Performance Evaluation Report

Molina Healthcare of California Partner Plan, Inc.

July 1, 2012–June 30, 2013

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

April 2014

TABLE OF CONTENTS

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Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It

[1] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

includes an aggregate assessment of MCPs' performance through organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Molina Healthcare of California Partner Plan, Inc. ("Molina" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

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

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

Molina became operational in Riverside and San Bernardino counties to provide MCMC services effective December 1997. The MCP expanded to Sacramento County in 2000 and San Diego County in 2005. As of June 30, 2013, Molina had 47,962 MCMC members in Riverside County, 61,670 in San Bernardino County, 38,481 in Sacramento County, and 90,375 in San Diego County—for a total of 238,488 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

The most recent routine monitoring review for Molina was conducted by DHCS's Member Rights/Program Integrity Unit (MR/PIU) January 24, 2011, through January 27, 2011, covering the review period of January 1, 2009, through March 31, 2010. HSAG reported on the detailed findings from this review in Molina's previous MCP-specific evaluation reports. MR/PIU conducted a follow-up review for Molina in October 2012. In addition to following up on the

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

findings identified during the January 2011 review, MR/PIU evaluated Molina's level of progress in performing cultural awareness and sensitivity training required to meet the needs of the SPD population and physical accessibility review surveys.

In a letter dated May 21, 2013, DHCS summarized the results of the October 2012 review. DHCS indicated that Molina had taken appropriate actions to correct the findings from the January 2011 review in the areas of Member Grievances and Prior Authorization Notification. Additionally, the letter indicated that MR/PIU found the MCP's progress on providing SPD sensitivity, facility site review tool, and physical accessibility trainings satisfactory.

Strengths

Molina took actions to fully address the findings from the January 2011 MR/PIU Routine Monitoring Review and has made satisfactory progress on providing SPD sensitivity, facility site review tool, and physical accessibility trainings.

Opportunities for Improvement

Since Molina resolved all areas of concern identified through the January 2011 MR/PIU survey, HSAG does not have any recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Molina Healthcare of California Partner Plan, Inc.,* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that Molina followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- As in prior years, Molina demonstrated a sound process for ensuring accurate provider demographic information and audited its provider network files weekly and monthly throughout the year.
- Molina had a robust disaster recovery plan, and the components of the plan met or exceeded HEDIS reporting expectations.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions* ‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient 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)*
CBP	*Controlling High Blood Pressure*
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*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
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*
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*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 through Table 3.4 present a summary of Molina's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 through Table 3.4 show the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Molina—Riverside/San Bernardino Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	20.13%	30.23%	★★	↑	18.98%	33.33%
ACR	Q, A	--	14.65%	--	Not Comparable	--	--
AMB–ED	‡	43.22	43.60	‡	Not Comparable	‡	‡
AMB–OP	‡	285.69	260.50	‡	Not Comparable	‡	‡
CAP–1224	A	94.88%	93.65%	★	↓	95.56%	98.39%
CAP–256	A	83.76%	83.03%	★	↔	86.62%	92.63%
CAP–711	A	82.68%	81.96%	★	↔	87.56%	94.51%
CAP–1219	A	84.19%	84.51%	★	↔	86.04%	93.01%
CBP	Q	--	53.83%	--	Not Comparable	--	--
CCS	Q,A	62.00%	52.75%	★	↓	61.81%	78.51%
CDC–BP	Q	59.33%	56.52%	★★	↔	54.48%	75.44%
CDC–E	Q,A	54.83%	46.68%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	40.00%	43.48%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	48.76%	43.71%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	78.65%	81.92%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	34.83%	35.93%	★★	↔	28.47%	46.44%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Molina—Riverside/San Bernardino Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CDC–LS	Q,A	77.30%	82.61%	★★	↑	70.34%	83.45%
CDC–N	Q,A	81.80%	83.30%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	59.63%	63.86%	★	↔	64.72%	82.48%
IMA–1	Q,A,T	60.88%	69.10%	★★	↑	50.36%	80.91%
LBP	Q	76.40%	78.21%	★★	↔	72.04%	82.04%
MMA–50	Q	--	31.87%	--	Not Comparable	--	--
MMA–75	Q	--	14.51%	--	Not Comparable	--	--
MPM–ACE	Q	81.55%	86.05%	★★	↑	83.72%	91.33%
MPM–DIG	Q	NA	92.11%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	81.41%	84.41%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	77.17%	64.27%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	43.84%	28.99%	★	↓	58.70%	74.73%
W-34	Q,A,T	74.77%	68.39%	★★	↔	65.51%	83.04%
WCC–BMI	Q	44.32%	42.00%	★★	↔	29.20%	77.13%
WCC–N	Q	64.97%	59.40%	★★	↔	42.82%	77.61%
WCC–PA	Q	57.08%	49.42%	★★	↓	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
Molina—Sacramento County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	28.29%	23.08%	★★	↔	18.98%	33.33%
ACR	Q, A	--	13.20%	--	Not Comparable	--	--
AMB–ED	‡	44.96	47.83	‡	Not Comparable	‡	‡
AMB–OP	‡	238.15	261.22	‡	Not Comparable	‡	‡
CAP–1224	A	95.79%	94.81%	★	↔	95.56%	98.39%
CAP–256	A	84.21%	84.09%	★	↔	86.62%	92.63%
CAP–711	A	83.45%	83.80%	★	↔	87.56%	94.51%
CAP–1219	A	83.38%	84.20%	★	↔	86.04%	93.01%
CBP	Q	--	51.29%	--	Not Comparable	--	--
CCS	Q,A	63.11%	50.51%	★	↓	61.81%	78.51%
CDC–BP	Q	58.22%	54.65%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.22%	47.91%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	46.89%	46.05%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	40.89%	43.26%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	81.78%	78.60%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	33.78%	31.63%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	69.33%	70.00%	★	↔	70.34%	83.45%
CDC–N	Q,A	83.11%	80.47%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	50.12%	54.06%	★	↔	64.72%	82.48%
IMA–1	Q,A,T	55.32%	66.04%	★★	↑	50.36%	80.91%
LBP	Q	84.03%	83.24%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	31.72%	--	Not Comparable	--	--
MMA–75	Q	--	17.24%	--	Not Comparable	--	--
MPM–ACE	Q	78.84%	73.99%	★	↓	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	74.23%	73.63%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	81.45%	69.62%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	51.36%	37.47%	★	↓	58.70%	74.73%
W-34	Q,A,T	76.10%	73.21%	★★	↔	65.51%	83.04%

