Performance Evaluation Report

Molina Healthcare of California Partner Plan, Inc.

July 1, 2011–June 30, 2012

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

June 2013

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1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans 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 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[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.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, Molina Healthcare of California Partner Plan, Inc. ("Molina" or "the plan"), which delivers care in Riverside, Sacramento, San Bernardino, and San Diego counties, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

Molina is a full-scope Medi-Cal managed care plan operating in Riverside, Sacramento, San Bernardino, and San Diego counties.

Molina serves members in Riverside and San Bernardino counties as a nongovernmental commercial plan (CP) under the Two-Plan Model. In a Two-Plan Model county, DHCS contracts with two managed care plans to provide medical services to Medi-Cal beneficiaries. Most Two-Plan model counties offer a Local Initiative (LI) plan and a nongovernmental CP. Medi-Cal Managed Care beneficiaries in Riverside and San Bernardino counties may enroll in Molina, the CP, or in the alternative LI plan.

Molina serves MCMC beneficiaries in Sacramento and San Diego counties under the Geographic Managed Care (GMC) Model. In the GMC Model, DHCS contracts with several commercial health plans within a specified geographic area. This provides MCMC enrollees with more choices. Medi-Cal Managed Care beneficiaries in Sacramento and San Diego counties may enroll in Molina or in an alternative CP within their respective county.

Molina became operational in Riverside and San Bernardino counties in December 1997. The plan expanded to Sacramento County in 2000 and San Diego County in 2005. As of June 30, 2012, Molina had 201,260 MCMC members in Riverside, Sacramento, San Bernardino, and San Diego counties, collectively.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from 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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

Although a review by the State Controller's Office was conducted with Molina in March and April 2011 covering the audit period of December 1, 2009, through November 30, 2010, the results from this audit were not approved by DHCS and are therefore not summarized in this report. The most recent approved medical performance review was conducted in December 2005 for the period December 1, 2004, through November 30, 2005. HSAG initially reported the findings from this review in Molina's 2008–2009 plan-specific evaluation report.[4] In Molina's 2009–2010 plan-specific evaluation report[5], HSAG reported that the plan had resolved all identified deficiencies.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

The most recent MR/PIU review was conducted with Molina in January 2011, covering the review period of January 1, 2009, through March 31, 2010. HSAG initially reported the detailed findings from this audit in Molina's 2009–2010 plan-specific evaluation report[6] and summarized them in

[4] *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/MMCDQualPerfMsrRpts.aspx

[5] *Performance Evaluation Report—Molina Healthcare of California Partner Plan, Inc., July 1, 2009 – June 30, 2010*. California Department of Health Care Services. December 2011. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

[6] Ibid.

the plan's 2010–2011 plan-specific evaluation report. The findings were in the areas of Member Grievances and Prior Authorization Notification.

Molina was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings.

Findings

Member Grievances

- One of 98 member grievance case files reviewed contained a resolution letter that exceeded the 30-day time frame.
- One of 98 member grievance case files reviewed was not resolved within the 30-day time frame, and the member was not notified in writing of the status of the grievance or estimated completion date for resolution, as required.

Prior Authorization Notification

- One of 180 prior authorization notification case files reviewed contained a Notice of Action (NOA) letter that was not deposited with the United States Postal Service in time for pickup no later than the third working day after the decision had been made. The NOA also did not meet the required 14-calendar-day time frame from the receipt of the original request.

HSAG found the following information regarding actions the plan has taken that appear to address the findings:

- Molina's self-report indicated that the plan implemented internal controls and processes to ensure grievances are timely acknowledged and resolved. Grievances are monitored daily, weekly, and monthly; and cases are prioritized based on urgency and the length of time they have been in the grievance process.
- Molina's self-report indicated that the plan's Utilization Management Delegation Oversight Unit will review 100 percent of the NOAs submitted by the plan's delegated groups. The process will include a review of all turnaround time requirements and use of correct NOA templates and appeal attachments. As issues are identified, the responsible delegate will be provided with appropriate education and training. Corrective action plans (CAPs) for any element of the file review not scoring 100 percent will be sent quarterly. CAPs will not be closed until appropriate response has been received.

Strengths

Molina appears to have taken action to address the findings from the most recent MR/PIU review through implementation of tracking and monitoring mechanisms to ensure the grievance and prior-authorization processes meet the required time frames.

Opportunities for Improvement

HSAG does not have recommendations for improvement but instead recommends that Molina continue its efforts to ensure the plan meets the grievance and prior authorization time frame requirements.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[7] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of Molina in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

[7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Validation Findings

HSAG's auditors determined that Molina followed the appropriate specifications to produce valid rates. Additionally, HSAG noted that each time a clinic provider submitted a claim, the rendering provider was included and Molina captured that information internally, which was identified as a best practice, since many of the measure specifications require a specific provider type and capture of the rendering provider is needed for this purpose.

Performance Measure Results

After validating the plan's performance measure rates, HSAG assessed the results. The following table displays a performance measure name key with abbreviations contained in Tables 3.2 through 3.4.

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Tables 3.2 through 3.4 present a summary of Molina's HEDIS 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (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.

While DHCS requires plans 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.

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Molina Healthcare of California Partner Plan, Inc.—Sacramento County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	27.2%	28.3%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	45.0	--	Not Comparable	--	--
AMB–OP	‡	--	238.1	--	Not Comparable	--	--
AWC	Q,A,T	35.8%	60.4%	★★	↑	39.6%	64.1%
CAP–1224	A	--	95.8%	--	Not Comparable	--	--
CAP–256	A	--	84.2%	--	Not Comparable	--	--
CAP–711	A	--	83.5%	--	Not Comparable	--	--
CAP–1219	A	--	83.4%	--	Not Comparable	--	--
CCS	Q,A	60.1%	63.1%	★	↔	64.0%	78.7%
CDC–BP	Q	59.6%	58.2%	★★	↔	54.3%	76.0%
CDC–E	Q,A	48.8%	56.2%	★★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	45.8%	46.9%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	41.8%	40.9%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	79.3%	81.8%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	36.2%	33.8%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	69.5%	69.3%	★	↔	70.4%	84.2%
CDC–N	Q,A	77.0%	83.1%	★★	↑	73.9%	86.9%
CIS–3	Q,A,T	54.3%	50.1%	★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	55.3%	--	Not Comparable	--	--
LBP	Q	78.9%	84.0%	★★★	↔	72.3%	82.3%
MPM–ACE	Q	--	78.8%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	74.2%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	73.3%	81.4%	★★	↑	80.3%	93.2%
PPC–Pst	Q,A,T	49.4%	51.4%	★	↔	59.6%	75.2%
W-34	Q,A,T	73.5%	76.1%	★★	↔	66.1%	82.9%
WCC–BMI	Q	61.9%	62.3%	★★	↔	19.7%	69.8%
WCC–N	Q	62.6%	64.7%	★★	↔	39.0%	72.0%
WCC–PA	Q	55.7%	58.4%	★★	↔	28.5%	60.6%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.3—Comparison of 2011 and 2012 Performance Measure Results for Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino Counties

