operations
6. Director of Operations, Molina Medical Group

V. COMMITTEE LEADER(s) AND RESPONSIBILITIES

The Chief Medical Officer shall convene and preside over regularly scheduled meetings or shall arrange for another member of the B2A Committee to preside at meetings when he or she is not available. The Chief Medical Officer will present or appoint a presenter to report action items and recommendations to the MHC Senior Leadership Team or other internal committees as appropriate. The Chief Medical Officer shall also convene special meetings, as needed.

The Recorder shall serve as meeting coordinator and perform the following:

- Schedule meetings;
- Prepare agendas;
- Record and draft minutes and/or action logs from meetings;
- Remind presenters of needed actions for next meeting;
- Assemble and distribute B2A Committee packets that include minutes and action logs to all known attendees of next meeting;
- Maintain B2A Committee files and documents;

Molina Healthcare of California	
Charter No.:	**Committee:** Molina Bridge 2 Access Statewide Advisory Committee (B2A Committee)
Title: B2A Committee Charter	**Effective Date:**

- Prepare meeting action logs, B2A Committee activities and/or recommendations and distribute to MHC Senior Leadership Team and Quality Improvement Committee (QIC)
- Coordinate travel, accommodations and any other expense incurred by members to attend the meeting.

VI. SUBCOMMITTEES

The B2A Committee may, by resolution passed by a majority of the members, designate one or more subcommittees. Each subcommittee will consist of one or more of the members of the B2A Committee. The B2A Committee may delegate authority to a subcommittee as they deem appropriate.

VII. TERM OF SERVICE

The term of service for a B2A Committee member is two (2) years with no term limits. Molina Healthcare of California's president and chief medical officer are responsible for approving membership on the B2A Committee.

VIII. FREQUENCY OF MEETINGS

The B2A Committee will meet twice annually consisting of a lunch followed by time for discussion and making recommendations. Workgroups and/or subcommittees may be implemented as needed and may schedule meetings separate from B2A Committee meetings.

MOLINA HEALTHCARE OF CALIFORNIA

Molina Bridge 2 Access Statewide Advisory Committee

2011-2012 Roster

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MOLINA HEALTHCARE OF CALIFORNIA

Molina Bridge 2 Access Statewide Advisory Committee

2011-2012 Roster

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MOLINA HEALTHCARE OF CALIFORNIA

Molina Bridge 2 Access Statewide Advisory Committee

2011-2012 Roster

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MOLINA HEALTHCARE OF CALIFORNIA

Molina Bridge 2 Access Statewide Advisory Committee

2011-2012 Roster

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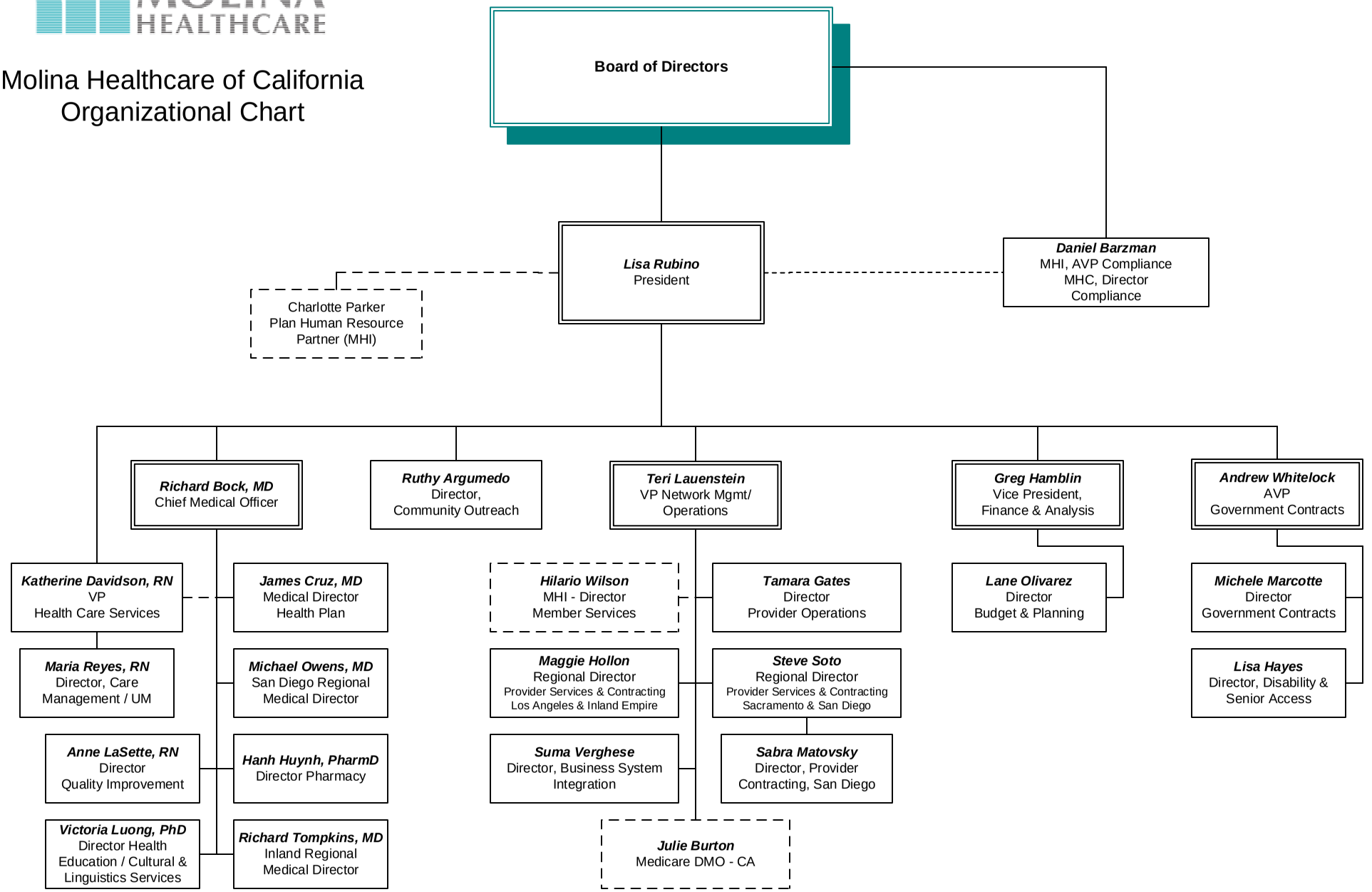
Molina Healthcare of California Organizational Chart



Molina Healthcare of California Partner Plan, Inc.

Attachment 6.2-1

Senior Leadership Team

v. 012612

Draft Work Plan - Duals Demonstration Project Implementation in 2012-2013

Molina Healthcare of California Partner Plan, Inc. ("Molina")

Item	Responsible Area	Description	Target Date	Completion Date	Comments/Updates
Pre-Awarding of Duals Demonstration Contract					
1		Continue to meet regularly with the county IHSS/Public Authority to discuss integrating services with the plan under the Duals Demonstration	Ongoing		
2		Continue to meet regularly with the county mental health and substance use services staff to discuss care for existin plan members and the Duals Demonstration	Quarterly (more frequently as needed)		
3		Contact social services support agencies and providers to build relationships and discuss ways to effectively partner together under the Duals Demonstrtation	Monthly in 2012		
4		Meet regularly with the other potential participating plans in the county's Duals Demonstration to discuss coordination and integration of services	Monthly		
5		Provide requested responses to DHCS and or CMS in response to plan's Duals Demosntration RFS	As requested		
6		Receive notice about awarding of Duals Demonstration sites in California	7/30/12		
7		Lead regularly scheduled Bridge-2-Access meetings and participate in other beneficiary/stakeholder forums concerning the Duals Demonstration to receive feedback on the plan's activities and address comments & concerns	Quarterly in 2012		
Duals Demonstration - Program Design					
1		Submit proposed plan benefit package under the Duals Demonstration to CMS	6/4/12		
2		Provide feedback and comments to DHCS and CMS on the Duals Demonstration program design, requirements and standards	Ongoing in 2012		
3		Assess skills and experience of plan's staff for serving dual eligibles under the Duals Demonstration, and adjust plan's staffing based upon identified programmatic needs	10/1/12		
4		Make necessary preparations and develop materials as needed for annual coordination election period between October 15 - December 7, 2012	10/1/12		
5		Ensure plan is prepared to receive new enrollments of dual eligible beneficiaries under the Duals Demonstration effective January 1, 2013	12/15/12		
6		Develop plan's New Member Welcome & Outreach Program tailored to the specific needs of the plan's enrolling dual eligible beneficiaries under the Duals Demonstration	11/15/2012		
7		Implement plan's New Member Welcome & Outreach Program for dual eligible beneficiaries enrolling under the Duals Demonstration	1/1/2013		
County Public Agency Coordination					
1		Amend MOU with county behavior health agency to ensure appropriate coordination of care for plan's dual eligibles under the Dual Demonstration	12/31/12		
2		Establish a contract with the county In-Home Supportive Services (IHSS)/Public Authority to coordinate and integrate IHSS services under the Duals Demonsrtration	12/31/12		
3		Continue participation in county collaborative activities involving county agencies and health plans to ensure effective coordination and services integration under the Duals Demonstration	Monthly or as scheduled		
4		Review plan's MOU with the county public health agency and revise as necessary	12/31/12		
State & Federal Regulatory Agency Contracts					
1		Upon awarding of Duals Demonstration site, begin negotiating three-way contracts with DHCS and CMS, including plan rates	8/1/2012		
2		Finalize three-way contracts with DHCS and CMS for Duals Demonstration site	9/30/2012		
3		Assess/outline contract Implementation deliverables for three-way contracts with CMS and DHCS	10/15/12		
4		Implement contract performance and reporting requirements as set forth in three-way contract with CMS and DHCS	12/31/12		

Draft Work Plan - Duals Demonstration Project Implementation in 2012-2013

Molina Healthcare of California Partner Plan, Inc. ("Molina")

Item	Responsible Area	Description	Target Date	Completion Date	Comments/Updates
5		Complete Department of Managed Health Care (DMHC) filings as applicable	12/31/12		
Healthcare Services					
1		Complete implement and testing of plan's system readiness for handling care coordination functions	11/1/12		
2		Develop and enhance plan's health education programs to target unique challenges and needs of dual eligible beneficiaries	11/1/12		
3		Educate plan's 24/7 Nurse Advice Line to ensure readiness for serving dual eligible beneficiaries under the Duals Demonstration	12/1/12		
4		Develop and enhance disease management programs for serving dual eligible beneficiaries	12/15/12		
5		Implement plan's Integrated Care Management model for serving dual eligible beneficiaries under the Duals Demonstration	12/31/2012		
Pharmacy					
1		Part D formulary submission due to CMS	5/14/12		
2		Submit additional and supplementary pharmacy benefit filings through HPMS	6/8/12		
3		Conduct pharmacy service location analysis to ensure adequacy for serving enrolled dual eligibles under the Duals Demonstration	8/1/12		
4		Notify PBM of requirements for serving dual eligible beneficiaries under the Duals Demonstration	10/1/12		
5		Assess/amend drug formulary as necessary per Dual Demonstration requirements	10/1/12		
Network Development					
1		Assess adequacy of plan's current Medicare and Medi-Cal provider network to serve dual eligible beneficiaries under the Duals Demonstration	6/30/2012		
2		Identify long-term care support services providers and other social support services providers to contract for the Duals Demonstration site	6/30/2012		
3		Identify long-term care support services providers (including long term custodial care in nursing facilities) and other social support services providers to contract for the Duals Demonstration site	6/30/2012		
4		Revise plan's provider manual to incorporate Duals Demonstration requirements, processes and key programmatic information	10/15/12		
5		Develop provider directory for the Duals Demonstration	11/1/12		
6		Establish contracts with targeted providers to ensure plan has a comprehensive network for providing covered services to enrolled dual eligible beneficiaries under the Duals Demonstration	11/30/12		
External Communication Strategy					
1		Develop community outreach strategy to educate stakeholders, advocates and other impacted groups about the Duals Demonstration and associated changes in the delivery of physical health, behavioral health and social support services	7/15/12		
2		Develop provider education and outreach strategy to educate plan providers as well as key non-contracted providers about the Duals Demonstration and serving dual eligible beneficiaries	8/15/12		
3		Assess CMS "Cy 2013 Medicare & You" handbook as part of developing plan's member handbook/EOC for dual eligible beneficiaries under the Duals Demonstration	9/30/12		
4		Work with CMS and DHCS to ensure proper notifications are sent to affected dual eligible beneficiaries regarding the enrollment process under the Duals Demonstration	10/1/12		
5		Develop plan's marketing and outreach strategy under the Duals Demonstration and receive necessary regulatory and agency approvals in order to begin marketing/outreach on October 1, 2012	10/1/12		
6		Implement educational outreach and informational activities regarding the Duals Demonstration targeting dual eligible beneficiaries, providers, stakeholders, advocates and other communit-based organizations	10/15/12		

Draft Work Plan - Duals Demonstration Project Implementation in 2012-2013

Molina Healthcare of California Partner Plan, Inc. ("Molina")

Item	Responsible Area	Description	Target Date	Completion Date	Comments/Updates
7		Develop a member handbook/EOC specific to the Duals Demonstration and obtain necessary DHCS, DMHC and CMS approval	12/1/12		
Internal Communication Strategy					
1		Provide staff education and awareness training for serving dual eligible populations	11/30/12		
2		Provide targed education to plan's member and provider call center staff to ensure they are well informed and prepared to handle calls relating to the Duals Demonstration	12/15/12		
Information Technology (IT), Configuration & User Testing					
1		Assess plan's production environment, information technology capabilities and configuration to ensure adequate resources are in-place to meet Duals Demonstration requirements	7/1/12		
2		Configure program benefits for the Duals Demonstration and test for accuracy	10/1/12		
3		Develop data extracts for reporting requirements based upon three-way contract with CMS and DHCS	11/1/12		
4		Develop eligibility imports and exports	11/1/12		
5		Test plan's claims production environment to ensure accuracy of claims payment for covered services rendered to plan's dual eligible beneficiaries under the Duals Demonstration	12/15/12		
6		Provide targed education to plan's member and provider call center staff to ensure they are well informed and prepared to handle calls relating to the Duals Demonstration	12/15/12		
7		Review claim system readiness for imports and exports	12/31/12		
Monitoring & Evaluation					
1		Assess plan's readiness to meet expected Duals Demonstrtation requirements in preparation of DHCS/CMS Readiness Review	7/15/12		
2		Provide requested documents and submissions to CMS and DHCS in advance of the Duals Demonstration Readiness Review and prepare plan for on-site review	Late July/Early September		
3		Monitor member grievance and appeals, and all other feedback received from the plan's dual elibible beneficiaries, to identify and resolve access to care problems and other issues	Monthly		
4		Report monthly to DHCS and or CMS on the status of plan's activities to successfully implement and comply with requirements set forth in plan's three-way contracts with CMS and DHCS	Monthly in 2013		
5		Meet regularly in standing stakeholder community forums to discuss progress under the Duals Demonstration and proactively addess problems/issues	Regularly as scheduled		
6		Monitor plan's claims adjudication and encounter data submissions under the Duals Demonstration to ensure accuracy, completeness and appropriateness	Monthly in 2013 and go-forward		

ASSOCIATE VICE PRESIDENT – MICHELLE PURRINGTON
(562) 544-3129 – Michelle.Purrington@Molinahealthcare.com

PROFESSIONAL EXPERIENCE:

MOLINA HEALTHCARE INC. (Long Beach, California) February 2005 to Present
Molina Healthcare is one of the leaders in providing quality healthcare for financially vulnerable individuals and families. Currently, Molina Healthcare arranges for the delivery of healthcare services or offers health information management solutions for nearly 4.3 million individuals and families who receive their care through Medicaid, Medicare and other government funded programs in 16 states.

