Performance Evaluation Report

Molina Healthcare of California Partner Plan, Inc.

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

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1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and state-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014.* This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and

[1] *Medi-Cal Managed Care Enrollment Report—June 2014.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Molina Healthcare of California Partner Plan, Inc. ("Molina" or "the MCP"), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

In Riverside and San Bernardino counties, Molina is a full-scope MCP delivering services to its MCMC members as a "commercial plan" (CP) under the Two-Plan Model (TPM). In TPM counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is a "Local Initiative" (LI) and the other a CP. DHCS contracts with both plans. The LI is established under authority of the local government (with input from State and federal agencies, local community groups, and health care providers) to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries in Riverside and San Bernardino counties may enroll in Molina, the CP; or in Inland Empire Health Plan, the alternative LI.

In Sacramento and San Diego counties, Molina delivers services to its MCMC members under a Geographic Managed Care (GMC) model. In the GMC model, DHCS allows MCMC beneficiaries to select from several commercial MCPs within a specified geographic area. The GMC model currently operates in San Diego and Sacramento counties.

As part of the expansion authority, under Section 1115 of the Social Security Act, MCMC expanded into several new counties. Under the expansion, DHCS contracted with Molina to provide MCMC services in Imperial County. In the Imperial model, DHCS contracts with two CPs to provide MCMC services.

Molina became operational in Riverside and San Bernardino counties to provide MCMC services in December 1997. The MCP expanded to Sacramento County in 2000 and San Diego County in 2005. Molina began providing services in Imperial County beginning November 1, 2013. As of June 30, 2014, Molina had 11,509 MCMC members in Imperial County, 58,522 in Riverside County, 74,318 in San Bernardino County, 47,873 in Sacramento County, and 127,581 in San Diego County—for a total of 319,803.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP'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. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-County Organized Health System (COHS) counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

DHCS conducted no compliance reviews with Molina during the review period for this report. The most recent routine monitoring review for Molina was conducted by DHCS's Member Rights/Program Integrity Unit (MR/PIU) January 24, 2011, through January 27, 2011. MR/PIU conducted a follow-up review in October 2012. During the follow-up review, MR/PIU also evaluated Molina's level of progress in performing cultural awareness and sensitivity training required to meet the needs of the SPD population and the MCP's progress in conducting physical accessibility review surveys. HSAG included a summary of the MR/PIU reviews in the MCP's 2012–13 MCP-specific evaluation report.

Strengths

Molina has no outstanding findings from the most recent reviews conducted by DHCS.

Opportunities for Improvement

Since Molina has no outstanding findings from the most recent reviews, HSAG has no recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[4] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

In order to report HEDIS measure rates, MCPs must first have members meet continuous enrollment requirements for each measure being reported, which typically means members need to be enrolled in the MCP for 11 of 12 months during the measurement year. No Molina Medi-Cal members in Imperial County had continuous enrollment during 2013. Consequently, HSAG did not include Imperial County in the 2014 NCQA HEDIS Compliance Audit conducted with Molina, and no data for Imperial County are included in this report. HSAG will include Imperial County in the 2015 NCQA HEDIS Compliance Audit process, and rates for Imperial County will be included in Molina's 2014–15 MCP-specific evaluation report.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Molina Healthcare of California Partner Plan, Inc.* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that Molina followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings is included below.

- Molina provided good oversight of its vendors.

[5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[6] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

- Molina added primary care practitioners during the measurement year with no negative impact on the measures' rates.
- Molina improved its HEDIS audit process from 2013 by designating staff responsible for working specifically on the HEDIS project.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 through Table 3.3 present a summary of Molina's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 through Table 3.3 show the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. 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.

Note: While DHCS generally requires MCPs to report county-level data, DHCS made an exception and allowed Molina to continue to report Riverside and San Bernardino counties as one combined rate.

The reader should note the following regarding Table 3.1 through Table 3.3:

- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:

- All four *Children and Adolescents' Access to Primary Care* measures.
- *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.
- *Comprehensive Diabetes Care—LDL-C Control*. (This measure is being eliminated for HEDIS 2015.)
- *Comprehensive Diabetes Care—LDL-C Screening*. (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
Molina—Riverside/San Bernardino Counties

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.65%	14.03%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	43.22	43.60	39.94	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	285.69	260.50	206.96	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**81.55%**	86.05%	87.83%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	92.11%	95.56%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**81.41%**	84.41%	86.60%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	21.50%	20.13%	30.23%	27.64%	↔
Cervical Cancer Screening	Q,A	—	—	—	60.81%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**53.04%**	**59.63%**	**63.86%**	69.57%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.88%**	**93.65%**	**92.67%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**83.76%**	**83.03%**	**85.02%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**82.68%**	**81.96%**	**85.15%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**84.19%**	**84.51%**	**83.63%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	58.09%	59.33%	56.52%	59.60%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**37.36%**	54.83%	46.68%	50.99%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	78.13%	78.65%	81.92%	82.56%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	**34.40%**	40.00%	43.48%	**38.19%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	28.70%	34.83%	35.93%	34.00%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	75.63%	77.30%	82.61%	79.69%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.73%	81.80%	83.30%	81.90%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	**55.58%**	48.76%	43.71%	48.79%	↔
Controlling High Blood Pressure	Q	—	—	53.83%	**47.22%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	60.88%	69.10%	73.77%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**31.87%**	**43.36%**	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**14.51%**	25.22%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**50.88%**	**43.84%**	**28.99%**	**47.46%**	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**68.58%**	**77.17%**	**64.27%**	**71.52%**	↑
Use of Imaging Studies for Low Back Pain	Q	76.13%	76.40%	78.21%	77.08%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	42.46%	44.32%	42.00%	55.19%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	55.22%	64.97%	59.40%	66.00%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	44.08%	57.08%	49.42%	57.40%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	71.50%	74.77%	68.39%	72.73%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.2—Performance Measure Results
Molina—Sacramento County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.20%	13.71%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	44.96	47.83	50.20	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	238.15	261.22	257.68	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**78.84%**	**73.99%**	**79.52%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	**82.86%**	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**74.23%**	**73.63%**	**79.48%**	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	27.19%	28.29%	23.08%	32.39%	↑
Cervical Cancer Screening	Q,A	—	—	—	60.63%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**54.31%**	**50.12%**	**54.06%**	**59.42%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.79%	**94.81%**	**94.51%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**84.21%**	**84.09%**	**83.89%**	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**83.45%**	**83.80%**	**82.85%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**83.38%**	**84.20%**	**80.58%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	59.62%	58.22%	54.65%	**52.76%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	48.83%	56.22%	47.91%	48.79%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	79.34%	81.78%	78.60%	79.25%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	45.77%	46.89%	46.05%	45.25%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	36.15%	33.78%	31.63%	34.44%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	69.48%	**69.33%**	**70.00%**	75.28%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.00%	83.11%	80.47%	79.47%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	41.78%	40.89%	43.26%	46.36%	↔
Controlling High Blood Pressure	Q	—	—	51.29%	**47.23%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	55.32%	66.04%	67.33%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**31.72%**	51.36%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**17.24%**	22.27%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**49.44%**	**51.36%**	**37.47%**	**43.93%**	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**73.27%**	81.45%	**69.62%**	**74.39%**	↔
Use of Imaging Studies for Low Back Pain	Q	78.95%	84.03%	83.24%	81.50%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	61.95%	62.33%	54.61%	45.70%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	62.65%	64.65%	59.34%	56.51%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	55.68%	58.37%	49.65%	49.89%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.49%	76.10%	73.21%	**67.31%**	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—Performance Measure Results
Molina—San Diego County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.45%	14.93%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	43.3	45.58	40.54	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	331.91	305.90	228.23	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	86.72%	85.15%	86.03%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	94.74%	**79.66%**	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	85.85%	86.01%	87.07%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**17.28%**	**18.21%**	**17.33%**	28.29%	↑
Cervical Cancer Screening	Q,A	—	—	—	68.11%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	72.33%	73.19%	75.00%	76.89%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.76%**	95.93%	95.73%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	88.46%	88.02%	88.81%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**87.55%**	88.31%	89.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**83.75%**	**85.26%**	86.20%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	70.40%	62.00%	62.30%	60.71%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	49.33%	56.44%	58.55%	55.63%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	82.06%	84.44%	88.76%	87.64%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	42.60%	46.22%	57.85%	49.45%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	35.65%	42.22%	47.54%	40.18%	↓
Comprehensive Diabetes Care—LDL-C Screening	Q,A	76.91%	78.22%	86.42%	82.12%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.35%	80.22%	84.31%	84.99%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	48.21%	46.67%	32.55%	41.50%	▼
Controlling High Blood Pressure	Q	—	—	52.76%	53.88%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	71.30%	80.83%	81.44%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**35.33%**	45.12%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**18.63%**	25.18%	↑