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	21.5%	20.1%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	43.2	--	Not Comparable	--	--
AMB–OP	‡	--	285.7	--	Not Comparable	--	--
AWC	Q,A,T	42.6%	56.3%	★★	↑	39.6%	64.1%
CAP–1224	A	--	94.9%	--	Not Comparable	--	--
CAP–256	A	--	83.8%	--	Not Comparable	--	--
CAP–711	A	--	82.7%	--	Not Comparable	--	--
CAP–1219	A	--	84.2%	--	Not Comparable	--	--
CCS	Q,A	62.2%	62.0%	★	↔	64.0%	78.7%
CDC–BP	Q	58.1%	59.3%	★★	↔	54.3%	76.0%
CDC–E	Q,A	37.4%	54.8%	★★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	34.4%	40.0%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	55.6%	48.8%	★★	↑	52.1%	29.1%
CDC–HT	Q,A	78.1%	78.7%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	28.7%	34.8%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	75.6%	77.3%	★★	↔	70.4%	84.2%
CDC–N	Q,A	79.7%	81.8%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	53.0%	59.6%	★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	60.9%	--	Not Comparable	--	--
LBP	Q	76.1%	76.4%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	81.6%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	81.4%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	68.6%	77.2%	★	↑	80.3%	93.2%
PPC–Pst	Q,A,T	50.9%	43.8%	★	↓	59.6%	75.2%
W-34	Q,A,T	71.5%	74.8%	★★	↔	66.1%	82.9%
WCC–BMI	Q	42.5%	44.3%	★★	↔	19.7%	69.8%
WCC–N	Q	55.2%	65.0%	★★	↑	39.0%	72.0%
WCC–PA	Q	44.1%	57.1%	★★	↑	28.5%	60.6%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.4—Comparison of 2011 and 2012 Performance Measure Results for Molina Healthcare of California Partner Plan, Inc.—San Diego County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	17.3%	18.2%	★	↔	18.8%	31.6%
AMB–ED	‡	--	43.3	--	Not Comparable	--	--
AMB–OP	‡	--	331.9	--	Not Comparable	--	--
AWC	Q,A,T	41.5%	53.0%	★★	↑	39.6%	64.1%
CAP–1224	A	--	94.8%	--	Not Comparable	--	--
CAP–256	A	--	88.5%	--	Not Comparable	--	--
CAP–711	A	--	87.6%	--	Not Comparable	--	--
CAP–1219	A	--	83.8%	--	Not Comparable	--	--
CCS	Q,A	70.8%	68.9%	★★	↔	64.0%	78.7%
CDC–BP	Q	70.4%	62.0%	★★	↓	54.3%	76.0%
CDC–E	Q,A	49.3%	56.4%	★★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	42.6%	46.2%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	48.2%	46.7%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	82.1%	84.4%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	35.7%	42.2%	★★	↑	27.3%	45.9%
CDC–LS	Q,A	76.9%	78.2%	★★	↔	70.4%	84.2%
CDC–N	Q,A	77.4%	80.2%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	72.3%	73.2%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	71.3%	--	Not Comparable	--	--
LBP	Q	77.7%	72.0%	★	↔	72.3%	82.3%
MPM–ACE	Q	--	86.7%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	85.9%	★★	Not Comparable	--	--
PPC–Pre	Q,A,T	83.6%	88.9%	★★	↑	80.3%	93.2%
PPC–Pst	Q,A,T	63.2%	61.4%	★★	↔	59.6%	75.2%
W-34	Q,A,T	74.7%	78.9%	★★	↔	66.1%	82.9%
WCC–BMI	Q	53.0%	57.7%	★★	↔	19.7%	69.8%
WCC–N	Q	58.6%	61.9%	★★	↔	39.0%	72.0%
WCC–PA	Q	54.6%	52.3%	★★	↔	28.5%	60.6%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

A review of Molina's performance measure rates shows below-average performance in 2012. Across all counties, 10 measures performed below the MPLs and two measures had a statistically significant decline in performance. Sacramento County was the only county with a measure performing above the HPL (*Use of Imaging Studies for Low Back Pain*). Despite the overall below-average performance, Sacramento and San Diego counties each had four measures with statistically significant improvement from 2011 to 2012, and Riverside/San Bernardino counties had six measures with statistically significant improvement from 2011 to 2012.

HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Molina was required to submit IPs for nine measures in 2012 based on its 2011 HEDIS performance. Below is a summary of each IP and HSAG's analysis of the progress the plan 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 in 2012 because the measure's rate was below the MPL in 2011. The plan identified several barriers to success in reaching the MPL for this measure, including:

- Providers' lack of awareness of effective non-antibiotic treatments for acute bronchitis.
- Members' lack of awareness of the risk of antibiotic resistance with inappropriate use of antibiotics.
- Providers' reluctance to educate members about appropriate use of antibiotics.

To address the identified barriers, Molina focused on provider and member education to reduce the use of antibiotics in the treatment of adults with a diagnosis of acute bronchitis. Specific efforts included:

- Distribution of educational materials to providers on avoidance of antibiotic treatment for acute bronchitis and appropriate treatment for acute bronchitis.
- Distribution of talking points to providers on clinical protocols and evidence-based clinical practice guidelines for appropriate treatment of acute bronchitis for use with patients during office visits.

The rate for this measure increased by approximately one percentage point from 2011 to 2012; however, the rate still fell below the MPL in 2012. Molina will be required to continue the IP for this measure for San Diego County.

Adolescent Well-Care Visits

Molina was required to submit an IP for the *Adolescent Well-Care Visits* measure for Sacramento County in 2012 because the measure's rate was below the MPL in 2011. The plan identified several barriers to success in reaching the MPL for this measure, including:

- Providers' lack of awareness of members who have not completed annual well-care visits.
- Parental lack of understanding of the importance and benefit of annual well-care visits.
- Adolescents' disinterest in completing their annual well-care visits and lack of awareness of the available "teen-friendly" providers in their area.