Associate Vice President, Implementations and Integrations – August 2010. (Director, prior to August 2010)
Responsible for implementing business operations in new markets and integrating acquired businesses into the Molina family of companies. Leads cross-functional teams to form subsidiary companies, obtain required licensing, and develop and modify business operations and systems to deliver contracted results. Requires extensive knowledge of Medicaid, Medicare, as well as business operations including but not limited to provider/vendor contracting, provider relations, system configuration, member services, eligibility, finance, medical services, government relations, quality assurance, human resources and physical plant functions.

PREMERA BLUE CROSS (Seattle, Washington) July 2000 to February 2005
Premera Blue Cross is a nonprofit, independent licensee of the Blue Cross Blue Shield Association. The Premera family of companies employs approximately 3,000 people to provide health care coverage and related services to 1.6 million members and their families in Washington, Alaska, and Oregon.

Strategic Project and Progam Manager. Responsible for leading a cross-organizational team of 17 directors responsible for implementing strategic service improvement projects to streamline processes, reduce costs, improve quality, and improve customer experience. Requires knowledge of Federal and State regulations as well as all aspects of health care operation

Director, Regional Services. Responsible for a multi-state, multi-company division with more than 200 employees; departments included mail services, document storage and retrieval, data entry, reprographics, and fulfillment. Developed and managed an annual operational budget in excess of $17 million and a project budget in excess of $6.6 million. Adminstered Medicaid, self-funded, and commercial insurance programs, complying with Federal, State, and contract requirements.

CAREMARKRX (PCS Health Systems, Inc.) (Scottsdale, Arizona) September 1998 to July 2000
A nationwide pharmacy benefit administrator with revenues of more than $25 billion annually, processing millions of individual prescriptions each year for more than 2000 customers including employers, insurance companies, HMOs, and other organizations that pay for health care products and services.

Manager, Client Services Technology Integration Responsible for a team of 10 project managers and analysts, maintaining technology systems and implementing more than 20 projects annually. Accountable for interactive voice response (IVR) unit, automated call distribution (ACD) system, online fax system, telephone display boards, employee change database, contract database, an outsourced client satisfaction survey, and a workload productivity tool. Developed and managed an operational budget in excess of $8 million.

PACIFICARE HEALTH PLAN ADMINISTRATOARS (Phoenix, Arizona) April 1993 to September 1998
Serving PacifiCare of Arizona, Inc., PacifiCare of Nevada, Inc. and PacifiCare Life Assurance Company - formerly FHP, Inc. - this diversified multi-state, for-profit health maintenance organization headquartered in southern California operates health care plans in 8 states and Guam. The combined companies exceed 3 million health plan and 9 million specialty plan members with over 7500 employees and gross revenues in excess of $11 billion.
Director, Business Services, Desert Regional Service Center. Responsible for 40 employees and a $6 million operating budget for a multi-state division including mail services, copy center, courier services, identification card production and distribution, document storage and retrieval, and regulatory compliance for all member, provider, employer, and broker collateral.

GTE HEALTH SYSTEMS (Phoenix, Arizona) November 1990 to April 1993
A wholly owned subsidiary of GTE Corporation, the Health Care group is part of the Commercial Services division of GTE Data Services. This division provides systems, data processing services, engineering design and support, and facilities management/outsourcing.

Business Analyst. Responsible regression testing for Medicaid software programs.

EDUCATION:
University of California, Berkeley
Project Management Certification Program

University of Phoenis
Arizona State University
Studied Business Management

Certified in Quality Improvement Education Program 1999

Molina Healthcare · Bridge 2 Access

PATIENT ACCESS ACCOMODATION REQUIREMENTS

The following information should be completed by patients with disabilities or mobility limitations who need an access accommodation to ensure they can receive the full benefit of the healthcare visit. Information may be supplied through the patient's designated personal assistant or with the assistance of office staff, and thereafter retained in the patient's file or chart for ease of reference.

Name: _____

Email: _____ Date:_____

Please write a brief description of the impact of your disability (for example, I use a wheelchair and require assistance to transfer to an exam table; I have a visual impairment and cannot read regular print text; I am hard-of-hearing and require written communications; I take medications and require an afternoon appointment; I have a developmental disability and need additional time for office visits; I am a senior who uses a walker and needs help getting on the exam table.)

Please check any of the following accommodations that you require to make an appointment, during your healthcare visit, or for follow-up:

COMMUNICATIONS ACCOMMODATIONS

Required for making/confirming appointments and/or exchanging information:
California Relay Service: ☐
Email: ☐
Text messages: ☐
Sign Language Interpreters: ☐
Assisted Listening (Amplifier) Device: ☐
Other: ☐

_____

_____

Required for receiving information typically relayed through print:
Large print: ☐
Braille: ☐
Email: ☐
Electronic format (CD): ☐
Audiotape or Audio CD: ☐
Other: ☐

_____

_____

MEDICAL EQUIPMENT/EXAMINATION SPACE

Required for effective examination:
Height adjustable exam table: ☐
Wheelchair accessible weight scale: ☐
Height adjustable mammography: ☐
Lifting assistance: ☐
Exam room space to maneuver mobility device: ☐
Other: ☐

_____

_____

ANY OTHER REQUIRED ASSISTANCE

Extended appointment time: ☐
Assistance with paperwork: ☐
Appointment time flexibility: ☐
Simplified English: ☐
Other: ☐

_____

_____

THIS LICENSE IS NOT TRANSFERABLE OR ASSIGNABLE

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY
DEPARTMENT OF CORPORATIONS

LICENSE
HEALTH CARE SERVICE PLAN

MOLINA MEDICAL CENTERS
1 Golden Shore
Long Beach, CA 92714

PLAN NO. 933-0322
Order No. S-205

IS HEREBY LICENSED AS A HEALTH CARE SERVICE PLAN PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975, AS AMENDED, AND IS AUTHORIZED TO OFFER SERVICES TO MEDI-CAL BENEFICIARIES, SUBJECT TO THE UNDERTAKINGS OF MOLINA MEDICAL CENTERS, DATED MARCH 9, 1994, INCORPORATED BY REFERENCE AS "ATTACHMENT 1" IN THE ZIP CODES IN LOS ANGELES AND SACRAMENTO COUNTIES DESIGNATED AS "ATTACHMENT 2" AND INCORPORATED BY REFERENCE.

THIS LICENSE IS ISSUED AND EFFECTIVE ON THE DATE APPEARING BELOW.

DATE: March 14, 1994

GARY S. MENDOZA
Commissioner of Corporations

By _____
ANITA J. OSTROFF
Senior Corporations Counsel

( )

ATTACHMENT 1

UNDERTAKINGS OF
MOLINA MEDICAL CENTERS

In order to fulfill conditions required by the California Department of Corporations ("DOC") prior to its licensure of Molina Medical Centers ("the Plan") to operate as a Knox-Keene Health Care Service Plan, the Plan does hereby enter into the following undertaking with the DOC, and certifies to the DOC that:

1. Prior to engaging in any marketing activity as a health care service plan, with the exception of marketing activities related to the Geographic Managed Care Program in Sacramento County where the Plan has an unrestricted license to operate for purposes of serving the Geographic Managed Care Program, the Plan will demonstrate to the satisfaction of the Department of Corporations that the Plan's financial and accounting operations/arrangements comply with the standards for plan organization set forth in Title 10, Rule 1300.67.3 of the California Code of Regulations.

2. The Plan will use its best efforts to obtain a provider contract with the anesthesiology group currently serving Sutter Hospitals. Until such time as the Plan provides the DOC with copies of such a contract, the Plan agrees to pay such anesthesiology group its usual and customary fee-for-service rates associated with such services rendered. Any provider contract between the Plan and the anesthesiology group will conform to all applicable requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended ("the Act").

3. The Plan will use its best efforts to obtain, within thirty (30) days of licensure, a provider contract for tertiary burn care with the University of California, Davis Medical Center ("UCDMC"). Until such time as the Plan provides the DOC with copies of such a contract, the Plan agrees to pay such burn care unit its usual and customary fee-for-service rates associated with such services rendered. Any provider contract between the Plan and UCDMC will conform to all applicable requirements of the Act.

4. Within two weeks of the date of filing this undertaking, the Plan shall file additional documentation requested by the Department in order to confirm appropriate accreditation and licensure of the following hospitals: Terrace Plaza, Antelope Valley, Covina Valley, Childrens, and St. Mary's.

5. Until the Plan obtains a provider contract with a rheumatologist holding staff privileges at Pomona Valley Hospital, the Plan will provide rheumatology services on a fee-for-service basis in that area in order to make available in-hospital rheumatology services at Pomona Valley Hospital.

6. Until the Plan obtains a provider contract with a neurologist holding staff privileges at High Desert Hospital, the Plan will provide neurology services on a fee-for-service basis in that area in order to make available in-hospital neurology services at High Desert Hospital.

7. Concurrent with licensure of the Plan as a health care service plan, the Plan's bylaws and/or corporate structure will permanently and immediately reflect the following:

a. The Plan's Board of Directors will be increased to seven members and will be comprised of a majority of disinterested outside board members. Outside board members shall not maintain any financial interest in the Plan. As used herein, "financial interest" includes not only any equity ownership in the Plan, but also the existence of a provider contract on other independent contractor relationship;

b. The Vice President for Quality Assurance and Medical Director shall regularly report to the Board of Directors on the status of matters under their respective responsibility. As used in these paragraphs 6.b., 6.c., and 6.d., "regularly" shall mean no less than quarterly and more frequently if requested by the Board or if necessitated by identification of a problem that merits the attention of the Board;

c. All Quality Assurance Committees (i.e. Peer Review, Q.A.I.C. and Pharmacy Committee) shall at all times be composed of a majority of persons unrelated to individuals holding an ownership interest in the Plan; and

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d. All reports prepared by the Peer Review, Q.A.I.C. and Pharmacy Committee shall be regularly delivered to the Board of Directors for consideration along with any summaries prepared by the Vice President for Quality Assurance.

Dated: March 9, 1994

MOLINA MEDICAL CENTERS

By _____
Mark L. Andrews
Attorney for the Plan

mla\molina\under.3

ATTACHMENT 2

Description of Regional Service Areas by Zip Code:

Region 1 Long Beach - Zip Codes:

90710	90803
90712	90804
90713	90805
90731	90806
90732	90807
90744	90808
90745	90810
90746	90813
90748	90814
90801	90815
90802	

Region 2 Pomona Valley - Zip Codes:

91701	97163
91710	91765
91711	91766
91730	91767
91739	91768
91750	91773
91761	91786
91762	

Region 3 Antelope Valley -Zip Codes:

93532	93551
93534	93552
93535	93553
93536	93584
93539	93590
93543	93591
93550	93599

Region 4 Metropolitan Sacramento - Zip Codes:

95608	95815
95610	95816
95621	95817
95626	95818
95628	95819
95630	95820
95655	95821
95660	95822
95662	95823
95670	95824
95671	95825
95673	95826
95742	95827
95800	95828
95801	95829
95802	95830
95803	95831
95804	95832
95805	95833
95806	95834
95807	95835
95808	95836
95809	95837
95810	95838
95811	95840
95812	95841
95813	95842
95814	95864

DEPARTMENT OF
Managed Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
Phone: 916-445-7401
Email: reuren@dmhc.ca.gov

February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Kelly A. Ryan
Assistant General Counsel
Molina Healthcare, Inc.
300 University Avenue, STE 100
Sacramento, CA 95825

Re: Letter of Standing – Molina Healthcare of CA Partner Plan, Inc. and Molina Healthcare of California

Dear Ms. Ryan:

On February 2, 2012, you requested a letter regarding Molina Healthcare of CA Partner Plan, Inc. ("MHCPP") and Molina Healthcare of California's ("MHC") standing as licensees under the Knox-Keene Health Care Service Plan Act.[1] MHCPP and MHC make this request to satisfy requirements for a Request for Solutions ("RFS") issued by the California Department of Health Care Services, for the Dual Eligibles Demonstration Project.