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	63.19%	61.40%	**51.52%**	64.68%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.59%	88.94%	**79.72%**	83.00%	↔
Use of Imaging Studies for Low Back Pain	Q	77.66%	**71.98%**	**72.00%**	**68.64%**	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	53.01%	57.67%	64.79%	68.30%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	58.56%	61.86%	65.96%	62.28%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	54.63%	52.33%	55.16%	53.57%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	74.71%	78.89%	74.74%	74.29%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[7] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

[7] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care health plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Table 3.4 through Table 3.9, which present a summary of Molina's 2014 SPD measure results. Table 3.4 through Table 3.6 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[8] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.7 through Table 3.9 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[8] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.4 through Table 3.6.

Table 3.4—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—Riverside/San Bernardino Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.46%	16.27%	▼	14.03%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.84%	89.83%	↑	87.83%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	95.00%	Not Comparable	95.56%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.00%	89.26%	↑	86.60%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	92.80%	NA	Not Comparable	92.67%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	85.22%	78.45%	↓	85.02%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.22%	83.40%	↔	85.15%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.03%	76.02%	↓	83.63%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	54.97%	49.34%	↔	59.60%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	42.16%	45.13%	↔	50.99%
Comprehensive Diabetes Care—HbA1c Testing	79.69%	78.76%	↔	82.56%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.88%	40.71%	↔	38.19%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.91%	35.62%	↔	34.00%
Comprehensive Diabetes Care—LDL-C Screening	76.82%	78.32%	↔	79.69%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.38%	82.96%	↑	81.90%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.53%	48.23%	↔	48.79%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.5—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.34%	15.39%	▼	13.71%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	77.06%	80.05%	↔	79.52%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	83.87%	Not Comparable	82.86%
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.81%	80.25%	↔	79.48%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.72%	NA	Not Comparable	94.51%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.98%	80.95%	↔	83.89%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.01%	79.07%	↔	82.85%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	81.09%	74.85%	↓	80.58%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	42.49%	51.66%	↑	52.76%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	44.02%	50.33%	↔	48.79%
Comprehensive Diabetes Care—HbA1c Testing	74.81%	76.82%	↔	79.25%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	39.44%	45.92%	↔	45.25%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.75%	33.11%	↔	34.44%
Comprehensive Diabetes Care—LDL-C Screening	68.70%	73.73%	↔	75.28%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.77%	81.90%	↑	79.47%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	50.89%	44.59%	↔	46.36%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.6—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.52%	17.07%	▼	14.93%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.81%	87.49%	↑	86.03%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	80.36%	Not Comparable	79.66%
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.50%	88.57%	↑	87.07%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.85%	NA	Not Comparable	95.73%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.86%	86.83%	↔	88.81%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.22%	84.92%	↓	89.06%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	86.40%	81.87%	↓	86.20%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.85%	53.86%	↔	60.71%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.27%	56.73%	↑	55.63%
Comprehensive Diabetes Care—HbA1c Testing	82.78%	88.08%	↑	87.64%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.03%	52.54%	↑	49.45%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.22%	43.05%	↑	40.18%
Comprehensive Diabetes Care—LDL-C Screening	76.38%	83.00%	↑	82.12%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.38%	88.30%	↑	84.99%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.02%	39.51%	▲	41.50%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.7—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—Riverside/San Bernardino Counties

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
192.15	35.41	312.01	72.83

*Member months are a member's "contribution" to the total yearly membership.

Table 3.8—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—Sacramento County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
204.58	44.36	423.73	68.46

*Member months are a member's "contribution" to the total yearly membership.

Table 3.9—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—San Diego County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
197.22	35.84	434.68	71.93

*Member months are a member's "contribution" to the total yearly membership.

Performance Measure Result Findings

The rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure for Riverside/San Bernardino counties was above the HPL in 2014. Across all counties, 24 rates were below the MPLs. San Diego County had the fewest measures with rates below the MPLs (two), and Sacramento County had the most measures with rates below the MPLs (13). Riverside/San Bernardino counties had nine measures with rates below the MPLs.

Across all counties, 19 rates improved significantly from 2013 to 2014. The statistically significant improvement for the following measures resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Diego County.

- *Medication Management for People with Asthma—Medication Compliance 50% Total* in Sacramento and San Diego counties. Note that DHCS did not hold the MCPs accountable for meeting the MPL for this measure in 2013 since 2013 was the first year the measure was reported.
- *Medication Management for People with Asthma—Medication Compliance 75% Total* in Riverside/San Bernardino and San Diego counties. Note that DHCS did not hold the MCPs accountable for meeting the MPL for this measure in 2013 since 2013 was the first year the measure was reported.
- *Prenatal and Postpartum Care—Postpartum Care* in San Diego County.