To address the identified barriers, Molina focused on provider and member outreach and education. Specific activities included:

- Sending semi-annual reports to providers that listed members who had not been seen for their well-care visit.
- Offering provider incentives for timely and accurate submission of the confidential screening/billing report (PM 160) forms, which include information on adolescent well-care visits.
- Making telephone calls to members who have not been seen for their well-care visit to remind them to schedule their appointment.
- Distributing educational information to members on the importance of annual well-care visits through brochures and the plan's teen newsletter.
- Offering incentives to teens who provide documentation that they have been seen for their annual well-care visit.

Molina's interventions in Sacramento County resulted in the 2012 rate for this measure improving by almost 25 percentage points, which is a statistically significant improvement from 2011. Additionally, this rate is approximately four percentage points away from reaching the HPL. Molina will not be required to continue the IP for this measure in 2013.

Cervical Cancer Screening

Molina was required to submit an IP for the *Cervical Cancer Screening* measure for Sacramento County in 2012 because the measure's rate was below the MPL in 2011. The plan identified several barriers to success in reaching the MPL for this measure. Molina indicated that the biggest challenges were related to cultural issues. Additional challenges included:

Members

- Lack of awareness of the importance of cervical cancer screenings.
- Concern about the pain and discomfort associated with preventive care screenings.
- Lack of transportation.
- Job and family obligations being a priority over attending preventive care appointments.

Providers

- Variation in practice patterns related to preventive health counseling and cervical cancer screening.
- Lack of awareness of which members have not received their cervical cancer screening.
- Language barriers with members.
- Limited office hours.

Health Plan

- Not having updated addresses and telephone numbers for transient members.
- Members change their plan and/or primary care provider and are lost for care coordination and follow-up.

To address the identified barriers, Molina continued previously-implemented interventions and implemented two new interventions:

- The plan sent cervical cancer screening bracelets to members in English and Spanish.
- The plan contracted with a new medical record copy/abstraction company to improve data quality.

Although the rate for this measure improved slightly in Sacramento County from 2011 to 2012, the rate remained below the MPL. Additionally, the rate in Riverside/San Bernardino counties fell from above the MPL in 2011 to below the MPL in 2012. Molina will be required to continue its IP for this measure in Sacramento and include Riverside/San Bernardino counties in the IP for 2013.

Comprehensive Diabetes Care

Molina was required to submit IPs for three comprehensive diabetes care measures for Riverside/San Bernardino counties in 2012 because the rates for these measures were below the MPLs in 2011:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*

The plan identified several common barriers to success in reaching the MPLs for these measures, including:

- Members living large distances from provider offices. Although the plan makes a great effort to inform members of the availability of transportation, many members do not take advantage of the service and therefore do not regularly attend their medical appointments.
- Not having updated addresses and telephone numbers from transient members.

Two barriers were identified related to the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure:

- The vision care provider directory is not readily available to all Molina health care providers and members, which makes it difficult for members to easily locate a vision provider.
- Molina has not been able to determine the effectiveness of the plan's member services area providing members with the toll-free number to the vision care provider so members can schedule their appointments.

Molina identified common barriers to the plan performing above the MPLs for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)* and *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* measures, including:

- Members have socioeconomic challenges, which result in a focus on day-to-day survival rather than seeking preventive health care services and keeping their primary care provider (PCP) notified of address and telephone number changes.
- The majority of the members in Riverside and San Bernardino counties are Hispanic, and their diet tends to be high in carbohydrates, which makes controlling their diabetes difficult.

- Members who feel well are less likely to go to their PCP for monitoring and preventive health care services.

To address the identified barriers, Molina implemented several interventions to impact the rates for all three measures, including:

- Sending providers a "Needed Services Report" three times a year emphasizing diabetes screening and monitoring.
- Making diabetes clinical practice guidelines available to providers through the plan's Web site and quality improvement newsletter.
- Educating providers on cultural and linguistic issues to improve care and communication with patients.
- Referring members with complex diabetes care needs to the case/disease management staff members for ongoing assistance and case/disease management.
- Making outreach telephone calls to diabetic members to encourage them to seek care and schedule appointments and/or transportation as needed.

To improve performance on the retinal eye exam measure, Molina expanded the plan's incentive program for completion of the retinal eye exam to include all diabetic members, not just members in case management programs. Additionally, the plan requested that the vision care provider send a retinal examination brochure to each diabetic member annually.

Some providers do not use Molina's contracted laboratory (lab) vendor. To improve performance on the HbA1c measures, the plan monitored the volume of data coming from these other labs and confirmed that the data were being submitted into the plan's database.

Molina's comprehensive diabetes care IPs were effective in improving the rates on all three measures for Riverside/San Bernardino counties, resulting in all three performing above the MPLs in 2012. Molina will not be required to submit IPs for these measures in 2013; however, the plan will be required to submit an IP for the *Comprehensive Diabetes Care—LDL-C Screening* measure for Sacramento County in 2013 since performance on this measure declined from above the MPL in 2011 to below the MPL in 2012.

Childhood Immunization Status—Combination 3

Molina was required to continue the IP for the *Childhood Immunization Status—Combination 3* measure for Sacramento and Riverside/San Bernardino counties in 2012 because the rate for this measure was below the MPL in 2011.

As previously indicated by the plan, lack of sufficient and accurate encounter data resulted in incomplete administrative data for this measure, which led to a low rate and performance below

the MPL. Additionally, Molina indicated that the interventions had not been implemented long enough to make an impact on the measure's rate.

To address the identified barriers, Molina's main focus was on improving the administrative data capture. Interventions continued from the previous IP included:

- Exchanging the data file monthly with the California Immunization Registry (CAIR).
- Sending reports to providers three times a year that listed members who had not received childhood immunization services, based on encounter/claims data.
- Offering provider incentives for timely and accurate submission of the confidential screening/billing report (PM 160) forms, which include information on immunizations.

Molina added one new intervention to the IP for this measure. The plan implemented a monthly administrative tracking spreadsheet to track the administrative rate changes from year to year and from the initial month of the measurement year.

Although not statistically significant, the rate for the *Childhood Immunization Status—Combination 3* measure declined in Sacramento County from 2011 to 2012. Riverside/San Bernardino counties saw a slight improvement in the measure rate from 2011 to 2012; however, performance was still below the MPL in 2012. Molina will be required to continue the IP for this measure in 2013, which will be the third year the plan is required to do so for this measure. The plan will need to assess the factors that are leading to continued poor performance on this measure and modify its strategies to improve the rates.