The Department of Managed Health Care ("DMHC") confirms that, as of today's date, both MHCPP and MHC are licensed, and permitted to operate in the State of California, as Knox-Keene health care service plans.

A review of the Enforcement Action Database shows that there are currently zero enforcement actions involving MHCPP and MHC. The plans are not currently under supervision, a corrective action plan or special monitoring by the Office of Enforcement. The Office of Enforcement does not comment on past, pending, or anticipated Enforcement actions against any plan that might potentially impact its licensing with the State.

The Division of Financial Oversight ("DFO") has reviewed MHCPP and MHC and both are currently in compliance with the Department's financial solvency requirements, including Tangible Net Equity ("TNE") and financial viability.

The Division of Plan Surveys ("DPS") shows that the last Routine Medical Survey Report for MHCPP and MHC was issued on May 2, 2006. There were no identified deficiencies from this

[1] California Health and Safety Code Sections 1340 et seq. (the "Act"). References herein to "Section" are to Sections of the Act. References to "Rule" refer to the regulations promulgated by the Department at Title 28 California Code of Regulations.

Routine Medical Survey. The next Routine Medical Survey is scheduled to begin on November 12, 2013.

Please contact me with any questions or concerns.

Sincerely,

Richard Euren
Health Program Manager II, Licensing Division
Office of Health Plan Oversight

cc: Suzanne Goodwin-Stenberg, Division of Financial Oversight
Anthony Manzanetti, Division of Enforcement
Marcy Gallagher, Division of Plan Surveys
Gary Baldwin, Division of Licensing
Amy Krause, Division of Licensing
David Bae, Division of Licensing
Melissa Moon, Division of Licensing
Tom Chan, Division of Financial Oversight

Medicare Compliance

MEMO

To: File

CC:

From: John Tanner,

Molina Medicare Compliance Officer

Date: 2/18/2012

Re: Medicare sanctions and penalties against Molina in last Five Years

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Medicare levied a Civil Monetary Penalty (CMP) of $11,200 on Molina on November 10, 2009 for the late mailing of the Annual Notice of Change/Evidence of Coverage (ANOC/EOC) to a total 532 members in 5 states, of which 107 were Molina Medicare members in California. The mailing was to be completed October 31, 2008, and Molina completed it on January 12, 2009.

The penalty described in the above paragraph is the extent of any sanctions or penalties levied by Medicare against Molina in the last 5 years.

Attachment 7a

Sanctions and penalties taken by a state of California government entity in the last five years.

1. Department of Managed Health Care, December 27, 2009, Penalty $250,000, claims settlement practices

2. Department of Managed Health Care, August 3, 2007, Penalty $75,000, claims settlement practices

3. Department of Managed Health Care, June 18, 2007, Penalty $5,000, failure to issue written provider dispute resolution explanation within 45 days

State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE SEP 2 1 2011

MMCD All Plan Letter 11-021
(Supersedes APL 11-002)

TO ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM REQUIREMENTS FOR 2012

PURPOSE

The purpose of this All Plan Letter (APL) is to clarify the Quality and Performance Improvement Program requirements for Medi-Cal managed care health plans for 2012. All Medi-Cal managed care health plans are contractually required to report annual performance measurement results, participate in a consumer satisfaction survey, and conduct ongoing quality improvement projects (QIPs).

Not all of the requirements presented below are applicable to specialty health plans (AHF Healthcare Centers, Family Mosaic Project, and SCAN Health Plan). For these health plans, requirements are noted where applicable, but health plans should refer to their contracts for further information.

REQUIREMENTS

1. External Accountability Set Performance Measurement Requirements

   a) All Medi-Cal managed care health plans must submit annual scores for the required External Accountability Set (EAS) performance measures. With the exception of the specialty health plan Family Mosaic Project, the Department of Health Care Services (DHCS) currently requires all contracted health plans to report selected Healthcare Effectiveness Data Information Set (HEDIS®) measures in order to comply with the EAS reporting requirement. DHCS requires the Family Mosaic Project to report on two performance measures developed specifically for that health plan. (See Attachment 1.)

Medi-Cal Managed Care Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

b) All contracted health plans must submit to an annual on-site EAS compliance audit, currently referred to as the "HEDIS Compliance Audit™," except for the Family Mosaic Project. This audit is a two-part process consisting of an information systems capabilities assessment, followed by an evaluation of an organization's ability to comply with HEDIS audit specifications. The HEDIS audit methodology was developed by the National Committee for Quality Assurance (NCQA) and is used to assure standardized quality performance measure reporting throughout the health care industry. The Family Mosaic Project must undergo a performance measure audit of its two (2) internally-developed measures.

c) All health plans must use DHCS's selected contractor for the HEDIS Compliance Audit. The Health Services Advisory Group (HSAG) is DHCS's current External Quality Review Organization (EQRO) contractor, and will perform the 2012 HEDIS audits. HSAG may subcontract with one or more independent auditors licensed by the NCQA to conduct some of the HEDIS audits. These audits are paid for by the State.

d) DHCS has introduced five new measures for the 2012 reporting year and deleted two measures. Several of the new measures may be utilized to support performance measurement related to the implementation of mandatory enrollment of Medi-Cal only Seniors and Persons with Disabilities, as required by Welfare and Institutions Code Section 14182 (as added by Stats.2010, c. 714 (SB 208) § 20). Final measure selection was made after consultation with contracted plans and input from the EQRO and other stakeholders during 2011.

   Attachment 1 lists all 14 HEDIS and DHCS developed measures required for reporting year 2012 (i.e., measurement year 2011) for full-scope health plans. Note that some measures have multiple indicators. Attachment 1 also includes the two HEDIS or other performance measures to be reported by each specialty plan. These measures have been agreed upon between DHCS and each health plan as appropriate for each health plan's membership.

e) Each health plan (any model type) must report to the EQRO the results on all the performance measures required of that health plan, while adhering to HEDIS or other specifications for the reporting year. Each health plan must populate NCQA's Interactive Data Submission System (IDSS) with the final measure rates for all reporting units/counties by June 1, 2012 for final auditor review.

f) All health plans must calculate and report HEDIS rates at the county level unless otherwise approved by DHCS. Current exceptions to this requirement were approved many years ago for health plans operating in Riverside and San Bernardino counties and the County Organized Health System (COHS) plans operating in Monterey, Santa Cruz, Napa, Solano, and Yolo counties. When existing health plans expand into new counties, if enrollment exceeds 1,000 members as of July of a given calendar year, health plans are required to report separate HEDIS rates for each county. DHCS does not intend to approve new combined county reporting of HEDIS measures if a health plan has 1,000 or more members in any new county.

g) Each contracted health plan will calculate its scores for the required performance measures, and these scores will be confirmed by the EQRO or its subcontractor and reported to DHCS.

h) Health plans must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required HEDIS measure. The 2012 MPL for each required measure is the 25th percentile of the national Medicaid results for that measure as reported in the most current edition of NCQA's *2011 Audit Means, Percentiles, and Ratios* at the time the EQRO provides the annual HEDIS rates to DHCS.

i) DHCS adjusts the MPLs each year to reflect the 25th percentile of the national Medicaid results for each measure. The percentiles are drawn from the most current edition of NCQA's *Audit Means, Percentiles and Ratios* at the time the EQRO provides HEDIS rates to DHCS.

j) For <u>each</u> measure that does not meet the established MPL or is reported as a "Not Report" (NR), the health plan must submit an Improvement Plan (IP) within 60 days of being notified by DHCS of the measures for which IPs are required For example, a health plan with HEDIS scores falling below the MPL for two of the required measures must submit two IPs – one for each measure.

- Health plans must submit the required IPs to DHCS using the *HEDIS Improvement Plan Submission Form* (Attachment 2). The most current version of this form is provided to each health plan at the time DHCS notifies the plans of the measures for which IPs must be submitted and the due date.

- The IPs are submitted to DHCS at qipsmail@dhs.ca.gov, the address established by MMCD's Performance Measurement Unit for this purpose.

- Health plans serving multiple counties under a single contract may submit an IP that addresses more than one county if the health plan's scores fell below the MPL for the same measure in more than one county covered by that contract. However, in the IP the health plan must discuss how it will address the targeted population in each county.

- Plans are not subject to the MPL in the first year scores are reported for a newly required measure as this score is considered the baseline score. Therefore plans do not have to submit an IP if a score for a new measure is below the MPL. These first-year scores will be reported in the annual aggregate report with an acknowledgement that these are baseline scores that are not subject to the MPL.

k) DHCS will publicly report the audited HEDIS or other performance measurement results for each contracted health plan, along with the Medi-Cal managed care program average, the national Medicaid average, and the national commercial average for each DHCS-required performance measure.

l) DHCS establishes a High Performance Level (HPL) for each required performance measure and publicly acknowledges health plans that meet or exceed the HPLs. The 2012 HPL for each required measure is the 90th percentile of the national Medicaid results for that measure as reported in the 2011 edition of NCQA's *Audit Means, Percentiles and Ratios*.

2. Under/Over-Utilization Monitoring

a) Health plans are required to report rates for selected HEDIS Use of Services measures for the monitoring of under and over-utilization. For 2012, the selected Use of Services measures are listed in Attachment 3 and include:

- *Frequency of Selected Procedures* –Procedures selected for reporting year 2012 are: back surgery, bariatric weight loss surgery, lumpectomy, and mastectomy.
- *Inpatient Utilization: General Hospital/Acute Care* – Includes utilization of acute inpatient services in various categories
- *Ambulatory Care* – Includes outpatient visits and emergency department visits.

b) Health plan processes for arriving at rates for selected HEDIS Use of Services measures used for the monitoring of under and over-utilization are not audited, but the rates for these measures are reported to the NCQA-certified auditor performing the HEDIS audits under the direction of DHCS's EQRO. These Use of Services rates are for internal use and are not publicly reported. In future years, MMCD may modify the selected measures, may establish benchmarks, and/or may begin publicly reporting the results.

3. Consumer Satisfaction Surveys

a) The next Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for both adults and children will be administered by the EQRO in 2013.

b) In years when the CAHPS surveys are administered, results will be reported by the EQRO for each health plan at the county level. County-level reporting allows the DHCS, contracted health plans, and other stakeholders to better understand how member satisfaction and health plan services varies in individual counties.

c) Although specialty health plans are not required to participate in the CAHPS survey, these health plans are required to conduct a member satisfaction survey at least every other year and to provide DHCS with results specific to the health plan's Medi-Cal managed care members. Each specialty health plan must provide DHCS with a copy of the survey instrument and the survey calculation/ administration methodology, so that the EQRO may evaluate them for compliance with both federal and contract requirements.

4. Quality Improvement Projects

Number of QIPs Required

Full-scope health plans are required to conduct and/or participate in two QIPs – the Department-led statewide collaborative (SWC) QIP and *either* an internal QIP (IQIP) or a health plan-led small group collaborative (SGC) QIP. Health plans holding multiple Medi-Cal managed care contracts are required to conduct two QIPs for each contracted entity.

Specialty health plans also are required to conduct two QIPs, but are not required to participate in the Department-led statewide collaborative QIP. For these health plans, the two QIPs usually will be IQIPs, although health plans may request approval to participate in a SGC appropriate to their member population.

Both IQIPs and SGCs must be approved by DHCS and validated by the EQRO in accordance with the Centers for Medicare and Medicaid Services (CMS) requirements for performance improvement projects. Full-scope health plans that establish new contracts with DHCS after the current statewide collaborative begins will be required to participate in a SGC or to develop an IQIP in place of their participation in the statewide collaborative after the plan has been operational for one year, subject to DHCS approval.

Requirements for QIPs

Title 42, CFR, Section 438.240(b)(1) requires that QIPs "be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable affect on health outcomes and enrollee satisfaction."

a) In order to demonstrate significant and sustained improvement, each health plan is required to provide the following information in the QIP status reports and the QIP final report:

   - A quality indicator baseline result followed by subsequent measurement results for the same quality indicator during and after implementation of improvement interventions. Note that sustained improvement is demonstrated when two consecutive re-measures result in a statistically significant improvement.

   - Tests of statistical significance calculated on baseline and repeat indicator measurements. For example, a health plan might use a P value of less than 0.05 as the threshold for statistical significance.

   - Prospective identification of indicator goals. Existing benchmarks should be strongly considered when establishing indicator goals. DHCS recommends that indicator goal(s) be based on the following sources in order of precedence: benchmarks of performance, a DHCS-specified goal, or a well-defined goal submitted in advance by the health plan. If a benchmark or DHCS-specified goal is not used, the health plan must provide justification for the chosen goal(s).

b) QIPs may be based on HEDIS measures, although this is not required. Under such circumstances, health plans must adhere to the HEDIS specifications in place at the time the QIP proposal is approved by DHCS and validated by the EQRO. If, during the course of the QIP, HEDIS specifications change for the

QIP's HEDIS measure, DHCS and the EQRO, in collaboration with the health plan, will evaluate the impact of the changes. Any change in methodology for trending QIP performance must be approved by DHCS.

c) QIPs typically last 12 to 36 months, and use of the Rapid Cycle Improvement approach is expected when feasible. Health plans wishing to conduct a QIP beyond 36 months must get approval from DHCS.

d) If desired, health plans serving multiple counties under a single contract may submit a QIP that addresses the same improvement topic in more than one county, provided the targeted improvement is relevant in more than one county covered by that contract. However, the QIP proposal and subsequent status reports must specifically address the targeted population in each county included in the QIP by submitting county-specific data and results for the following QIP activities:

- Sampling methods
- Data collection procedures
- Assessment of improvement strategies
- Data analysis and interpretation of study results
- Assessment for real improvement
- Assessment for sustained improvement

The above QIP activities and others are documented by health plans on the *QIP Summary Form* and validated by the EQRO.