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
Molina—Sacramento County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–BMI	Q	62.33%	54.61%	★★	↓	29.20%	77.13%
WCC–N	Q	64.65%	59.34%	★★	↔	42.82%	77.61%
WCC–PA	Q	58.37%	49.65%	★★	↓	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
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[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
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[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
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[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
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★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
Molina—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	18.21%	17.33%	★	↔	18.98%	33.33%
ACR	Q, A	--	14.45%	--	Not Comparable	--	--
AMB–ED	‡	43.30	45.58	‡	Not Comparable	‡	‡
AMB–OP	‡	331.91	305.90	‡	Not Comparable	‡	‡
CAP–1224	A	94.76%	95.93%	★★	↔	95.56%	98.39%
CAP–256	A	88.46%	88.02%	★★	↔	86.62%	92.63%
CAP–711	A	87.55%	88.31%	★★	↔	87.56%	94.51%
CAP–1219	A	83.75%	85.26%	★	↑	86.04%	93.01%
CBP	Q	--	52.76%	--	Not Comparable	--	--
CCS	Q,A	68.91%	59.51%	★	↓	61.81%	78.51%
CDC–BP	Q	62.00%	62.30%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.44%	58.55%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	46.22%	57.85%	★★	↑	42.09%	59.37%
CDC–H9 (>9.0%)	Q	46.67%	32.55%	★★	▲	50.31%	28.95%
CDC–HT	Q,A	84.44%	88.76%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	42.22%	47.54%	★★★	↔	28.47%	46.44%
CDC–LS	Q,A	78.22%	86.42%	★★★	↑	70.34%	83.45%
CDC–N	Q,A	80.22%	84.31%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	73.19%	75.00%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	71.30%	80.83%	★★	↑	50.36%	80.91%
LBP	Q	71.98%	72.00%	★	↔	72.04%	82.04%
MMA–50	Q	--	35.33%	--	Not Comparable	--	--
MMA–75	Q	--	18.63%	--	Not Comparable	--	--
MPM–ACE	Q	86.72%	85.15%	★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	94.74%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	85.85%	86.01%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	88.94%	79.72%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	61.40%	51.52%	★	↓	58.70%	74.73%
W-34	Q,A,T	78.89%	74.74%	★★	↔	65.51%	83.04%

Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
Molina—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–BMI	Q	57.67%	64.79%	★★	↑	29.20%	77.13%
WCC–N	Q	61.86%	65.96%	★★	↔	42.82%	77.61%
WCC–PA	Q	52.33%	55.16%	★★	↔	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The

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

selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Tables 3.5 through 3.10, which present a summary of Molina's 2013 SPD measure results. Tables 3.5, 3.7, and 3.9 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Tables 3.6, 3.8, and 3.10 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

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

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Tables 3.5, 3.7, and 3.9.

