

Performance Evaluation Report

Molina Healthcare of California
Partner Plan, Inc.

July 1, 2009–June 30, 2010

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

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TABLE OF CONTENTS

1. INTRODUCTION	1
Purpose of Report	1
Plan Overview	2
2. ORGANIZATIONAL ASSESSMENT AND STRUCTURE.....	3
Conducting the Review.....	3
Findings.....	3
Medical Performance Review	3
Medi-Cal Managed Care Member Rights and Program Integrity Review.....	4
Strengths	5
Opportunities for Improvement	5
3. PERFORMANCE MEASURES	6
Conducting the Review.....	6
Findings.....	6
Performance Measure Validation.....	6
Performance Measure Results	7
HEDIS Improvement Plans	11
Strengths	14
Opportunities for Improvement	14
4. QUALITY IMPROVEMENT PROJECTS	16
Conducting the Review.....	16
Findings.....	16
Quality Improvement Projects Conducted.....	16
Quality Improvement Project Validation Findings	17
Quality Improvement Project Outcomes	19
Strengths	21
Opportunities for Improvement	22
5. MEMBER SATISFACTION SURVEY	23
Conducting the Review.....	23
Findings.....	23
National Comparisons	24
Strengths	26
Opportunities for Improvement	26
6. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS	27
Overall Findings Regarding Health Care Quality, Access, and Timeliness.....	27
Quality	27
Access	28
Timeliness.....	29
Follow-Up on Prior-Year Recommendations	30
Conclusions and Recommendations.....	30
APPENDIX A. FOLLOW-UP ON THE PRIOR YEAR’S RECOMMENDATIONS GRID	A-1

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)¹ 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- ◆ The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- ◆ Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

¹ Medi-Cal Managed Care Enrollment Report, June 2010. Available at:
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

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, for the review period of July 1, 2009, to June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

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.

The Knox-Keene Health Care Service Plan Act of 1975, as amended, is the set of laws passed by the California State Legislature to regulate health maintenance organizations within the State for the protection of health plan members. Molina has been Knox-Keene licensed with the State of California since 2005.

Molina delivers care to members using the Two-Plan model type for two counties and using the Geographic Managed Care (GMC) model for two counties.

In a Two-Plan model county, the DHCS contracts with two managed care plans to provide medical services to members. Most Two-Plan model counties offer a local initiative (LI) plan and a nongovernmental commercial plan (CP) from which members may select. Molina delivers care to members as the CP option in Riverside and San Bernardino counties.

The GMC model type allows enrollees to choose from several commercial plans within a specific geographic area. In Sacramento and San Diego counties, Molina serves members using this model type.

Molina began services under the MCMC Program in Riverside and San Bernardino counties in 1998. The plan expanded into Sacramento County in 2000 and San Diego County in 2005. As of June 30, 2010, Molina had 182,751 enrolled members under the MCMC Program for all of its contracted counties.²

Throughout this report, references to “Sacramento County,” “San Diego County,” “Riverside County,” and “San Bernardino County” shall mean the Molina’s health plan contracted with Medi-Cal managed care in the referenced county.

² Medi-Cal Managed Care Enrollment Report, June 2010,
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

2. ORGANIZATIONAL ASSESSMENT AND STRUCTURE

for Molina Healthcare of California Partner Plan, Inc.

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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work with DMHC to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. The most recent medical performance review was completed in April 2011, and findings from the report are not yet available. The prior audit findings (covering the review period of December 1, 2004, through November 30, 2005) were addressed in the 2008–2009 plan evaluation report.

Findings from the previous audit were in the area of availability and accessibility of services. The plan had been cited for not having a process in place to ensure that emergency service claims were paid in a timely manner when they were submitted directly to the plan instead of to the appropriate delegated entity. The DHCS *Medical Audit Close-Out Report* letter dated October 26, 2006, noted that the plan corrected this deficiency. In addition, HSAG reviewed Molina's Quality Improvement Program Evaluation covering the period of January 1, 2009, through December 31, 2009, and saw evidence that the plan was monitoring emergency room claims payment reports twice per year.

The prior audit report also indicated that Molina did not have standards for provider wait times to answer and return member telephone calls. Based on the program evaluation report, HSAG noted that Molina monitored physician office speed of answering phone calls and compared physician performance to an internal plan benchmark. Additionally, the DHCS *Medical Audit Close-Out Report* indicated that all audit deficiencies were resolved by the plan.

Finally, the DHCS determined that Molina was fully compliant with the requirements of the plan's MCMC Hyde contract, according to the *Medical Audit Close-Out Report*. The Hyde contract covers abortion services funded only with State funds, as these services do not qualify for federal funding.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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 member rights reviews are conducted 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 member rights 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, 2010. The most current MRPIU review of Molina was conducted in January 2011, covering the review period of January 1, 2009, through March 31, 2010. The review covered all four counties and focused on the areas of member grievances, prior-authorization notification, cultural and linguistic services, and marketing. In addition, the review evaluated processes for prevention, detection, and reporting of suspected fraud/abuse.

Member Grievances Findings

In a combined review of 98 member grievance files of Riverside and San Bernardino counties, MRPIU identified one case in which the resolution letter was not sent out by the 30-day time frame. In addition, the plan did not notify the member of the status or provide an estimated resolution date.

Prior-Authorization Notifications Findings

For Molina's San Diego County plan, a review of 180 prior-authorization notification files found one Notice of Action letter that was not sent within the required time frame.

Program Integrity/Antifraud and Abuse Findings

The review covered the policies and procedures and internal controls within the plan to address suspected fraud and/or abuse. The review showed that Molina's policies and procedures and applicable contract language met DHCS requirements.

Strengths

Molina fully met all requirements related to fraud and abuse prevention, detection, and reporting across all four Medi-Cal managed care county plans.

Opportunities for Improvement

Based on the MRPIU review findings, Molina has an opportunity to enhance its internal controls to ensure that all time frame requirements are met acknowledging receipt and resolution of member grievances.

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 provide a standardized method for 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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Performance Measure Validation

HSAG performed an NCQA HEDIS[®] Compliance Audit[™] of Molina in 2010.³ The audit team determined that all measures were reportable and no information system issues were identified that impacted any of the performance measure results.

³ HEDIS[®] refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA HEDIS Compliance Audit[™] is a trademark of the NCQA.