The *Quality Improvement Assessment (QIA) Guide for Medi-Cal Managed Care Plans* explains the CMS requirements for QIPs and how the EQRO validates plan QIPs for compliance with the federal requirements. The *QIA Guide* is available on the DHCS website at:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/QIA_Assessment_Guide_November_2010.pdf

Approval and Validation Process for QIP Proposals and Status Reports

All QIP proposals and status reports must be submitted on HSAG's *QIP Summary Form* or *QIP Summary Form for Multi-Counties*. The forms are available to health plans on HSAG's File Transfer Process (FTP) site. (*Note:* All current Medi-Cal managed care health plans already have identified FTP users who have been assigned user names

and passwords by HSAG in order to access each health plan's specific folder. To establish additional user profiles or remove previous users, health plan staff should contact Denise Driscoll at DDriscoll@hsag.com.)

a) Health plans first submit QIP proposals to MMCD for approval. Once MMCD has approved the topic of the QIP proposal, MMCD forwards the proposal to the EQRO for validation. Once a health plan's QIP proposal is fully approved and validated, the health plan must submit status reports at least annually or according to a timeline agreed upon by the health plan, MMCD, and the EQRO.

b) QIP proposals, both for IQIPs and SGCs, should be sent to qipsmail@dhs.ca.gov, the e-mail address established by MMCD's Performance Measurement Unit for submission of QIP proposals and status reports.

c) Within approximately one month of receiving a QIP proposal, MMCD will send the health plan either an approval of the QIP or a request for further development. Once a proposal is approved by MMCD, staff will forward it to the EQRO for validation and notify the health plan that the QIP's validation process has begun. The EQRO will send validation results to both the health plan and to MMCD and may request modifications to the health plan's proposal before final validation that the health plan's QIP proposal is in compliance with both DHCS and CMS requirements.

d) Health plans must send baseline reports (if not included in the proposal), annual status reports, and final reports for all QIPs directly to the EQRO via HSAG's FTP site with a "cc" to qipsmail@dhs.ca.gov.

e) Within 90 days of receiving EQRO notification that a final closing QIP report has been validated and meets requirements, health plans must submit a new QIP proposal to MMCD as described above.

f) Attachment 4 presents an overview of QIP requirements in table form.

KEY CONTACTS

If you have questions or concerns about the information in this letter, please contact the following individuals via e-mail according to your area of concern:

- General questions about MMCD's quality and performance improvement program requirements: Helen MacDonald, Chief, MMCD Performance Measurement Unit, at Helen.MacDonald@dhcs.ca.gov
- HEDIS MPLs and HPLs and the submission of HEDIS Improvement Plans: Helen MacDonald at Helen.MacDonald@dhcs.ca.gov
- HEDIS 2012 audit requirements and QIPs validation process: Jennifer Lenz, Associate Director of EQRO Services, HSAG, at jlenz@hsag.com
- The current statewide collaborative QIP on reducing avoidable ER visits: Rose Recostodio, Nurse Consultant, MMCD Medical Policy Section, at Rose.Recostodio@dhcs.ca.gov.
- The upcoming statewide collaborative QIP on hospital readmissions: Desire Kindarara, Nurse Consultant, MMCD Medical Policy Section, at Desire.Kindarara@dhcs.ca.gov.
- Required QIPs, the submission of QIP proposals and status reports, and QIP due dates: Sarah Reed, Associate Governmental Program Analyst, MMCD Performance Measurement Unit, at Sarah.Reed@dhcs.ca.gov.

Performance measurement and quality improvement are important aspects of the Medi-Cal managed care program. The partnership between MMCD, its contracted health plans, and the EQRO results in ongoing improvement of the quality of care and services provided to Medi-Cal beneficiaries. We look forward to continuing this positive relationship.

Sincerely,

Jane Ogle, Deputy Director
Health Care Delivery Systems

Attachments (4)

Attachment 1

2012 HEDIS PERFORMANCE MEASURES FOR FULL-SCOPE PLANS
August 3, 2011

	HEDIS Reporting Year 2012[1]	***Measure Type***
1.	Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	Hybrid measure (Medicaid) *Used for Auto Assignment*
2.	Adolescent Well-Care Visits	Hybrid measure (Medicaid) *Used for Auto Assignment*
3.	Childhood Immunization Status – Combo 3	Hybrid measure (Medicaid) *Used for Auto Assignment*
4.	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care • Postpartum Care	Hybrid measure (Medicaid) *Timeliness of Prenatal Care indicator used for Auto Assignment*
5.	Use of Imaging Studies for Low Back Pain	Admin measure (Medicaid)
6.	Cervical Cancer Screening	Hybrid measure (Medicaid) *Used for Auto Assignment*
7.	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	Hybrid measure (Medicaid)
8.	Comprehensive Diabetes Care (8 indicators): • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/Dl) • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attn. for Nephropathy • Blood pressure control (<140/90 mm Hg)	Hybrid measure (Medicaid) *HbA1c Testing indicator used for Auto Assignment*
9.	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Admin measure (Medicaid)
10.	***NEW FOR 2012*** Children & Adolescents' Access to Primary Care Practitioners	Admin measure (Medicaid)
11.	***NEW FOR 2012*** Immunizations for Adolescents	Hybrid measure (Medicaid)
12.	***NEW FOR 2012*** Annual Monitoring for Patients on Persistent Medications (w/out anticonvulsant indicator)	Admin measure (Medicaid) - addresses members 18 yrs & older
13.	***NEW FOR 2012*** Ambulatory care: • Outpatient visits • Emergency Department visits	Admin measure (Medicaid) - addresses members <1 yr through 85+ yrs
14.	***NEW FOR 2012*** All-Cause Readmissions – Statewide Collaborative QIP measure	Admin measure Statewide Collaborative QIP to define specific measure
		8 Hybrid & 6 Admin measures+

[1] Uses data from 1/1/11 through 12/31/11, "measurement year."

Attachment 1

2011 HEDIS PERFORMANCE MEASURES ELIMINATED FROM THE 2012 MEASUREMENT SET

	2011 HEDIS Measure	Measure Type
1.	Appropriate Treatment for Children with Upper Respiratory Infection	Admin measure (Medicaid)
2.	Breast Cancer Screening	Admin measure (Medicaid)

HEDIS PERFORMANCE MEASURES TO BE CONSIDERED FOR 2013

This is not a complete list, other measures may be considered based upon additional information.

- Controlling High Blood Pressure (Hybrid measure - Medicaid)
- The following measures and/or others *may be considered* for stratified reporting for SPDs in 2013:
    - Children & Adolescents' Access to Primary Care Practitioners
    - Cervical Cancer Screening
    - Controlling High Blood Pressure
    - Ambulatory Care (outpatient visits and emergency department visits)
    - All-Cause Readmissions – Statewide Collaborative QIP measure

    DHCS will develop the requirements for stratified reporting with technical assistance from the EQRO and in consultation with plans.

2013 HEDIS PERFORMANCE MEASURES DEVELOPMENT PROCESS

This approach provides the plans with the draft HEDIS performance measure set prior to when they start collecting data, but allows DHCS to modify the measures based on additional information such as any HEDIS revisions, plan performance, or other factors to be determined.

October to December 2011	DHCS begins identifying performance measures for 2013, including gathering input from Dr. Kohatsu, plans, Medical Directors, QI/HEDIS representatives, the MMCD and SPD Advisory Groups, and MMCD staff.
December 2011	DHCS issues a draft of the 2013 Performance Measure set, which is subject to adjustments based on review of 2011 HEDIS data and other key reasons, such as NCQA revising the technical specifications of a HEDIS measure.
May 2012	DHCS issues "final" set of 2013 Performance Measures including identifying measures used to stratify and report the SPDs.
June 2012	DHCS issues APL.
November 2012	• Measures included in auto assignment default algorithm developed and approved. • Assess the new performance measure set development process.

Attachment 1

REQUIRED PERFORMANCE MEASURES FOR SPECIALTY PLANS: 2012

AHF Healthcare Centers

- Colorectal Cancer Screening
- Controlling High Blood Pressure

Family Mosaic Project

- *Inpatient Hospitalizations:* The percentage of Medi-Cal managed care members enrolled in Family Mosaic who have a mental health admission to an inpatient hospital facility during the measurement period.

- *Out-of-Home Placements:* The percentage of Medi-Cal managed care members enrolled in Family Mosaic who are discharged to an out-of-home placement during the measurement period.

SCAN

- Breast Cancer Screening
- Osteoporosis Management in Women Who Had a Fracture (*new for 2012*)

Attachment 2

MEDI-CAL MANAGED CARE DIVISION

HEDIS IMPROVEMENT PLAN SUBMISSION FORM

Plan Name: _____

HEDIS Measure: _____

MMCD "Minimum Performance Level" (MPL): _____

County:	Plan's 2011 Score for Measure:

1. Performance Standard and Goal
   Briefly describe your plan's performance goal for this measure, including the target score your plan hopes to achieve in the next two reporting years (2012 and 2013).

2. Plan for Improvement
   Briefly describe the overall plan for improved performance for this measure. Include a description of the strengths and opportunities for improvement This may include improvement suggestions for the following year, such as modifications to goals and objectives, newly established goals and objectives, changes in methodology due to an unforeseen nuance, or other changes that will enhance the program in the short and/or long term.

3. Barriers and Challenges
   Report the internal and/or external barriers, issues and/or factors that impacted the HEDIS result, identifying the reasons that:
   - Improvement was not made or sustained for reporting year 2011;
   - Goals could not be reached in reporting year 2011; and/or
   - Study, project or intervention could not be completed in time to affect the reporting year 2011 score.

   Note: Internal barriers are often associated with lack of a particular resource. Once identified, barriers often become opportunities for improvement for the following year or next remeasurement cycle.

Attachment 2

4. Repeat Improvement Plan
If your plan has been previously required to submit an Improvement Plan for this measure for **more than two consecutive years**, please describe how your plan has applied previous lessons learned to the development of this Improvement Plan and how this IP differs from previous IPs or why it does not.

5. Improvement Plan Grid
List the interventions your plan will use to improve performance for this measure. Indicate whether the intervention is new (N) or continued (C) from a previous IP.

Item	Interventions	New (N) or Continued (C)	Anticipated Completion Date	Responsible Person(s)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

_____ _____
Name and title of person completing this HEDIS Improvement Plan Date

_____ _____
Name and title of person in plan approving this HEDIS Improvement Plan Date

Attachment 3

REQUIRED USE OF SERVICES MEASURES FOR FULL-SCOPE PLANS: REPORTING YEAR 2012

In the 2012 reporting year, Medi-Cal managed care health plans (with the exception of specialty plans) are required to submit unaudited HEDIS rates for measurement year 2011 for the HEDIS Use of Services Medicaid measures listed below:

1. *Frequency of Selected Procedures* – This measure summarizes the number and rate of various frequently performed procedures. For Medicaid members, plans report the absolute number of procedures and the number of procedures per 1,000 member months by age and sex. The following indicators are reported:
   a) Back surgery
   b) Bariatric Weight Loss Surgery
   c) Lumpectomy
   d) Mastectomy

2. *Inpatient Utilization: General Hospital/Acute Care* – This measure summarizes utilization of acute inpatient services in the following categories: total inpatient, medicine, surgery, and maternity. The following data are reported for each category:
   a) Discharges
   b) Discharges/1,000 member months
   c) Days
   d) Days/1,000 member months
   e) Average length of stay

3. Ambulatory Care – This measure summarizes utilization of ambulatory services for the following indicators, all expressed per 1,000 member months by ages:
   a) Outpatient visits
   b) Emergency Department visits

Note: Results for these measures are reported to the EQRO consistent with HEDIS technical specifications and in a format designated by DHCS. However, these measures are not included in the EQRO's audit process.

MMCD QUALITY IMPROVEMENT PROJECT (QIP) REQUIREMENTS: 2012

	Internal QIP (IQIP)	***Small Group Collaborative (SGC)***	***Statewide Collaborative (SWC) QIP***
Required number of plans	One	At least four health plans (Proposals for SGCs with fewer plans require justification & must be approved by MMCD.)	All contracted plans (except specialty plans)
Required meetings	NA	Health plans are expected to work collaboratively to review progress, provide insights on overcoming barriers, share specific interventions & tools, adopt process and system changes, & establish best practices. • Plans must conduct at least one meeting each quarter each year for this purpose. • At least one staff member from each participating plan must attend each meeting (in person or by telephone). • The designated MMCD contact for the SGC from MMCD's Medical Policy Section should be invited to meetings.	MMCD will organize meetings at least quarterly each year to work collaboratively with health plans to review progress, provide insights on overcoming barriers, share specific interventions & tools, adopt process and system changes, & establish best practices.
Data reporting	As specified in the approved/validated IQIP proposal	• The SGC must, at a minimum, collect and report baseline data and then annual re-measurement data for two consecutive years. • At the end of the second re-measurement, subsequent re-measurements and continuation of the SGC will be evaluated jointly by MMCD and the health plans involved in the SGC.	Determined by agreement between MMCD and plans & specified in the approved & validated SWC QIP proposals submitted by each plan. ***Note:*** The next annual status reports are due 10/29/11. Submit to: qipsmail@dhs.ca.gov
Objectives and indicators	As indicated in the approved/validated QIP proposal	Plans must work on the same measurable objectives and use the same performance measure indicators. These performance measures may be process or outcome measures as applicable to the specific collaborative[1].	
Methodology for measuring	As indicated in the approved/validated	Plans must measure improvement toward the outcome or process objectives using the same measurement methods[2] to compare post-intervention to baseline	

[1] Acceptable: "All plans in this SGC will increase diabetes screening rates for HbA1C, LDL, and eye exams by 10%." Unacceptable: "Plan A will increase HbA1C screening rates, while Plan B will decrease mean HbA1C levels."

