Performance Evaluation Report

Molina Healthcare of California Partner Plan, Inc.

July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
Health Care Services

November 2010

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1. Executive Summary

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.4 million beneficiaries in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to *domains of care*. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008—June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. The plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains. This report is specific to the MCMC Program's contracted plan, Molina Healthcare of California Partner Plan, Inc. ("Molina" or "the plan"), which delivers care in Riverside, San Bernardino, Sacramento, and San Diego counties.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses performance measures and QIP results to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, the DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPL indicate low performance, rates at or above the HPL indicate high performance, and rates at the MPL or between the MPL and HPL demonstrate average performance.

Molina reports rates for its plan in Riverside and San Bernardino counties as one combined rate when reporting performance measures, which is consistent with DHCS contract requirements for plans operating in Riverside and San Bernardino counties.

Overall, Molina demonstrated average performance for its plans in San Diego and Sacramento counties and below-average performance for its plan in Riverside/San Bernardino counties for the quality domain of care. HSAG based this on Molina's 2009 performance measure rates (which reflect 2008 measurement data), its QIP outcomes, and compliance review standards related to measurement and improvement.

Molina's plan in Sacramento County had performance measure rates above the MPL for all but two measures and had one measure exceed the HPL. The Sacramento County plan remained stable compared to 2008 performance with only one statistically significant increase and no statistically significant decreases.

Molina in San Diego County had performance measure rates at or above the MCMC-established MPL for all but one measure and had three measures exceed the HPL. Molina–San Diego had mostly stable and improved performance with four statistically significant increases and two statistically significant decreases.

In Riverside/San Bernardino counties, Molina's poor 2008 performance declined further in 2009, with six statistically significant declines and only one statistically significant improvement. Further, 7 of the 17 performance measures reported by Molina in Riverside/San Bernardino counties in 2009 were below the MPL.

Despite the initiation of improvement plans for performance measures with low rates, the plan has had little success with improving its rates for postpartum care, avoidance of antibiotics for acute bronchitis, and appropriate medication management for people with asthma. The plan needs to modify or explore new efforts to improve rates instead of repeating ongoing interventions if they have not been effective.

Molina demonstrated strength on the *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* performance measure. All of Molina's plans showed statistically significant improvement over their 2008 rates for this measure. In addition, the plan had strong performance with *Adolescent Well-Care Visits (AWC)* across its counties.

Molina performed best in San Diego County, followed by its results in Sacramento and Riverside/San Bernardino counties.

Molina showed improvement in all counties for its *Appropriate Treatment for Children With Upper Respiratory Infection* QIP during its first remeasurement period. Molina had statistically significant improvement in its plans in Riverside/San Bernardino and San Diego counties. While demonstrating potential for further success, the plan has an opportunity to improve its documentation of both the URI QIP and the ER collaborative QIP to meet compliance with federal requirements for conducting a QIP.

Overall, the DHCS found Molina compliant with review standards related to administrative and organizational capacity. Molina has a quality improvement program that monitors, evaluates, and addresses opportunities for improvement. DHCS audit findings showed that the plan had adequate resources and operational structure to comply with State and federal requirements.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Molina demonstrated average performance for its plans in Sacramento and San Diego counties and below-average performance in Riverside/San Bernardino counties for the access domain of care based on its 2009 performance measure rates that relate to access and compliance review standards.

In San Diego County, all of Molina's access-related performance measures were above the MPL in 2009, with both well-child visits measures exceeding the HPL. In Sacramento County, Molina's rates ranged from below the MPL (breast cancer screening and postpartum care) to above the HPL. In Riverside/San Bernardino counties, Molina had four of its access-related performance measures below the MPL for breast cancer screening, diabetes care, postpartum care, and well-child visits.

Across all of Molina's plans, its strength was in providing adolescent well-care. All of Molina's rates for that measure were above the MCMC average in 2009. Additionally, out of 38 MCMC county-specific reporting units in 2009, Molina in San Diego County shared the highest rate with another MCMC plan, followed by Molina in Riverside/San Bernardino counties, which ranked third, and Molina in Sacramento County, which ranked seventh.[1]

The plan has an opportunity to improve breast cancer screening and postpartum care performance measure rates in every county.

Based on access-related standards audited by the DHCS, Molina demonstrated strength in monitoring access to care and services through review of geographic access reports of its provider network, monitoring of appointment wait times, and review of member grievances related to access and availability.