Performance Measure Results

In addition to validating the plan’s HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Tables 3.2–3.4.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
AWC	<i>Adolescent Well-Care Visits</i>
BCS	<i>Breast Cancer Screening</i>
CCS	<i>Cervical Cancer Screening</i>
CDC–BP	<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)</i>
CDC–E	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>
CDC–H8 (<8.0%)	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)</i>
CDC–H9 (>9.0%)	<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>
CDC–HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC–LC (<100)	<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>
CDC–LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC–N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS–3	<i>Childhood Immunization Status—Combination 3</i>
LBP	<i>Use of Imaging Studies for Low Back Pain</i>
PPC–Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC–Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
URI	<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
W34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
WCC–BMI	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>
WCC–N	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>
WCC–PA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>

The tables below present a summary of Molina’s HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan’s HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs). While the DHCS requires that plans report county-level data, the DHCS made an exception and allowed Molina and the other Medi-Cal managed care plan operating in Riverside and San Bernardino counties to continue to report these counties as one combined rate.

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance’s (NCQA’s) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, 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 national Medicaid 10th percentile.

Table 3.2—2009–2010 Performance Measure Results for Molina Healthcare of California Partner Plan, Inc.—Riverside and San Bernardino Counties (reported as one combined rate)

Performance Measure ¹	Domain of Care ²	2009 HEDIS Rates ³	2010 HEDIS Rates ⁴	Performance Level for 2010	Performance Comparison ⁵	MMCD's Minimum Performance Level ⁶	MMCD's High Performance Level (Goal) ⁷
AAB	Q	18.4%	24.4%	★★	↑	20.2%	33.4%
AWC	Q,A,T	53.9%	45.1%	★★	↓	37.9%	59.4%
BCS	Q,A	44.2%	50.2%	★★	↑	45.0%	63.0%
CCS	Q,A	70.3%	62.3%	★★	↓	60.9%	79.5%
CDC–BP	Q	‡	58.6%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	55.9%	43.1%	★	↓	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	32.8%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	56.5%	57.9%	★	↔	50.6%	29.2%
CDC–HT	Q,A	69.8%	79.6%	★★	↑	76.5%	89.3%
CDC–LC (<100)	Q	27.4%	29.2%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	70.6%	77.1%	★★	↑	71.5%	82.5%
CDC–N	Q,A	76.7%	80.0%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	67.1%	60.0%	★	↓	62.4%	80.6%
LBP	Q	‡	74.8%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	79.1%	80.5%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	48.5%	52.3%	★	↔	57.9%	72.7%
URI	Q	89.5%	86.6%	★★	↓	81.1%	94.5%
W34	Q,A,T	77.8%	77.5%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	55.0%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	62.5%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	60.6%	Not Comparable	Not Comparable	NA	NA

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

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

³ HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

⁴ HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

⁵ Performance comparisons are based on the Chi-Square 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 DHCS did not require plans to report this measure in 2009.

NA = The DHCS does not establish an MPL/HPL for first year measures.

★ = 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 3.3—2009–2010 Performance Measure Results for Molina Healthcare of California Partner Plan, Inc. —Sacramento County

Performance Measure ¹	Domain of Care ²	2009 HEDIS Rates ³	2010 HEDIS Rates ⁴	Performance Level for 2010	Performance Comparison ⁵	MMCD's Minimum Performance Level ⁶	MMCD's High Performance Level (Goal) ⁷
AAB	Q	30.3%	29.5%	★★	↔	20.2%	33.4%
AWC	Q,A,T	51.6%	52.3%	★★	↔	37.9%	59.4%
BCS	Q,A	40.9%	48.7%	★★	↑	45.0%	63.0%
CCS	Q,A	65.6%	67.3%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	61.6%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	61.3%	48.9%	★★	↓	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	47.8%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	44.9%	41.2%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	78.6%	78.4%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	37.7%	33.8%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	68.6%	74.0%	★★	↔	71.5%	82.5%
CDC–N	Q,A	79.6%	79.9%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	63.7%	61.1%	★	↔	62.4%	80.6%
LBP	Q	‡	87.3%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	78.0%	84.8%	★★	↑	78.5%	92.2%
PPC–Pst	Q,A,T	51.9%	53.2%	★	↔	57.9%	72.7%
URI	Q	95.8%	94.2%	★★	↔	81.1%	94.5%
W34	Q,A,T	75.9%	79.6%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	63.7%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	70.3%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	59.6%	Not Comparable	Not Comparable	NA	NA

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

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

³ HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

⁴ HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

⁵ Performance comparisons are based on the Chi-Square 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 DHCS did not require plans to report this measure in 2009.

NA = The DHCS does not establish an MPL/HPL for first year measures.

★ = 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 3.4—2009–2010 Performance Measure Results for Molina Healthcare of California Partner Plan, Inc.—San Diego County

Performance Measure ¹	Domain of Care ²	2009 HEDIS Rates ³	2010 HEDIS Rates ⁴	Performance Level for 2010	Performance Comparison ⁵	MMCD's Minimum Performance Level ⁶	MMCD's High Performance Level (Goal) ⁷
AAB	Q	20.6%	24.2%	★★	↔	20.2%	33.4%
AWC	Q,A,T	56.3%	47.7%	★★	↓	37.9%	59.4%
BCS	Q,A	47.4%	54.6%	★★	↑	45.0%	63.0%
CCS	Q,A	70.6%	70.3%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	60.8%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	58.1%	47.7%	★★	↓	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	42.1%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	48.5%	48.4%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	79.3%	82.0%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	33.8%	33.8%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	76.9%	76.4%	★★	↔	71.5%	82.5%
CDC–N	Q,A	79.0%	77.1%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	77.8%	78.9%	★★	↔	62.4%	80.6%
LBP	Q	‡	77.4%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	87.4%	89.7%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	62.5%	57.7%	★	↔	57.9%	72.7%
URI	Q	96.1%	94.1%	★★	↓	81.1%	94.5%
W34	Q,A,T	82.4%	78.5%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	56.9%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	57.7%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	51.6%	Not Comparable	Not Comparable	NA	NA

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

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

³ HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

⁴ HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

⁵ Performance comparisons are based on the Chi-Square 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 DHCS did not require plans to report this measure in 2009.

NA = The DHCS does not establish an MPL/HPL for first year measures.

★ = 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

A review of Molina's HEDIS results showed mixed performance across all four Medi-Cal managed care county plans, with some notable gains as well as some concerning declines. In general, the plan's Sacramento and San Diego counties demonstrated stronger performance than Riverside and San Bernardino counties.

In Molina's Riverside and San Bernardino counties, four measures (eye exams for diabetics, poor HbA1c control, children's immunizations, and postpartum care) were below the MPLs and no measures exceeded the HPLs. Although the plan had five measures with a statistically significant decline from the prior year (well-care visits for adolescents, cervical cancer screening, eye exams for diabetics, children's immunizations, and treatment of upper respiratory infections), the plan also had notable gains. Four measures (avoidance of antibiotics for bronchitis, breast cancer screening, and lab testing for HbA1c and LDL-C screening in members with diabetes) showed statistically significant improvement.