	Internal QIP (IQIP)	***Small Group Collaborative (SGC)***	***Statewide Collaborative (SWC) QIP***
improvement	QIP proposal	and to compare results across plans.	
Interventions	As indicated in the approved/validated QIP proposal	At least some interventions must be the same or similar across plans.[3] Other interventions may differ across plans.	
Evidence-based interventions	If evidence-based interventions exist, it is preferable that they be applied. In addressing topics for which evidence-based interventions do not exist, a plan (for IQIPs) or plans (for SGCs & the SWC QIPs) may try other interventions based on community standards, best practices, etc. to see what works with their plan model and/or their provider and membership populations.		
Intermediate process measures	Plans may use different intermediate process measures[4] based on the specific interventions being implemented. These process measures should be collected (but not necessarily reported to MMCD) more frequently than the outcome measures to guide "course corrections" in the Plan-Do-Study-Act (PDSA) cycles or the rapid cycle improvement process.		
Timing of re-measurement	Re-measurement of quality indicators after baseline should be performed after implementation of improvement interventions and over comparable time periods. Note: sustained improvement is demonstrated when two consecutive re-measures result in statistically significant improvement.		
Use of goals	Goals, as specified by MMCD and found in industry standards, or defined in advance by the health plan, should be prospectively identified. The plan's quality indicator results should be compared with the stated goals. For example, a goal might be to reduce the performance gap (the percent of cases in which the measure failed) by at least 10 percent.		
Use of HEDIS measures	QIPs may be based on HEDIS measures. When QIPs are HEDIS-based, health plans must adhere to the HEDIS specifications in place at the time the QIP proposal is approved & validated. If the HEDIS specifications change during the course of the QIP, MMCD and the EQRO, in collaboration with the health plan, will evaluate the impact of the changes. Any change in methodology for trending QIP performance must be approved by MMCD.		
Statistical testing	Tests of statistical significance should be calculated between baseline and repeat indicator measurement periods. For example, a health plan might use a P value of less than .05 as the threshold for statistical significance.		
Duration	QIPs typically last 12 to 36 months. Use of the Rapid Cycle Improvement approach is expected when		

[2] Acceptable: "All plans in this SGC will measure HbA1C screening rates by chart review." Unacceptable: "Plan A will measure HbA1C screening rates by chart review, while Plan B will measure HbA1C screening rates by a survey of its physicians."

[3] Acceptable: "All plans in this SGC will participate in a joint training and will establish a diabetes registry. Plan A will also use group visits, while Plan B will improve linkages to community resources." Unacceptable: "Plan A and B do not plan to implement similar interventions. Plan A will conduct training and will establish a diabetes registry, while Plan B will conduct group visits and will improve linkages to community resources."

[4] Acceptable: "Plan A will track number/percent of provider practices using group visits, while Plan B will determine the percent of patients referred to ophthalmologists."

	Internal QIP (IQIP)	***Small Group Collaborative (SGC)***	***Statewide Collaborative (SWC) QIP***
	feasible.		
Format for submission of proposals and reports	All QIP proposals and reports must be submitted using HSAG's *QIP Summary Form*. • Initial proposals are first submitted to MMCD for approval and then submitted to the EQRO for validation. • Once a QIP proposal is approved, status reports must be submitted at least annually and in accordance with the timeline agreed upon by the health plan(s) and MMCD.		
Submission of QIP proposals	Submit proposals for IQIPs, SGCs & SWCs on HSAG's *QIP Summary Form* to qipsmail@dhs.ca.gov . When a proposal is approved, MMCD will forward the approved proposal to the EQRO for validation. Proposals are approved only after the EQRO certifies that it has passed validation requirements.		
Submission of QIP status reports	Submit baseline reports (if not included with proposal), annual status reports, and close-out reports to the EQRO via HSAG's FTP site with a "cc" to qipsmail@dhs.ca.gov.		Submit baseline reports (if not included with the proposal), annual status reports, and close-out final reports to the EQRO via HSAG's FTP site with a "cc" to qipsmail@dhs.ca.gov .
Submission of new proposal after close-out of QIP.	Within 90 days of receiving EQRO notification that a final closing QIP report has been validated and meets requirements, plans must submit a new QIP proposal to the MMCD.		Generally, within 90 days of receiving EQRO notification that a final closing QIP report has been validated, plans are to submit new proposals for the next SWC. However, the MMCD will determine the specific time frame for plans to submit new SWC proposals.

MMCD Program Data and Performance Measurement Section
8-11-11

<u>Attachment 8b</u>. Applicant has listed in this attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.

The MA-SNP quality requirements that apply to Molina Healthcare of California's D-SNP benefits plans in Sacramento and Los Angeles/Inland Empire/San Diego are described in Molina Healthcare's Medicare Quality Improvement Program (QIP), a copy of which can be provided upon request. The QIP covers the following areas of care and service for our members:

- Access to Care/Availability
- Network composition and adequacy to provide targeted clinical expertise
- Continuity/Coordination of Care and Transition Across Care Sites and Settings
- Beneficiary Health Status, Assessment and Stratification of Health Risk
- Disease Management and Behavioral Health Programs
- Guideline Management, Evidence-based Clinical Practice and Preventive Health
- Model of Care Program service and care coordination
- Chronic/Acute Care and Chronic Care Improvement Program (CCIP)
- Under/Over Utilization (medical, pharmacy, behavioral)
- HEDIS® Measurement/Reporting and activities to address performance gaps
- Preventive Care/Services and interventions to address service gaps
- Cultural, Ethnic, Racial and Linguistic Requirements of our Members
- High-Risk/High-Volume/Problem-Prone Care
- Member and Practitioner Satisfaction/Dissatisfaction, including CAHPS®
- Pharmacy Services and Medication Management
- Member Safety/Error Avoidance
- Quality of Care Review, Clinical Case Review and Serious Reportable Adverse Events and Hospital Acquired Conditions
- Health Plan Service Standards and Operational Performance Thresholds
- Plan determined quality improvement projects (QIP), internal and collaborative
- Applicable and appropriate measures of health outcomes and indices of quality for the target populations and sub-populations (such as the HOS)
- Co-morbid conditions and complexities associated with concurrent/on-going or unresolved medical and behavioral health issues
- Activities to assess functional, psychosocial, quality of life indicators such as the SF 12 and other health status tools and methods
- Part C and Part D reporting requirements

In addition to the quality requirements listed above, as a Medicare Advantage organization, Molina Healthcare of California is required to regularly report Health Plan Employer Data and Information Set (HEDIS®) Measures that include the Medicare Health Outcomes Survey (HOS) and the Medicare Consumer Assessment of Health Plans Study (CAHPS® 2.0H) to the Centers for Medicare and Medicaid Services. A brief summary of these reporting requirements follows:

A. **HEDIS annual survey of summary and patient-level data, and compliance audit**. Medicare Advantage organizations must submit summary measures by the end of June of each reporting year. The sampling frame/period is services delivered in the measurement

(previous) year (and earlier for some measures). Medicare Advantage organizations are required to participate if they have a minimum Medicare enrollment of 1,000 as of July 1 in the previous year (Molina meets this requirement). The minimum sample size is measure specific. CMS requires an external audit of the HEDIS measures before public reporting of annual survey results. Medicare Advantage organizations pay for the external HEDIS audit. HEDIS technical specifications are updated annually. The following HEDIS measures are applicable to Medicare Advantage organizations, including D-SNPs:

Effectiveness of Care

- Adult BMI Assessment
- Breast Cancer Screening
- Colorectal Cancer Screening
- Glaucoma Screening in Older Adults
- Care for Older Adults – Medication Review (SNP Measure Only)
- Care for Older Adults – Functional Status Assessment (SNP Measure Only)
- Care for Older Adults – Pain Screening (SNP Measure Only)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy of COPD Exacerbation
- Cholesterol Management for Patients With Cardiovascular Disease
- (LDL-C Screening only)
- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Comprehensive Diabetes Care-Screening
  (Eye Examination, LDL-C Screening, HbA1c Testing/Control, Nephropathy)
- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
- Osteoporosis Management in Women Who Had a Fracture
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness
- Annual Monitoring for Patients on Persistent Medications
- Medication Reconciliation Post-Discharge (SNP Measure Only)
- Potentially Harmful Drug-Disease Interactions
- Use of High-Risk Medications in the Elderly
- Flu Shots for Older Adults (collected through CAHPS)
- Medical Assistance With Smoking Cessation (Advising Smokers to Quit only) (collected through CAHPS)
- Pneumonia Vaccination Status for Older Adults (collected through CAHPS)

Access to/Availability of Care

- Adults' Access to Preventive/Ambulatory Health Services
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Call Abandonment
- Call Answer Timeliness

Health Plan Stability

- Board Certification
- Enrollment by Product Line (Member Years/Member Months)
- Enrollment by State
- Language Diversity of Membership
- Race/Ethnicity Diversity of Membership
- Total Membership

Use of Services

- Frequency of Selected Procedures
- Ambulatory Care
- Inpatient Utilization General Hospital/Acute Care
- Identification of Alcohol and Other Drug Services
- Mental Health Utilization
- Antibiotic Utilization
- Plan All-Cause Readmissions

Health Plan Descriptive Information

- Board Certification
- Total Enrollment by Percentage
- Enrollment by Product Line (Member Years/Months)

B. **Medicare Health Outcomes Survey** is an annual survey designed to obtain self-reported information from a sample of Medicare beneficiaries for the HEDIS functional status measure. Sampling frame/period is members continuously enrolled 6 months prior to survey sampling. Medicare Advantage organizations are required to participate if they have a Medicare contract in place no later than Jan. 1 of previous year (Molina meets this requirement). Each year a baseline cohort will be drawn and1,200 members are surveyed (for plans with less than 1200 enrollees, all members are surveyed). Additionally, each year a cohort measured two years previously at baseline will be resurveyed. The results of this re-measurement will be used to calculate a change score for the physical health and emotional well being of each respondent. Medicare Advantage organizations pay for an NCQA certified vendor to administer survey. The Medicare HOS survey covers the following topics:

- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Falls Risk Management (FRM)
- Management of Urinary incontinence in Older Adults (MUI)
- Osteoporosis Testing in Older Women (OTO)
- Physical Activity in Older Adults (PAO)

C. **Medicare Managed Care CAHPS Satisfaction Survey** is a survey completed in the fall of each year that consists of the core CAHPS questions plus additional questions specific to Medicare. For most plans, within the enrollee component of the MMC CAHPS Survey, the reporting unit consists of a random sample of 600 members who were continuously enrolled in the contract for 6 months and were not institutionalized. Medicare Advantage organizations are required to participate if they have a Medicare contract in place no later than July 1 of previous year (Molina meets this requirement). Medicare Advantage organizations pay for an NCQA certified vendor to administer survey. The Medicare Managed Care CAHPS satisfaction survey covers the following topics:

- Getting Care Quickly
- Getting Needed Care
- Rating of Health Plan
- How Well Doctors Communicate
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Drug Plan Provides Information or Help When Members Need It (Part D)
- Members' Overall Rating of Drug Plan(Part D)
- Members' Ability to Get Prescriptions Filled Easily When Using the Drug Plan (Part D)

D. **The Medicare CAHPS Disenrollment Reasons Survey** is a quarterly survey that asks beneficiaries about their reasons for leaving their Medicare managed care plan. CMS combines reasons for disenrolling with the annual disenrollment rates for reporting to beneficiaries through the Medicare Personal Plan Finder and Medicare Health Plan Compare on http://www.medicare.gov/ and at 1-800 MEDICARE. The sampling size is approximately 388, or if less than 388, all disenrolled members will be surveyed. Medicare Advantage organizations are required to participate if they have a Medicare contract in place no later than July 1 of previous year (Molina meets this requirement). CMS pays for survey administration.

MOLINA HEALTHCARE

Molina Healthcare of California

Molina's Bridge 2 Access Advisory Committee

Date:	**December 08, 2011**
Time:	**11:30am to 2:30pm**
Location:	**Molina - Arco Center Joe Heinz conference (2nd floor)**

AGENDA

Committee Members :	**FACILITATOR: Richard Bock, MD, Chief Medical Officer - MHC** **Andrew Whitelock**, AVP, Government Contracts, MHC **Brenda Premo**, Director, Harris Center for Disability & Health **Lisa Hayes**, Manager, Disability & Senior MHC **Mariana Bidart**, Disability & Senior Specialist , MHC **Peter Benavidez**, CEO Blindness Support Services **Ruthy Argumedo**, Dir. Community Outreach-MHC **Sal Pineda,** Greater Los Angeles Agency on Deafness (GLAD)	**Mary Rios**, Dis. Rights-LA **Hilario Wilson**, Director Member Services **Maggie Hollon**, Regional Director Molina Provider Services **Steven Soto**, Regional Director, Molina Provider Services **Lesley Po,** MD, MMG **Rafael Amaro**, MD, Med Dir, MMG **Paul Steussy,** Hamilton Relay **Liz Helms**, CA Chr. Care Coalition **Lillian Vasquez**, Autism Society **Janet Vadakkumcherry,** Director of Contracting, (CCHN) **Anne Cohen**, Disability & Health Policy Consultant	**Eliana Lois,** MD, Med Director Inland Regional Center **Teresa Favuzzi,** Director, CFILC **Rosemarie Punzalan,** Communication Specialist, CFILC **Cecilia Burch,** Exec. Director Independent Living Partnership **Lisa Jimenez**, Regional Director Braille Institute **Tina Padron,** Reg Director, MMG **Marvelyne Hawkins**, Molina member-Inland Empire **Andrew Lacroux,** Molina Mbr- LA **June Simmons,** CEO Partners in Care Foundation **Rosa Hidalgo**, IHSS
Molina SLT:	**Lisa Rubino,** Plan President**; Richard Bock,** MD CMO**; Andrew Whitelock,** AVP Government Contracts**; Teri Lauenstein,** VP Provider Network Management & Operations**; Greg Hamblin,** CFO.		
Guests:	**Maria Reyes,** Dir. UM**; Katherine Davidson,** AVP Hlth Care Svcs**; Hilario Wilson,** Dir. Member Services**; Michele Marcotte,** Dir. Govern Contract**; Brett Hubbard,** Dir. Medicare**; Barbara Johansson**,VP Care Coord;		