The rates for the following measures improved from 2013 to 2014; although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014:

- *Childhood Immunization Status—Combination 3* in Riverside/San Bernardino counties
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in San Diego County
- *Comprehensive Diabetes Care—LDL-C Screening* in Sacramento County
- *Medication Management for People with Asthma—Medication Compliance 75% Total* in Sacramento County. Note that DHCS did not hold the MCPs accountable for meeting the MPL for this measure in 2013 since 2013 was the first year the measure was reported.
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in San Diego County

Across all counties, eight rates were significantly worse in 2014 when compared to 2013. The significant decline for two measures resulted in the rates moving from above the MPLs in 2013 to below the MPLs in 2014:

- *Annual Monitoring for Patients on Persistent Medication—Digoxin* in San Diego County
- *Controlling High Blood Pressure* in Riverside/San Bernardino counties. Note that DHCS did not hold the MCPs accountable for meeting the MPL for this measure in 2013 since 2013 was the first year the measure was reported.

The rates for the following measures declined from 2013 to 2014; although the decline was not statistically significant, the change resulted in the rates moving from above the MPLs in 2013 to below the MPLs in 2014:

- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in Riverside/San Bernardino counties
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Sacramento County
- *Controlling High Blood Pressure* in Sacramento County. Note that DHCS did not hold the MCPs accountable for meeting the MPL for this measure in 2013 since 2013 was the first year the measure was reported.
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Sacramento County

Seniors and Persons with Disabilities Findings

The SPD rates for three measures in Riverside/San Bernardino counties, two measures in Sacramento County, and nine measures in San Diego County were significantly better than the non-SPD rates. For all counties, the SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Additionally, the SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure for Riverside/San Bernardino counties and *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure for San Diego County were significantly worse than the non-SPD rates.

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the Plan-Do-Study-Act cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

Molina had five existing IPs in 2013 and three new IPs. Below is a summary of each IP and HSAG's analysis of the progress the MCP made on improving performance on the measures.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Molina was required to submit an IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure for San Diego County for the third consecutive year. The MCP identified no new barriers and interventions included:

- Provider education on the clinical guidelines, HEDIS rates, and information available through the Alliance Working for Antibiotic Resistance Education (AWARE) program.
- A targeted member mailing with information on the appropriate use of antibiotics.

Molina's efforts resulted in the rate for this measure improving significantly from 2013 to 2014 and the rate moving from below the MPL to above the MPL. The MCP will not be required to continue this IP in 2014.

Childhood Immunization Status—Combination 3

Molina was required to submit an IP for the *Childhood Immunization Status—Combination 3* measure for Riverside/San Bernardino and Sacramento counties for the third consecutive year. The MCP identified the following new barriers to the rates being above the MPLs:

- Data quality and quantity that limit the extraction of administrative data to support this measure.
- Issues with coding that prevent data from being posted to the immunization registry databases.

- Staffing issues that delayed implementation of the IP interventions and negatively affected the outcomes.
- Difficulty tracking compliance with the measure due to members making frequent primary care provider changes and immunization registry database inadequacies.

Molina continued its interventions of providing member incentives, monitoring data, offering provider pay-for-performance incentives, and producing provider gap reports. The MCP implemented several new interventions, including:

- Developed a provider engagement team to provide awareness, tools, and education to providers.
- Developed a monthly provider profile and scorecard to provide performance feedback to providers.
- Met regularly with DHCS and the immunization database staff members to resolve immunizations registry issues.
- Redesigned the MCP's quality improvement program to standardize best practice tools and integrate quality improvement into Molina's organizational structure.
- Implemented a HEDIS Interventions Team to address organizational and member barriers.

In addition to the interventions listed above, the MCP implemented a rapid-cycle quality improvement project focused on increasing the administrative data retrieved through the immunization registry database and the Confidential Screening/Billing Report (PM160) claim forms. While the MCP saw improvement in the amount of data retrieved, the results were below the MCP's goals.

The MCP's efforts resulted in the rates for the measure for both counties improving from 2013 to 2014 (although the improvement was not statistically significant). The improvement for Riverside/San Bernardino counties resulted in the rate moving above the MPL; however, the rate remained below the MPL in Sacramento County. Molina will not be required to continue the IP for Riverside/San Bernardino counties; however, the MCP will be required to continue the IP for Sacramento County for the fourth consecutive year.

Prenatal and Postpartum Care

Molina was required to continue the IP for the *Postpartum Care* indicator for Riverside/San Bernardino and Sacramento counties for the third consecutive year and the IP for the *Timeliness of Prenatal Care* indicator for Riverside/San Bernardino counties for the third consecutive year. In 2013, the MCP was required to submit an IP for the first time for the *Postpartum Care* indicator for San Diego County and the *Timeliness of Prenatal Care* indicator for Sacramento and San Diego counties.

The MCP identified the following new barriers to the rates being above the MPLs:

- Revisions to the MCP's Motherhood Matters program were ineffective.
- Providers not utilizing the pregnancy notification form, resulting in the MCP's inability to identify pregnant members.
- Members' lack of understanding and awareness of the importance of timely prenatal care.

To improve the rates, Molina implemented the following interventions:

- Restructured the Motherhood Matters Program to be more robust.
- Implemented the Provider Engagement Project, which makes a team available to providers as the single point-of-contact for all quality issues. Additionally, facility site review nurses on the team worked with providers to increase use of the Pregnancy Notification Report for early identification of pregnant members.
- Expanded the pay-for-performance program to include obstetricians and gynecologists.
- Implemented a HEDIS Interventions Team to identify the qualifying population for a measure, verify positive hits for medical record data, and perform outbound calls to providers and members.

In addition to the interventions listed above, Molina was required to submit information on a rapid-cycle quality improvement project for the *Prenatal and Postpartum Care* measures. The objective of the rapid-cycle quality improvement project was to increase identification of the number of pregnant members in an effort to provide outreach and increase prenatal services obtained by pregnant members. The MCP implemented the following interventions:

- Conducted outreach to providers to increase their compliance with submitting the Pregnancy Notification Report (PNR). A significant increase in PNR submission was achieved as a result of this effort.
- Used information on prescriptions of prenatal vitamins to members to identify eligible members. The MCP found that while there was an initial increase of prenatal services rendered associated with the increased number of eligible members identified, using prenatal vitamin prescriptions as a way to identify pregnant members may yield a high percentage of false positives for pregnancy.

Following are the results of the MCPs efforts:

- The rates for the *Postpartum Care* indicator improved significantly for Riverside/San Bernardino and Sacramento counties from 2013 to 2014; however, the improvement was not enough to bring the rates above the MPLs.
- The rate for the *Timeliness of Prenatal Care* indicator for Riverside/San Bernardino counties improved significantly from 2013 to 2014; however, the rate remained below the MPL in 2014.
- The rate for the *Timeliness of Prenatal Care* indicator for Sacramento improved by more than 4 percentage points from 2013 to 2014; however, the rate remained below the MPL in 2014.
- The rate for both indicators for San Diego County improved to above the MPLs in 2014.

Molina will be required to continue the IPs for the *Prenatal and Postpartum Care—Postpartum Care* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measures for Riverside/San Bernardino and Sacramento counties. The MCP will not be required to continue the IPs for San Diego County since the rates for the measures were above the MPLs in 2014.