Prenatal and Postpartum Care

Molina was required to continue its IP for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* measures for Sacramento County and Riverside/San Bernardino counties in 2012 because the rates for these measures were below the MPLs in 2011. Molina identified several ongoing challenges to success in reaching the MPLs for these measures, including:

- The plan's inability to identify expectant mothers.
- Members enroll in the plan late in their pregnancy.
- Women who have cesarean section deliveries have lower postpartum checkup rates.

To address the challenges and improve the rates for these measures, Molina implemented several new interventions, including:

- Reviewing all pregnancy-related claims (pre- and post-delivery) to identify where each member might have received care.

- Making outreach calls to members, scheduling appointments, assisting with transportation, and following up with providers to request medical records of members who had kept their appointment.
- Transitioning the Motherhood Matters Program into Integrated Disease Management High Risk Pregnancy Services to provide a more coordinated approach to care for pregnant members.
- Implementing a weekly authorization report of member deliveries that was used to make outreach telephone calls.
- Making enhancements to Molina's Web portal, including HEDIS missed service alerts and HEDIS reports.

Sacramento County and Riverside/San Bernardino counties had statistically significant improvement on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, which resulted in the rate on this measure in Sacramento County performing above the MPL in 2012. The rate in Riverside/San Bernardino counties, however, remained below the MPL in 2012; and the plan will need to continue the IP in these counties in 2013.

Although not statistically significant, Sacramento County had a slight improvement in the 2012 rate on the *Prenatal and Postpartum Care—Postpartum Care* measure. The measure had a statistically significant decline in performance in Riverside/San Bernardino counties. Despite efforts to improve performance to above the MPLs, the rates remained below the MPLs and Molina will be required to continue the IP for Sacramento and Riverside/San Bernardino counties in 2013.

Use of Imaging Studies for Low Back Pain

San Diego County performed below the MPL on the *Use of Imaging Studies for Low Back Pain* measure in 2012. Molina will be required to submit an IP for this measure for San Diego County in 2013.

Strengths

Sacramento County performed above the HPL on the *Use of Imaging Studies for Low Back Pain* measure and had statistically significant improvement on four measures from 2011 to 2012. Riverside/San Bernardino counties had six measures with statistically significant improvement from 2011 and four measures in San Diego County had statistically significant improvement. Molina's IPs for the following measures were effective in bringing the rates above the MPLs in 2012:

- *Adolescent Well-Care Visits* in Sacramento County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Riverside/San Bernardino counties.

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* in Riverside/San Bernardino counties.
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Riverside/San Bernardino counties.
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Sacramento County.

Opportunities for Improvement

Similar to 2011 results, the opportunities for improvement on performance measures impact all three domains of care—quality, access, and timeliness. The plan will need to submit new IPs for two measures and continue IPs for five measures. The plan has an opportunity to have technical assistance calls with the EQRO to discuss the plan's barrier analysis and interventions for measures that have consecutive years of performance below the MPLs without improvement to increase the likelihood of future success. The plan should also consider selecting areas of poor performance as a formal QIP topic.

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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* 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 plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). 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 Project Objectives

Molina had two clinical QIPs and one clinical QIP proposal in progress during the review period of July 1, 2011–June 30, 2012. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the current DHCS statewide collaborative QIP project. Molina's second project was an internal QIP aimed at improving hypertension control in members 18 to 85 years of age. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older. The three QIPs fell under the quality and access domains of care.

The current statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider in an office or clinic setting. At the initiation of the QIP, Molina had identified 10,766 ER room visits that were avoidable,

which was 17.5 percent of its ER visits. The percentage of avoidable ER visits for Molina's four counties ranged from 14.5 to 19.6 percent. The plan's objective was to reduce the rate of avoidable ER visits by 10 percent with the use of member, provider, and system improvement strategies. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The new statewide collaborative QIP proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. 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 hypertensive members 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

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Molina Healthcare of California Partner Plan, Inc.—Riverside, Sacramento, San Bernardino, and San Diego Counties July 1, 2011, through June 30, 2012

Name of Project/Study	County	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIPs					
Reducing Avoidable ER Visits	Riverside	Annual Submission	89%	100%	*Met*
	San Bernardino	Annual Submission	89%	100%	*Met*
	Sacramento	Annual Submission	95%	100%	*Met*
	San Diego	Annual Submission	89%	100%	*Met*
*All-Cause Readmissions**	Riverside/San Bernardino	Proposal	Not Applicable	Not Applicable	*Pass*
	Sacramento	Proposal	Not Applicable	Not Applicable	*Pass*
	San Diego	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs					
Improving Hypertension Control	Riverside/San Bernardino	Annual Submission	94%	100%	*Met*
	Sacramento	Annual Submission	94%	100%	*Met*
	San Diego	Annual Submission	94%	100%	*Met*

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

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that the annual submission by Molina of its *Reducing Avoidable Emergency Room Visits* and *Improving Hypertension Control Postpartum Care* QIPs all received an overall validation status of *Met*. For the

All-Cause Readmissions proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

Table 4.2 summarizes the aggregate validation results for Molina's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Molina Healthcare of California Partner Plan, Inc.—Riverside, Sacramento, San Bernardino, and San Diego Counties (Number = 7 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

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%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved	32%	0%	68%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**75%**	**0%**	**25%**

*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.

Molina submitted Remeasurement 1 data for its *Improving Hypertension Control* QIP, so HSAG validated Activities I through IX. The *Reducing Avoidable Emergency Room Visits* QIP included Remeasurement 3 data and was validated for Activities I through X. Molina demonstrated a strong understanding of the design and implementation stages, receiving a *Met* score for 100 percent of the applicable evaluation elements within the seven activities.

For the outcomes stage, Molina was scored lower in Activity IX for not demonstrating statistically significant improvement for any of its projects' outcomes. Similarly, in Activity X, the plan did not

achieve sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP outcome. Sustained improvement is defined as improvement in performance over baseline that 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 and Interventions

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 of California Partner Plan, Inc.—Riverside, Sacramento, San Bernardino, and San Diego Counties July 1, 2011, through June 30, 2012

QIP #1—Reducing Avoidable Emergency Room Visits						
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**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of avoidable ER visits^	Riverside	19.6%	21.6%*	21.8%	22.2%	No
	San Bernardino	19.1%	20.9%*	21.6%	21.8%	No
	Sacramento	14.5%	16.7%*	16.1%	15.8%	No
	San Diego	15.3%	16.2%*	15.9%	16.0%	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¥**
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%	42.6%*	‡	‡
	Sacramento	56.6%	50.8%	‡	‡
	San Diego	66.4%	58.3%*	‡	‡

^A lower percentage indicates better performance.

