

# Performance Evaluation Report

## Molina Healthcare of California Partner Plan, Inc.

July 1, 2010–June 30, 2011

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

June 2012



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# Performance Evaluation Report

## Molina Healthcare of California Partner Plan, Inc.

July 1, 2010 – June 30, 2011

### 1. INTRODUCTION

## Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)<sup>1</sup> in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- ◆ The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- ◆ Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

<sup>1</sup> *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

This report is specific to the MCMC Program’s contracted plan, Molina Healthcare of California Partner Plan, Inc. (“Molina” or “the plan”), which delivers care in Riverside, San Bernardino, Sacramento, and San Diego counties, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

## Plan Overview

Molina Healthcare of California Partner Plan, Inc., is a full-scope Medi-Cal managed care plan operating in four counties—Riverside, San Bernardino, Sacramento, and San Diego.

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

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

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

Molina began services under the MCMC Program in Riverside and San Bernardino counties in 1998. The plan expanded into Sacramento County in 2000 and San Diego County in 2005. As of June 30, 2011, Molina had 195,731 enrolled members under the MCMC Program for all of its contracted counties.<sup>2</sup>

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

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<sup>2</sup> *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

## 2. ORGANIZATIONAL ASSESSMENT AND STRUCTURE

for Molina Healthcare of California Partner Plan, Inc.

### Conducting the Review

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

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

### Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about Molina's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

#### *Medical Performance Review*

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

HSAG reviewed the most current medical performance audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards.

As stated in Molina's July 1, 2009–June 30, 2010, evaluation report, the most recent medical performance review audit was completed in April 2011. At the time of this report, findings from the audit were not yet available. The detailed findings from the audit conducted in December 2005 for the period December 1, 2004 through November 30, 2005, and details from the October 26, 2006, DHCS *Medical Audit Close-Out Report* letter were included in Molina's 2008–2009 evaluation report<sup>3</sup>. The close-out report noted that all audit deficiencies were resolved by the plan.

### ***Medi-Cal Managed Care Member Rights and Program Integrity Review***

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

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

The most current MRPIU review of Molina was conducted in January 2011, covering the review period of January 1, 2009, through March 31, 2010. The findings of this review were detailed in the previous evaluation report and included two findings in the area of member grievances and one in the area of prior-authorization notification. The review also showed that Molina's policies and procedures and applicable contract language met the DHCS's requirements related to program integrity/anti-fraud and abuse.

<sup>3</sup> *Performance Evaluation Report – Molina Healthcare of California Partner Plan, Inc., July 1, 2008 – June 30, 2009*. California Department of Health Care Services. November 2010. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>.

## Strengths

HSAG reviewed Molina's internal *Quality Improvement Program Evaluation Report* for the period of January 1, 2010–December 31, 2010, and saw evidence that the plan continued to implement strategies that address deficiencies noted in the December 2005 audit. The report showed that the plan continued to monitor emergency room claims payment reports twice per year to ensure the claims are paid in a timely manner. Molina also continued to monitor physician office telephone answer time. The report indicated a performance rate of 98.36 percent for the telephone answer time, which exceeded the plan's 2010 goal of 90 percent.

## Opportunities for Improvement

As stated in the previous evaluation report, the findings of the MRPIU review revealed the opportunity for Molina to review and modify its grievance system to ensure all time frames are met related to acknowledging receipt and resolution of member grievances. It also may benefit from reviewing its processes for sending Notice of Action letters to members to ensure these letters are sent within the required time frame. Improving the grievance and notice of action processes will potentially result in improved member satisfaction and ensure timely access to services.

### Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

### Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Molina's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

#### *Performance Measure Validation*

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>)<sup>4</sup> measures; therefore, HSAG performed a HEDIS Compliance Audit<sup>™</sup> of Molina in 2011 to determine whether the plan followed appropriate specifications to produce valid rates. Audit results indicate the plan is fully compliant with all information standards and there are no areas of concern.

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<sup>4</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).



**Performance Measure Results**

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

**Table 3.1—HEDIS® 2011 Performance Measures Name Key**

<b>Abbreviation</b>	<b>Full Name of HEDIS® 2011 Performance Measure</b>
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
AWC	<i>Adolescent Well-Care Visits</i>
BCS	<i>Breast Cancer Screening</i>
CCS	<i>Cervical Cancer Screening</i>
CDC–BP	<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)</i>
CDC–E	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>
CDC–H8 (<8.0%)	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (&lt; 8.0 Percent)</i>
CDC–H9 (>9.0%)	<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt; 9.0 Percent)</i>
CDC–HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC–LC (<100)	<i>Comprehensive Diabetes Care—LDL-C Control (&lt;100 mg/dL)</i>
CDC–LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC–N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS–3	<i>Childhood Immunization Status—Combination 3</i>
LBP	<i>Use of Imaging Studies for Low Back Pain</i>
PPC–Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC–Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
URI	<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
W34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
WCC–BMI	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>
WCC–N	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>
WCC–PA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>

The tables below present a summary of Molina’s HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan’s HEDIS 2011 performance compared to MCMC-established MPLs and HPLs.

For all but one measure, MCMC based its MPLs and HPLs on the National Committee for Quality Assurance’s (NCQA’s) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on Medicaid’s 75th percentile and the HPL is based on the national Medicaid 10th percentile.