Use of Imaging Studies for Low Back Pain

Molina was required to submit an IP for the *Use of Imaging Studies for Low Back Pain* measure for the second consecutive year for San Diego County. The MCP's analysis revealed that a large percentage of inappropriate imaging studies are being conducted in the emergency room (ER) and at federally qualified health centers. To address this issue, Molina continued to implement existing interventions. Additionally, the MCP implemented the following interventions:

- The medical director reviewed hospital policies and procedures for low back pain guidelines when preparing educational sessions with ER physicians.
- The quality improvement department performed quarterly data analysis on the measure and sent follow-up letters to providers who were not in compliance with the low back pain guidelines.

Despite the MCP's efforts, the rate for this measure remained below the MPL for San Diego County for the third consecutive year. Molina will be required to continue the IP for this measure in 2014.

Annual Monitoring for Patients on Persistent Medications

In 2013, Molina was required to submit an IP for the *ACE Inhibitors or ARBs* and *Diuretics* indicators for the *Annual Monitoring for Patients on Persistent Medications* measure for Sacramento County. The MCP identified the following barriers to the rates for these indicators being above the MPLs:

- Data quality issues with the MCP's main contracted lab vendor.
- Lack of provider knowledge of medication monitoring requirements due to the MCP's delay in provider education outreach efforts.

To improve the measure's rate, Molina implemented the following interventions:

- Worked with the vendor to improve data integrity and completeness.
- Provided gap reports to primary care providers three times per year.
- Provided education, tools, quality performance feedback, and a single point of contact regarding quality issues to help providers improve provision and documentation of quality health care to members.

Molina's efforts were not successful in bringing the rates above the MPLs, and the MCP will be required to continue the IPs in 2014.

New Improvement Plans for 2014

Based on 2014 performance measure rates and DHCS's prioritization of key quality improvement areas, Molina will be required to submit new IPs for the following measures:

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for Sacramento County
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* for Riverside/San Bernardino counties
- *Controlling High Blood Pressure* for Riverside/San Bernardino and Sacramento counties
- *Medication Monitoring for People with Asthma—Medication Compliance 50% Total* for Riverside/San Bernardino counties
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Sacramento County

Strengths

Molina improved its HEDIS audit process from 2013 by designating staff responsible for working specifically on the HEDIS project.

The rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure for Riverside/San Bernardino counties was above the HPL in 2014. Across all counties, 19 rates improved significantly from 2013 to 2014 and 11 rates improved from below the MPLs in 2013 to above the MPLs in 2014.

Opportunities for Improvement

Molina continues to have many opportunities for improvement related to performance measures. The MCP will be required to continue most of its IPs and to submit new IPs for six measures. The MCP has the opportunity to continue to use technical assistance calls with DHCS and the EQRO to discuss how the MCP can modify its strategies to improve the likelihood of positive outcomes. Additionally, since San Diego County is performing better than the other counties, the MCP may benefit from implementing strategies in the other counties that are resulting in positive outcomes in San Diego County. Finally, for measures with SPD rates significantly worse than the non-SPD rates, the MCP has the opportunity to assess the factors leading to the significantly worse rates to ensure that the MCP is meeting the needs of the SPD population. While Molina provided a summary of actions taken to address the significantly higher rate of readmissions for the SPD population (see Appendix D), SPD readmissions continued to be significantly higher in 2014 for all counties; therefore, HSAG recommends that Molina continue to assess whether or not the MCP has processes in place to meet the SPD population's health care needs.

Conducting the EQRO 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 CMS validation protocol[9] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

HSAG organized, aggregated, and analyzed Molina's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[9] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Quality Improvement Project Objectives

Molina participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2013–June 30, 2014.

Table 4.1 below lists Molina's QIPs and indicates the county in which the QIP is being conducted, whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for Molina
July 1, 2013, through June 30, 2014

QIP	Counties	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Riverside/San Bernardino, Sacramento, and San Diego	Clinical	Q, A
Improving Hypertension Control	Riverside/San Bernardino, Sacramento, and San Diego	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members, leading to improved health outcomes.

Molina's *Improving Hypertension Control* QIP evaluated whether members' blood pressure was controlled. Controlled blood pressure in members with hypertension is associated with reductions in stroke, myocardial infarction, and heart failure incidences. At the initiation of the QIP, the percentage of hypertensive members with controlled blood pressure ranged between 56.6 to 66.4 percent for Molina's counties. For this QIP, the rates for Riverside and San Bernardino counties are combined to be consistent with HEDIS reporting since the project outcome is a HEDIS measure; Sacramento and San Diego counties' rates are reported separately.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2013, through June 30, 2014

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	All counties received the same score	Annual Submission	69%	86%	*Partially Met*
		Annual Resubmission 1	100%	100%	*Met*
Internal QIPs					
Improving Hypertension Control	Riverside/San Bernardino	Annual Submission	77%	90%	*Not Met*
		Annual Resubmission 1	94%	100%	*Met*
	Sacramento	Annual Submission	74%	90%	*Not Met*
		Annual Resubmission 1	91%	100%	*Met*
	San Diego	Annual Submission	79%	90%	*Not Met*
		Annual Resubmission 1	91%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that Molina's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, Molina resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score. The *Improving Hypertension Control* QIP annual submission received an overall validation status of *Not Met*. Molina resubmitted the QIP and achieved an overall *Met* validation status, with at least 91 percent of the

evaluation elements and 100 percent of the critical elements receiving a met score across all counties.

Table 4.3 summarizes the aggregated validation results for Molina's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
(Number = 12 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	95%	0%	5%
Design Total		**98%**	**0%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	86%	6%	8%
	VIII: Appropriate Improvement Strategies**	51%	17%	31%
Implementation Total		**75%**	**10%**	**15%**
Outcomes	IX: Real Improvement Achieved	33%	0%	67%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**33%**	**0%**	**67%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through VIII for Molina's *All-Cause Readmissions* QIP annual submission and Activities I through IX for the MCP's *Improving Hypertension Control* QIP annual submission.

Molina demonstrated a strong application of the Design stage, meeting 98 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. Molina did not describe its data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. Molina met all requirements for all applicable evaluation elements within the Design stage for its *Improving Hypertension Control* QIP.

Both QIPs progressed to the Implementation stage during the reporting period. The MCP demonstrated an adequate application of the Implementation stage, meeting 75 percent of the

requirements for all applicable evaluation elements within the study stage for both QIPs. In the initial submission of the *All-Cause Readmissions* QIP, Molina did not document a data analysis plan, did not indicate if there were factors that threatened the internal or external validity of the findings, and did not provide a description of its causal/barrier analysis process, resulting in lower scores for Activities VII and VIII. The MCP corrected the deficiencies, and upon resubmission the QIP achieved an overall *Met* validation status. In the initial submission of the *Improving Hypertension Control* QIP, Molina did not indicate if there were factors that threatened the internal or external validity of the findings, provided inaccurate interpretation of its outcomes, did not document the MCP's causal/barrier analysis process, did not include planned interventions, and did not include an evaluation plan for each intervention, resulting in lower scores for activities VII and VIII. In the resubmission, the MCP provided additional documentation, resulting in both the scores for these activities improving and the QIP achieving an overall *Met* validation status.