Audit findings revealed that Molina has an opportunity to improve coordination of care for members eligible for early intervention services and for individuals with developmental disabilities. In addition, 50 percent of Molina's provider offices reviewed indicated that they had not received training specific to cultural diversity and Medi-Cal managed care.

[1] California Department of Health Care Services. *2009 HEDIS Aggregate Report.*

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on the clinical urgency of the situation, minimize any disruptions to care, and provide a health care service quickly after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess a plan's compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

Based on 2009 performance measure rates for providing timely care and compliance review standards related to timeliness, Molina demonstrated above-average performance in the timeliness domain of care in San Diego County, average performance in Sacramento County, and below-average performance in Riverside/San Bernardino counties.

Molina's plan in San Diego County had all 2009 access-related performance measures above the MPL, exceeding the HPL for both well-child visits measures and demonstrating above-average performance for childhood immunizations, adolescent well care, and prenatal care. In Sacramento County, Molina had all access-related performance measures above the MPL, except for postpartum care. In Riverside/San Bernardino counties, Molina performed below the MPL for *Well-Child Visits in the First 15 Months of* Life *(W15)* and *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*.

Across counties Molina performed best on the *Adolescent Well-Care Visits (AWC)* measure and on *Childhood Immunization Status—Combination 3 (CIS–3)*.

The plan has an opportunity to improve postpartum care performance measure rates across counties.

Audit findings related to timeliness of care showed that Molina provided timely utilization management decisions. The review revealed that the plan handled and resolved member grievances in a timely manner. The plan had adequate procedures in place to provide routine, urgent, and emergency services to its members.

The plan has an opportunity to ensure that its provider offices report grievance information to the plan for grievance tracking. The plan also should include a specific citation supporting the action taken by the plan within its prior-authorization notifications.

Conclusions and Recommendations

Overall, Molina demonstrated mixed performance in providing quality, timely, and accessible health care services to its MCMC members.

Molina's plans in San Diego and Sacramento counties demonstrated average and, in some cases, above-average performance in providing care to members. Across counties, Molina demonstrated improvement in providing appropriate treatment to children with a URI during the first remeasurement period of its QIP.

Molina performance in Riverside/San Bernardino counties in 2009 remained below average and showed further decline from 2008.

Based on available compliance review information, the plan demonstrated compliance with most MCMC standards for enrollee rights and protections, structure and operations, and access and availability. Molina's opportunities related to policies and procedures for tracking of all member grievances, coordination of care for early intervention services and for developmentally disabled members, providing cultural diversity training to contracted providers, and including specific citations within its prior-authorization notifications.

Based on the overall assessment of Molina in the areas of quality, access, and timeliness of care, HSAG recommends the following:

- Explore implementing alternative strategies to increase performance measure rates for postpartum care, avoidance of antibiotics for acute bronchitis, and appropriate medication for people with asthma since the plan has not had success with its existing and ongoing interventions.
- Analyze areas of high performance, such as adolescent well-care visits and appropriate treatment for URI, to determine if modified intervention strategies can be applied to areas of low performance.
- Increase quality improvement resources for Molina's plan in Riverside/San Bernardino counties until performance trends upwards.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance for increasing compliance with the Centers for Medicare & Medicaid Services (CMS) protocol for conducting QIPs.
- Address deficient areas related to audit findings for grievances, coordination of care, prior-authorization notifications, and cultural diversity.

In the next annual review, HSAG will evaluate Molina's progress with these recommendations along with its continued successes.

Plan Overview

Molina Healthcare of California Partner Plan, Inc. is a full-scope Medi-Cal managed care plan operating in four counties—Riverside, San Bernardino, Sacramento, and San Diego. Molina began contracting with the MCMC Program in Riverside and San Bernardino counties in 1998 and then expanded into Sacramento County in 2000 and San Diego County in 2005. As of June 30, 2009, Molina had 166,798 enrolled members under the MCMC Program for all of its contracted counties combined.[2]

Molina delivers care to members as a Two-Plan model commercial plan in Riverside and San Bernardino counties and as a Geographic Managed Care (GMC) model commercial plan in Sacramento and San Diego counties.