In Molina's Sacramento County plan, two of its 2010 HEDIS measures were below the MPLs (children's immunizations and postpartum care) and none exceeded the HPL. In 2009, Sacramento County had one measure above the HPL. Two of the plan's measures showed statistically significant improvement (breast cancer screening and prenatal care), and one measure had a statistically significant decline (eye exams for diabetics).

In Molina's San Diego County plan, only one of its 2010 HEDIS measures was below the MPL (postpartum care), although no measures exceeded the HPLs. These results contrasted with the county's performance in 2009, when three measures achieved the HPLs. One of these three measures, however, was not included in the 2010 EAS. One measure (breast cancer screening) showed statistically significant improvement, while three measures (well-care visits for adolescents, eye exams for diabetics, and treatment of upper respiratory infections) experienced statistically significant declines.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline steps to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Avoidance of Antibiotic Treatment

Molina in Riverside and San Bernardino counties implemented a multifaceted plan to improve the 2009 AAB rate of 18.44 percent. Molina identified key barriers and categorized them as follows:

- ◆ Provider-related barriers included variations in practice prescribing patterns, lack of awareness of effective nonantibiotic bronchitis treatments, and reluctance to refuse parents' requests for antibiotics or correct parents' misunderstanding of appropriate antibiotic use.
- ◆ Member-related barriers included lack of awareness of the risk of inappropriate antibiotic use, nonantibiotic treatment options, and the importance of contacting a primary care provider (PCP) or the nurse advice line for clinical guidance.
- ◆ Health plan-related barriers included limited collaborative efforts to make systemwide changes and lack of analysis, assessment, and evaluation of provider practice variations.

Molina implemented various key interventions in the latter half of 2009. The plan participated in the 2009 AWARE work group, which developed practice guidelines and provider tool kits for management of acute bronchitis. The guidelines and tool kits were distributed to providers via various methods. The plan also used case management staff to follow up on members with comorbidities or a history of ER visits/hospitalizations, and the nurse advice line reinforced treatment plans and provided member education.

Molina's improvement plan was successful for Riverside and San Bernardino counties, resulting in a 2010 rate of 24.4 percent, a statistically significant improvement. The improvement plan included a well-constructed barrier analysis, well-defined objectives and timetables for completion, and a clear, methodic plan for involving the appropriate clinicians, health plan staff, and providers in intervention activities.

Breast Cancer Screening

Molina implemented a successful improvement plan targeting breast cancer screening in Riverside, San Bernardino, and Sacramento counties, achieving statistically significant improvement in 2010. Riverside and San Bernardino counties' rate of 50.2 percent was an increase of 8 percentage points over the 2009 result. Molina's Sacramento County plan's 2009 rate of 40.9 percent increased to 48.7 percent in 2010, an improvement of almost 8 percentage points, as well.

The plan identified several barriers and grouped them into internal plan-related barriers and external member-related barriers and provider-related barriers.

Interventions targeted the different barriers, and many appeared to be ongoing activities since 2007.

Diabetes Care

HbA1c testing and control has been a challenge for Molina in Riverside and San Bernardino counties. The plan indicated that most improvement efforts have been in place since 2007. HSAG noted mixed success based on the improvement plan. The HbA1c testing rate had a statistically significant improvement, increasing from 69.8 percent in 2009 to 79.6 percent in 2010. The rate exceeded the MPL for the measure. Less success was seen, however, in HbA1c control. Plan performance on the HbA1c poor control measure declined between 2009 and 2010.

Molina identified some barriers impacting the two measures, which included difficulty reaching members due to inaccurate phone numbers and addresses as well as cultural differences that affected poor dietary choices. Interventions targeted mainly providers and included providing member HbA1c values to providers, distributing clinical practice guidelines, increasing provider awareness of the disease management program and cultural disparities, and referrals to complex case management.

HSAG noted that Molina performed a drill-down analysis to evaluate the results of the interventions. Most notable was a large difference in performance between Molina's Riverside and San Bernardino county plans in the area of HbA1c control. Riverside County appeared to have performed substantially better than Molina's San Bernardino plan, although HSAG noted some inconsistencies in how the improvement plan presented the results. The plan should validate this internally.

Although some success was achieved, HSAG recommends that Molina reevaluate the interventions to better align them with the stated barriers. In addition, Molina should explore implementing more targeted efforts toward its San Bernardino County plan if a significant disparity exists.

Postpartum Care

Molina's performance on the postpartum care measure has been a consistent challenge for the plan. Riverside, San Bernardino, and Sacramento counties each had 2009 HEDIS rates below the MPL. Its improvement plan indicated that Molina will continue with ongoing interventions, including the Motherhood Matters Program. The plan identified various barriers to improving performance, which included:

- ◆ Members' lack of knowledge of the importance of postpartum care or cultural differences.
- ◆ Postpartum visits that were provided, but were outside of the measure time frames.
- ◆ Enrollment by members late in their pregnancy and the lack of timely notification to Molina of the pregnancy and/or delivery.
- ◆ Lack of tracking systems in provider offices to ensure that members are scheduled for and make their postpartum visit appointments.
- ◆ Incorrect member phone numbers and addresses.

- ◆ Failure by providers to forward to the plan a pregnancy notification form once a member is determined to be pregnant.

Molina had various ongoing interventions to address the barriers, which included providing member incentives for visits, providing lists of missing services to providers, working with high-volume providers to improve postpartum care results, conducting member outreach calls, enrolling members in the Motherhood Matters Program, and communicating with providers.

Molina had moderate success with the improvement plan. Riverside, San Bernardino, and Sacramento counties had a slight improvement in their 2010 postpartum care rates; however, the improvement was not statistically significant. In addition, San Diego County had a decline in its 2010 rate, which fell below the MPL (although the decline was not statistically significant).

Molina also submitted improvement plans for the use of appropriate medications for people with asthma and well-child visits in the first 15 months of life; however, these measures were removed from the 2010 EAS and, therefore, HSAG did not evaluate their effectiveness.

Strengths

Molina had statistically significant improvement for its breast cancer screening measure across all four Medi-Cal managed care county plans. Riverside and San Bernardino counties, in fact, had four measures that showed statistically significant improvement between 2009 and 2010. In addition, Molina demonstrated that it can implement effective interventions that bring about real change when targeting specific areas that need improvement.