Only the *Improving Hypertension Control* QIP progressed to the Outcomes stage during the reporting period. The QIP received a lower score in Activity IX for Sacramento and San Diego counties because there was no improvement in the study indicator's rate from Remeasurement 2 to Remeasurement 3. The QIP received a lower score for Activity IX in all counties because the study indicator did not achieve statistically significant improvement over baseline. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included for this QIP in this report. The MCP implemented many interventions to reduce readmissions, including:

- Conducted inpatient review rounds with the MCP's medical director and utilization management staff to discuss members currently hospitalized. (Members are identified for case management prior to hospital discharge.)
- Case managers made a "Welcome Home Call" to the member within 24 hours of discharge. The purpose of the call is to both determine that the member understood the discharge instructions and confirm that the member scheduled the follow-up appointment with the primary care physician (PCP).
- Conducted Interdisciplinary Care Team meetings with the MCP's medical directors and care/case managers to address all aspects of members' health care, including medical, behavioral, and social health needs. Care transition clinicians communicated discharge plans to physicians and other community service providers to ensure appropriate follow-up care of members after discharge.
- Encouraged members to be active participants in their own care.
- Planned to hire five more care/case managers plus community health workers and support staff as needed.

- Reorganized discharged member assignment to care/case managers to promote timely care coordination and discharge follow-up.
- Upon admission to the MCP case management program, provided timely verbal and written communication of member issues, interventions, and medication adjustments to the PCP.
- Notified PCPs of member admission and discharge and provided discharge plans to the PCPs.
- Facilitated safe discharges by making on-call discharge staff available after hours, on weekends, and on holidays.
- Care managers arranged for in-home support services so members received required care in the community. Additionally, community health workers are assigned to members to provide social support.
- Care managers, community connectors, or member services staff assisted members in receiving all transportation related to health care.
- Care managers, community connectors, and member services staff continually educated members regarding their plan benefits, health problems, treatment requirements and options, use of translator services, and use of other support services to optimize recovery and prevent health problems.

Outcome information for the *All-Cause Readmissions* QIP will be included in Molina's 2014–15 MCP-specific evaluation report.

Table 4.4 summarizes the *Improving Hypertension Control* QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Table 4.4—Quality Improvement Project Outcomes for Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2013, through June 30, 2014

QIP #1—Improving Hypertension Control					
Study Indicator: Percentage of members 18 to 85 years of age who had both a systolic and diastolic blood pressure of <140/90.					
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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
Riverside/San Bernardino	59.6%	42.6%*	53.7%*	53.8%	‡
Sacramento	56.6%	50.8%	53.1%	51.3%	‡
San Diego	66.4%	58.3%*	55.0%	52.8%	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

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

Improving Hypertension Control QIP

In 2013, Molina submitted Remeasurement 3 results for the *Improving Hypertension Control* QIP. The rates for all three counties remained below the baseline rate at Remeasurement 3. A review of the MCP's QIP Summary Form and QIP Validation Tools revealed the following observations:

- Molina did not provide complete and/or accurate information throughout the QIP Summary Form and had to resubmit the QIP.
- Initially, Molina did not thoroughly document its causal/barrier analysis, planned interventions, or evaluation plan for each of the interventions; however, the MCP provided this documentation in the resubmission.
- During Remeasurement 3, Molina noted that the SPD population almost doubled in each county, which may have affected the rates.
- Molina performed a causal/barrier analysis that applied to all counties instead of performing county-specific causal/barrier analyses.
- Although the interventions were not successful in improving the QIP outcomes, following is a brief description of the interventions implemented by Molina:
  - Provider Engagement Project: The MCP provided an expert resource who worked with designated provider groups to improve provision and documentation of quality health care for members.
  - Provider Profile Scorecard: The MCP set goals and informed providers of the goals relevant to quality performance.
  - Quality Improvement Redesign: The MCP implemented quality improvement redesign to align all organization-wide performance activities with strategic goals, standardize best practice tools and trainings, and establish sufficient and efficient resources.

Strengths

Molina demonstrated an excellent application of the QIP Design stage for both QIPs. The MCP met all requirements for all applicable evaluation elements within the Design stage for its *Improving Hypertension Control* QIP.

Opportunities for Improvement

Since Molina had several instances of incomplete data, the MCP has the opportunity to ensure that all required documentation is included in the QIP Summary Form. The MCP should reference the QIP Completion Instructions and previous QIP validation tools to ensure that all documentation requirements for each activity have been addressed prior to submission.

Although Molina indicated the MCP would build on the success shown in Riverside/San Bernardino and Sacramento counties for the *Improving Hypertension Control* QIP (see Appendix D), the MCP was unable to demonstrate any improvement at Remeasurement 3. Molina has the opportunity both to assess if the MCP should discontinue or modify existing interventions or identify new interventions to better address the large influx of SPD members. The MCP also has the opportunity to perform county-specific casual/barrier analyses to determine whether or not different barriers exist in each county and to then implement appropriate county-specific interventions as needed.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the MCPs' medical audit/SPD medical survey reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix C.

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[10]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP 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, DHCS monitors aspects of an MCP'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. DHCS also uses the results

[10] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed Molina's quality improvement program description, which includes details of the MCP's quality program structure and approaches to quality improvement. Additionally, the MCP's work plan includes goals designed to ensure that quality care is provided to members.

The rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure, which falls into the quality domain of care, was above the HPL in Riverside/San Bernardino counties. Across all counties, 16 rates for measures falling into the quality domain of care improved significantly from 2013 to 2014.

Across all counties, 16 rates for measures falling into the quality domain of care were below the MPLs, with only two of those rates being in San Diego County. The rates for the following quality measures were significantly worse in 2014 when compared to 2013:

- *Annual Monitoring for Patients on Persistent Medications—Digoxin* in San Diego County, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in San Diego County
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in San Diego County
- *Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)* in San Diego County
- *Controlling High Blood Pressure* in Riverside/San Bernardino counties, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014. Note that DHCS did not hold the MCPs accountable for meeting the MPL for this measure in 2013 since 2013 was the first year the measure was reported.
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Sacramento County

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. The SPD rates for three measures in Riverside/San Bernardino counties, two measures in Sacramento County, and nine measures in San Diego County were significantly better than the non-SPD rates. For all counties, the SPD rates for the *All-Cause Readmissions* measure, which falls into the quality domain of care, were significantly worse than the non-SPD rates.

Both of Molina's QIPs fell into the quality domain of care. Only the *Improving Hypertension Control* QIP progressed to the Outcomes stage during the reporting period. The QIP did not show improvement, suggesting that the MCP has opportunities for improvement in the quality of care being provided to MCMC members with hypertension.

Overall, Molina showed below-average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed Molina's available quality improvement information and found descriptions of activities and processes designed to ensure members' access to care. Molina's 2013 Quality Improvement Report describes results of quality improvement activities and, as was true in 2012, the MCP met or exceeded most access-related goals. Additionally, the report provides information about opportunities for improvement and interventions the MCP plans to implement to address the areas in need of improvement.