In a Two-Plan model county, the DHCS contracts with two managed care plans to provide health care services to members. Most Two-Plan model counties offer Medi-Cal beneficiaries in both mandatory and voluntary aid codes the choice between a local initiative plan and a nongovernmental commercial health plan. In the GMC model, Medi-Cal beneficiaries in both mandatory and voluntary aid codes choose between several commercial plans within a specified county.

[2] *Medi-Cal Managed Care Enrollment Report, June 2009*, http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about Molina's performance in providing quality, accessible, and timely health care services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

The DHCS's Audits and Investigations (A&I) Division works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, the DHCS's A&I Division periodically conducts non-joint medical audits of five MCMC plans; however, Molina is not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards.

The joint audit review scheduled for Molina in December 2008 did not occur; therefore, HSAG reviewed findings from the audit conducted in December 2005, covering the review period of December 1, 2004, through November 30, 2005.[3] The scope of the audit covered six categories of performance: utilization management, continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity.

Under the utilization management category, the audit findings showed that Molina provided timely utilization management decisions on prior authorizations and had appeal procedures in place that the plan followed with timely resolution. Molina demonstrated processes to monitor under- and overutilization. One area was identified for corrective action: Molina's prior-authorization denial notification letters did not include "Aid Paid Pending" language regarding continuation of service until a State fair hearing decision is made. The audit report noted that the plan corrected this.

For continuity of care, Molina was compliant with standards related to coordinating care for members receiving services from out-of-plan providers, unusual specialty services, and the carved-out services provided through the California Children's Services (CCS) program. Molina uses its case managers to assist in coordination of care. The audit identified two areas for corrective actions related to identifying and coordinating care for members eligible for early intervention services and for individuals with developmental disabilities. Both areas were repeat findings from the March 2003 medical audit. Molina provided a corrective action plan to address these findings.

Molina demonstrated adequate procedures in place to provide routine, urgent, and emergency services. The plan monitors provider appointment wait times and reviews member complaints and grievances related to access and availability issues. Molina monitors its provider network using geographic access software, access reports, and member grievances. The audit report noted the following findings for Molina under availability and accessibility:

- The plan did not have a process in place to ensure that emergency service claims submitted to the plan, instead of the delegated entities, were paid in a timely manner.
- The plan lacked provider office standards for wait times to answer and return member telephone calls.
- The plan did not ensure that members have a sufficient amount of medication in emergency circumstances to last until a member can reasonably be expected to have a prescription filled.

Overall, Molina was compliant with standards in the member rights category. The plan demonstrated that it handled and resolved member grievances in a timely manner and with the appropriate member notification of rights. The plan also was compliant with all aspects of cultural and linguistic requirements and member confidentiality. The audit showed one finding in which

[3] California Department of Health Services, *Audits and Investigations Medical Review*. Report issued May 2, 2006. Accessed at http://www.dmhc.ca.gov/healthplans/med/med_default.aspx.

Molina lacked a plan officer with primary responsibility for maintenance of the grievance system, which the plan corrected.

The audit found that Molina was fully compliant in the quality management category. Molina has a quality improvement program that monitors, evaluates, and addresses opportunities for improvement.

Molina was compliant with all but one area covered under the administrative and organizational capacity category. The audit report found that the plan had adequate resources and operational structure to comply with State and federal requirements. One finding from the report indicated that Molina had an opportunity to ensure that all newly contracted providers received MCMC program training within 10 working days of becoming active.

Member Rights and Program Integrity Monitoring Review

The Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These reviews are done before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted a review of Molina in September 2007. This review covered the review period of July 1, 2006, through June 30, 2007. The review showed that Molina was fully compliant with marketing requirements; however, the plan had two member grievance findings, one prior-authorization finding, and one cultural and linguistic finding.

Under member grievances, the plan lacked documentation within its policy and procedure to provide oral notice of resolution for an expedited review. In addition, although the plan is responsible for tracking grievance information received by the plan or from any delegated entity, 7 of the 24 provider offices reviewed by MRPIU indicated that they do not report grievance information to the plan. The prior-authorization finding was due to a number of files that did not contain a specific citation supporting the action taken by the plan.

MRPIU's review also noted that staff members at 12 out of 24 provider offices had not received training specific to cultural diversity and Medi-Cal managed care.

Strengths

Joint audit and MRPIU findings showed that Molina was compliant with many areas under the scope of the audit as they related to the quality, access, and timeliness of care.