Opportunities for Improvement

While some improvements were noted, Molina's overall performance declined. Molina had no measures that achieved the HPLs in any of its four Medi-Cal managed care county plans. The plan experienced statistically significant declines in all counties in eye exam rates for diabetics, a concerning trend. The elimination of the Medi-Cal benefit related to dispensing optician services (such as eyeglasses or contact lenses) in July 2009 may have led to member confusion and affected the rates. Nonetheless, Molina should examine this downward trend and implement targeted interventions.

Molina also has an opportunity for improvement in the area of postpartum care. All of its county plans reported rates below the MPL in 2010, despite an ongoing improvement plan. HSAG recommends that Molina conduct an in-depth analysis of the effectiveness of the interventions and explore other mechanisms to either enhance the existing interventions or add new activities. Given that difficulty contacting members due to inaccurate phone numbers and addresses was

identified as a barrier in several improvement plans, Molina should explore efforts to improve member demographic information.

Similar to 2009, Molina's performance measures that needed improvement spanned all three domains of care: quality, timeliness, and access.

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 clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that 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 a QIP.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review

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.

Quality Improvement Projects Conducted

Molina had two clinical QIPs and one QIP proposal in progress during the review period of July 1, 2009, through June 30, 2010. 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 with several other MCMC plans, which focused on decreasing inappropriate antibiotic use for the treatment of upper respiratory infection (URI) for members 3 months through 18 years of age. Since Molina's URI QIP was closing out, the plan submitted a proposal for an internal QIP aimed at improving hypertension control in members 18 to 85 years of age.

The statewide collaborative QIP has sought to reduce ER visits that could have been more appropriately managed by and/or referred to a 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 to decrease 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.

Molina’s *Improving Hypertension Control* QIP evaluated prescriptions for hypertension and blood pressure control medications. The QIP falls under both the quality and access domains of care.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both of Molina’s QIPs across the CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Molina Healthcare of California Partner Plan, Inc.—Riverside, San Bernardino, Sacramento, and San Diego Counties July 1, 2009, through June 30, 2010

Name of Project/Study	County	Type of Review ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Overall Validation Status ⁴
Statewide Collaborative QIP					
<i>Reducing Avoidable Emergency Room Visits</i>	Riverside	Annual Submission	86%	100%	<i>Met</i>
	San Bernardino	Annual Submission	92%	100%	<i>Met</i>
	Sacramento	Annual Submission	86%	100%	<i>Met</i>
	San Diego	Annual Submission	86%	100%	<i>Met</i>
Internal QIPs					
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	All Counties	Annual Submission	69%	50%	<i>Partially Met</i>
		Resubmission 1	95%	100%	<i>Met</i>
<i>Improving Hypertension Control</i>	All Counties	Proposal	72%	50%	<i>Partially Met</i>
¹ Type of Review —Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG’s validation criteria to receive an overall <i>Met</i> validation status. ² Percentage Score of Evaluation Elements <i>Met</i> —The percentage score is calculated by dividing the total elements <i>Met</i> (critical and noncritical) by the sum of the total elements of all categories (<i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i>). ³ Percentage Score of Critical Elements <i>Met</i> —The percentage score of critical elements <i>Met</i> is calculated by dividing the total critical elements <i>Met</i> by the sum of the critical elements <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> . ⁴ Overall Validation Status —Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> .					

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG’s application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results for Molina’s QIPs during the review period of July 1, 2009, through June 30, 2010, are described below.

The plan’s annual submission of its *Reducing Avoidable Emergency Room Visits* QIP for all four counties received an overall validation status of *Met*, with 86 percent to 92 percent of all evaluation elements and 100 percent of critical elements receiving a *Met* score.

Molina received a *Partially Met* validation status for the initial submission of its URI QIP. All of the counties received the same score, 69 percent of all elements and 50 percent of critical elements received a *Met* validation score. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted this QIP and achieved an overall *Met* validation status.

For its *Improving Hypertension Control* QIP proposal submission, Molina received a *Partially Met* validation status, with all counties receiving the same score. The plan’s resubmission fell outside of this review period; therefore, HSAG will include the validation results in the next evaluation report.

Table 4.2 summarizes the validation results for all three of Molina’s QIP topics across the CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Molina Healthcare of California Partner Plan, Inc.—Riverside, San Bernardino, Sacramento, and San Diego Counties (Number = 10 QIP Submissions, 3 QIP Topics) July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	70%	30%	0%
	III: Clearly Defined Study Indicator(s)	87%	13%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		91%	9%	0%
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		100%	0%	0%
Outcomes	VIII: Sufficient Data Analysis and Interpretation	84%	16%	0%
	IX: Real Improvement Achieved	46%	11%	43%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		72%	14%	14%
*The activity average rate represents the average percentage of applicable elements with a <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> finding across all the evaluation elements for a particular activity.				

Molina demonstrated a strong understanding of the design and implementation stages, scoring 100 percent on all evaluation elements for four of the six applicable activities. Conversely, for the outcomes stage, Molina’s score was lower in Activity VIII because the plan did not provide the required *p* values from the statistical tests conducted to compare measurement periods for the URI QIP.

Not all of the QIP outcomes demonstrated statistically significant improvement (considered “real improvement” or improvement that is unlikely due to chance); therefore, Molina received a score of 46 percent for Activity IX. The URI QIP achieved sustained improvement and was the only QIP that progressed to Activity X. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period’s results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

**Table 4.3—Quality Improvement Project Outcomes for Molina Healthcare of California Partner Plan, Inc.—Riverside, San Bernardino, Sacramento, and San Diego Counties
(Number = 10 QIPs, 3 QIP Topics)
July 1, 2009, through June 30, 2010**

QIP #1—Reducing Avoidable Emergency Room Visits ¹					
QIP Study Indicator	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 [^]	Overall	17.5%	18.9%*	‡	‡
	Riverside	19.6%	21.6%*	‡	‡
	San Bernardino	19.1%	20.9%*	‡	‡
	Sacramento	14.5%	16.7%*	‡	‡
	San Diego	15.3%	16.2%*	‡	‡

¹ For this measure, a lower rate indicates better performance.
[^] The county-specific rates are provided for informational purposes since only the overall rate was included in the validation.
[¥] Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period’s results must reflect improvement when compared to the baseline results.
* A statistically significant difference between the measurement period and the prior measurement period (*p* value < 0.05).
‡ 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	County	Baseline Period (1/1/07–6/30/07)	Remeasurement 1 (7/1/07–12/31/07)	Remeasurement 2 (1/1/08–6/30/08)	Remeasurement 3 (7/1/08–12/31/08)	Sustained Improvement [¥]
Percentage of PCPs who prescribed an antibiotic to treat a URI for a member who was younger than 19 years of age	Riverside and San Bernardino	7.3%	10.1%	5.2%*	4.3%	Yes
	Sacramento	5.4%	2.5%	1.1%	4.5%	Yes
	San Diego	5.6%	4.0%	5.4%	3.4%	Yes
QIP Study Indicator 2	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 diagnosed with an upper respiratory infection and were not dispensed an antibiotic prescription	Riverside and San Bernardino	70.9%	78.2%*	89.5%*	Yes	
	Sacramento	88.2%	89.9%	95.8%*	Yes	
	San Diego	87.8%	90.4%*	96.1%*	Yes	
[¥] Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results. [*] A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05).						