Topic	Person(s)	Time
I. Lunch & Mingle	All	11:30
II. Welcome and Opening Remarks	Lisa Rubino, Plan President	12:00
III. Introductions	Dr. Bock/All	12:05
IV. Approval of June 2011 Minutes	Dr. Bock	12:15
V. Member Services Update	Hilario Wilson	12:20
VI. Care Management Update	Dr. Bock/Maria Reyes	12:30
VII. Current Plan Priorities – Heading into 2012 • Integrated Care for Duals Pilots • LTC Coordination Options • Status Report on Enrollment of SPD's • Adult Day Health Care (ADHC) Medi-Cal Benefit • SPD Health Navigator/Community Connect Pilots	Andrew Whitelock Brenda Premo Andrew Whitelock Katherine Davidson/Dr. Bock Katherine Davidson/Lisa Hayes	12:45
VIII. Policy Discussion: Lanterman Developmental Center Closure	Dr. Bock/Andrew Whitelock/ Lisa Hayes	1:35
IX. Medicare Priorities in 2012	Brett Hubbard	2:00
X. Outreach Priorities in 2012	Ruthy Argumedo	2:20
XI. Save the Date Next Meeting: May 22, 2012	Dr. Bock	2:30

Molina's Bridge2Access Statewide Advisory Committee
December 8, 2011

Committee invitee(s):

Richard Bock, MD, MBA; CMO, MHC (Chairperson)
Andrew Whitelock, AVP, Government Contracts, MHC
Ruthy Argumedo, Manager, Enrollment Growth, MHC
Rafael Amaro, MD, Medical Director, MMG
Gloria Calderon, VP Clinic Operations, MMG
Lisa Hayes, Manager, Molina Sr. & Dis. Svcs., MHC
Maggie Hollon, Regional Director, Provider Services, MHC
Tina Padron , Regional Director Clinic Operations, MMG
Lesley Po, MD, MMG
Maria Reyes, Director, Utilization Management, MHC
Lisa Rubino, President, MHC
Diane Sanchez, Director, MMG
Steven Soto, Regional Director, Provider Services, MHC (teleconference)
Veronica Rodriguez, Member Services, MHC for Hilario Wilson
Mariana Bidart, Disability & Senior Specialist
Hilario Wilson, Director, Member Services, MHC
Teri Lauenstein, VP Provider Network Management & Operations
Brett Hubbard, Director , Medicare
Peter Benavidez, CEO, Blindness Support Services
Michael Carbine, Independent Living Partnership
Teresa Favuzzi, Executive Director, CFILC
Kathleen Graham, Molina member; Sacramento
Marvelyne Hawkins, Molina member; Inland Empire
Liz Helms, CA Chronic Care Coalition
Lisa Jimenez, Regional Director, The Braille Institute
Andrew Lacroux, Molina member; Los Angeles
Eliana Lois, MD, Medical Director, Inland Regional Center
Christie Mac Donald, MacDonald Consulting
Sal Pineda, Greater LA Agency on Deafness (GLAD)
Brenda Premo, Director, CDHP
Mary Rios, Disability Rights California
Paul Steussy, Greater LA Agency on Deafness
Lillian Vasquez, Autism Society
Janet Vadakkumcherry, Director of Contracting (telephone)
Rosemarie Punzalan, Communication Specialist, CFLIC

Anne Cohen, Disability & Health Policy Consultant
Alma Sandoval (minutes)

II. Welcome and Opening Remarks

Dr. Bock welcomed everyone and called meeting to order.

Message from Plan President
Lisa Rubino welcomed all and informed every one of activity and transition within Molina to prepare for the Seniors and Person's with Disability population. Molina Medical Clinics accessible accommodations continue (ie, height adjustable exam tables, wc weight scale, larger room, lowered counters,) Other projects also included ADHC, CBAS Foundation and the upcoming Pilots with the Dual Eligible's. Lisa encouraged committee member feedback to gain understanding of our level of readiness.

Dr. Bock attended a state assembly meeting for the oversight of legislature regarding Seniors and Persons with Disabilities. He expressed that the state assembly members posed a question regarding Seniors and Persons with Disability members and the lessons learned in the SPD transition that can be applied to other members who might be enrolled.

III. Introductions of Committee Members

All attendees introduced themselves.

IV. Approval of Minutes
Minutes of the 6/10/2011 meeting were approved with a minor correction on spelling of the Adelanto Clinic. The minutes were first approved by Peter Benavidez, and then seconded by Tina Padron.

V. Members Services Update
Veronica Rodriguez reported that the Member Services Department assist our SPD members through the following:
1. Explaining benefits available through the health plan
2. Assisting with physician transfer requests
3. Researching and providing the status on authorization requests
4. Arranging transportation to medical appointments at members request

5. Contacting physician offices to ensure prior authorization for medications are submitted on behalf of the member, when the circumstance requires a prior authorization
6. Assisting with scheduling appointments
7. Arranging for face-to-face interpreters, including sign language, at medical appointments based on members needs
8. Informing members of their appeal and grievance rights
9. Agents spend as much time on calls as required to resolve or explain an item to a member
10. Since June 2011, following mandatory enrollment of the SPD population into managed care, average daily call volume and average talk time have shown significant increases.

Anne Cohen mentioned that she was asked to serve on an advisory committee on care coordination and the SPD enrollment. They were asked to evaluate the type of service that Maximus and HCO are providing prior to enrollment for our members. Anne requested feedback from Veronica to see how the members are screened and their experience with Maximus for our next committee meeting.
Veronica Rodriguez will bring feedback to our next meeting.

VI. Care Management Update

Dr. Richard Bock, Chief Medical Officer :

Dr. Bock gave an update on Care Management and SPD transition:

- The importance of how members are being enrolled into managed care.
- Choice in selecting a managed care plan is low.
- Continuity of Care was discussed many people did not recognize that they had a choice. Dr. Bock expressed that our outreach is vital for members and providers who are fee for service.
- Physicians were not prepared for issues with enrollment, disenrollments, and medical exemption requests.

Old Rules: Medical Exemptions

- Dr. Bock stated that old rules indicated that if a member was in the midst of complex care or acute condition with a non-contracted physician they could

request an emergency disenrollment up to a 12 month period to stay with that provider.

- Most of those requests have been granted.

New Rules: Medical Exemptions

- Only about 50% of medical exemptions are being approved over the last few months since the enrollment of Senior's and Persons with Disabilities.

- New rules state that in addition to being in the midst of complex care the member also needs to be unstable to transition to a new physician.

- Dr. Bock states that there needs to be clear rules and apply them efficiently and continuously.

- An example was given of physician who already put in 350 forms in bulk for all his patients.

- Molina is striving to educate providers and bring them on board. We want for providers to get used to us with letters of agreements and potentially have hospitals and providers contract with us.

- Rosemarie Punzalan asked if there was an appeals process for denied exemption. Dr. Bock responded appeals need to go through Ombudsmen, and they conduct fair hearings. Molina has not had any denied exemptions to date. There have been multiple requests from physician and members. Five of the denied requests went to a fair hearing and all five were turned down. The exemptions are being upheld. Molina prefers that those appeals come through our member services department and we would like to help the members and know that they are having issues.

- Sal Pineda asked regarding waiver forms for continuity of care if that based on six options based on the medical reasons and are those options on the form? Dr. Bock responded that he is referring to the Continuity of Care form were the managed care plan need to allow for continued care by an existing physician relationship as long as that physician agrees to work with managed care and accepts the fee for service rate for up to 12 months. Our experience 1% percent of our new SPD members have requested continuity of care with a non-contracted provider and 40% percent for primary care physicians.

Maria Reyes, RN, Utilization Management Director:
Maria presented on the SPD Risk stratification and SPD Continuity of Care requests from June to November of 2011. The following illustrations were presented.
New SPD's completed health risk assessment survey and were then determined to be lower risk: 291
Number of SPDs completed risk assessment survey and were determined to be higher risk: 15
Number of new SPDs completed risk assessment survey and remained the same risk: 2215
Maria mentioned that SPD risk assessments are required by state to be completed as follows:

- 45 days for High Risk Assessments
- 60 days for Low Risk Assessments

Molina has met timeliness for completing the high and low risk assessments at one hundred percent. Results are being shared with our Molina Medical Clinics, Community Clinic of San Diego and our IPA's.

Anne Cohen asked if we are solely using the state initial health assessment. Maria responded that we are using an assessment tool approved by the state.
Maria also shared a couple of program success stories and expressed Molina is truly dedicated in the members care.

VII. Current Plan Priorities – Heading into 2012.

Andrew Whitelock, AVP Government Contracts:

Integrated Care for Duals Pilot:

Andrew mentioned that the purpose for our meetings is for the committee to give us feedback, what are we doing better and how we can improve our processes. Andrew shared information on an upcoming pilot involved the Integrated Care for Duals and encouraged feedback on how the plan should move forward in preparation for application submission and readiness. The following comments were presented.

- The pilot was led by the Centers for Medicare and Medicaid Services and the Department of Health Care Services.

- Three (3) year pilot targeting dual eligible beneficiaries eligible for Medicare and Medi-Cal.
- Provide improved coordination of care to dual eligible beneficiaries.
- Provide effective models to improve the beneficiary health and quality of life by reducing current fragmented care delivery and system inefficiencies.
- The state is looking at four (4) counties to participate in this duals pilot.
- Molina currently participates with Medi-Cal and Medicare in (4) counties. San Diego, Los Angeles, Riverside, San Bernardino and Sacramento.
- Across California there are 1.1 million individuals who are dually eligible for Medi-Cal and Medicare.

Molina Healthcare's Positions for Duals Pilot:

- Integrate behavioral health, home & community based services, long-term care and physical health care services (don't just focus on "coordination")
- Patient-centric care model
- Passive enrollment into the Duals Pilot with option to disenroll
- Work collaboratively with In Home Supportive Services (IHSS) providers
- Develop incentives under the Duals Pilot to keep dual eligible beneficiaries in their communities and with their chosen providers

Andrew introduced Brenda Premo. Brenda discussed the Long Term Care system part of the Duals Pilot. Andrew discussed that LTC will be a part of the integrated system of care for the duals pilot. There are five (5) options that were being discussed and Brenda will be educating us. Molina would like feedback, perspectives and or recommendations from the committee on what position can Molina advocate in regards to Long Term Care benefit underneath the Duals Pilot?

Brenda Premo, Director, Harris Center for Disability & Health:

Brenda gave a brief introduction and perspective on duals pilots.

Options for Long Term Services were also illustrated during her presentation.

Option 1: Status Quo

Option 2: Coordination of Institutional and HCBS Services; IHSS Status Quo

Option 3: Coordination Pass-through Payment

Option 4: Partial Integration Existing System (Full Risk/ Shared Operations)

Option 5: Full Integration of Services provided to Duals

Brenda expressed a great opportunity to think now about the type of system that people will want that would allow them to have the care they need when they need it, in the place that they want. If Molina becomes a successful program and people are healthier, they are doing more prevention and are talking to us.

Plan Recommendation: If selected as a demonstration site, be thinking how you will increase preventative care access, i.e., network providers with accessible equipment like exam tables, mammography, radiology, etc.

The state will want everyone to follow the same guidelines. Brenda stated CMS and legislature will be looking at these programs very closely because many people will be impacted.

Peter Benavidez commented that he brought copies of letters that he sent to community based providers stating that he supports Molina's effort in competing to work with this pilot. He expressed his personal experience with Molina and stated that Molina has innovative thinking.

Plan Recommendation: There needs to more accessible programs that focus on health and wellness; referred to his "Team BSS" program. Molina's implementation of programs and activities directly impact people with disabilities. He believes in what Molina is doing and there approach towards accessibility in regards to people with disabilities, would like to see more of this.

Peter asked how long it would take to make a decision on the Duals Pilot project. Brenda responded that there were 45 different presentation and proposals. Each plan is currently working with the Department of Health Care Services to declare their interest. Process was in a negotiating stage. We should see it here in the spring of 2012 in terms of the negotiating process. An Advisory Committee will take a look at access issues, rights of the member, the integration process and coordination. The state is very serious about keeping members in their community with high quality care at a stable cost point.

Dr. Bock mentioned that during state hearing yesterday with the senate and state assembly members Jane Ogle stated that the Dual Pilots will be awarded by June of 2012. Notifications would go out to potential members in October 2012 and the plans could start January 1, 2013.

Anne Cohen commented that these Dual Eligible pilots will be all over the country and one topic under a lot of debate was home and community based services. If a dual eligible plan takes in this money what type of services can they provide under a community based service.

Plan Recommendation: Anne suggested that as Molina is writing a proposal they should get feedback from consumers and other agencies, i.e. PA, IHSS about what type of home support services beyond what is currently offered.

Ongoing Enrollment of Seniors and Persons with Disabilities (SPD's):

Andrew states that Molina will continue to provide feedback with the following:

- Updates on New Member Enrollments & Plan Activities.
- Success Stories
    - Molina's Program for Risk Stratification and Health Risk Assessments
    - Molina's Member Services Call Center
- Plan Performance – Q3 2011
    - 35 member grievances by SPD members (43% related to access issues)
    - 119 continuity of care requests for FFS Medi-cal providers
    - 38 new primary care and 73 new specialty care providers added to network
- Challenges & Opportunities Going Forward

Dr. Richard Bock, Chief Medical Officer:

Adult Day Health Care (ADHC) Medi-Cal Benefit:

Dr. Bock mentioned that ADHC will evolve into the CBAS Program. Community Based Adult Services will only be available in managed care. Effective July 1, 2012 this will be a Medi-Cal managed benefit. There will be two transition periods were the state has re-evaluated all ADHC participants and enrolled into CBAS program. Anyone who would like to continue in the CBAS program will have to

enroll into a managed care plan. The state expects over 50% of current ADHC beneficiaries will qualify for CBAS benefits.