**Table 3.2—2010–2011 Performance Measure Results for Molina Healthcare—Sacramento County**

Performance Measure <sup>1</sup>	Domain of Care <sup>2</sup>	2010 HEDIS Rates <sup>3</sup>	2011 HEDIS Rates <sup>4</sup>	Performance Level for 2011	Performance Comparison <sup>5</sup>	MMCD's Minimum Performance Level <sup>6</sup>	MMCD's High Performance Level (Goal) <sup>7</sup>
AAB	Q	29.5%	27.2%	★★	↔	19.7%	35.9%
AWC	Q,A,T	52.3%	35.8%	★	↓	38.8%	63.2%
BCS	Q,A	48.7%	50.3%	★★	↔	46.2%	63.8%
CCS	Q,A	67.3%	60.1%	★	↓	61.0%	78.9%
CDC–BP	Q	61.6%	59.6%	★★	↔	53.5%	73.4%
CDC–E	Q,A	48.9%	48.8%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	47.8%	45.8%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	41.2%	41.8%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	78.4%	79.3%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	33.8%	36.2%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	74.0%	69.5%	★★	↔	69.3%	84.0%
CDC–N	Q,A	79.9%	77.0%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	61.1%	54.3%	★	↓	63.5%	82.0%
LBP	Q	87.3%	78.9%	★★	↓	72.0%	84.1%
PPC–Pre	Q,A,T	84.8%	73.3%	★	↓	80.3%	92.7%
PPC–Pst	Q,A,T	53.2%	49.4%	★	↔	58.7%	74.4%
URI	Q	94.2%	94.4%	★★	↔	82.1%	94.9%
W34	Q,A,T	79.6%	73.5%	★★	↓	65.9%	82.5%
WCC–BMI	Q	63.7%	61.9%	★★	↔	13.0%	63.0%
WCC–N	Q	70.3%	62.6%	★★	↓	34.3%	67.9%
WCC–PA	Q	59.6%	55.7%	★★	↔	22.9%	56.7%

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

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

<sup>3</sup> HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

<sup>4</sup> HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

<sup>5</sup> Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

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

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

**Table 3.3—2010–2011 Performance Measure Results for Molina Healthcare—  
Riverside/San Bernardino Counties**

Performance Measure <sup>1</sup>	Domain of Care <sup>2</sup>	2010 HEDIS Rates <sup>3</sup>	2011 HEDIS Rates <sup>4</sup>	Performance Level for 2011	Performance Comparison <sup>5</sup>	MMCD's Minimum Performance Level <sup>6</sup>	MMCD's High Performance Level (Goal) <sup>7</sup>
AAB	Q	24.4%	21.5%	★★	↔	19.7%	35.9%
AWC	Q,A,T	45.1%	42.6%	★★	↔	38.8%	63.2%
BCS	Q,A	50.2%	49.9%	★★	↔	46.2%	63.8%
CCS	Q,A	62.3%	62.2%	★★	↔	61.0%	78.9%
CDC–BP	Q	58.6%	58.1%	★★	↔	53.5%	73.4%
CDC–E	Q,A	43.1%	37.4%	★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	32.8%	34.4%	★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	57.9%	55.6%	★	↔	53.4%	27.7%
CDC–HT	Q,A	79.6%	78.1%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	29.2%	28.7%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	77.1%	75.6%	★★	↔	69.3%	84.0%
CDC–N	Q,A	80.0%	79.7%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	60.0%	53.0%	★	↓	63.5%	82.0%
LBP	Q	74.8%	76.1%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	80.5%	68.6%	★	↓	80.3%	92.7%
PPC–Pst	Q,A,T	52.3%	50.9%	★	↔	58.7%	74.4%
URI	Q	86.6%	87.4%	★★	↔	82.1%	94.9%
W34	Q,A,T	77.5%	71.5%	★★	↓	65.9%	82.5%
WCC–BMI	Q	55.0%	42.5%	★★	↓	13.0%	63.0%
WCC–N	Q	62.5%	55.2%	★★	↓	34.3%	67.9%
WCC–PA	Q	60.6%	44.1%	★★	↓	22.9%	56.7%