Molina demonstrated that it made utilization management decisions within appropriate time frames, which helps ensure members receive care after a need is identified and without disruption. The plan ensures access to care and services by conducting routine geographic access reports, monitoring appointment wait times, and reviewing member grievances related to access and availability.

Another strength identified was Molina's compliance with member rights and protections. Molina notified members of their rights and provided timely resolution of member grievances.

Molina has a quality improvement program that monitors, evaluates, and addresses opportunities for improvement.

Opportunities for Improvement

Molina has an opportunity to identify and coordinate care for members eligible for early intervention services and for individuals with development disabilities. Both areas were repeat findings from the March 2003 medical audit. This finding reflects limited access to care and services for these members.

The plan should resolve all outstanding audit and review findings for grievances, coordination of care, prior-authorization notifications, and cultural diversity.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provides a standardized method of objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Molina's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[4] of Molina in 2009, covering the measurement period of January 1, 2008, through December 31, 2008. HSAG found all measures to be reportable and that Molina's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit involved obtaining more complete encounter data from Molina's providers and implementing a process to reconcile pended encounters, both of which would increase data completeness. In addition, Molina should explore mechanisms to capture the rendering provider on claims when a multispecialty group submits them.

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[4] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit™ is a trademark of the NCQA.

Performance Measure Results

Tables 4.1–4.3 present a summary of Molina's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measure results (based on calendar year 2007 data). In addition, the tables show the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs. While the DHCS requires that plans report county-level data, the DHCS provided Molina and the other plan operating in Riverside and San Bernardino counties with an exception to continue to report these counties as one combined rate.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the Medicaid 10th percentile.

Appendix A includes a performance measure name key with abbreviations contained in the following tables.

Table 4.1—2008–2009 Performance Measure Results for Molina–Riverside/San Bernardino Counties

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	25.8%	18.4%	★	↓	20.6%	35.4%
ASM	Q	81.7%	83.8%	★	↔	86.1%	91.9%
AWC	Q,A,T	48.8%	53.9%	★★	↔	35.9%	56.7%
BCS	Q,A	42.7%	44.2%	★	↔	44.4%	61.2%
CCS	Q,A	67.0%	70.3%	★★	↔	56.5%	77.5%
CDC–E	Q,A	58.6%	55.9%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	27.9%	21.4%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	52.5%	56.5%	★	↔	52.5%	32.4%
CDC–HT	Q,A	76.4%	69.8%	★	↓	74.2%	88.8%
CDC–LC (<100)	Q	33.8%	27.4%	★★	↓	25.1%	42.6%
CDC–LS	Q,A	78.0%	70.6%	★★	↓	66.7%	81.8%
CDC–N	Q,A	79.2%	76.7%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	65.0%	67.1%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	84.4%	79.1%	★★	↓	76.6%	91.4%
PPC–Pst	Q,A,T	53.1%	48.5%	★	↔	54.0%	70.6%
URI	Q	78.2%	89.5%	★★	↑	79.6%	94.1%
W15	Q,A,T	49.1%	40.4%	★	↓	44.5%	73.7%
W34	Q,A,T	77.9%	77.8%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] Performance comparisons are based on the z test of statistical significance with a p value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC-H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC-H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC-H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.

Table 4.2—2008–2009 Performance Measure Results for Molina–Sacramento County

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	27.3%	30.3%	★★	↔	20.6%	35.4%
ASM	Q	75.0%	86.7%	★★	↔	86.1%	91.9%
AWC	Q,A,T	53.2%	51.6%	★★	↔	35.9%	56.7%
BCS	Q,A	46.8%	40.9%	★	↔	44.4%	61.2%
CCS	Q,A	66.6%	65.6%	★★	↔	56.5%	77.5%
CDC–E	Q,A	63.5%	61.3%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	27.8%	32.8%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	50.2%	44.9%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	73.3%	78.6%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	34.1%	37.7%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	67.8%	68.6%	★★	↔	66.7%	81.8%
CDC–N	Q,A	76.5%	79.6%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	65.5%	63.7%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	79.8%	78.0%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	53.8%	51.9%	★	↔	54.0%	70.6%
URI	Q	90.0%	95.8%	★★★	↑	79.6%	94.1%
W15	Q,A,T	57.5%	60.4%	★★	↔	44.5%	73.7%
W34	Q,A,T	76.6%	75.9%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC-H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC-H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC-H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.