Katherine Davidson, AVP HealthCare Services:

Adult Day Health Care (ADHC) Medi-Cal Benefit:

Katherine gave brief overview ADHC and these comments were brought:

- ADHC members will be considered high risk.
- Upfront approach for ADHC members
- Molina has develop a relationship with Partners in Care
- Partners in Care will help coordinate care and complete assessments for these types of members.
- The advantages with a partnership with Partners in Care, is that they are familiar with this type of membership. They understand who Molina is and we are looking for opportunities to care and support our members.

Anwar Zoueihid, Board of Director, Partners in Care:

Adult Day Health Care (ADHC) Medi-Cal Benefit:

Anwar commented on Partners in Care's updates in preparation for the ADHC membership and partnership with Molina. These comments were brought:

- Nurses are being trained to evaluate the ADHC participants and it should be completed within 1 week.
- Nurse will begin the evaluation process to see if and how many current participants qualify for the program.

Lisa Hayes, Manager, Disability & Seniors and Persons with Disabilities.

SPD Health Navigator / Community Connect Pilots:

- Lisa Hayes discussed the 30% contact rate within our telephonic case management program and expressed how Molina is thinking of new and

creative ways to change the dynamics and increase face time with our members. Molina is concerned with issues members are experiencing. We are interested to know if there is someone who can come and visit the member, assess their ADL's, assess if they need home modifications, do they need in home support services and address challenges with Section 8.

These are the comments that were discussed:

- Molina will try pilots in three (3) counties.
- Molina will be out in the community and building relationships with people that are out in the community.
- Potential Partnerships with An Independent Living Center, and El Sol.
- ILC supports with peer counseling, information/ referrals and access they received a grant to help with the community connecter.
- Intent is to increase face time and be able to go out to where member is and where they access service.
- Provide and assign a Social Worker and Case Manager to the member.
- Looking for ILC in Sacramento County.
- Bridge to Long Term Coordination.

Plan Recommendations: Anne Cohen commented that one of the challenges with people with disabilities is they don't go to community based organization. Suggested for Molina to do joint mailings with the community based organization and the services they are offering to directly increase contact with these members.

Peter Benavidez commented that Molina should have people staffed that are sensitive to needs of the members and bilingual. **Plan Recommendation**: Telephonic Assessments may not be successful – face to face may be more appropriate with new populations. Make sure that this person understands consumer disability and availability of community resources.

Sal Pineda states that there are concerns of being able to identify members in the deaf community. Brenda stated that there is no set mechanism for process in identifying members and this is a huge criticism with the Medicaid Aide codes. There is a need to better identify beneficiary disability types.

Janet Vadakkumcherry suggested for Molina to look into Capitol Community Health Network who received a grant to do a pilot in South Sacramento for the Community Connect Navigator program. Lisa responded that they will be talking to Capitol Community next month.

VIII. Lanterman Developmental Center Closures

Andrew Whitelock, AVP Government Contracts:

Andrew presented on the Lanterman Developmental Center Closure Project and the following was brought:

- This is a coordinated Effort between DDS and DHCS
- Transitioning Lanterman Residents to Community Residential Facilities/Homes
- Anticipated that Most Lanterman Residents will Enroll with Medi-Cal Plans as part of Transition
- 75% of Lanterman residents are Medicare eligible and almost all are covered by Medi-Cal
- 300 Lanterman Residents will Enroll with Medi-Cal Plans in LA, Inland Empire and SD in Spring 2012
- Challenge: Develop an Appropriate Care Model

Lisa Hayes, Manager, Disability & Seniors and Persons with Disabilities.

Discussion about some of the challenges identified thus far. Molina has an internal Lanterman integration team actively working to ensure needs will be met. Working with IRC and SDRC Lanterman teams to identify homes. Not all placements have been identified. Working w/Regional centers also regarding provider network.

Lanterman population: Dual Eligible

- **Many with Primary Psych Diagnosis**
- **Aggressive/Combative**

- **Self Injurious**

- **Multiple Chronic Conditions**

  - UTI's
  - Blind, Blind/Deaf
  - Non-Ambulatory

60% have Lived in Lanterman for over 30 years.

Physician a, Network, RX Needs/ Concerns

1. Mobile Physicians
   - Primary Care
   - PT/OT
   - Other Ancillary
2. Specialists
   - Experience working with DD
   - Flexible Appointment Schedule & Time
3. Formularies: Keeping members on existing RX where possible
4. Covering Adult Brief
5. Dental

Updates will be shared in the next meeting on progress

IX. Medicare Priorities in 2012
Brett Hubbard, Director, Medicare Regional Sales:
Brett Hubbard gave a brief overview of the history of Molina Medicare Program.

Molina Options Plus is Available in the following counties:

- Los Angeles
- Sacramento
- San Diego
- Riverside
- San Bernardino

The following are the eligibility requirements to join the Molina Options, and Option Plus plans.

- Molina Option Plus Must BE FULL Medicare and Medicaid. Partial Medicare/Medicaid is not allowed on plan
- Must be entitled and enrolled in Medicare Part A and Medicare Part B Plan
- Must live in the plan's service network area.

- Must not have End Stage Renal Disease (ESRD).
- ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.
- Must use providers, pharmacy and services within the Molina Network.

SNP Dual Eligibles

- SNP's for dual eligibles are different from other MA plans.
- Plans cannot assume members can/will pay premiums or cost-sharing
- Different enrollment rules:
- Auto-enrollment
- Lock-in does not apply to dual eligibles
- Plans need to understand Medicaid rules and social dynamics
- Much of the "dual eligible" population has some form of disability:
- Mental Health– 59% have a mental/psychiatric disorder
- Frail Elders – 41% have three or more ADL restrictions or are unable to walk without assistance

X. Outreach Priorities in 2012

Liz Helms, CA Chr.Care Coalition:

Liz Helms gave a brief overview of the activities going on with the California Care Coalition. The following items were presented:

- **Involved with many pilots in the works.**
- **San Diego County huge target for Heart Attack (Free Zone)**
- **Sacramento Innovation Channeling working on looking for partners.**
- **All activities are highly targeting the SPD population.**
- **Opportunities for Molina and CA Care Coalition to participate in these events together.**

Ruthy Argumedo, Director of Community Outreach-MHC:

Ruthy shared the upcoming events Molina will be participating in 2012. Review of services and benefits to members.

- **Molina is closely working with the Medicare Team and meeting with IHSS.**
- **Molina would like to initiate trainings, hand out materials to community based programs to let them know about Molina and what we offer.**
- **Molina Healthcare /Health Fair June 2012. Molina will host a San Bernardino County Health Fair and have a free health clinic day.**
- **All county agencies will be available including pediatrics, acupuncture, pharmacy.**

- **Ruthy commented on Community Calendar link where Molina and other agencies communicate to the community of all events on a monthly basis.**

Anne Cohen suggested that Molina have a wheel chair repair clinic at the upcoming health fair in San Bernardino that Molina is hosting. Ruthy commented that Molina can definitely look into having a wheelchair repair clinic. Anne also suggested having a relay box and handouts with frequently asked questions regarding Molina benefits.

Sal Pineda stated that Glad has a sister agency and he will pass on the information to Ruthy regarding the relay box.
Ruthy will send out the link to the Community Calendar to all committee members.

Sal will send information to Ruthy regarding sister agency for assistance with the relay box.

Adjournment
There being no further business, the meeting was adjourned at 2:30 p.m.

The next meeting will be held on 5/22/12.
__Signature on file_____
Richard Bock, M.D., CMO

_____
Alma Sandoval, Minutes recorder

MQR-12 Stakeholder Involvement Narrative - Sacramento

In 2009, Molina established the Bridge2Access (B2A) Advisory Committee to provide a forum for structured input on operations and services the plan provides to its growing population of seniors and people with disabilities. The Bridge2Access Advisory Committee includes plan members who are dual eligible beneficiaries and SPDs, advocates and other stakeholders from several disability and senior organizations, including but not limited to Independent Living Centers, Regional Centers, Aging & Adult Services, as well as organizations that serve dual eligible beneficiaries, deaf/ hard of hearing and blind/low vision. The committee currently meets biannually with the objectives of:

- Advising plan leadership on developing innovative and unique programs to address the needs of people facing barriers when accessing healthcare; and
- Serving as a key forum for reviewing Molina's existing programs and services in order to provide feedback and recommendations for improvement.

The Bridge2Access Committee includes individuals from every county that Molina serves, SPDs and dual eligible members, and community organizations that are familiar with the disabilities and chronic conditions of Molina's dual eligible members. The B2A Committee reviews Molina's existing programs and services, providing feedback and recommendations for improvement. As a key forum for topics of concern to Molina's dual eligible and SPD members, the B2A Committee will serve in an advisory capacity to monitor Molina's care coordination partnerships and its progress toward integrating LTSS for dual eligible members.

Molina discussed our interest in participating in the Dual Integration Pilots at the December 8, 2011 Bridge2Access committee meeting. (See Attachment MQR12 B2A Agenda and Minutes).

The plan pursued feedback and B2A Committee members responded with the following recommendations:

- Consider how home and community based services be expanded if plans are given risk for these services;
- Survey consumers, public authorities, IHSS, about the needs that exist beyond what they currently have;
- Telephonic assessments and interaction may not be appropriate for these beneficiaries;
- Emphasis on preventative care; beneficiaries need to have access to services that are historically inaccessible (exam tables, radiology, mammography, etc);
- Provide accessible wellness programs.

All of the committee's recommendations have been addressed in the development of this Application. We have consulted with Public Authorities and IHSS to better understand the programs as they exist now and to get an idea of how they would like to see them change. We are moving forward with a pilot program that focuses on accessible health and wellness, and are in the process of redesigning our care management program to include more face time with our members.

Logo: Area 4 Agency on Aging
February 16, 2012
Toby Douglas, Director
Department of Healthcare Services
1501 Capitol Avenue MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413
Dear Mr. Douglas:

I am writing on behalf of the Area 4 Agency on Aging (A4AA) to express our interest in participating with Molina Healthcare of California (Molina) as a partner in ensuring access to quality healthcare services. The mission of A4AA is to provide leadership on issues which affect the quality of life for all older persons, and to promote citizen involvement in the planning and delivery of programs and services necessary to ensure maximum independence and dignity for older individuals and functionally impaired adults.

A4AA was designated by the State in 1973 to administer the Older Americans Act for Older Californians residing in our seven-county area. A4AA develops, coordinates, funds and monitors services that help persons 60 years of age and lder maintain their health and independence. We help government and community-based organizations implement successful programs. A4AA is governed y a 17-member board comprised of members of the boards of Supervisors or their appointees from our seven-county area.

Molina has indicated to us that they intend to submit a Request for Solutions application for Sacramento County to be considered as one of the selected pilot program sites in the States Dual Eligibles Demonstration Project. We are interested in working with Molina to ensure that dual eligible beneficiaries in Sacramento County receive seamless access to quality care under the Dual Eigibles Demonstration Project. To this end, we encourage the State to include their plan in its dual integration efforts, including the Dual Eligibles Demonstration Project.

Thank you for your time and consideration of our letter of interest on behalf of Molina Healthcare of California.

Sincerely,
(signature of)
Deanna Lea
Executive Director
Area 4 Agency on Aging

Cc: Lisa Rubino, Plan President
Molina Healthcare of California

Serving Nevada, Placer, Sacramento, Sierra, Sutter, Yolo & Yuba Counties

2260 Park Towne Circle Suite 100/Sacramento, CA 95825/Ph 916 486 1876/fax 916 486 9454
web www.a4aa.com

Logo: Alta California, Regional Center
February 15, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413
Dear Mr. Douglas:
I am writing on behalf of Alta Regional Center (ACRC) to express our support for Molina Healthcare of California as a committed partner in ensuring access to quality healthcare services. ACRC assists persons with developmental disabilities. It is our mission to create partnerships to support individuals with intellectual and developmental disabilities, children at risk, and their families in choosing services and supports through individual lifelong planning as a means to achieve healthy and productive lives in their own communities.
ACRC has developed a collaborative and productive working partnership with Molina Healthcare in helping provide for the healthcare needs of disabled and aged populations who traditionally face challenges in receiving access to quality care. We work with Carmie Avila, Nurse Case Manager and Alta Regional Center liaison and Lisa Hayes, Director of Disability and Senior Access Services, on a regular basis, in addition to other plan staff.
We have had many positive experiences working with Molina Healthcare. This includes receiving positive feedback from our staff and the beneficiaries we serve about the services provided by Molina Healthcare. Molina Healthcare has indicated that the plan is interested in serving the dual eligible population (i.e. those persons eligible for Medi-Cal and Medicare covered services) through the State's Dual Eligibles Demonstration Project. We believe that Molina Healthcare is a good partner to work with and will capably serve the needs of dual eligible beneficiaries.
We agree to work together with Molina Healthcare to ensure that dual eligible beneficiaries receive seamless access to quality care under the Dual Eligibles Demonstration Project. To this end, we support Molina Healthcare's efforts to participate in the Dual Eligibles Demonstration Project and encourage the State to include the plan in its dual integration efforts, including the Dual Eligibles Demonstration Project.

Thank you for your time and consideration of our recommendation for Molina Healthcare of California.
Sincerely,
(signature of Phil Bonnet)
Phil Bonnet, Executive Director
Alta California Regional Center

cc: Lisa Rubino, Plan President
Molina Healthcare of California

www.alz.org/californiasouthland
California Southland Chapter
760328-767p
7603282747f
Coachella Valley Regional Office
69730 Highway 111, Ste 202
Rancho Mirage, CA 92270
Alzheimer's (logo) Association

January 30, 2012

To Whom It May Concern:

I am writing on behalf of Alzheimer's Association, California Southland Chapter, Coachella Valley Service Center to express our support for Molina Healthcare. Our organization serves/does the following: provide information and referrals as well as support groups for individual and families experiencing Alzheimer's disease; meets with families at the Eisenhower Medical Center Memory Assessment Center; networks with culturally diverse communities to counsel individuals and families; and advocates for Alzheimer's disease research and public awareness.