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

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

<sup>3</sup> HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

<sup>4</sup> HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

<sup>5</sup> Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

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

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

**Table 3.4—2010–2011 Performance Measure Results for Molina Healthcare—San Diego County**

Performance Measure <sup>1</sup>	Domain of Care <sup>2</sup>	2010 HEDIS Rates <sup>3</sup>	2011 HEDIS Rates <sup>4</sup>	Performance Level for 2011	Performance Comparison <sup>5</sup>	MMCD's Minimum Performance Level <sup>6</sup>	MMCD's High Performance Level (Goal) <sup>7</sup>
AAB	Q	24.2%	17.3%	★	↔	19.7%	35.9%
AWC	Q,A,T	47.7%	41.5%	★★	↔	38.8%	63.2%
BCS	Q,A	54.6%	54.2%	★★	↔	46.2%	63.8%
CCS	Q,A	70.3%	70.8%	★★	↔	61.0%	78.9%
CDC–BP	Q	60.8%	70.4%	★★	↑	53.5%	73.4%
CDC–E	Q,A	47.7%	49.3%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	42.1%	42.6%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	48.4%	48.2%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	82.0%	82.1%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	33.8%	35.7%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	76.4%	76.9%	★★	↔	69.3%	84.0%
CDC–N	Q,A	77.1%	77.4%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	78.9%	72.3%	★★	↓	63.5%	82.0%
LBP	Q	77.4%	77.7%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	89.7%	83.6%	★★	↓	80.3%	92.7%
PPC–Pst	Q,A,T	57.7%	63.2%	★★	↔	58.7%	74.4%
URI	Q	94.1%	95.0%	★★★	↔	82.1%	94.9%
W34	Q,A,T	78.5%	74.7%	★★	↔	65.9%	82.5%
WCC–BMI	Q	56.9%	53.0%	★★	↔	13.0%	63.0%
WCC–N	Q	57.7%	58.6%	★★	↔	34.3%	67.9%
WCC–PA	Q	51.6%	54.6%	★★	↔	22.9%	56.7%

<sup>1</sup> DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).  
<sup>2</sup> HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).  
<sup>3</sup> HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.  
<sup>4</sup> HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.  
<sup>5</sup> Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.  
<sup>6</sup> The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.  
<sup>7</sup> The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.  
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.  
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.  
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.  
↓ = Statistically significant decrease.  
↔ = Nonstatistically significant change.  
↑ = Statistically significant increase.

## Performance Measure Result Findings

Molina's HEDIS results indicate below-average performance in Sacramento and Riverside/San Bernardino counties and average performance in San Diego County. In terms of measures performing above and below the HPLs and MPLs, San Diego County had the best performance, followed by Sacramento County and then Riverside/San Bernardino counties.

*Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* were the lowest-performing measures, scoring below the MPL in both Riverside/San Bernardino and Sacramento counties. In all three counties, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure had a statistically significant decrease in the past year. Another problematic measure is *Childhood Immunization Status—Combination 3* in all three counties. This measure had a statistically significant decrease, during the year, with scores below the MPL in Sacramento and Riverside/San Bernardino counties.

In Molina—Sacramento County, *Adolescent Well-Care Visits* and *Cervical Cancer Screening* measures were below the MPLs and had a statistically significant decrease. Two measures were between the MPLs and HPLs and had a statistically significant decrease: *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*.

In Molina—Riverside/San Bernardino counties, the following measures were below the MPLs: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*, and *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*. The following measures were between the MPLs and HPLs but had a statistically significant decrease: *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*.

In San Diego County, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* was below the MPL with no statistically significant change during the year. Across all counties, only one measure, *Appropriate Treatment for Children With Upper Respiratory Infection*, performed above the HPL in San Diego County.

### *HEDIS Improvement Plans*

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

For plan measure rates requiring a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL or is progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or develop new improvement plans.

Scores falling below the MPL required Molina—Sacramento County to produce five improvement plans, Molina—Riverside/San Bernardino counties to produce six improvement plans, and Molina—San Diego County to produce one improvement plan.

### *Childhood Immunizations*

In Riverside/San Bernardino and Sacramento counties, Molina did not perform above the MPL for *Childhood Immunization Status—Combination 3*. The plan did identify one main barrier in 2010. The registry, an internal barrier derived from data file transfer error, negatively impacted HEDIS data.

To address this barrier, the plan renewed emphasis on the importance of having a complete and accurate administrative database by collaborating with HEDIS database operations and external data source organizations to address and identify solutions to data barriers or errors. Molina also began conducting regular internal quality control and assurance checks on the administrative HEDIS database for completeness, accuracy, and validity.

Other interventions included:

- ◆ Member outreach calls.
- ◆ Providing physicians with a missed service report, which lists members that did not receive immunizations.
- ◆ Provider incentives for timely and accurate submissions.
- ◆ Grow and Stay Healthy brochures, informing members of immunization schedules.

Although the plan had a sound improvement plan and strategies, it was unable to bring *Childhood Immunization Status—Combination 3* above the MPL for the second consecutive year. In fact, rates had a statistically significant decrease in both counties in 2011. Another improvement plan will be required in 2012, and the plan will need to revise its strategies for improving rates.

## Diabetes Care

Molina's improvement plan for *Eye Exam (Retinal) Performed* and *HbA1c Poor Control (> 9.0 Percent)*, in Riverside/San Bernardino counties, identified barriers, which included:

- ◆ Members' lack of knowledge regarding the importance of diabetic measures.
- ◆ Member changes in PCP, or health plan, causing poor coordination of care and follow-up.
- ◆ Members' lack of resources in getting to locations for testing.
- ◆ Lack of member engagement.
- ◆ Practitioners' unfamiliarity of comprehensive diabetes services for patients.
- ◆ Practitioners not reviewing a quarterly missed services report which includes CDC and HEDIS measures.

The plan identified two county-specific barriers for Molina—Riverside/San Bernardino counties. These counties had the highest percentage of transfers from primary care providers to Independent Practice Associates (IPAs), and the data was compromised during the transfer process. In addition, these counties had a seven percentage point increase in the Hispanic population, resulting in associated cultural barriers to health care.