Table 3.5—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Molina—Riverside/San Bernardino Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.17%	18.15%	▼	14.65%
CAP–1224	93.77%	NA	Not Comparable	93.65%
CAP–256	83.13%	79.18%	↔	83.03%
CAP–711	81.88%	84.52%	↔	81.96%
CAP–1219	84.55%	83.44%	↔	84.51%
CDC–BP	67.63%	56.25%	↓	56.52%
CDC–E	46.89%	46.88%	↔	46.68%
CDC–H8 (<8.0%)	42.32%	47.40%	↔	43.48%
CDC–H9 (>9.0%)	46.06%	44.79%	↔	43.71%
CDC–HT	84.23%	80.21%	↔	81.92%
CDC–LC (<100)	37.76%	42.19%	↔	35.93%
CDC–LS	84.65%	76.56%	↓	82.61%
CDC–N	83.40%	88.02%	↔	83.30%
MPM–ACE	83.14%	87.80%	↑	86.05%
MPM–DIG	NA	90.63%	Not Comparable	92.11%
MPM–DIU	80.14%	87.06%	↑	84.41%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.6—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—Riverside/San Bernardino Counties

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
247.94	40.14	346.49	67.24

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

Table 3.7—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Molina—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.02%	14.68%	▼	13.20%
CAP–1224	94.90%	NA	Not Comparable	94.81%
CAP–256	84.18%	79.27%	↔	84.09%
CAP–711	83.64%	87.88%	↔	83.80%
CAP–1219	84.55%	79.40%	↓	84.20%
CDC–BP	57.40%	55.80%	↔	54.65%
CDC–E	44.84%	47.83%	↔	47.91%
CDC–H8 (<8.0%)	38.12%	52.17%	↑	46.05%
CDC–H9 (>9.0%)	50.22%	44.20%	↔	43.26%
CDC–HT	74.44%	73.91%	↔	78.60%
CDC–LC (<100)	27.35%	34.06%	↔	31.63%
CDC–LS	64.13%	63.77%	↔	70.00%
CDC–N	71.30%	81.88%	↑	80.47%
MPM–ACE	71.60%	74.59%	↔	73.99%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	70.51%	74.40%	↔	73.63%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.8—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—Sacramento County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
218.18	42.97	415.90	65.28

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

Table 3.9—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Molina—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.37%	17.65%	▼	14.45%
CAP–1224	96.16%	80.65%	↓	95.93%
CAP–256	88.11%	84.13%	↔	88.02%
CAP–711	88.25%	89.63%	↔	88.31%
CAP–1219	85.32%	84.01%	↔	85.26%
CDC–BP	60.21%	58.45%	↔	62.30%
CDC–E	45.42%	52.11%	↔	58.55%
CDC–H8 (<8.0%)	46.83%	57.75%	↑	57.85%
CDC–H9 (>9.0%)	42.25%	37.32%	↔	32.55%
CDC–HT	81.69%	85.21%	↔	88.76%
CDC–LC (<100)	33.80%	51.41%	↑	47.54%
CDC–LS	72.18%	83.80%	↑	86.42%
CDC–N	71.13%	90.14%	↑	84.31%
MPM–ACE	83.63%	85.79%	↔	85.15%
MPM–DIG	NA	94.12%	Not Comparable	94.74%
MPM–DIU	81.40%	88.10%	↑	86.01%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.10—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—San Diego County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
273.91	43.19	512.86	61.02

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

Performance Measure Result Findings

Molina continues to show below-average performance on its performance measures. All counties had more measures with rates below the MPLs in 2013 than in 2012 and more measures with rates that declined significantly from 2012 to 2013 than from 2011 to 2012. Across all counties, 25 measures had rates below the MPLs—15 more than in 2012—and 16 measures had rates that declined significantly from 2012 to 2013.

Although the MCP continues to show below-average performance, in Sacramento County the rate for the *Use of Imaging Studies for Low Back Pain* measure was above the HPL for the second year in a row, and San Diego County had two *Comprehensive Diabetes Care* measures with rates above the HPLs—*LDL-C Control (<100 mg/dL)* and *LDL-C Screening*. Across all counties, 11 measures had rates with statistically significant improvement from 2012 to 2013.