Table 4.3—2008–2009 Performance Measure Results for Molina–San Diego County

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	29.3%	20.6%	★★	↓	20.6%	35.4%
ASM	Q	79.1%	83.0%	★	↔	86.1%	91.9%
AWC	Q,A,T	46.6%	56.3%	★★	↑	35.9%	56.7%
BCS	Q,A	49.1%	47.4%	★★	↔	44.4%	61.2%
CCS	Q,A	68.5%	70.6%	★★	↔	56.5%	77.5%
CDC–E	Q,A	62.3%	58.1%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	32.8%	32.0%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	47.4%	48.5%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	84.0%	79.3%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	37.5%	33.8%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	78.8%	76.9%	★★	↔	66.7%	81.8%
CDC–N	Q,A	82.1%	79.0%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	66.9%	77.8%	★★	↑	59.9%	78.2%
PPC–Pre	Q,A,T	88.4%	87.4%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	55.2%	62.5%	★★	↑	54.0%	70.6%
URI	Q	90.5%	96.1%	★★★	↑	79.6%	94.1%
W15	Q,A,T	83.4%	76.4%	★★★	↓	44.5%	73.7%
W34	Q,A,T	78.8%	82.4%	★★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.

[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.

[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

[5] Performance comparisons are based on the z test of statistical significance with a p value of <0.05.

[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC-H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC-H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC-H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Molina demonstrated mixed performance across its counties. The plan had average performance for San Diego and Sacramento counties and below-average performance for Riverside/San Bernardino counties.

Molina's plan in Sacramento County showed either stable or improved rates across all performance measures in 2009 compared to 2008. Its Sacramento County rates ranged from below the MPL for two measures to above the HPL for one measure, with all others falling in between.

In San Diego County, Molina had relatively stable performance, with most rates showing no statistically significant change, statistically significant improvement for four rates, and a statistically significant decline in two.

In Riverside/San Bernardino counties, Molina demonstrated a significant decline in performance in 2009 compared to 2008, with 6 of its 17 comparable performance measures showing statistically significant declines in 2009 compared to 2008. Seven of the plan's performance measure scores in Riverside/San Bernardino counties were below the MPL.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPL. Plans that have rates below this minimum level must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

Molina had eight HEDIS improvement plans required for 2008 performance. For 2009 performance, Molina had ten HEDIS improvement plans required.

Asthma Medication Management

All three of Molina's reporting units—Riverside/San Bernardino, Sacramento, and San Diego—required an improvement plan for 2008 performance on *Use of Appropriate Medications for People With Asthma (ASM).*

To improve appropriate use of medications for its members with asthma, Molina continued many existing interventions. The plan added two additional strategies in 2008. The plan partnered with Pacific Coast Pharmacy in the first quarter of 2008 to enhance provider and member outreach, education, and facilitation of asthma refills. In the third quarter of 2008, the plan included

information about the importance of encouraging members with asthma to have annual influenza vaccinations in its "No Inhaled Steroid Use" provider letter.

The plan's rates in all four counties improved in 2009 compared to 2008; however, none reflected a statistically significant increase. Molina's rate in Sacramento County of 86.7 percent met the MPL in 2009 of 86.1 percent. The plan's rates in Riverside/San Bernardino counties and San Diego County did not achieve rates above the MPL for 2009; therefore, improvement plans will continue for these counties.

Although Molina documented its improvement plan well, only one of its added interventions linked to an identified cause/barrier. While encouraging members to receive an influenza vaccination may help reduce the severity and frequency of asthma exacerbations, it is likely to have little to no impact on improving appropriate use of asthma medications.

The plan should consider targeted interventions that directly link to the identified causes/barriers. This may involve the modification of existing interventions or the addition of new ones. In addition, the plan may consider exploring whether there is a provider prescribing barrier or a member compliance barrier to help determine an intervention that would have the greatest impact.

Although the DHCS has eliminated this measure as part of its formal External Accountability Set for 2010, the plan should continue to monitor its performance in this area.

Appropriate Antibiotic Use

Molina in Riverside/San Bernardino counties submitted an improvement plan for its 2008 *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* rate, which was below the MPL. The plan collaborated with the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) and other health plans to develop and disseminate an antibiotic awareness provider tool kit. In addition, Molina along with other MCMC plans involved with the AWARE project formed a small-group collaborative (SGC) and worked on this topic as a formal QIP.