The plan has been working on improvement plans for consecutive years and will continue implementing the same interventions, which include:

- ◆ Postcard mailings to members.
- ◆ Provider notification of missed services.
- ◆ Increasing provider cross-cultural awareness.

For the *Eye Exam (Retinal) Performed* measure, the plan implemented two new interventions: Molina's Information Technology (IT) department sent monthly enrollment files to vendors for transmitting lab results, and transfers to IPAs were completed.

Despite implementation of these improvements in 2010, the plan's 2011 HEDIS results did not reflect a positive change. Instead, rates decreased in 2011, and another improvement plan will be required in 2012.

## Prenatal and Postpartum Care

Molina's performance on the postpartum care measure has been a consistent challenge for the plan. Riverside, San Bernardino, and Sacramento counties each had 2009 HEDIS rates below the MPLs and that trend continued in 2010. Molina's improvement plan indicated that it will continue with ongoing interventions such as the Motherhood Matters Program. The plan identified various barriers to improving performance, which included:

- ◆ Member perception that there is no need for postpartum care, especially with multiparous women.
- ◆ Limited ability to contact members due to incorrect contact information.
- ◆ Plan enrollment late in a member's pregnancy: For 2010 HEDIS, 34 percent of eligible members joined the plan at 34 weeks, 56.18 percent joined after their first trimester in Riverside/San Bernardino counties, and 26.52 percent joined 28 weeks or more into their pregnancy. For both San Diego and Sacramento counties, 52 percent joined after their first trimester.
- ◆ Lack of internal resources to foster new initiatives.
- ◆ Minimum collaboration with UM Motherhood Matters to leverage resources and identify delivery dates, obstetricians, and prenatal/postpartum visits.

Molina's improvement plan self-admittedly did not offer new interventions but maintained existing interventions enhanced by a re-evaluation of identified barriers.

Molina's improvement plan had little success. Molina—San Diego was the only county able to achieve the MPL in 2011. Riverside/San Bernardino and Sacramento counties had decreases in performance despite consecutive years of conducting improvement plans for the *Prenatal and Postpartum Care—Postpartum Care* measure.

## Strengths

In San Diego County, Molina performed above the HPL for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure. Also, in San Diego County, the plan improved *Prenatal and Postpartum Care—Postpartum Care* rates above the MPL through implementation of its improvement plan.

## Opportunities for Improvement

Similar to 2010, Molina's 2011 performance measures needing improvement spanned all three domains of care: quality, timeliness, and access.

Overall plan performance declined for the second consecutive year. Molina's area of greatest need is in postpartum care. Sacramento and Riverside/San Bernardino counties had rates below the MPL in 2011, despite an ongoing improvement plan. HSAG recommends Molina revise its intervention strategies and have a technical assistance call with DHCS and HSAG to review the barrier analysis and proposed interventions. Additionally, the plan should implement a rapid-cycle of evaluation to identify effective, or ineffective, interventions for reducing the likelihood of another year without improved rates.



### Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

### Findings

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

#### *Quality Improvement Projects Conducted*

Molina had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS's statewide collaborative QIP. Molina's second project was an internal QIP aimed at improving hypertension control in members 18 to 85 years of age. Both QIPs falls under the quality and access domains of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Molina's *Improving Hypertension Control* QIP evaluated whether members' blood pressure was controlled. Controlled blood pressure in hypertensive members is associated with reductions in stroke, myocardial infarction, and heart failure incidences.

**Quality Improvement Project Validation Findings**

The table below summarizes the validation results for seven QIPs across CMS protocol activities during the review period. HSAG validated QIPs at the county level beginning July 1, 2010, for new QIP projects and validated existing projects at the overall plan level; therefore, HSAG validated four QIP submissions for the *Reducing Avoidable Emergency Room Visits* QIP and three county-level QIP submissions for the *Improving Hypertension Control* QIP.

**Table 4.1—Quality Improvement Project Validation Activity for Molina Healthcare—Riverside, San Bernardino, Sacramento, and San Diego Counties July 1, 2010, through June 30, 2011**

Name of Project/Study	County	Type of Review <sup>1</sup>	Percentage Score of Evaluation Elements <i>Met</i> <sup>2</sup>	Percentage Score of Critical Elements <i>Met</i> <sup>3</sup>	Overall Validation Status <sup>4</sup>
<b>Statewide Collaborative QIP</b>					
<i>Reducing Avoidable Emergency Room Visits</i>	Riverside	Annual Submission	87%	100%	<i>Met</i>
	San Bernardino	Annual Submission	87%	100%	<i>Met</i>
	Sacramento	Annual Submission	90%	100%	<i>Met</i>
	San Diego	Annual Submission	90%	100%	<i>Met</i>
<b>Internal QIPs</b>					
<i>Improving Hypertension Control</i>	Riverside/San Bernardino	Annual Submission	100%	100%	<i>Met</i>
	Sacramento	Annual Submission	100%	100%	<i>Met</i>
	San Diego	Annual Submission	100%	100%	<i>Met</i>
<sup>1</sup> <b>Type of Review</b> —Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG’s validation criteria to receive an overall <i>Met</i> validation status. <sup>2</sup> <b>Percentage Score of Evaluation Elements <i>Met</i></b> —The percentage score is calculated by dividing the total elements <i>Met</i> (critical and noncritical) by the sum of the total elements of all categories ( <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> ). <sup>3</sup> <b>Percentage Score of Critical Elements <i>Met</i></b> —The percentage score of critical elements <i>Met</i> is calculated by dividing the total critical elements <i>Met</i> by the sum of the critical elements <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> . <sup>4</sup> <b>Overall Validation Status</b> —Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> .					