¥ Sustained improvement is defined as improvement in performance over baseline that 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 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.

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, Molina set an overall objective to decrease the rate of ER visits designated as avoidable by 6 percent. For this project outcome, a lower rate demonstrates improved performance. The plan did not meet its overall objective for any of the four counties. The plan's four counties demonstrated statistically significant declines in performance from baseline to the first remeasurement period. Furthermore, from the first to the third remeasurement period, none of the counties documented any statistically significant change in their rates. Without statistically significant improvement, the plan could not achieve sustained improvement for the project. An analysis of the plan's improvement strategies identified some weaknesses which may have led to the lack of improvement in the project's outcome.

- Molina discussed its general process to identify barriers and develop interventions including data analyses; however, the plan did not document the specific results, with the exception of the member and provider survey results. Additionally, except for the provider and member surveys, the plan did not provide evidence of county-specific barrier analyses. The plan presented the same fishbone diagram and reported the same barriers for all of its counties. The plan did not provide the rationale for how it prioritized barriers. The plan did not update the barrier analyses information for each measurement period or provide the justification for continuing interventions that were not associated with outcome improvement.
- The plan implemented over 40 interventions without documenting a method to evaluate the efficacy of the interventions. Approximately 30 of the interventions were designated as ongoing throughout the project even though the plan did not achieve improvement for any measurement period.
- Activities to identify barriers, i.e., geo-access analyses, member and provider surveys, and quality improvement meetings, were documented as interventions instead of components of the barrier analyses.
- The plan implemented one county-specific intervention: three urgent care centers were added to Riverside/San Bernardino counties.
- Collaborative interventions were initiated in early 2009; however, they did not correspond to any improvement in performance. The plan did, however, document some success with the plan-hospital data collection collaborative intervention in 2010. The plan documented receiving 94.0 percent of the ER visit data from the participating hospital within 5 days of the ER visit. The plan reported contacting 62.4 to 64.5 percent of the members within 14 days of their ER visit. Additionally, the rate of avoidable ER visits at the participating hospital was lower than the overall plan rate (18.5 percent versus 19.1 percent); however, with only one participating hospital, any small improvement would not measurably affect the overall outcome of the project.

Improving Hypertension Control QIP

For the *Improving Hypertension Control* QIP, Molina set a project goal to exceed the 2010 NCQA National Medicaid 75th percentile of 60.0 percent for all of its counties. At baseline, San Diego County was already above the project goal; however, from baseline to the first remeasurement period, the county demonstrated a statistically significant decline in performance. As a result, by the first remeasurement period, the plan had not achieved its project goal for any of its counties. In addition to San Diego County, Riverside/San Bernardino counties also reported a statistically significant decline in performance from baseline to the first remeasurement period, while Sacramento County did not demonstrate a statistically significant change. A critical analysis of the plan's improvement strategy led to the following observations.

- The plan identified its primary barriers through literature searches and published surveys. The plan did not document whether it then used its own data to verify the applicability of the barriers to each of its counties.
- Molina reported that evaluations of its interventions would require several measurement periods of outcome results to determine efficacy.
- For one of its listed interventions, Molina analyzed whether the quarterly change in the percentage of hypertensive members without any fills for antihypertensive class medications correlated with the change in the percentage of hypertensive members with controlled blood pressure. The plan reported difficulty in determining the results of the analysis. Molina, based on the identification of hypertensive members without antihypertensive medication fills, implemented additional interventions:
  - Sent hypertensive members postcards to educate and encourage members to fill antihypertensive medications. The plan did not track efforts or conduct follow-up calls.
  - Distributed a list to providers of their members without a hypertensive medication fill. The plan did not document what was expected of the providers or how they would evaluate the providers' efforts.

Alternatively, and potentially more appropriately, the plan could have reviewed whether the percentage of hypertensive members filling antihypertensive medications differed between hypertensive members with controlled blood pressure compared to hypertensive members with uncontrolled blood pressure. The results of this proposed analysis would enable the plan to identify whether or not filling antihypertensive medications was a barrier to controlling blood pressure. Based on the analysis results, the plan could then develop an improvement strategy to improve the fill rates for antihypertensive medications in its hypertensive members.

Strengths

Molina demonstrated a strong application of the design and implementation stages and received *Met* scores for all evaluation elements. 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 and sustain improvement of its QIP outcomes. At a minimum, barrier analyses 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 annual analyses alone. Barrier analyses should not be considered interventions.

The interventions implemented should address the high-priority barriers. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

With the implementation of any intervention and especially for multiple interventions, the plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

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

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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.

Overall, Molina demonstrated below-average performance in the quality domain of care. Across all counties, 10 measures falling into the quality domain of care performed below the MPLs in 2012. The only quality measure performing above the HPLs was the *Use of Imaging Studies for Low Back Pain* measure. Fourteen quality measures had statistically significant improvement from 2011 to 2012, and two quality measures had statistically significant decline in performance.

The IPs for the following measures falling under the quality domain of care resulted in performance improving from below the MPLs to above the MPLs:

- *Adolescent Well-Care Visits*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

All of the plan's QIPs fall under the quality domain of care. For all QIP proposals, Molina demonstrated a strong application of the design and implementation stages and received *Met* scores for all evaluation elements on the first submission. Molina did not meet its overall objective for any of the four counties or achieve sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP. The *Improving Hypertension Control* QIP showed statistically significant decline in performance from baseline to Remeasurement 1 in Riverside/San Bernardino and San Diego counties.

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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Overall, Molina demonstrated below-average performance in the access domain of care. Across all counties, eight measures falling into the access domain of care performed below the MPLs; and no access measures performed above the HPLs. Ten access measures had statistically significant improvement from 2011 to 2012, and one measure falling into the access domain of care had a statistically significant decline in performance. Additionally, two of the quality measures with successful IPs also fell into the access domain of care—*Adolescent Well-Care Visits* and *Comprehensive Diabetes Care Eye Exam (Retinal) Performed*.

All of Molina's QIPs fell into the access domain of care. As stated above, although Molina demonstrated strong application of the design and implementation stages, the plan failed to achieve sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP and had statistically significant decline in performance in Riverside/San Bernardino and San Diego counties from baseline to Remeasurement 1 for the *Improving Hypertension Control* QIP.

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.

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.