In 2008, the plan mailed providers the names of their patients with a URI diagnosis for whom they may have inappropriately prescribed antibiotics.

The URI rate for Molina's plan in Riverside/San Bernardino counties had a statistically significant increase from 78.2 percent in 2008 to 89.5 percent in 2009, which was well above the 2009 MPL of 79.6 percent. None of Molina's plans required an improvement plan for this measure based on its 2009 performance.

Due to the success of its URI rates, Molina may consider expanding and modifying its interventions to address *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* (AAB). For

this measure, Molina in Riverside/San Bernardino counties had to submit an improvement plan for its 2009 rate of 18.4 percent, which fell from its 2008 rate of 25.8 percent, a statistically significant decrease. In addition, Molina in San Diego County had a statistically significant decrease in its 2009 rate compared to its 2008 rate, from 29.3 percent to 20.6 percent. While Molina does not have to submit an improvement plan for San Diego County for 2009 since its rate equaled the MPL of 20.6 percent, the plan should explore factors that contributed to the statistically significant decrease to avoid a further decline in performance.

Breast Cancer Screening

To improve breast cancer screening rates for its plan in Riverside/San Bernardino counties, Molina targeted both members and providers. Beginning in the first quarter 2008, Molina began outreach calls to members to help them schedule their mammography appointment. The plan conducted data analysis on its prior-year rates and identified that 44.5 percent of members who did not receive a mammogram were Hispanic. The plan began providing bilingual reminders and educational materials to members regarding the importance of mammography. In addition, the plan used its nurse advice line to encourage screening when speaking with members. Molina gave providers a missed services report quarterly and distributed practice guidelines.

While Molina's rate of 44.2 percent in Riverside/San Bernardino counties fell short of the 44.4 percent MPL for 2009, it demonstrated improvement in both 2008 and 2009. The plan will need to continue to monitor its improvement plan and interventions until it achieves the MPL. In addition, the plan will need to implement improvement interventions for Sacramento County since its screening rate fell from 46.8 percent in 2008 to 40.9 percent in 2009, which is now below the MPL. While not a statistically significant decrease, the plan should investigate factors that contributed to the decrease.

Comprehensive Diabetes Care

Based on its 2008 rate of 73.3 percent, Molina in Sacramento County initiated a HEDIS improvement plan to improve hemoglobin A1c (HbA1c) testing among its members with diabetes. In addition to its existing interventions, the plan documented one new intervention in the fourth quarter of 2007, a mixed model of live outreach calls and interactive voice recording messages regarding the need for diabetes care. In 2009, Molina in Sacramento County achieved the MPL of 74.2 percent with a rate of 78.6 percent.

The plan will need to initiate an improvement plan for Riverside/San Bernardino counties for its HbA1c screening rate, which had a statistically significant decrease from 76.4 percent in 2008 to 69.8 percent in 2009. In addition, Molina had to submit a plan for Riverside/San Bernardino counties to reduce the number of members with Hb1Ac test results of greater than 9.0 percent.

Postpartum Care

Molina's plans in Sacramento County and Riverside/San Bernardino counties have struggled to achieve the MPL for postpartum care. Molina had to submit an improvement plan for both service areas in 2008, and since their 2009 rates deteriorated, Molina had to submit a modified improvement plan.

Efforts to improve rates outlined in Molina's improvement plans included member education, member enrollment in the plan's Motherhood Matters Program, member reminders, member incentives, provider faxes to encourage timely follow-up, and provider education. Most interventions included those already in effect.

Since the plan has not had success with increasing postpartum care rates in either county with the existing and ongoing interventions, the plans should explore implementing alternative strategies.

HSAG has noted sustained improvement of postpartum care in QIPs that implemented interventions such as bus tokens or taxi vouchers for transportation, a database for tracking patients who missed postpartum visits and contacting members, and inclusion of a postpartum appointment as part of the hospital discharge plan.

Well-Visits for Children and Adolescents

Molina in Riverside/San Bernardino counties had a HEDIS 2009 rate below the MPL for *Well-Child Visits in the First 15 Months of Life (W15)*. The plan will need to initiate an improvement plan to address the decline in performance since all of Molina's counties met the MPL in 2008.