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that Molina’s annual submission of its *Reducing Avoidable Emergency Room Visits* QIP for all four counties received an overall validation status of *Met*, with 87 percent to 90 percent of all evaluation elements and 100 percent of critical elements receiving a *Met* score. For its *Improving Hypertension Control* QIP submission, Molina received a *Met* validation status, with all counties receiving the same score.

Table 4.2 summarizes the validation results for seven of Molina’s QIPs across CMS protocol activities during the review period.

**Table 4.2—Quality Improvement Project Average Rates\* for Molina Healthcare—  
Riverside, San Bernardino, Sacramento, and San Diego Counties  
(Number = 7 QIP Submissions, 2 QIP Topics)  
July 1, 2010, through June 30, 2011**

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%
<b>Design Total</b>		<b>100%</b>	<b>0%</b>	<b>0%</b>
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	90%	10%	0%
<b>Implementation Total</b>		<b>98%</b>	<b>2%</b>	<b>0%</b>
Outcomes	VIII: Sufficient Data Analysis and Interpretation	91%	9%	0%
	IX: Real Improvement Achieved	50%	0%	50%
	X: Sustained Improvement Achieved	0%	0%	100%
<b>Outcomes Total</b>		<b>76%</b>	<b>6%</b>	<b>18%</b>
*The activity average rate represents the average percentage of applicable elements with a <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> finding across all the evaluation elements for a particular activity.				

Molina submitted Remeasurement 2 data for its *Reducing Avoidable Emergency Room Visits* QIPs and was therefore assessed through Activity X. Only baseline data were included in the *Improving Hypertension Control* QIPs, so HSAG assessed Activities I through VIII.

Molina demonstrated a strong understanding of the design and implementation stages, scoring 100 percent on all evaluation elements for six of the seven activities. However, in Activity VII for two of the four counties’ *Reducing Avoidable Emergency Room Visits* QIPs, the plan did not include how interventions would be standardized or monitored based on the study indicator outcomes.

For the outcomes stage, Molina’s score was lower in Activity VIII because the plan did not include a comparison to the goals in its interpretation of the results for all four counties’ *Reducing Avoidable Emergency Room Visits* QIP. While some of the *Reducing Avoidable Emergency Room Visits* QIP outcomes demonstrated improvement, none of the improvement was statistically significant (considered “real improvement” or improvement that is unlikely due to chance); therefore, Molina received a score of 50 percent for Activity IX. For Activity X, none of the counties’ *Reducing Avoidable Emergency Room Visits* QIPs achieved sustained improvement. Sustained improvement is

defined as improvement in performance over baseline which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period’s results must reflect improvement when compared to the baseline results.

**Quality Improvement Project Outcomes**

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

**Table 4.3—Quality Improvement Project Outcomes for Molina Healthcare—  
Riverside, San Bernardino, Sacramento, and San Diego Counties  
(Number = 7 QIP Submissions, 2 QIP Topics)  
July 1, 2010, through June 30, 2011**

QIP #1—Reducing Avoidable Emergency Room Visits <sup>1</sup>					
QIP Study Indicator	County	Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	Sustained Improvement <sup>‡</sup>
Percentage of avoidable ER visits	Riverside	19.6%	21.6%*	21.8%	No
	San Bernardino	19.1%	20.9%*	21.6%	No
	Sacramento	14.5%	16.7%*	16.1%	No
	San Diego	15.3%	16.2%*	15.9%	No
QIP #2—Improving Hypertension Control					
QIP Study Indicator	County	Baseline Period 1/1/09–12/31/09	Remeasurement 1 1/1/10–12/31/10	Remeasurement 2 1/1/11–12/31/11	Sustained Improvement <sup>‡</sup>
Percentage of members 18 to 85 years of age who had both a systolic and diastolic blood pressure of <140/90	Riverside/San Bernardino	59.6%	‡	‡	‡
	Sacramento	56.6%	‡	‡	‡
	San Diego	66.4%	‡	‡	‡
<sup>1</sup> For this measure, a lower rate indicates better performance. <sup>‡</sup> Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period’s results must reflect improvement when compared to the baseline results. * A statistically significant difference between the measurement period and the prior measurement period ( <i>p</i> value < 0.05). ‡ The QIP did not progress to this phase during the review period and could not be assessed.					

For the *Reducing Avoidable Emergency Room Visits* QIP, only Sacramento and San Diego counties demonstrated improvement from Remeasurement 1 to Remeasurement 2; however, the improvement was not statistically significant and may have been due to chance. Although collaborative interventions were initiated in early 2009, they did not correspond to any

improvement in performance from Remeasurement 1 to Remeasurement 2. For all four counties, the Remeasurement 2 rate was higher than the baseline rate, which reflected an overall decline in performance. Therefore, none of the counties achieved sustained improvement. Molina was not successful in reducing the percentage of avoidable ER visits.