QIP #3—Improving Hypertension Control					
QIP Study Indicator 1	County	Baseline Period (1/1/10–6/30/10)	Remeasurement 1 (7/1/10–12/31/10)	Remeasurement 2 (1/1/11–6/30/11)	Sustained Improvement [¥]
Percentage of members 18 to 85 years of age who did not fill a prescription for an antihypertensive class medication	All Counties	‡	‡	‡	‡
QIP Study Indicator 2	County	Baseline Period (1/1/09–12/31/09)	Remeasurement 1 (1/1/10–12/31/10)	Remeasurement 2 (1/1/11–12/31/11)	Sustained Improvement
Percentage of members 18 to 85 years of age who had both a systolic and diastolic blood pressure of <140/90	All Counties	‡	‡	‡	‡
[¥] Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results. [‡] The QIP did not progress to this phase during the review period and could not be assessed.					

During the reporting period covered by this evaluation (July 1, 2009–June 30, 2010), Molina submitted Remeasurement 1 data for the *Reducing Avoidable Emergency Room Visits* QIP. For the URI QIP, Molina submitted Remeasurement 3 data for the first study indicator and Remeasurement 2 data for the second study indicator.

For the *Reducing Avoidable Emergency Room Visits* QIP, avoidable ER visits increased in all counties, indicating a decline in performance. This decline was statistically significant. The plan implemented the statewide collaborative work group interventions following Remeasurement 1. Since collaborative interventions were not initiated until 2009, HSAG cannot evaluate the effectiveness of those interventions until the next reporting cycle (July 2010 through June 2011).

The URI QIP was effective, with improvement in both indicators. All counties demonstrated sustained improvement from baseline to Remeasurement 3, decreasing the percentage of PCPs who prescribed an antibiotic for a member with a URI. Additionally, all counties demonstrated statistically significant improvement for the percentage of members who were not dispensed an antibiotic prescription, which was sustained from baseline to Remeasurement 2. Molina continued its participation with 16 other plans 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. These interventions were ongoing based on the plan's previous and current success in improving the outcomes.

The URI QIP was retired after achieving sustained improvement through two remeasurement periods. HSAG will report the baseline and remeasurement 1 results for the *Improving Hypertension Control* QIP in the 2010–2011 plan evaluation report.

Strengths

QIP validation findings showed that Molina demonstrated a good understanding of documenting the necessary activities in the design and implementation stages. The plan has demonstrated that it gained some proficiency with QIP validation during the review period despite the need to resubmit QIPs.

Molina showed real improvement, with statistically significant increases in the second remeasurement period results in all counties for one URI QIP study indicator. The concerted effort between the plans and the California Medical Association may have increased Molina's likelihood of success.

Opportunities for Improvement

Molina has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. The plan should report the corresponding p value when presenting the results of statistical testing. Additionally, HSAG recommends that the plan include a method to evaluate the effectiveness of each intervention implemented on the desired QIP outcome. The evaluation plan should include subgroup analyses to determine the effects of the intervention across the population.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) health plan surveys.⁴

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about Molina's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

- ◆ *Rating of Health Plan*
- ◆ *Rating of All Health Care*
- ◆ *Rating of Personal Doctor*
- ◆ *Rating of Specialist Seen Most Often*

⁴ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CAHPS Composite Measures:

- ◆ *Getting Needed Care*
- ◆ *Getting Care Quickly*
- ◆ *How Well Doctors Communicate*
- ◆ *Customer Service*
- ◆ *Shared Decision Making*

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS[®] benchmarks and thresholds or NCQA's national Medicaid data, when applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

The DHCS requires that plans report county-level CAHPS data; however, the DHCS made an exception that allowed Molina and the other Medi-Cal managed care plans operating in Riverside and San Bernardino counties to continue to report these counties as one combined rate.

Table 5.2—Molina Healthcare Adult Medi-Cal Managed Care County-Level Global Ratings

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Riverside and San Bernardino	★	★	★	★★ ⁺
Sacramento	★	★	★	★ ⁺
San Diego	★	★	★	★
<i>+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.</i>				

Table 5.3—Molina Healthcare Child Medi-Cal Managed Care County-Level Global Ratings

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Riverside and San Bernardino	★	★	★	★★ ⁺
Sacramento	★	★	★	★ ⁺
San Diego	★★	★★	★★★★★	★★ ⁺

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.4—Molina Healthcare Adult Medi-Cal Managed Care County-Level Composite Measures

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Riverside and San Bernardino	★	★	★	★ ⁺	★ ⁺
Sacramento	★	★	★	★ ⁺	★
San Diego	★	★	★	★ ⁺	★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.5—Molina Healthcare Child Medi-Cal Managed Care County-Level Composite Measures

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Riverside and San Bernardino	★ ⁺	★	★	★★ ⁺	★ ⁺
Sacramento	★ ⁺	★	★	★ ⁺	★ ⁺
San Diego	★	★	★★	★★★ ⁺	★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

Molina's San Diego County plan showed very strong performance on the child global rating for *Rating of Personal Doctor*, the only CAHPS result achieving high performance across all counties, all global ratings, and all composite measures. In general, San Diego County performed better on all the child global ratings and two of the child composite measures.

Opportunities for Improvement

The opportunities for improvement for Molina are numerous with respect to consumer satisfaction. The results for adults across all counties, global ratings, and composite measures were poor. For one global rating (*Rating of Specialist Seen Most Often*) Riverside and San Bernardino counties exceeded the 25th percentile; however, the number of respondents was fewer than 100 and should be interpreted with caution. Performance on the children's global ratings and composite measures in Sacramento County was also very low compared with the other counties, which each achieved at least one result above the lowest performance level.

HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Molina's highest priority: *Rating of All Health Care*, *Rating of Health Plan*, and *Getting Needed Care*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 Molina CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

6. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

for Molina Healthcare of California Partner Plan, Inc.

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 quality improvement project (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.

The plan showed average to below average performance in the area of quality. HSAG based its assessment on Molina's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

None of Molina's counties achieved an HPL in the area of performance measures, and each had at least one result below the MPL. Most performance measure results fell between the MPL and HPL, with some noted improvements as well as some concerning declines.