The rates for the following access measures improved significantly from 2013 to 2014:

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in Riverside/San Bernardino and San Diego counties; however, the rate for Riverside/San Bernardino remained below the MPL for the third consecutive year.
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Riverside/San Bernardino counties; however, the rate remained below the MPL for the third consecutive year.
- *Prenatal and Postpartum Care—Postpartum Care* in all three counties; however, the rates for Riverside/San Bernardino and Sacramento counties remained below the MPLs for the fourth consecutive year.
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Riverside/San Bernardino counties; however, the rate remained below the MPL for the fourth consecutive year.

San Diego County had no access measures with rates below the MPLs. The rates for six access measures in Riverside/San Bernardino counties and eight access measures in Sacramento County were below the MPLs. The rates for Riverside/San Bernardino and Sacramento counties for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure, which falls into the access domain of care, declined significantly from 2013 to 2014.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rates for one measure in Riverside/San Bernardino counties, one measure in Sacramento County, and four measures in San Diego County were significantly better than the non-SPD rates. For all counties, the SPD rates for the *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measures, which fall into the access domain of care, were significantly worse than the non-SPD rates. Additionally, the SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure for Riverside/San Bernardino counties and *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure for San Diego County were significantly worse than the non-SPD rates.

Both of Molina's QIPs fell into the access domain of care. Only the *Improving Hypertension Control* QIP progressed to the Outcomes stage during the reporting period. The QIP did not show improvement, suggesting that the MCP has opportunities for improvement in ensuring access to care for MCMC members with hypertension.

Overall, Molina showed below-average performance related to the access domain of care.

Timeliness

The timeliness domain of care relates to an MCP'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.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' 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. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

HSAG's review of Molina's quality documents found descriptions of monitoring processes and goals related to ensuring timeliness of care for MCMC members. Molina's 2013 Quality Improvement Report describes results of quality improvement activities and the report indicates that the MCP met or exceeded most timeliness goals.

The rates for the following timeliness measures were below the MPLs:

- *Childhood Immunization Status—Combination 3* in Sacramento County for the fourth consecutive year.

- *Prenatal and Postpartum Care—Postpartum Care* in Riverside/San Bernardino and Sacramento counties for the fourth consecutive year, despite the rates for both counties improving significantly from 2013 to 2014.
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Riverside/San Bernardino and Sacramento counties for the fourth consecutive year for Riverside/San Bernardino counties and the second consecutive year for Sacramento County. (Note that the rate for Riverside/San Bernardino counties improved significantly from 2013 to 2014.)
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Sacramento County.

Overall, Molina showed below-average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. Molina's self-reported responses are included in Appendix D.

Recommendations

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

- Continue to use technical assistance calls with DHCS and the EQRO to discuss how Molina can modify its strategies to improve the likelihood of positive outcomes. Specifically, focus efforts on the following measures, for which the MCP is required to submit IPs in 2014:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for Sacramento County
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics* for Sacramento County
  - *Childhood Immunization Status—Combination 3* for Sacramento County
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for Sacramento County
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* for Riverside/San Bernardino counties
  - *Controlling High Blood Pressure* for Riverside/San Bernardino and Sacramento counties
  - *Medication Monitoring for People with Asthma—Medication Compliance 50% Total* for Riverside/San Bernardino counties
  - *Prenatal and Postpartum Care—Postpartum Care* for Riverside/San Bernardino and Sacramento counties

  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Riverside/San Bernardino and Sacramento counties
  - *Use of Imaging Studies for Low Back Pain* for San Diego County
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Sacramento County

- Since San Diego County is performing better than the other counties, consider implementing strategies in the other counties that are resulting in positive outcomes in San Diego County.
- For measures with SPD rates significantly worse than the non-SPD rates, assess factors leading to the significantly worse rates to ensure that the MCP is meeting the needs of the SPD population. While Molina provided a summary of actions the MCP has taken to address the significantly higher rate of readmissions for the SPD population (see Appendix D), SPD readmissions continued to be significantly higher in 2014 for all counties; therefore HSAG recommends that Molina continue to assess whether or not the MCP has processes in place to meet the SPD population's health care needs.
- Ensure that all required documentation is included in the QIP Summary Form. The MCP should reference the QIP Completion Instructions and previous QIP validation tools to ensure that all documentation requirements for each activity have been addressed prior to submission.
- For its *Improving Hypertension Control* QIP, both to assess if the MCP should discontinue or modify existing interventions or identify new interventions to better address the large influx of SPD members. Additionally, perform county-specific causal/barrier analyses to determine whether or not different barriers exist in each county and to then implement appropriate county-specific interventions as needed.

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

Table A.1 through Table A.3 provide two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the tables:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table A.1—HEDIS 2014 SPD Trend Table
Molina—Riverside/San Bernardino Counties

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	18.15%	16.27%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	67.24	72.83	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	346.49	312.01	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.80%	89.83%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	90.63%	95.00%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.06%	89.26%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	79.18%	78.45%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	84.52%	83.40%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.44%	76.02%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	56.25%	49.34%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.88%	45.13%	↔
Comprehensive Diabetes Care—HbA1c Testing	80.21%	78.76%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	47.40%	40.71%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	42.19%	35.62%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.56%	78.32%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	88.02%	82.96%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	44.79%	48.23%	↔

*Member months are a member's "contribution" to the total yearly membership.

Table A.2—HEDIS 2014 SPD Trend Table
Molina—Sacramento County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	14.68%	15.39%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	65.28	68.46	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	415.90	423.73	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	74.59%	80.05%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	83.87%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	74.40%	80.25%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	79.27%	80.95%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.88%	79.07%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	79.40%	74.85%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.80%	51.66%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.83%	50.33%	↔
Comprehensive Diabetes Care—HbA1c Testing	73.91%	76.82%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.17%	45.92%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.06%	33.11%	↔
Comprehensive Diabetes Care—LDL-C Screening	63.77%	73.73%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.88%	81.90%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	44.20%	44.59%	↔

*Member months are a member's "contribution" to the total yearly membership.

Table A.3—HEDIS 2014 SPD Trend Table
Molina—San Diego County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	17.65%	17.07%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	61.02	71.93	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	512.86	434.68	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.79%	87.49%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	94.12%	80.36%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.10%	88.57%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	80.65%	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	84.13%	86.83%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.63%	84.92%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.01%	81.87%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.45%	53.86%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.11%	56.73%	↔
Comprehensive Diabetes Care—HbA1c Testing	85.21%	88.08%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	57.75%	52.54%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	51.41%	43.05%	↔
Comprehensive Diabetes Care—LDL-C Screening	83.80%	83.00%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	90.14%	88.30%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	37.32%	39.51%	↔

*Member months are a member's "contribution" to the total yearly membership.