The *Improving Hypertension Control* QIPs had not progressed beyond baseline and could not be evaluated for real or sustained improvement.

## Strengths

Molina demonstrated an accurate application of the design and implementation stages and received *Met* scores for all evaluation elements for six of the seven activities. The plan achieved these scores without the benefit of resubmission, indicating proficiency with the QIP validation process.

## Opportunities for Improvement

Molina has an opportunity to improve its intervention strategies in order to achieve sustained improvement of its QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone. The plan should ensure that the barrier analyses for both QIP topics are county-specific and interventions are targeted to the county-specific barriers.

Additionally, HSAG recommends that Molina implement a method to evaluate the effectiveness of each intervention. Based on the evaluation results, the plan can make appropriate revisions or implement new interventions, if necessary. If the intervention evaluation demonstrates that an intervention is successful, the plan should clearly document the process and how it was used to monitor and standardize the intervention in the QIP.

## 5. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

for Molina Healthcare of California Partner Plan, Inc.

### Overall Findings Regarding Health Care Quality, Access, and Timeliness

#### Quality

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

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

Molina's performance in the quality domain was below average. HSAG based its assessment on 2011 performance measure rates (which reflect 2010 measurement data) and QIP outcomes.

Overall, Molina in San Diego County outperformed the plan in Sacramento and Riverside/San Bernardino counties on quality measures, with only one quality measure falling below the MPL. Molina in Sacramento County had five quality measures with rates below the MPLs, and Molina in Riverside/San Bernardino counties had six measures with rates below the MPLs.

Although Molina improved in the *Breast Cancer Screening* measure and had statistically significant improvements in seven HEDIS rates for 2010, this was not the case in 2011. Molina in Sacramento County experienced only a slight increase in performance in the *Breast Cancer Screening* measure, and Molina in Riverside/San Bernardino and San Diego counties had slight decreases. All counties had statistically significant decreases in performance on at least two quality measures: Molina—Sacramento County on seven measures, Molina—Riverside/San Bernardino counties on six measures, and Molina—San Diego County on two measures. All counties experienced a statistically significant decrease in performance on *Childhood Immunization Status—Combination 3* and *Timeliness of Prenatal Care*.

Molina—San Diego County improved performance on the *Prenatal and Postpartum Care—Postpartum Care* measure to above the MPL; however, Molina in Sacramento and Riverside/San Bernardino counties saw a decrease in performance despite consecutive years of improvement plans.

Molina demonstrated strong understanding and application of the design and implementation stages for its *Reducing Avoidable Emergency Room Visits* and *Improving Hypertension Control* QIPs. However, Molina was not successful in achieving sustained improvements for the *Reducing Avoidable Emergency Room Visits* QIP. The plan's *Improving Hypertension Control* QIP had not progressed beyond baseline, so assessment of outcomes and impact has not yet been conducted.

## ACCESS

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of, and access to, all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Molina had below-average performance in the area of access. HSAG based its assessment on review of 2011 performance measure rates related to access and QIP outcomes.

Molina—San Diego County performed best on access performance measures, with average performance on all access measures. Molina in Sacramento and Riverside/San Bernardino counties had below-average performance on five and four access measures, respectively. All counties saw a statistically significant decrease in performance on two, or more, access measures.

As stated above in the "Quality" section, Molina was unable to demonstrate sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP. Since this QIP also falls under the access domain of care, these results were used to determine the overall assessment of below-average performance in the access domain of care.

## Timeliness

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

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

Molina demonstrated below-average performance in the timeliness domain. HSAG based its assessment on 2011 performance measure rates for providing timely care, medical performance, and member rights reviews.

Molina—San Diego County outperformed Molina—Sacramento and Riverside/San Bernardino counties on the five measures that comprise the timeliness domain. Molina—Sacramento County did not achieve the MPLs on four measures, and Molina—Riverside/San Bernardino counties did not achieve the MPLs on three measures. All counties had a statistically significant decrease in performance on two, or more, timeliness measures. Molina—Sacramento County had the greatest number of measures with a statistically significant decrease in performance (four measures), followed by Molina—Riverside/San Bernardino counties (three measures), and Molina—San Diego County (two measures). All other timeliness measures had a decrease in performance, with the exception of the *Prenatal and Postpartum Care—Postpartum Care* measure in Molina—San Diego County, which had a slight increase in its performance rate.

As noted in the previous evaluation report, findings from the most recent medical audit conducted in April 2011 were not available at the time of this report. All deficiencies from the December 2005 medical audit have been resolved. Also noted in the previous evaluation report, the most recent MRPIU review identified findings in the timeliness domain in member grievances and prior-authorization notification. HSAG did not receive any information indicating Molina has implemented changes to address these findings.



## Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. Molina’s self-reported responses are included in Appendix A.

## Conclusions and Recommendations

Overall, Molina demonstrated below-average performance in providing quality, timely, and accessible health care services to MCMC members. This is evident in its poor performance on performance measures, inability to reduce avoidable ER visits, and lack of change in grievance and prior-authorization systems to address MRPIU findings.