Molina showed notable improvement in the *Breast Cancer Screening* measure, with all four of its Medi-Cal managed care county plans having statistically significant improvement over the 2009 HEDIS rates. Overall, the plan had statistically significant improvement in a total of seven HEDIS rates.

Molina continued to have poor performance in postpartum care visits. Despite an ongoing improvement plan, results for all counties fell below the MPL in 2010. The other measure of concern across all four of Molina's Medi-Cal managed care county plans was eye exams for diabetics, which had statistically significant declines in rates in all counties.

Molina's URI QIP was successful, achieving sustained improvement in both indicators and statically significant improvement in one. These outcomes translate to better member health, as in providers not overprescribing antibiotics for URI, a practice that can lead to antibiotic resistance. Of concern, however, were statistically significant declines in rates for the URI measure in 2010 for two counties following retirement of the QIP, although all rates still exceeded the MPL.

San Diego and Sacramento counties performed better than Riverside and San Bernardino counties on performance measures and the URI QIP in the area of quality. In fact, San Diego County had only one performance measure rate below the MPL and had more statistically significant improvements in the QIP remeasurement rates than Sacramento or Riverside and San Bernardino counties. Sacramento County, however, had only one measure with a statistically significant decline in the performance, compared with three in San Diego County.

Based on the MRPIU review findings, the plan was found fully compliant with the routine monitoring review of program integrity related to fraud and/or abuse.

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 a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. 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 showed average to below average performance in the area of access. HSAG based its assessment on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results.

Performance measure rates for which HSAG identified a need for focused improvement efforts—*Postpartum Care*, *Childhood Immunization Status*, and *Comprehensive Diabetes Care—Eye Exams*—all fell under the access domain of care.

Member satisfaction results for adults and children demonstrated poor performance for the *Getting Needed Care* composite in all counties. The *Getting Needed Care* composite assesses members'

satisfaction with accessing care once a need is identified. This was a significant opportunity for improvement.

Molina's performance declined in its *Reducing Avoidable Emergency Visits* QIP in the first remeasurement period. Since the statewide intervention activities did not start until after the first remeasurement period, HSAG is unable to report on the impact of those interventions until the next review period (July 1, 2010, through June 30, 2011).

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, to minimize any disruptions to care, and to 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 plans' 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.

Molina demonstrated average to below average performance in the timeliness domain of care. HSAG based its assessment on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness.

Molina continued to have a significant opportunity to improve postpartum care rates across its four Medi-Cal managed care county plans. Lower performance was also seen in childhood immunizations, with Riverside and San Bernardino having a statistically significant decline compared with the 2009 result, falling below the MPL. Sacramento County also reported its immunization rate for Combination 3 as falling below the MPL.

Based on the MRPIU review findings, Molina had a deficiency related to timely mailing of a notice of action letter for denial. The plan also had one finding related to resolution of a grievance extending beyond the 30-day time frame, as well as failure to notify the member of the status of the resolution within the allotted turnaround time.

Member satisfaction results showed that the plan demonstrated poor performance for the *Getting Care Quickly* category for both the adult and child populations. This suggests that members perceive that they do not always receive care in a timely manner.

Molina's results for well-child visits across all four Medi-Cal managed care county plans showed strong performance, with rates well above the MPL. In fact, all rates exceeded the national Medicaid 75th percentile.

Follow-Up on Prior-Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. Molina's self-reported responses are included in Appendix A.

Conclusions and Recommendations

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

Overall performance for Molina on the HEDIS measures declined, with no measures achieving the HPL in 2010 compared with four in 2009. Molina, however, showed improvement in *Breast Cancer Screening*, and Riverside and San Bernardino counties reported fewer rates below the MPL compared with 2009 results.

Molina achieved success in the URI QIP, showing improvement in both indicators.

Molina's member satisfaction results were generally poor, except for Molina's San Diego County plan, which scored particularly high in the children's category, *Rating of Personal Doctor*.

Based on available compliance review information, the plan generally demonstrated compliance, with minimal findings on the standards covered under the scope of the audit. The findings related to timely notification of members when processing grievances and prior-authorization requests.

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

- ◆ Ensure that all MRPIU deficiencies have been fully addressed.
- ◆ Focus improvement efforts on the lower performing and/or declining performance measures, including postpartum care visits, childhood immunizations, and eye exams for diabetics.
- ◆ Explore factors that contributed to the significant drop in *Comprehensive Diabetes Care—Retinal Eye Exam* rates.
- ◆ Stay vigilant with maintaining gains in the URI QIP.
- ◆ Reevaluate performance measure improvement plan interventions that are not effective and explore methods to better address key barriers, especially incomplete and inaccurate member phone numbers and addresses.

- ◆ Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Rating of All Health Care*, *Rating of Health Plan*, and *Getting Needed Care* priority areas.

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

APPENDIX A. FOLLOW-UP ON THE PRIOR YEAR'S RECOMMENDATIONS GRID

for Molina Healthcare of California Partner Plan, Inc.

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
<p>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.</p>	<p>Barrier analysis for the low HEDIS 2009 rate for avoidance of antibiotics for acute bronchitis revealed that this was primarily a practitioner-driven performance measure. 2009–2010 strategies to increase performance measure rates for avoidance of antibiotics for acute bronchitis therefore focused on increasing the practitioner knowledge of best practices for appropriate treatment of adults with acute bronchitis and providing these practitioners with educational materials to be shared with members whose expectations included an antibiotic prescription. The HEDIS Riverside/San Bernardino rate for avoidance of antibiotics for acute bronchitis increased to 24.45 percent in 2010 from 18.44 percent in 2009. Interventions are continuing in 2011.</p> <p>Barrier analysis for the low HEDIS 2009 rate for appropriate medication for people with asthma revealed that although there was a component of practitioner-driven performance, this was primarily a member-driven measure. Member-driven causal factor weighs more than the practitioner-driven factor, since it is ultimately up to the member to adhere to the practitioner's recommendation on appropriate medication for his/her asthma. 2009–2010 strategies to increase performance measure rates for appropriate medication for people with asthma focused on practitioners, but more strongly on members:</p> <ul style="list-style-type: none"> ◆ Discussions held with PCPs whose members had not filled prescriptions for an inhaled corticosteroid revealed that most times the PCP had given the member a prescription for the inhaled corticosteroid, but the member refused to comply with the treatment plan. ◆ Prescription histories were made available to the PCPs, postcards were sent to remind members to make asthma care follow-up appointments with their PCPs, and members were referred to both the Breathe with Ease Asthma Program Disease Management team and Utilization Management (UM) case managers for follow-up. ◆ Member asthma education articles were published in the spring and fall "Asthma-COPD" newsletter; and practitioner educational articles and asthma information were published in the quality improvement (QI) provider newsletters and also distributed via "Just the Fax", Molina Healthcare of California Partner Plan Inc. (Molina) provider bulletin. ◆ In early 2011, Molina partnered with its pharmacy benefit manager (PMB), Caremark, to provide PCPs with profiles of prescriptions filled by their members. Also, meetings have been held to strengthen pediatric member educational materials. <p>These strategies are ongoing as new members are identified with inappropriate use of asthma medications.</p>