Strengths

Overall, Molina showed stable and improved rates in San Diego and Sacramento counties in 2009 compared to 2008. The plan in San Diego and Sacramento counties performed at or above the MPL for all but one performance measure in 2009. Molina demonstrated strong performance in providing *Appropriate Treatment for Children With Upper Respiratory Infection* (URI) across its service areas. Molina's rates in Sacramento, San Diego, and Riverside/San Bernardino counties showed statistically significant improvement in 2009 over its 2008 rates, with the plans in San Diego and Sacramento counties achieving the HPL. The plan also had strong performance across its counties for *Adolescent Well-Care Visits (AWC),* with all rates well above the MCMC weighted average of 43.1 percent.[5]

[5] California Department of Health Care Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program* (June 2010).

Molina exceeded the HPL for:

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*—Sacramento and San Diego counties
- *Well Child Visits in the First 15 Months of Life (W15)*—San Diego County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*—San Diego County

Molina's plan in San Diego County performed best compared to Sacramento and Riverside/San Bernardino counties, with three of its rates above the HPL.

Opportunities for Improvement

Areas that required additional focus included postpartum follow-up, appropriate treatment for asthma and acute bronchitis, and breast cancer screening.

Molina's 2009 performance was below the MCMC-established MPL in the follow areas:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)*—Riverside/San Bernardino counties
- *Appropriate Medications for People With Asthma (ASM)*—Riverside/San Bernardino and San Diego counties
- *Breast Cancer Screening (BCS)*—Riverside/San Bernardino and Sacramento counties
- *Comprehensive Diabetes Care—HbA1c Poor Control (CDC–H9)*—Riverside/San Bernardino counties
- *Comprehensive Diabetes Care—HbA1c Testing (CDC–HT)*—Riverside/San Bernardino counties
- *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*—Riverside/San Bernardino and Sacramento counties
- *Well-Child Visits in the First 15 Months of Life (W15)*—Riverside/San Bernardino counties

Molina's plan in Riverside/San Bernardino counties showed the greatest opportunity for improvement as 7 of 17 performance measures in 2009 were below the MPL and required an improvement plan. In addition, the plan in Riverside/San Bernardino counties had six measures with statistically significant declines and only one with statistically significant improvement.

Despite the initiation of improvement plans for low performance, the plan has had little success with improving its rates for postpartum care, avoidance of antibiotics for acute bronchitis, and appropriate medication management for people with asthma. Postpartum care spans the quality, access, and timeliness domains of care. Appropriate treatment for acute bronchitis and asthma fall under the quality domain of care, specifically through the provision of health services that are consistent with practice guidelines.

The plan needs to modify or explore new efforts to improve rates instead of repeating ongoing interventions if they have not been effective.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas.

HSAG reviews each QIP using CMS' validating protocol to ensure plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from the QIP.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about Molina's performance in providing quality, accessible, and timely care and services to its MCMC members. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

Molina had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS's statewide collaborative QIP. Molina's second project was part of a small-group collaborative effort among several of the other MCMC plans, which focused on decreasing inappropriate antibiotic use for the treatment of a URI for members 3 months through 18 years of age.

The statewide collaborative QIP seeks to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. The ER collaborative falls under both the quality and access domains of care.

Molina's URI QIP targets high-volume providers as a means of decreasing inappropriate antibiotic use, which can lead to an individual developing a resistance to antibiotics over time, making the medication ineffective. The URI QIP falls under the quality domain of care.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

Molina submitted separate QIP submissions for each of its four counties: Riverside, Sacramento, San Bernardino, and San Diego. Table 5.1 summarizes the validation results across the CMS protocol activities for Molina's *Reducing Avoidable Emergency Room Visits* QIP. The results are for all four counties during the review period. Validation of the URI QIP occurred before HSAG's contract; therefore, the validation results are not included.

Table 5.1—Quality Improvement Project Validation Results for Molina (N = 4 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	100%	0%	0%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	57%	29%	14%
IV.	Correctly Identified Study Population	0%	33%	67%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	33%	17%	50%
VII.	Appropriate Improvement Strategies	100%	0%	0%
VIII.	Sufficient Data Analysis and Interpretation	38%	28%	34%
IX.	Real Improvement Achieved	25%	0%	75%
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements *Met*		**49%**		
Validation Status		***Not Applicable****		

‡ The QIP did not progress to this phase during the review period and could not be assessed.
* QIPs were not given an overall validation status during the review period.

HSAG found that its application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans.