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

- ◆ Ensure all MRPIU deficiencies have been fully addressed. Specifically, HSAG recommends that Molina review and modify its grievance and prior-authorization processes to ensure it meets the required time frames.
- ◆ Revise HEDIS intervention strategies and have a technical assistance call with DHCS and HSAG to review the barrier analysis and proposed interventions.
- ◆ Implement a rapid-cycle of intervention evaluation to determine which interventions are effective, and should be continued, and those that are ineffective.
- ◆ Focus improvement efforts on lower performing and/or declining performance measures, including *Childhood Immunization Status—Combination 3* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.
- ◆ Conduct barrier analysis to identify and prioritize barriers for each QIP measurement period.
- ◆ Ensure barrier analyses for both QIP topics are county-specific and interventions are targeted to county-specific barriers.
- ◆ Implement a method to evaluate the effectiveness of each QIP intervention and use the results to make revisions, or implement new interventions, if necessary.
- ◆ If QIP evaluation demonstrates a successful intervention, clearly document the process used to monitor, and standardize, the QIP intervention.

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

*APPENDIX A. GRID OF PLAN'S FOLLOW-UP ON EQR RECOMMENDATIONS FROM THE JULY 1, 2009–JUNE 30, 2010 PERFORMANCE EVALUATION REPORT*

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*for Molina Healthcare of California Partner Plan, Inc.*

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with Molina's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions that the plan self-reported in the grid.

**Table A.1—Grid of Molina’s Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report**

2009–2010 EQR Recommendation	Molina’s Self-Reported Actions That Address the EQR Recommendation
<p>Ensure that all MRPIU deficiencies have been fully addressed. (MRPIU—Medi-Cal Managed Care Program Member Rights/Program Integrity Unit)</p>	<p>Molina Healthcare (MHC) implemented a number of internal controls/processes to ensure grievances are acknowledged and resolved timely. These include:</p> <ol style="list-style-type: none"> <li>1. Enhanced Appeals and Grievances Tracking database</li> <li>2. Enhanced automated system date notifications</li> <li>3. Daily review of open cases to ensure that all required time frames are met.</li> </ol>
<p>Focus improvement efforts on the lower-performing and/or declining performance measures, including postpartum care visits, childhood immunizations, and eye exams for diabetics.</p>	<p><u>Postpartum care:</u>                      MHC identifies all pregnancy-related admissions and contacts the member to remind them about postpartum care. Phone calls and faxed reminders regarding postpartum care are also sent to providers. MHC offers to schedule appointments and arrange transportation for members. MHC contacted or attempted to contact the members in the HEDIS sample that did not have prenatal and/or postpartum care to survey where they received services. The majority of the respondents reported that they did not access care because they felt fine, despite reminders and incentives. The member calls also reinforced MHC’s conclusion that women who had a C-section did not keep their postpartum visit after they have their incision check. Because our C-Section rate is about 35 percent—similar to national data—MHC implemented a focused call-out in December for that subset.</p> <p><u>Childhood immunizations:</u>                      As identified on the previous improvement plan submission, the primary internal barrier was a lack of sufficient and accurate encounter data, specific to the State immunization registry known as California Immunization Registry (CAIR). This resulted in incomplete administrative data and negatively impacted the CIS-3 administrative numerators in Riverside/San Bernardino and Sacramento counties. San Diego County was not affected because they administer their immunization registry, LINK, separately from CAIR, that monitors:</p> <ul style="list-style-type: none"> <li>◆ Current month’s administrative rate changes in comparison to the same month of a prior year.</li> <li>◆ Current month’s administrative rate progress from the initial month of the measurement year.</li> </ul> <p>Although activities and interventions were implemented to improve the immunization encounter data, improvements were not made within the limited time frame. Therefore, the evaluation of the effectiveness of intervention is premature to draw a conclusion.</p>

**Table A.1—Grid of Molina’s Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report**

2009–2010 EQR Recommendation	Molina’s Self-Reported Actions That Address the EQR Recommendation
	<p><u>Eye exams for diabetics:</u></p> <ul style="list-style-type: none"> <li>◆ MHC notifies providers of the importance of appropriate diabetic screenings and monitoring by providing a “Needed Services Report” three times a year.</li> <li>◆ Diabetic Clinical Practice Guidelines are available to all providers online and in print via the Molina Healthcare Web site. MHC started a Provider Quality Improvement newsletter to emphasize diabetic clinical care and DREs, including updating the clinical practice guidelines, as needed, on the Web site.</li> <li>◆ Educate diabetic members, physicians, and their office staff about MHC’s “Healthy Living with Diabetes Program” that is available to all diabetic members and their families.</li> </ul>
<p>Focus improvement efforts on the lower-performing and/or declining performance measures, including postpartum care visits, childhood immunizations, and eye exams for diabetics. (cont’d)</p>	<ul style="list-style-type: none"> <li>◆ MHC implemented outreach calls to diabetic members to remind them of all diabetic needed services. MHC offers to schedule appointments with the PCP and calls the member the day before the appointment to remind him/her of the appointment.</li> <li>◆ Members with complex diabetic care needs are referred to the Case/Disease Management staff for ongoing assistance, facilitation, and management.</li> </ul>
<p>Explore factors that contributed to the significant drop in <i>Comprehensive Diabetes Care—Retinal Eye Exam</i> rates.</p>	<p>The MPL for the DRE measure was not met because of the change in the members’ benefits. From July 2009 to July 2010, the members were required to have their DREs performed by an ophthalmologist rather than an optometrist causing this exam to need an authorization. On July 2010, the benefit was reinstated allowing the members to go to either an optometrist or ophthalmologists for the eye exam. This protocol change with respect to accessing this service may have led to the low rates.</p> <p>MHC’s goal is to educate members about the current process to receive a DRE. The health plan mailed newsletters, postcards and sent letters to members explaining the protocol needed to receive a DRE. A \$25 incentive was advertised in the diabetes disease management newsletter to encourage the members to get their exams.</p>
<p>Stay vigilant with maintaining gains in the URI QIP.</p>	<p>MHC continues to participate in the CMA’s AWARE Project activities for upper respiratory infections and control of antibiotic prescribing. The Aware Toolkit containing both provider and patient materials is mailed to providers each year.</p> <p>The greatest barrier to maintaining control of the antibiotic prescribing is parents taking their children to the ER if the PCP will not prescribe an antibiotic.</p>