We work with Jacqueline Portillo at Molina Healthcare on a regular basis. We have had positive experiences working with Molina such as the Molina Healthcare's representative, Ms. Portillo's dedicated and continuing service on our Latino Outreach Network. In addition, Molina Healthcare and the Alzheimer's Association have partnered on several local health fairs.

Molina has indicated that they are interested in serving the dual eligible population through the state's pilot programs. We believe that Molina is a good partner to work with and will serve the needs of the duals. We support their efforts and encourage the state to consider Molina in its short- and long-term dual integration efforts.

Thank you.

Sincerely,

Signature of Stephen M. Harmon, LMFT

Stephen M. Harmon, LMFT
Regional Director
Coachella Valley Service Center

Cc: Lisa Rubino, Molina Healthcare of California

Easter Seals Logo: Postage stamp with Easter-Lily. Easter Seals Disability Services written in lower part of stamp.
Ronald H. Melchin, Chairman
Gary T. Kasai, President and CEO
David Ramos, MD FAAEM, Medical Director

Easter Seals Superior California Corporate Office
3205 Hurley Way. Sacramento, CA 95864-3898. 916 485 6711 Ph. 916 485 2653 fax.
www.myeasterseals.org

February 14, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Douglas:
I am writing on behalf of Easter Seals Superior in Sacramento to express our support for Molina Healthcare of California as a committed partner in ensuring access to quality healthcare services. Easter Seals Superior is dedicated to empowering people with disabilities by offering a wide range of service and leadership opportunities designed to encourage maximum independence.
Easter Seals Superior Sacramento has developed a collaborative and productive working partnership with Molina Healthcare in helping provide for the healthcare needs of disabled and aged populations who traditionally face challenges in receiving access to quality care. We work with Lisa Hayes, Director of Disability and Senior Access Services, Sindy Ausmer, Sacramento Territory Manager in addition to other plan staff.
We have had many positive experiences working with Molina Healthcare. This includes receiving positive feedback from our staff and the beneficiaries we serve about the services provided by Molina Healthcare. Molina Healthcare has indicated that the plan is interested in serving the dual eligible population (i.e. those persons eligible for Medi-Cal and Medicare covered services) through the State's Dual Eligibles Demonstration Project. We believe that Molina Healthcare is a good

partner to work with and will capably serve the needs of dual eligible beneficiaries.
We agree to work together with Molina Healthcare to ensure that dual eligible beneficiaries receive seamless access to quality care under the Dual Eligibles Demonstration Project. To this end, we support Molina Healthcare's efforts to participate in the Dual Eligibles Demonstration Project and encourage the State to include the plan in its dual integration efforts, including the Dual Eligibles Demonstration Project.
Thank you for your time and consideration of our recommendation for Molina Healthcare of California.

Sincerely,
(signature of Gary Novak)

Gary A. Novak
Vice President of Marketing and Development
Easter Seals Superior California
2629 Alta Arden
Sacramento, CA 95825

cc: Lisa Rubino, Plan President
Molina Healthcare of California

Logo. Western University
Harris Family Center for Disability and Health Policy

February 18, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Douglas:

I am writing on behalf of the Harris Family Center for Disability and Health Policy HFCDHP at Western University, I would like to express our support for Molina Healthcare of California as a committed partner in ensuring access to quality healthcare services.

HFCEHP's goals include development of health policies and practices which increase access for seniors and individuals with disabilities.

Harris Family Center for Disability and Health Policy has developed a collaborative and productive working partnership with Molina Healthcare in helping provide for the healthcare needs of disabled and aged populations who traditionally face challenges in receiving access to quality care. We work with Lisa Rubino, Plan President, Andrew Whitelock, AVP Government contracts and Lisa Hayes, Director of Disability and Senior Access Services, in addition to other plan staff.

Molina has focused on increasing access for seniors and people with disabilities in their clinics and contracted networks. Molina has created a Director level position staffed by Lisa Hayes to focus on issues for seniors and people with disabilities in California.

Molina Healthcare has indicated that the plan is interested in serving the dual eligible population (i.e. those persons eligible for Medi-Cal and Medicare covered services) through the State's Dual Eligibles Demonstration Project. We believe that Molina Healthcare is a good partner to work with and will capably serve the needs of dual eligible beneficiaries.

Logo. Western University
Harris Family Center for Disability and Health Policy

We agree to work together with Molina Healthcare to ensure that dual eligible beneficiaries receive seamless access to quality care under the Dual Eligibles Demonstration Project. To this end, we support Molina Healthcare's efforts to participate in the Dual Eligibles Demonstration Project and encourage the State to include the plan in its dual integration efforts, including the Dual Eligibles Demonstration Project.

Thank you for your time and consideration of our recommendation for Molina Healthcare of California.

Sincerely,
Signature of Brenda Premo

Brenda Premo, Director
Harris Family Center for Disability and Health Policy
Western University

cc: Lisa Rubino, Plan President
Molina Healthcare of California

February 18, 2012
Toby Douglas
Director, Department of Healthcare Services
1501 Capitol Ave. MS0000
PO Box 997413
Sacramento, CA 95899-7413
RE: California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

Partners in Care Foundation enthusiastically supports Molina Healthcare in their bid to develop new managed care systems to serve California's Medicare/Medi-Cal Duals population. Molina Healthcare was founded on the belief that the most vulnerable among us deserve the same quality care as those most able to pay. The Molina family and Molina Healthcare have demonstrated an enduring commitment to that belief and the organization is well-positioned to serve the dual-eligible population. Their expertise with low-income populations is long-standing, their skills with diverse and complex populations are highly-regarded, and their scale and ability to build innovative and cost-effective quality care in many geographic locations is legend.
Partners in Care Foundation is a community-based non-profit dedicated to testing new models of care for at-risk populations by engaging them with culturally, linguistically and clinically competent care through patient activation and sustainable models. We also provide care management targeting the often missed or neglected social and environmental determinants of health. Partners was founded in 1998 and provides services throughout Southern California and nationally.

We are currently working with Molina providing care transition and care management services for Duals who are adult day health care participants transitioning into managed care. Partners has long enjoyed a strong and mutually beneficial working relationship with Molina Healthcare who participated on our regional Blue Ribbon panel in 2008 and 2009 that proposed and advocated for moving Medi-Cal and Dual participants into managed care in California. Beyond excellence as care providers, their organization is an active advocate for policies

that bring sustainable access to quality care for low-income populations. This unique leadership, clinically and in systems change, led us to honor their organization this past year for remarkable long-term leadership and for scaling their vision from one clinic to a multi-state system serving millions.

Molina Healthcare is a consumer-focused health care organization that truly understands the needs of complex patients and is already one of the largest Medi-Medi plans in California. Molina's pioneering work has strengthened health care and improved access to care for many who face cultural and linguistic barriers in the past. A partner in Care believes that Molina Healthcare would be an obvious choice to build optimum new managed care systems in the demonstration of models of care for these individuals.

We are confident that Molina Healthcare can provide unparalleled service to California's dual-eligibles and manage their care with dignity and quality care. Partners in Care supports Molina Healthcare and looks forward to our continued partnership and commitment to the populations we both serve.

Sincerely,
Signature of W. June Simmons
W. June Simmons, President & CEO
Partners in Care Foundation
Cc: Lisa Rubino, Plan President
Molina Healthcare of California

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W. June Simmons, President/Chief Executive Officer Partners in Care Foundation

ULTCW SEIU (LOGO)
United Long Term Care Workers

February 7, 2012
Lisa Rubino, President
Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802
Re: Support for California's Dual Eligible Demonstration Project Application

Dear Lisa:

On behalf of SEIU California and its locals ULTCW and UHW, I would like to express our organizations' support for Molina's application to the Department of Health Care Services to participate in the Dual Eligible demonstration in the five counties in which Molina currently operates: Los Angeles, Riverside, San Bernardino, Sacramento and San Diego. We are committed to working with you to improve delivery of care to California's most vulnerable and chronically ill beneficiaries, specifically through our shared collaboration with the In-Home Supportive Services program benefit.

SEIU believes that IHSS consumers can plan an important role in care coordination as well as enhancing consumer satisfaction with the managed care plan. The proximity and consistency of the IHSS provider to the beneficiary allows them to recognize behavior or health changes that may have significant effects to their heath and ability to live independently in the least restrictive setting possible.

We appreciate Molina's recognition of this role and look forward to working with you in a collaborative manner to include IHSS provider in the care process as well as to provide additional training opportunities to improve the quality of care delivered to the beneficiary.
Sincerely,
Signature of
Laphonza Butler
President, SEIU, ULTCW

Signature of
Dave Regan
President, SEIU, UHW

Locations:
Los Angeles/Ventura. 2515 Beverly Blvd., Los Angeles, CA 90057
San Bernardino. 195 N. Arrowhead Ave. San Bernardino CA 92408
Watsonville. 10 Alexander St, Watsonville, CA 95076
Sacramento, 1127 11th St. Suite 523. Sacramento CA 95814
Oakland. 440 Grand Ave., Suite 250. Oakland, CA 94610
Salinas. 334 Monterey Street, Salinas CA 93901
Member Action Center. 877-My ULTCW; 877 698 5829 www.seiu-ultcw.org

MOLINA HEALTHCARE

Three Year Trending & Benchmark Analysis

Molina Healthcare of California

Sacramento -- Medicaid	HEDIS Reporting Year 2009	2010	2011	Rate Change 2009 to 2011	2010 to 2011	NCQA Medicaid Benchmarks -- 2010 50th	75th	90th	Molina Ranking
Childhood Immunization Status									
Combination 3	63.66%	61.11%	54.31%	-9.35%	-6.80%	71.00%	76.60%	82.00%	
Imms for Adolescents									
Combination 1 Immunizations	NA	45.45%	46.64%	NA	1.19%	42.40%	53.90%	65.90%	Above 50th
Well Child Care: First 15 Months									
Six or more visits	60.44%	49.58%	44.28%	-16.16%	-5.30%	60.10%	69.70%	76.30%	
Well Child Care: Years 3 to 6	75.93%	79.63%	73.49%	-2.44%	-6.14%	71.80%	77.30%	82.50%	Above 50th
Well Child Care: Adolescent	51.62%	52.31%	35.81%	-15.81%	-16.50%	46.80%	56.00%	63.20%	
URI Treatment	95.82%	94.23%	94.42%	-1.40%	0.19%	85.80%	90.60%	94.90%	Above 75th
Breast Cancer Screening	40.94%	48.73%	50.28%	9.34%	1.55%	52.00%	59.60%	63.80%	
Cervical Cancer Screening	65.57%	67.29%	60.14%	-5.43%	-7.15%	67.80%	72.90%	78.90%	
Prenatal/Postpartum Care									
Timeliness of prenatal care	77.99%	84.84%	73.27%	-4.72%	-11.57%	86.00%	90.00%	92.70%	
Postpartum care	51.91%	53.17%	49.44%	-2.47%	-3.73%	65.50%	70.30%	74.40%	
Comprehensive Diabetes Care									
HbA1c Testing	78.55%	78.37%	79.34%	0.79%	0.97%	81.10%	86.40%	90.20%	
HbA1c Control	NA	58.78%	45.77%	NA	-13.01%	46.6%	54.2%	58.8%	
HbA1c Poor Control	44.89%	41.22%	41.78%	-3.11%	0.56%	53.40%	43.20%	33.80%	Above 75th
Eye Exam	61.35%	48.85%	48.83%	-12.52%	-0.02%	54.00%	63.70%	70.10%	
LDL-C Screening	68.58%	74.05%	69.48%	0.90%	-4.57%	75.40%	80.10%	84.00%	
LDL Less than 100	37.66%	33.84%	36.15%	-1.51%	2.31%	33.60%	40.90%	45.50%	Above 50th
Monitoring for Nephropathy	79.55%	79.90%	77.00%	-2.55%	-2.90%	77.70%	82.70%	86.20%	
BP<140/90	NA	NA	59.62%	NA	NA	61.6%	68.2%	73.4%	
Avoid Abx Bronchitis	NA	29.46%	27.19%	NA	-2.27%	23.5%	27.0%	35.9%	Above 75th
Use Imaging Low Back	NA	87.26%	78.95%	NA	-8.31%	76.20%	79.80%	84.10%	Above 50th
Weight Assessment and Counseling for Nutrition and Physical									
BMI Screening - Total	NA	63.75%	61.95%	NA	-1.80%	29.3%	45.2%	63.0%	Above 75th
Counseling on Nutrition - Total	NA	70.32%	62.65%	NA	-7.67%	46.2%	57.7%	67.9%	Above 75th
Counseling on Physical Activity - Total	NA	59.61%	55.68%	NA	-3.93%	35.3%	45.5%	56.7%	Above 75th

Molina Healthcare of California
Sacramento -- Medicaid

HEDIS 2011
Executive Fact Sheet

Three-year Trend Analysis

HEDIS 2009 versus HEDIS 2011
- Improved performance on 27 of 55 selected measures from 2009 to 2011 (49.091%)
- Average improvement of 7.182 percentage points from 2009 to 2011 -- simple average for all reported measures

HEDIS 2010 versus HEDIS 2011
- Improved performance on 28 of 55 selected measures from 2010 to 2011 (50.909%)
- Average improvement of 4.133 percentage points from 2010 to 2011 -- simple average for all reported measures

National Benchmark Comparison
- Exceeded 75th percentile for 22 of 78 selected measures
- Of these, 14 exceeded the 90th percentile
- Obtained or exceeded the Molina goal of the 75th percentile for 28% of reported measures

Note: Submeasures that are discretely independant are counted as seperate measures in summary statistics/statements.
For example: Each individual antigen within Childhood Immunization Status counts as one measure.