Overall, Molina demonstrated below-average performance in the timeliness domain of care. Across all counties, five measures falling into the timeliness domain of care performed below the MPLs; and no timeliness measures performed above the HPLs. Six timeliness measures showed statistically significant improvement from 2011 to 2012, and one timeliness measure had statistically significant decline in performance. Additionally, one of the quality measures that had a successful IP also fell into the timeliness domain of care—*Adolescent Well-Care Visits*.

Molina appears to have taken action to address all timeliness-related findings identified during the plan's most recent MR/PIU review.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. Molina's self-reported responses are included in Appendix B.

Recommendations

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

To ensure successful IPs for measures that performed below the MPLs in 2012:

- Participate in technical assistance calls with the EQRO to discuss the plan's barrier analysis and interventions for measures that have consecutive years of performance below the MPLs without improvement to increase the likelihood of future success.
- Consider selecting a performance measure with poor performance as a formal QIP topic for future studies to focus resources on the areas in greatest need of improvement.
- Evaluate whether the interventions implemented leading to a slight increase in the rate on the *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* measure in San Diego County are effective. If they are not effective, consider whether to modify or replace these interventions to bring the rate above the MPL in 2013.
- Repeat barrier analysis and modify or implement new interventions for the *Cervical Cancer Screening* measure to help bring the rate for this measure to above the MPL in Sacramento and Riverside/San Bernardino counties in 2013.
- Identify the factors that led to a decline in performance on the *Comprehensive Diabetes Care—LDL-C Screening* measure in Sacramento County from above the MPL in 2011 to below the MPL in 2012 and identify interventions that will lead to an improvement in the rate to above the MPL in 2013.
- Thoroughly assess factors that have led to continued poor performance on the *Childhood Immunization Status—Combination 3* measure and modify the IP interventions, as appropriate, to move performance to above the MPL.
- Apply lessons learned in Sacramento County that led to improvement on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure from below the MPL in 2011 to above the MPL in 2012 to Riverside/San Bernardino counties, which continue to perform below the MPL on this measure.
- Evaluate effectiveness of existing interventions for the *Prenatal and Postpartum Care—Postpartum Care* measure in Sacramento County and Riverside/San Bernardino counties.
- Identify the factors that led to a decline in performance in San Diego County on the *Use of Imaging Studies for Low Back Pain* measure from above the MPL in 2011 to below the MPL in 2012. Develop interventions to address the identified factors to bring the rate above the MPL.

To ensure successful QIPs:

- Perform barrier analyses 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 annual analyses alone. Barrier analyses should not be considered interventions.
- Ensure interventions address the high-priority barriers. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.
- Ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

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

Quality, Access, and Timeliness

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

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Tables 3.2 through 3.4)

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

- **Validation** *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.
  - **Above Average** is not applicable.
  - **Average** = *Met* validation status.
  - **Below Average** = *Partially Met* or *Not Met* validation status.
- **Outcomes** *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**
  - **Above Average** = All study indicators demonstrated statistically significant improvement.
  - **Average** = Not all study indicators demonstrated statistically significant improvement.
  - **Below Average** = No study indicators demonstrated statistically significant improvement.

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **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 performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity 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.

Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

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

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with Molina's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table B.1—Grid of Molina's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Molina's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Ensure that all MR/PIU 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.	Molina Healthcare of California (Molina) Appeals and Grievance Unit has an established tracking and monitoring mechanism to ensure every grievance received at the plan is resolved within 30 days of receipt. Molina monitors grievances on a daily/weekly/monthly basis and prioritizes cases based on urgency and aging. In the event a grievance cannot be resolved within the 30-day time frame and an extension is needed, Molina contacts the member and explains the unforeseen circumstances and requests the member's approval for an extension not to exceed 14 days. Upon approval Molina updates the case notes on the member's grievance and a follow-up letter is issued to the member as confirmation of the agreed-upon extension. A final resolution letter is issued to the member within 44 days of receipt of the grievance. The Utilization Management (UM) Delegation Oversight unit will continue to monitor the groups' prior authorization Notice Of Action (NOA) files by completing a review of 100% of the NOAs submitted by the delegated groups. The review includes the review of all turnaround time (TAT) requirements and use of correct NOA templates and appeal attachments. As issues/deficiencies are identified, the delegate will be provided with telephonic or electronic education and training. Any delegate with ongoing issues will receive an onsite denial presentation/education on-site for further education. Corrective Action Plans (CAPs) for any element of the file review not scoring 100% will be sent quarterly. CAPs will not be closed until an appropriate response has been received from the group. As a result of the ongoing monitoring and education of the delegates, we continue to see outstanding compliance to TAT requirements
Revise HEDIS intervention strategies and have a technical assistance call with DHCS and HSAG to review the barrier analysis and proposed interventions.	Barriers to improving HEDIS scores include inconsistent or incomplete data collection or submission. Subsequent to the 2011 HEDIS reporting in June 2011 and throughout 2012, Molina implemented numerous interventions encompassing members, providers, data transmission from IPA, and encounter data. These included: <u>Member Needed Services Report:</u> • To overcome the barrier of providers not identifying members needing services, Molina's strategy is to identify members at the start of each calendar year who are continuously enrolled and who could be in the reporting denominator at the end of the year. The data are loaded onto an encrypted CD by PCP, member, and measure, and transmitted 3 times a year for the provider to use as a basis of contacting members and providing services. • Molina enhanced its ePortal for a more user-friendly access; and in 2013, the needed services reports will be loaded onto the ePortal rather than on CDs.

Table B.1—Grid of Molina's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Molina's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
	Submission/Collection of accurate data: • Molina enhanced its ePortal CHDP/PM 160 forms for electronic completion by providers. This capability will assist with children immunization status (CIS) and anticipatory guidance documentation. • As part of technical process enhancements, during 2012, Molina implemented ongoing outreach to providers for select critical measure data to enhance data collection and transmission. The data are transmitted electronically, abstracted onto a temporary application, and subsequently transmitted to the HEDIS data application, MedAssurant. • Molina determined that a factor in the low immunization rates was due to program and programmer changes at the California Immunization Registry (CAIR) and San Diego Immunization Registry (SDIR). In an effort to enhance immunization data exchange, Molina coordinated file layouts and data exchange schedules with CAIR and SDIR. Molina is optimistic the immunization rates will improve. • Molina contracted with a data collection vendor to collect the delivery records and the first hepatitis B shots from hospitals. The Hepatitis B data will help improve the immunization rates. Molina hoped to use delivery data collected to identify the OB providing prenatal care and be able to contact the member to access postpartum care; unfortunately, the only OB identified was the delivery OB, in most cases the OB on call. • In order to overcome the barrier of IPA's utilization of non-contracted lab vendors, Molina contracted with a vendor to collect lab and radiology data. Molina noticed that there was significant improvement in the measures dependent upon lab data. • Molina is working with its subcontracted IPAs to address encounter data gaps and the importance of submitting files using a file layout that meets technical specifications for the encounter reporting repository. This has an impact on many HEDIS measures. Member Outreach: • Molina found that members have been responsive to gift card incentive programs only for the adolescent well-child visit incentive and a diabetic retinal exam (DRE) incentive. The notifications for the incentives are placed in the semi-annual teen newsletter and the diabetic newsletter. The notifications were continued, and the plan believes they contributed to HEDIS score improvements in these two measures. • In late 2011 Molina performed a member outreach to postpartum members to determine why they were not having their postpartum visit. During this outreach, plan staff learned