Table B.1 through Table B.3 provide two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the tables:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table B.1—HEDIS 2014 Non-SPD Trend Table
Molina—Riverside/San Bernardino Counties

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.17%	8.46%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	40.14	35.41	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	247.94	192.15	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.14%	83.84%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.14%	81.00%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.77%	92.80%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.13%	85.22%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.88%	85.22%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.55%	84.03%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.63%	54.97%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.89%	42.16%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.23%	79.69%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	42.32%	34.88%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.76%	30.91%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.65%	76.82%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.40%	76.38%	↓
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	46.06%	54.53%	▼

*Member months are a member's "contribution" to the total yearly membership.

Table B.2—HEDIS 2014 Non-SPD Trend Table
Molina—Sacramento County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.02%	7.34%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	42.97	44.36	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	218.18	204.58	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	71.60%	77.06%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	70.51%	75.81%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.90%	94.72%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	84.18%	83.98%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.64%	83.01%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.55%	81.09%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	57.40%	42.49%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	44.84%	44.02%	↔
Comprehensive Diabetes Care—HbA1c Testing	74.44%	74.81%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	38.12%	39.44%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	27.35%	28.75%	↔
Comprehensive Diabetes Care—LDL-C Screening	64.13%	68.70%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.30%	72.77%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	50.22%	50.89%	↔

*Member months are a member's "contribution" to the total yearly membership.

Table B.3—HEDIS 2014 Non-SPD Trend Table
Molina—San Diego County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.37%	8.52%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	43.19	35.84	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	273.91	197.22	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.63%	81.81%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.40%	82.50%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.16%	95.85%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.11%	88.86%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.25%	89.22%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.32%	86.40%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.21%	55.85%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	45.42%	43.27%	↔
Comprehensive Diabetes Care—HbA1c Testing	81.69%	82.78%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.83%	45.03%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.80%	34.22%	↔
Comprehensive Diabetes Care—LDL-C Screening	72.18%	76.38%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.13%	76.38%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	42.25%	47.02%	↔

*Member months are a member's "contribution" to the total yearly membership.

Quality, Access, and Timeliness Scoring Process

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[11] This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1 through Table 3.3)

Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
   - If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.
3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

[11] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
   - If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

Validation *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.4)*: Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Some, but not all, study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

APPENDIX D. MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT

for Molina Healthcare of California Partner Plan, Inc.

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with Molina's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—Molina's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to Molina	Actions Taken by Molina During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Since Molina had 25 measures with rates below the MPLs in 2013 and 16 measures with rates that were significantly lower in 2013 when compared to 2012, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.	Implementation of effective processes and interventions is the key driver in achieving high quality performance. In order to improve our measure rates, Molina focused on several priority areas during July 2013–June 30, 2014: • Molina participated in a technical assistance call with the DHCS's external quality review organization and Health Services Advisory Group, Inc. (HSAG), to identify priority areas for improvement and focus on priority areas—*Prenatal Postpartum Care* and *Childhood Immunization Status*. • Molina participated in two technical assistance calls with DHCS to discuss our HEDIS Improvement Plans (IPs) and develop interim measurement strategies – Plan/Do/Study/Act (PDSA) reports. Molina submitted PDSA reports for *Prenatal*, *Postpartum Care,* and *Childhood Immunization Status*. • Molina participated in a technical assistance call with DHCS for the *All-Cause Readmissions* statewide collaborative Quality Improvement Project (QIP). • *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)*: HEDIS educational sessions with provider groups and federally qualified health centers' (FQHC) leadership, including medical directors, were conducted by the Molina Medical Director. Session topics included HEDIS rates, opportunities for improvement of the *AAB* measure, and codes to identify clinically appropriate indications for *AAB* prescriptions. Meetings with the FQHCs occur quarterly. Molina Quality Improvement Department performed quarterly data review and followed up with communication letters to providers who were not in compliance with the *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* guidelines.

2012–13 External Quality Review Recommendation Directed to Molina	Actions Taken by Molina During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	• *Comprehensive Diabetes Care—LDL-C Screening (CDC-LS)*: Molina's computer system alerts the outreach staff and provides talking points when engaging members in motivational conversations about their healthcare needs and member benefits. • *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB): Comprehensive Diabetes Care—LDL-C Screening (CDC-LS)*: A data review of the contracted lab vendor was conducted to validate the data match between encounter data and lab vendor data. Member outreach to members in need of HEDIS services, aimed at getting all members appointments with their PCPs for annual diabetes care HEDIS related services. • *Low Back Pain (LBP)*: HEDIS educational sessions with provider groups and FQHC leadership, including medical directors, were conducted by the Molina Medical Director. Session topics included HEDIS rates and opportunities for improvement of the *LBP* measure to identify clinically appropriate indications for *LBP* imaging studies and to discuss the importance in avoiding imaging studies within 28 days of initial diagnosis of low back pain. Data review for the *Low Back Pain* HEDIS measure with follow-up communication letters to providers who were not in compliance. Quarterly progress reports provided to FQHC leadership. • *Childhood Immunization Status (CIS)*: Molina established a plan to rectify data issues found in the California Immunization Registry (CAIR). Resources are allocated to work towards a solution. Molina implemented a project aimed at enhancing the monitoring of encounter data, evaluating PM160 form submission, and measuring the volume and accuracy of submissions. • *Annual Monitoring for Patients on Persistent Medications (MPM)*: Molina conducted quarterly meetings for PCP office managers and other staff to provide education regarding HEDIS measures, including education regarding the necessary care and laboratory screening for members on persistent medications • *Prenatal and Postpartum Care (PPC-Pre and PPC-Pst)*: Molina redesigned and expanded its "Motherhood Matters" program. The program educates members and increases their understanding and awareness regarding prenatal and postpartum care and how essential it is to maintain child and maternal health. All members receive written materials, assistance with scheduling provider appointments, assistance with overcoming barriers to access, and pregnancy-related interventions.

<table>
<tr><th>2012–13 External Quality Review Recommendation Directed to Molina</th><th>Actions Taken by Molina During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation</th></tr>
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<u>All measures</u>:
Ongoing Provider Office Manager Meetings (POMMs) and Joint Operations meetings (JOMs) to discuss HEDIS measure requirements, codes, and related clinical guidelines to increase provider awareness and facilitate improvement in HEDIS rates.
Quality Improvement (QI) Department redesign: Implementation and expansion of the QI and HEDIS interventions staff to facilitate additional interventions, including medical record review and outbound calls to providers and members.

Molina implemented a Provider Engagement program to improve processes among our provider groups and to increase Molina's HEDIS rates. Molina's multi department team approach educated providers and their office staff about tools and resources to ensure Molina members receive all necessary services.

Implementation of the HEDIS profile tool for providers. The HEDIS profile tool facilitates member management for our providers and improves the quality of care to our members. This allows providers to track their progress in meeting HEDIS goals. Providers and groups are able to go to the plan's provider website and:
View their own HEDIS scores and compare performance against peers and national benchmarks along with ability to do the following functions:
Retrieve/print list of members who need HEDIS services completed
Search/filter for members with HEDIS needed services
Submit HEDIS chart documentation online for services completed to update our system
Access provider education material was developed in a pocket-sized format for physicians to increase their knowledge about HEDIS measures. This material was also distributed to providers during provider engagement visits.
Access monthly HEDIS reports to identify services that are in need of intervention and to allow for monitoring and evaluation of current interventions.