Consistent with other MCMC plans, none of Molina's QIPs validated during the review period fully met HSAG's requirements for compliance with CMS' protocol for conducting QIPs. Therefore, with DHCS approval, HSAG provided Molina with an overall validation status of *Not Applicable* for all four QIPs to allow time for the plan to become oriented to HSAG's validation requirements and receive technical assistance and training.

Quality Improvement Project Outcomes

Table 5.2 below displays Molina's data for its QIPs. For the ER collaborative QIP, the plan reported separate results for Riverside and San Bernardino counties and combined the results for the URI QIP.

For the ER collaborative QIP, Molina applied the State-defined collaborative goal of an overall plan reduction of 10 percent. The plan submitted its first remeasurement data in late 2010, at which time HSAG will assess for statistically significant improvement.

For its URI QIP, Molina's goal for the first study indicator was an overall plan decrease of five percent. For the second study indicator, the goal was to increase the rate to above the 25th Medicaid percentile. For Study Indicator 1, the plan will submit its first remeasurement data next year, at which time HSAG will assess for statistically significant improvement. For Study Indicator 2, the plan will submit its second remeasurement data next year, at which time HSAG will assess for both statistically significant and sustained improvement.

Table 5.2—QIP Outcomes for Molina

QIP #1—Reducing Avoidable Emergency Room Visits					
QIP Study Indicator	**Plan/ County**	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
Percentage of avoidable ER visits	Molina Riverside	19.6%	‡	‡	‡
	Molina Sacramento	14.5%	‡	‡	‡
	Molina San Bernardino	19.1%	‡	‡	‡
	Molina San Diego	15.3%	‡	‡	‡

‡ The QIP did not progress to this phase during the review period and could not be assessed.

QIP #2—Appropriate Treatment for Children with an Upper Respiratory Infection					
QIP Study Indicator 1	**Plan/County**	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
Percentage of PCPs who prescribed an antibiotic for a URI for a member who is under 19 years of age	Molina Riverside/ San Bernardino	8.7%	‡	‡	‡
	Molina Sacramento	4.0%	‡	‡	‡
	Molina San Diego	4.9%	‡	‡	‡
QIP #2—Appropriate Treatment for Children with an Upper Respiratory Infection					
QIP Study Indicator 2	**Plan/County**	**Baseline Period 1/1/06–12/31/06**	**Remeasurement 1 1/1/07–12/31/07**	**Remeasurement 2 1/1/08–12/31/08**	**Sustained Improvement**
Percentage of members 3 months of age through 18 years of age who were given a diagnosis of upper respiratory infection and who were not dispensed an antibiotic prescription	Molina Riverside/ San Bernardino	70.9%	78.2%*	‡	‡
	Molina Sacramento	88.2%	90.0%	‡	‡
	Molina San Diego	87.8%	90.5%*	‡	‡

‡ The QIP did not progress to this phase during the review period and could not be assessed.
* Designates statistically significant improvement over the prior measurement period.

To improve the appropriate treatment for children with an upper respiratory infection, Molina and 16 other plans participated as collaborative partners with the California Medical Association's AWARE project to develop and disseminate an antibiotic awareness provider tool kit. Other plan-specific interventions included mailing providers the names of their patients with a URI diagnosis for whom they may have inappropriately prescribed antibiotics.

The plan conducted analysis of its URI data by age group, race/ethnicity, and language. Molina found that more than 60 percent of members from birth to 18 years of age prescribed an antibiotic for URI were Hispanic. Therefore, its member interventions focused on Spanish-speaking members.

Molina had an increase in the percentage of children with a URI that were not prescribed an antibiotic for all its counties between baseline and Remeasurement 1 and statistically significant increases for its plans in Riverside/San Bernardino counties and San Diego County.

Strengths

QIP validation findings showed that Molina demonstrated a good understanding of documenting support for its QIP topic selection and identifying appropriate improvement strategies.

Molina showed real improvement with statistically significant increases for one URI QIP study indicator with first remeasurement period results in both Riverside/San Bernardino counties and San Diego County. The concerted effort between its plans and the California Medical Association may have increased Molina's likelihood of success.

Molina's plans with the highest percentage of Hispanic members in the study population achieved statistically significant improvement from baseline to Remeasurement 1. This suggests that the plan's data analysis and targeted interventions focusing on its Hispanic, Spanish-speaking members were effective.

Opportunities for Improvement

Molina has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with DHCS's requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*