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2010–2011 EQR Recommendation	Molina's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
	that members do not feel they need the visit and if they had a C-section they would have their wound checked without a subsequent visit. Molina will continue to contact postpartum members identified by UM referral by telephone and mail to inform them of the importance of postpartum care. • A Pay for Performance (P4P) program for providers was designed for critical HEDIS measures. Molina is pending regulatory approval for implementation. <u>Provider Education:</u> • Molina's Quality Improvement (QI) department produced a Provider Guide to HEDIS and Star in mid-2012. It identifies measures for different age groups, women's health, preventive care disease management and medications. Each measure has detailed instructions for medical record documentation, HEDIS coding, chart form examples and other resources that are useful for the office staff. These guides were distributed in person or by mail to primary care providers and OBs. • Molina's QI department produces an annual pocket-size booklet on HEDIS measure and codes for the office staff to use for encounter coding and claims submission. All activities described above will continue except collecting the prenatal data from the hospitals. As new programs or practices are identified, they will be added.
Implement a rapid-cycle of intervention evaluation to determine which interventions are effective and should be continued and those that are not effective.	As a rapid-cycle intervention evaluation, Molina loads activities that generated administrative or medical record data into spread sheets and combines them with data from encounters, claims, immunization registries, PM 160s, and medical record abstraction from all care sites. The needed services reports are generated three times a year and identify by IPA, PCP, and continuously enrolled (CE) members that will have an opportunity to be selected for the denominator at year end. All HEDIS measures are score carded against the needed services reports. The scorecard shows the progress over time of the measure data collection. Molina tracks, monitors, and maintains the scorecards to evaluate progress.
Focus improvement efforts on the lower performing and/or declining performance measures, including *Childhood Immunization Status—Combination 3* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.	**Childhood Immunization Status—Combination 3 (CIS-3)** Barriers to CIS-3 performance are composed of a collection and combination of both external and internal barriers. Molina continues to target both types of barriers. Molina is placing a substantial focus and efforts on internal barriers by improving and monitoring administrative processes to improve claims and encounter data capture, consequently improving CIS-3 administrative data. Moreover, Molina is targeting external barriers to address provider- and member-driven barriers.

Table B.1—Grid of Molina's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Molina's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
	In efforts to improve accurate and timely data file exchange with the state immunization registry, PM 160 and claims/encounter submissions. Molina has implemented the following process improvements: • Oversee and monitor data exchange with CAIR, California Immunization Registry, for Riverside/San Bernardino and Sacramento counties. • Track and monitor monthly administrative rates for CIS-3, including claims and encounters. • ePortal enhancements to efficiently and effectively process electronic PM 160 submission. In efforts to improve member compliance to receiving timely immunizations and proper medical record documentation by providers, the following interventions were implemented: • ePortal enhancements to improve the efficiency of PM 160 submission and documentation by providers. • Provider incentive for timely and accurate PM 160 submission. • Notify providers with Molina members that need preventive health services based on HEDIS specification. • Develop and distribute a provider's guide to HEDIS to educate timely provision of preventive health services that are part of HEDIS performance measures and appropriate medical record documentations to support as evidence of receiving services that impact HEDIS performance rates. • Developed and distributed age-specific immunization schedule charts in a magnetic wipe board layout to educate and remind members and parents/guardians of recommended children and adolescent immunizations. **Prenatal and Postpartum Care—Timeliness of Prenatal Care** Molina reviewed barriers and re-evaluated current interventions for Prenatal and Postpartum Care measures. Intervention strategies are focused on improving internal processes with data collection and in identifying pre- and post-delivery care services. The following processes were implemented: 1. A pull list report of all pregnancy diagnosis related claims are pulled from 9 months back pre-delivery to 3 months after delivery with the rendering provider specialty. This is matched against the HEDIS sample chase lists. 2. Members with matched chases are identified and the medical records are requested from PCPs and OBs. Once received, the charts are abstracted internally and manually entered into the QSHR (Quality Spectrum Hybrid Reporter). Unmatched chases are sent to our HEDIS vendor to pursue the records. 3. Molina's HEDIS vendor (Datafied) collects hospital delivery records according to claims and encounter data pull lists which are loaded to an FTP site. The medical records are abstracted

Table B.1—Grid of Molina's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Molina's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
	internally by Molina staff and abstraction results are loaded to QSI (Quality Spectrum Insight). 4. Molina made 100% postpartum care (*PPC)* calls to members on the missed services list who might have received prenatal and postpartum care services from other providers or service sites. Molina obtained 150 medical records as a result of successful member contact. Additionally, Molina contacts members with missed services, assists in setting up appointments, follow-up, and rescheduling appointments, assists with transportation needs, follows up with provider offices and requests medical records for kept appointments. Molina Medical Group offices also receive a weekly authorization and delivery claim file report for staff to call these members and remind them to schedule their postpartum care visits. Another significant improvement made was the Web portal enhancement which includes HEDIS missed services alerts and availability of HEDIS reports to meet provider needs.
Conduct barrier analysis to identify and prioritize barriers for each QIP measurement period.	**Hypertension – QIP** The causes of uncontrolled hypertension and barriers to achieving controlled blood pressure were evaluated and demonstrated in a cause-and-effect diagram and were reviewed and validated by EQRO. The factors related to uncontrolled blood pressure are primarily driven by practitioner- and member-related factors. The major causes of uncontrolled hypertension (barriers to controlled blood pressure) are inadequate or inappropriate therapy and patient noncompliance to clinically sound treatments. Interventions specifically targeting practice variation in hypertension control are equally important as targeting member/patient noncompliance. Even high levels of patient compliance do not result in controlled blood pressure if pharmacological regimen is inappropriate or inefficacious. Therefore, Molina focused on the following interventions that target practitioners: • Hypertension Pharmacy Profile: to address drug-related barriers and to encourage appropriate therapy as identified on the causal/barrier analysis by increasing the primary care practitioners' (PCPs') awareness to their hypertensive patients' pharmacological therapy. • Needed Service Report: to increase PCPs' awareness to their hypertension-diagnosed members and to encourage and emphasize the need for office visits within the measurement year to evaluate patient's current blood pressure. • Clinical Practice Guidelines: to inform treatment guidelines that are evidence-based and reduce practice variation in treating hypertension.