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
<p>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.</p>	<p>Alternative Strategies to Increase Postpartum Care Rates:</p> <ol style="list-style-type: none"> 1. Molina prenatal case managers and Member Services implemented a process to provide transportation for Molina high-risk OB members to medical appointments based on medical needs. 2. The hospital face sheets for all members who deliver are provided to staff making outbound calls to members post-delivery to assist them in scheduling/keeping their postpartum visit. Staff calling members post-C-section reinforces the importance of keeping the regular postpartum check-up appointment with their OB/GYN between 21–56 days of delivery (3–8 weeks). <ul style="list-style-type: none"> ◆ The turn-around time to contact members post-C-section is within 7 calendar days of delivery. ◆ The turn-around time to contact members post-normal vaginal delivery is 7–21 calendar days. ◆ Molina staff telephoning members post-delivery makes three attempts on different days and different times of day. If unable to contact the member by telephone, a Postpartum package is ordered through the fulfillment house to be mailed to the member. The Postpartum package includes the “Postpartum Visit Verification Card” (English and Spanish) with instructions and a contact telephone number at Molina if there are questions. ◆ Members who return the completed Postpartum Visit Verification card receive a gift card incentive. The card must be completed by the OB/GYN office staff including the date of the postpartum visit. <p>The director of UM, HEDIS manager and other health care service staff created the following strategies to ensure continued education for the need for postpartum care for Molina contracted networks:</p> <ul style="list-style-type: none"> ◆ Provide education to the OB/GYN providers a minimum of two times per year related to both the importance of the postpartum check-up at 21–56 days as well as notification of pregnant members as soon as there is a positive pregnancy test. ◆ Add this agenda topic to provider office manager meetings (POMM) in Sacramento, Riverside, and San Bernardino counties a minimum of once each calendar year in each county. ◆ Add written communication (QI newsletter and/or provider newsletter) regarding the postpartum check-up requirement at least one time during each calendar year. ◆ Provide education to the delegated IPA groups related to the postpartum visit at 21–56 days via the fast blast FAX from Molina’s Delegation Oversight Department at a minimum of one time each year.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
<p>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.</p>	<p>Modified intervention strategies that were found to be successful for appropriate treatment for URI have been applied to avoidance of antibiotics for acute bronchitis, an area of low performance for HEDIS 2009. These interventions included:</p> <ul style="list-style-type: none"> ◆ CMA <i>AWARE 2010 Toolkit</i>, mailed in September 2009 to providers who were identified as high antibiotic prescribers. The 2010 toolkit compendia included clinical practice recommendations and provider education materials for the appropriate treatment of acute bronchitis in adults. Planning meetings for the 2011 toolkit were held in February and May of 2010. Bronchitis was again a featured topic for the 2011 toolkit, mailed in September 2010. ◆ QI newsletter, Spring 2010, contained an article entitled, "Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis." Included were HEDIS 2008–2009 results for the bronchitis measure with comparisons to the MPL and NCQA 75th percentile benchmarks, principles of appropriate antibiotic use for acute bronchitis, and notification of the CPGs on the Molina provider Web site. ◆ CPG booklet, <i>Clinical Practice Guidelines and Protocols for Seniors and Persons with Disabilities/Chronic Conditions</i> was distributed to providers' offices by Provider Services in Spring 2010. This booklet included the bronchitis clinical practice recommendations. <p>The HEDIS Riverside/San Bernardino rate for avoidance of antibiotics for acute bronchitis increased to 24.45 percent in 2010 from 18.44 percent in 2009. Interventions are continuing in 2011.</p> <p>Interventions and activities that were derived to improve adolescent well-care visits were focused on both practitioners and members:</p> <ul style="list-style-type: none"> ◆ Molina provider survey for adolescent health care is administered to providers with a high volume of adolescent members (ages 12–18 years) in their practice. These providers are designated as teen-friendly practitioners in the Molina Provider Directory and Provider Online Directory. The providers were offered modules of the Adolescent Provider Toolkit and were encouraged to visit the Adolescent Health Working Group at http://www.ahwg.net/ for additional resources.
<p>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.</p>	<ul style="list-style-type: none"> ◆ Teen newsletter comes out twice a year in the spring and fall. Topics covered include flu and flu vaccine, obesity and nutrition, annual well-care visits with teen check-up certificate incentive, healthy lifestyle information for teens, how to protect self when having summer fun, and birth control. ◆ Member incentive upon completion of adolescent well care ◆ Patient health education handouts about chlamydia, teen and young adults, exercise, and nutrition ◆ Molina's provider bulletin, Just the Fax "Encouraging Children/Adolescents to Seek Their Annual Well-Care Visits" (8/21/09) ◆ Molina's provider bulletin, Just the Fax "Annual Well-Care Visits for Children and Adolescents" (7/30/10)

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
	<p>Although similar interventions and activities with the same focus have been applied to improve postpartum care visits, they were not as successful. This further interprets greater challenges that are associated with member-driven barriers on postpartum care. Although medical chart documentation of office follow-up calls and reminder mailings for postpartum visits have been implemented, these efforts were not enough to significantly improve performance. One intervention strategy that can be applied to improve performance is the improvement of the outreach process for members identified as pregnant and/or delivered.</p>
<p>Increase quality improvement resources for Molina's plan in Riverside/San Bernardino counties until performance trends upwards.</p>	<p>In order to improve performance rates in Riverside/San Bernardino, the following activities that require additional resources and activities have been implemented.</p> <p>Cultural and Linguistic Services:</p> <ul style="list-style-type: none"> ◆ Inland Empire provider office visits consisted of a component of cultural competency where a PowerPoint presentation was reviewed at provider offices (Q2 2010) ◆ Joint operation meeting (JOM) at Vantage Medical Group—Riverside was presented on C & L Services, including interpreter services and CME programs on cultural competency. Discussed health education resources, Staying Healthy Assessment requirements, teen newsletter, ER collaborative, health education referral form and weight management (7/8/2010) ◆ Presented at a Molina staff meeting in Colton. Staff who serve Inland Empire members were informed on interpreter services, how to work with an interpreter, and information on health education programs (9/18/09) ◆ Inland Empire Disabilities Collaborative: Regularly attended the collaborative meetings to discuss and collaborate on issues/programs/services surrounding the seniors and persons with disabilities population in the Inland Empire (monthly from 7/09-6/10) <p>Performed HEDIS outreach calls to members who have not had services rendered based on certain HEDIS measures, with emphasis on reminding members of importance of obtaining screenings, encouraging members to contact their doctor to find out if the following screening(s) were needed, and encouraging members to schedule an appointment or assist members in obtaining an appointment.</p> <ul style="list-style-type: none"> ◆ Adolescent Well Care (AWC) ◆ Mammograms (BCS) ◆ Cervical Cancer Screening(CCS) ◆ Diabetes—DRE and HbA1c ◆ Well Child <p>In addition to HEDIS outreach call intervention to increase performance on Comprehensive Diabetes Care (CDC), the Health Education Department provided member incentives to those who completed their diabetes screenings.</p>