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<tr><td>2. Since the SPD rate for the All-Cause Readmissions measure was significantly higher than the non-SPD rate in all counties, assess the factors that are leading to a higher rate of readmissions for the SPD population and identify strategies to ensure the MCP is meeting the needs of the SPD population.</td><td>The high rate of readmissions for the SPD population is a result of the complexity of illness, often the challenges of coordinating care during transition from the hospital to an alternative care setting, and the need for improvement of provider and hospital engagement.
Molina has an established Complex Case Management Transition of Care Model (ToC). The model is a patient-centered program designed to improve quality, reduce readmissions, and address complex care needs as the member transitions across settings.</td></tr>
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2012–13 External Quality Review Recommendation Directed to Molina	Actions Taken by Molina During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	Transition of Care Model Features: • The program has a "high-touch"; patient-centered focus with the ToC team conducting face-to-face visits during inpatient hospitalization and telephonic outreach within 30 days of discharge. The four critical elements that provide the foundation to help prepare members, including the SPD population, to navigate their transition are: o Medication Management—coordination of member medication authorizations as appropriate, medication therapy management, and member education. o Personal Health Record (PHR)—Molina staff assist members with completion of a portable document with pertinent medical history, practitioner information, discharge checklist, and medication record. The PHR ensures continuity across practitioners and settings. o Follow up with practitioner and/or specialist appointments—Molina staff facilitate appointment scheduling and transportation to ensure members keep follow-up appointments and understand the importance of sharing PHR and medication record. o Knowledge of 'Red Flags'—Molina staff will ensure that members are aware of signs and symptoms that may indicate that their condition is worsening and how to respond.
3. For its *Improving Hypertension Control* QIP, build on the successes from the interventions being implemented in Riverside/San Bernardino and Sacramento counties and apply applicable strategies in San Diego County that will hopefully result in the rate for the QIP study indicator achieving statistically significant and sustained improvement over baseline.	The goal of Molina's continuing *Controlling High Blood Pressure* (CBP) QIP is to achieve statistically significant and sustained improvement over baseline for all counties—Riverside/San Bernardino, Sacramento and San Diego. Data analysis was conducted to identify specific barriers and develop specific interventions to improve the rates for this QIP study for San Diego County as well as the other counties. • The Hypertension Toolkit project was developed to: Engage provider offices to improve specific clinical, coding, financial, and quality metrics with an emphasis in hypertension. This intervention addresses the barrier of practice variation in treatment of hypertension and lack of knowledge of the current clinical practice guideline for hypertension. Molina staff will coordinate with providers to understand how to use the tools provided by Molina to address opportunities for improvement: o Encourage providers to use automated blood pressure devices. o Encourage/remind providers to have their staff regularly evaluated for taking accurate blood pressure readings. o Encourage/remind providers to prescribe combination blood pressure medications. o Encourage providers to avoid overtreatment and under treatment o Discuss 8th Joint National Committee (JNC 8) new clinical practice guidelines.

2012–13 External Quality Review Recommendation Directed to Molina	Actions Taken by Molina During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	○ Provide office staff with a member education poster. • Member education is included which focuses on the importance of controlling blood pressure. This addresses the barriers of lack of member understanding of the importance of controlling hypertension and taking prescribed medications and patient noncompliance with prescribed medication therapy. A packet mailed to members includes: ○ An educational flyer explaining ways to control blood pressure. ○ A pill box to assist members with maintaining compliance with medication therapy. ○ A blood pressure wallet card with areas to list medications, a list of questions to ask their provider, a blood pressure log to track the date/time and blood pressure, and tips to help lower blood pressure. • A pre-paid pre-addressed postcard for members to give Molina feedback if they have any difficulties with their medications. Molina reviews returned postcards and outreaches to the members. ○ Member outreach calls to members in need of hypertension HEDIS services to address the barriers of lack of member understanding of the importance of controlling hypertension and taking prescribed medications, and patient noncompliance with prescribed medication therapy. ○ Molina implemented the HEDIS Profile tool. The HEDIS Profile tool facilitates member management for our providers and improves the quality of care to our members. The tool addresses the barriers of lack of PCP awareness of their assigned members' hypertension diagnosis and their need for an annual visit and appropriate treatments.
4. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Rating of Health Plan, Rating of Personal Doctor,* and *Rating of All Health Care* priority areas.	***Rating of Health Plan, Rating of Personal Doctor*** • Annual midyear CAHPS survey was conducted to measure member satisfaction and perception of the members during the interim period after the annual CAHPS survey. This is a proactive intervention to identify and improve member satisfaction. The survey provides more detailed insight into members' ratings of their plan and their doctor. The model: ○ Identifies elements that are drivers of overall ratings of the health plan. ○ Measures the relative importance of each of the elements. ○ Measures how well members think the plan performed on those elements.

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

2012–13 External Quality Review Recommendation Directed to Molina	Actions Taken by Molina During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	Rating of Health Plan, Rating of All Health Care • The Molina CAHPS Workgroup evaluates survey results to make recommendations to improve the member's experience with Molina. The workgroup is comprised of cross-functional departments: QI, Health Education, Provider Services, Community Engagement, and Molina provider groups. ***Rating of Personal Doctor, Rating of All Health Care*** • Molina developed a training curriculum to train physicians and office staff. o Training module is focused to develop behaviors that lead to superior customer service and how it applies to meet member needs. Specifics of modules include: o Holding conversation with members. o Dealing with special needs and special issues (cultural, language, ability). • Developed "What You Can Do to Make the Most of Your Doctor's Appointment" brochure to educate and inform members of Molina's standard access time frame for different types of appointments and what members can do to facilitate efficient doctor's visits. ***Rating of Health Plan*** • Implemented Every Member Counts (EMC) campaign. Trained and educated Molina staff on techniques to improve member satisfaction, including how to handle difficult calls and appropriate resolution of member concerns.
5. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.	• Molina reviewed the 2012–13 MCP- Specific Encounter Data Validation Study Report and created strategies for improvement. o Molina has developed a strategic plan to monitor provider group reporting and performance. Molina will monitor reporting patterns for under reporting and ensure that all files received are processed and all records received are submitted to the State. o Molina will work collaboratively with the provider groups to improve performance and accuracy, and incentives will be used to reinforce both improved performance and data accuracy. o Molina is working with pharmacy vendor and delegated entities to improve pharmacy record omission rate and record surplus. o Molina has initiated a review of data reported by provider groups to determine: (1) if the data is submitted consistently and correctly to Molina; (2) if the data is received, mapped, and stored correctly in Molina databases; and (3) if the data is mapped and submitted correctly to the State.

2012–13 External Quality Review Recommendation Directed to Molina	Actions Taken by Molina During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	○ Systems are in place to ensure that encounter reporting matches the National Uniform Billing Committee billing rules. Implemented the Health Insurance Portability and Accountability Act 837 format standards for hospital encounter reporting to increase the accuracy of hospital encounter data.