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2010–2011 EQR Recommendation	Molina's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
	Causal/barrier analysis diagram demonstrates that patient/member-related factors are derived from and associated with lack of knowledge, complicated regimens, and side effects of medication, inconvenient dosing schedule, unclear instructions, lifestyle and diet. The following interventions are implemented to target member-related external barriers and to improve compliance through education: • Member Postcards: an educational intervention to increase member knowledge and member empowerment, further improving patient compliance. • Member Call: Customer support service educates and reminds members with preventive services when a member calls, such as PCP visit for current blood pressure evaluation and receiving necessary follow-up treatments to control hypertension. Customer support services assist members in scheduling appointments, arranging interpretation services and transportation if needed. **ER Collaborative – QIP** Molina completed a causal/barrier analysis and used improvement strategies related to the causal/barriers identified through data analysis and quality improvement process. Causal barrier analyses are conducted every measurement period as demonstrated in QIPs through cause-and-effect/fishbone diagram which were reviewed and validated by EQRO. The study outcomes were presented at quality improvement committee (Quality Improvement Committee and Clinical Quality Management Committee) meetings engaging discussions and brainstorming to identify and prioritize barriers. Control charts, barrier/intervention tables were utilized in performing causal barrier/analysis A significant barrier to decreasing avoidable emergency room visits is related to member knowledge deficit and perception that the ER is an appropriate and convenient place of care. In an effort to improve these barriers, Molina focused on providing education to members and provider offices: • Self-care booklets designed to help members initially treat common health problems at home and hopefully avoiding going to ER. The booklets are available in threshold languages. • Molina conducts an assessment survey to obtain information about member emergency room use and other pertinent health information. The data are assessed for further case management if needed. • Provider Services PCP off-site visits continuously educate offices about avoidable ER visits and provide educational materials • ER follow-up outreach calls initiative by Molina Medical Group offices to remind members to see their PCP post ER visit.

Table B.1—Grid of Molina's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Molina's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Ensure that barrier analyses for both QIP topics are county-specific and interventions are targeted to the county-specific barriers.	**Hypertension – QIP** Based on causal/barrier analysis, the implication of causal factors and barriers to improve Controlling Blood Pressure are identified in all counties. Hence, implemented interventions to improve hypertension control are general in nature and apply to all counties. County-specific intervention applies to administrative data collection process that focuses on CAIR for Riverside/San Bernardino and Sacramento County immunization registry and SDIR for San Diego County immunization registry. Member-related materials are distributed in English and Spanish to meet member language preferences. **ER Collaborative – QIP** Due to variation in demographics and utilization rate, barrier analyses were conducted for each county and targeted interventions are county- specific Some examples of the interventions are hospital collaboration in San Bernardino county, distribution of ER booklets in threshold languages for each county, and ER follow-up outreach calls by Molina Medical Group Staff to members in Sacramento County.
Implement a method to evaluate the effectiveness of each QIP intervention and use the results to make revisions or implement new interventions, if necessary.	**Hypertension – QIP** Nationally recognized performance indicator, HEDIS, is used to evaluate the clinical outcome and ultimately evaluate the effectiveness of interventions that are implemented to improve Controlling Blood Pressure. Molina observed improvements in Controlling Blood Pressure HEDIS outcome measure between 2011 (2010 measurement) and 2012 (2011 measurement) years for Riverside/San Bernardino and Sacramento Counties. This observation interprets possible effectiveness of the intervention; however, true effectiveness of the intervention will be evaluated after the subsequent HEDIS outcome in 2013 for 2012 measurement period to evaluate the sustenance of improvements. **ER Collaborative – QIP** The goal of the ER Visit Collaborative is to achieve an annual 2% reduction rate of avoidable ER visits. The performance goal is used to determine and evaluate the effectiveness of QIP interventions. The study outcomes were presented to quality improvement committee meetings wherein barriers were analyzed, current interventions were reviewed for their effectiveness and proposal for new interventions were identified and considered. The rate results did not demonstrate improvement in San Bernardino, Riverside and San Diego counties. Although the improvement in Sacramento county was not statistically significant, an improvement was observed for Study Indicator 2 from Remeasurement 2 to Remeasurement 3 which appeared to be the result of the interventions. Interventions implemented in other counties were re-evaluated for their impact in reducing avoidable ER visits.

Table B.1—Grid of Molina's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Molina's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
If QIP intervention evaluation demonstrates that an intervention is successful, clearly document the process used to monitor and standardize the intervention in the QIP.	**Hypertension – QIP** Riverside/San Bernardino County showed a statistically significant improvement between Remeasurement 1 and Remeasurement 2 (2011 and 2012 HEDIS), and Sacramento County showed an improvement without statistical significance. It is critical to take into consideration that although some internal process improvements and structural interventions may show an immediate positive impact, member and provider interventions have a long-term effectiveness trait. This further implies that the true effectiveness of the interventions will not be observed or be apparent until multiple remeasurements are evaluated. For internal process improvements, value-based interventions have been standardized: • Needed Service Report: to increase PCPs' awareness to their hypertension-diagnosed members and to encourage and emphasize the need for an office visit within the measurement year to evaluate patient's current blood pressure. • Member Call: Customer support service educates and reminds members with preventive services when a member calls, such as PCP visit for current blood pressure evaluation and receiving necessary follow-up treatments to control hypertension. Customer support services assist members in scheduling appointments and arranging interpretation services and transportation if needed. **ER Collaborative – QIP** Sacramento County demonstrated improvement with Study Indicator 2 Remeasurement 3, and the improvement appeared to be the result of the interventions. Molina believes that repeated and continuous member and provider education will play an important long-term role in changing member behavior toward appropriate ER use. Some of the interventions appeared to be successful have been standardized: • UM Outreach calls to all members who had ER visits. • Molina Medical Group ER follow-up outreach calls initiative in Sacramento, San Bernardino, and Riverside counties. • Education campaign to members about appropriate ER visits, care management to high ER utilizers and providing educational sources.