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
<p>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.</p>	<p>Quality improvement project (QIP) documentation incorporated all major outlines found in the HSAG's QIP Summary Form. It addresses the following documentation structures as found in the HSAG's QIP Summary Form:</p> <ul style="list-style-type: none"> ◆ Study topic and the rationale of the QIP. ◆ Study question and its measurability. ◆ Study indicators that define quantifiable measures, including but not limiting to measurement period and goal. ◆ Methods for identifying study population and project methodology, including data collection, analysis and reporting cycle. ◆ Data analysis, including causal analysis, barriers and interpretation of the findings. ◆ Implemented interventions, activities and strategies for improvement. ◆ Remeasurements to monitor findings and evaluate effectiveness.
<p>Address deficient areas related to audit findings for grievances, coordination of care, prior-authorization notifications, and cultural diversity.</p>	<p><u>Coordination of Care for members eligible for early intervention services and for individuals with developmental disabilities:</u></p> <p>If the member's PCP, or a member's family member requests a referral for the Department of Developmental Services (DDS) or Early Start (ES) services, Molina's clinical staff will follow up with the referring PCP to identify the regional center requested and to verify that the PCP has completed the appropriate referral.</p> <p>Starting in 2009, Molina now receives a monthly report from the CA regional centers on all Molina members that are receiving ES and DDS services. This information is entered into Molina's internal database and flagged as an open case in Molina's medical management system. Molina staff sends notification either verbally or via fax to the member's PCP and coordinates any medically-appropriate service that is not provided by the regional center. If the member has a California Children's Services (CCS) eligible condition, the member information and supporting documentation will be submitted to the county-appropriate CCS entity.</p> <p><u>Address deficient areas related to audit findings for prior authorization notification:</u> At least annually the UM / Prior Authorization (PA) staff has received training related to member letter notification, content and turnaround-times. All denial notification letters are reviewed for accuracy and notification/criteria content by the PA manager before they are mailed to Molina members/providers. In addition, Molina's Delegation Oversight Team provides ongoing denial letter review and, as needed, training to Molina's IPAs, medical groups and plan partners who are delegated for UM / PA activities.</p>

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
<p>Address deficient areas related to audit findings for grievances, coordination of care, prior-authorization notifications, and cultural diversity.</p>	<p>Provide cultural diversity training to Molina's provider offices.</p> <p>On an ongoing basis, laminated Cultural and Linguistic Services grids are distributed to provider offices. These grids highlight Molina's interpreter services and cultural and linguistic consultation.</p> <p>In September 2009 a Molina provider bulletin, Just the Fax "Tips for Working with Interpreters" was sent to all contracted providers in all counties. In January 2010 a Molina provider bulletin Just the Fax "Cultural Note on Chaldeans (Iraqi Christians)" was sent to all contracted providers in San Diego.</p> <p>In June 2009 Molina's provider newsletter featured information on Molina's CME programs which address Vietnamese culture and Asian Indian and the Office of Minority Health's, "A Physician's Practical Guide to Culturally Competent Care" which provides tips on how to work with patients from diverse backgrounds and develop cultural competency for staff.</p> <p>Molina distributed weekly cultural notes to staff which Molina Medical Group staff and providers received during October 2009. These cultural notes highlighted topics on disabilities to focus on National Disability Employment Awareness Month.</p> <p>Molina's monthly new employee orientation which Molina Medical Group staff and providers attend received Cultural Competent Customer Service training on 8/10/09, 9/14/09, 10/12/09, 12/14/09, 3/8/10 and 5/10/10.</p> <p>Molina helped coordinated a Childhood Obesity Training/Workshop with providers and office staff in San Diego on August 19, 2009. This training included a cultural component, "Cultural Aspects of Obesity: Cute, Healthy or Dangerous?"</p>

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
<p>Address deficient areas related to audit findings for grievances, coordination of care, prior-authorization notifications, and cultural diversity.</p>	<p>During the 2nd quarter 2010, provider offices received cultural competency training during the quarterly provider office visits in Riverside and San Bernardino counties.</p> <p>Molina's Cultural and Linguistic Specialist presented at the Collaborating for Healthy Communication Conference on April 9, 2010, in San Diego. Many providers and provider office staff were in attendance and received training on cross cultural communication. Molina's C & L Specialist also participated in the conference closing panel, "From Quantity to Quality, a Look at Cultural Context to Improve Patient-Centered Communication."</p> <p>Information on Molina's Cultural and Linguistic Services and CME programs was presented at the provider office manager meetings (POMM) on 8/6/09 in Riverside/San Bernardino, 8/20/09 in San Diego and 9/10/09 in Sacramento. In addition, this information was also shared at the joint operations meetings (JOM) on 7/8/09 in Riverside, 11/19/09 in Sacramento, and on 6/10/10 in Riverside/San Bernardino.</p> <p>During this review period, a provider training curriculum was designed on cross cultural communication. This training addresses cultural influences that shape individual health behavior, cultural differences in patient-physician relationships, disease etiology in diverse patients, communication in patient-physician relationships, how to work effectively with interpreters and how to apply communication techniques to resolve conflicts in a culturally-sensitive way. (A total of four trainings were held in all counties of operation during the fourth quarter 2010, including the POMMs.)</p> <p>Policy and Procedure MS 10 was revised to include oral (telephone call) notification to members regarding resolution of expedited review, in addition to written notification.</p> <p>Molina's grievance form was modified to include Molina's mailing address (at bottom of form) to facilitate the tracking of grievance information submitted to the plan and from any delegated entity.</p>