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<p>Reevaluate performance measure improvement plan interventions that are not effective and explore methods to better address key barriers, especially incomplete and inaccurate member phone numbers and addresses.</p>	<p>The source of member demographic information is the Medi-Cal membership file that is refreshed each month. Since this file overrides data each month, MHC developed a database to store demographic information of members that contact any of the MHC call centers. MHC sends “unable to contact” postcards to members that were not reached by phone. This post card contains instructions to call the plan.</p>
<p>Review the 2010 plan-specific CAHPS results report and develop strategies to address the <i>Rating of All Health Care, Rating of Health Plan, and Getting Needed Care</i> priority areas.</p>	<p><b>Getting Needed Care:</b>  <b><u>Access to Care and Appointment Availability</u></b></p> <p>One of the key drivers of patient experience and satisfaction is access to care, including but not limited to appointment and after-hour access. The primary goal of access to timely appointments and after-hour availability is to ensure member safety and quality health care service. The results of the 2010 annual Access Survey emphasized common challenges, timely routine/non-urgent care and well-child preventive care appointments, and appropriate after-hour emergency instruction. These types of access need to be focused and improved. In order to overcome the challenges to practice change and to sustain improvements, effective interventions and corrective action plans are implemented. Accessibility and availability to health care services represent a degree of fit between the patients and health care provider; therefore, it is MHC’s goal to continue improving the performance rates.</p> <p>Getting needed care is an issue across all priority areas. The geo-access and availability surveys demonstrate that there are gaps in specialist availability. The annual access survey further demonstrates that specialists cannot meet specialty appointment standards. It must be noted the MHC has more stringent appointment standards across all appointment types.</p> <p><b><u>Practitioner Geo-Access and Availability</u></b></p> <ul style="list-style-type: none"> <li>◆ Overall, the practitioner geo-access and availability reports indicate that established standards are clearly being met.</li> <li>◆ Standards for language spoken in the office and gender are met. Data collection for ethnicity is difficult because the provider is not required to report these data and documentation using direct observation may be inaccurate.</li> </ul>

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	<ul style="list-style-type: none"> <li>◆ There continues to be limited geographical regions where the standards are not met for some specialty provider types; but in most of these cases, this limitation continues to be the result of a lack of providers within the region, especially for the subspecialties. In these cases, an ad hoc contract is developed in order for the members to receive care. MHC is unable to obtain permanent contracts with certain specialists, who cite rates as the reason for their refusal of a permanent contract. This is an issue for all Medi-Cal plans, and MHC continues to monitor and pursue leads.</li> </ul>
<p>Review the 2010 plan-specific CAHPS results report and develop strategies to address the <i>Rating of All Health Care, Rating of Health Plan, and Getting Needed Care</i> priority areas. (cont’d)</p>	<p><b>Rating of All Health Care and Rating of Health Plan</b></p> <p>The increases in member satisfaction from 2008 to 2009 did not continue in 2010. The rates either decreased or were flat in 2010 for the Medicaid Adult CAHPS® survey. Satisfaction levels improved only slightly for Customer Services. All other gains realized in 2009 were lost in 2010.</p> <p>Decreases in member satisfaction with the personal doctor and specialist were seen, and there were corresponding decreases in communication with their physicians and shared decision making. The quality of the relationship with their personal doctor weighs heavily in our member’s satisfaction.</p> <p>During the new member welcome call, the plan explains the importance of making and keeping an appointment within 60 days of enrollment to establish a relationship with the new PCP. The Top 10 Brochure is included in the new member information packet. This brochure contains information on how to access emergency and urgent care as well as contact information for some of the Health Education programs. MHC developed a brochure titled “What you can do to make the most out of your doctor’s appointment” to explain what to expect from the office visit, questions to ask, and the importance of keeping the appointment. This may have an impact on the CAHPS® low scores for shared decision making (52 percent) and doctor discussing pros and cons of treatment (50 percent).</p> <p>The plan decided to change to the Child CAHPS® survey in 2012. The reasons include volume of membership - &gt;75 percent of member are &lt; age 19, and increasing the number of members through the mandatory enrollment of the Seniors and Persons with Disabilities population into Medi-Cal managed care. These special populations create a hybrid type membership, and their satisfaction can be best assessed using other survey tools such as CG CAHPS®.</p>