Seniors and Persons with Disabilities Findings

Across all counties, the SPD rates for nine measures were significantly better than the non-SPD rates. San Diego County had five measures with SPD rates that were significantly better and Riverside/San Bernardino and Sacramento counties each had two measures with SPD rates that were significantly better than the non-SPD rates.

Across all counties, the SPD rates for seven measures were significantly worse than the non-SPD rates. The SPD rate for one of these measures, *All-Cause Readmissions*, was significantly worse than the non-SPD rate across all counties, meaning that in all counties, the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

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

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below

the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Molina was required to submit IPs for 10 measures with rates below the MPLs in 2012 (measurement year 2011). Below is a summary of each IP and HSAG's analysis of the progress the MCP made on improving performance on the measures.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Molina was required to submit an IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in San Diego County for the second year in a row. Molina identified several new barriers and challenges to the MCP's success in reaching the MPL for this measure, including:

- Many inappropriate antibiotic prescriptions being written at the time of an emergency room or urgent care visit.
- Emergency room physicians being focused on rapid and immediate care and not being aware of the importance of avoiding antibiotic treatment for acute bronchitis.
- Some prescribers at the federally qualified health center (FQHC) being mid-level physician assistants and nurse practitioners who may be less aware of the importance of avoiding antibiotic treatment for acute bronchitis.

To address the newly-identified barriers and challenges, Molina implemented several new interventions, including:

- Conducting a clinical study to assess practitioner practice pattern variations with acute bronchitis treatment and sending letters with information about the appropriate use of antibiotics to providers identified in the clinical study as prescribing antibiotics for the diagnosis of acute bronchitis.
- Sending educational postcards on the appropriate use of antibiotics to members identified in the clinical study as filling a prescription for an antibiotic for the treatment of acute bronchitis.
- Conducting provider education sessions that include independent practice association and FQHC leadership.

- Including articles in the quality improvement provider newsletters on the avoidance of antibiotics in the treatment of adults with acute bronchitis, with reminders of where to obtain the clinical practice guidelines and member education handouts.

The rate for this measure declined by a little less than 1 percentage point from 2012 to 2013, and the rate remained below the MPL. Molina will be required to continue the IP for this measure for San Diego County.

Cervical Cancer Screening

Molina was required to submit an IP for the *Cervical Cancer Screening* measure in Sacramento County for the second year in a row in 2012, and for Riverside/San Bernardino counties for the first time. The MCP indicated that all barriers identified in the previous IP remained and that no new barriers were identified. Molina indicated that the MCP conducted data and barrier analyses to determine why the 2012 HEDIS rates did not show improvement over the 2011 HEDIS rates. The following reasons were identified:

- An increase in the female membership.
- Younger members not getting screened.
- Members not using the MCP's free transportation services.
- Providers with high membership not performing screenings.

To address the identified challenges, Molina continued several interventions and identified new interventions to implement. New interventions included:

- Implementing a pay-for-performance program that targets high-volume providers who are not performing the screenings.
- Implementing an incentive program for female members that includes a letter being mailed to them with information about needed services, instructions on how to schedule an appointment with their provider, and a form to complete and submit that triggers the MCP sending them a gift.
- Posting information in Molina Medical Group clinics about Molina's free neighborhood shuttles and distributing the information to all members.
- Mailing and faxing information to high-volume providers who are not performing screenings.

Despite the MCP's efforts, the rate for this measure declined significantly in Riverside/San Bernardino and Sacramento counties from 2012 to 2013. Additionally, the rate for this measure in San Diego County declined significantly from 2012 to 2013, which resulted in the rate moving from above the MPL in 2012 to below the MPL in 2013. Although the rates for this measure in Riverside/San Bernardino, Sacramento, and San Diego counties were below the MPLs in 2013,

Molina will not be required to continue its IP for this measure. In August 2013, it was learned that significant changes were made to the specifications for the *Cervical Cancer Screening* measure. NCQA will therefore not publically report this measure for HEDIS 2014, and DHCS made a decision that the MCPs with *Cervical Cancer Screening* rates below the MPLs in 2013 would not be required to submit an IP for the measure. Although this decision was made after the review period for this report, since the decision was made prior to the report being finalized, the information is included.

Comprehensive Diabetes Care—LDL-C Screening

Molina was required to submit an IP for the *Comprehensive Diabetes Care—LDL Screening* measure in Sacramento County because the rate for this measure was below the MPL in 2012. Molina identified several member, provider, and MCP barriers and challenges preventing the rate for this measure being above the MPL, including:

Members

- Lack of knowledge about the relevance of LDL-cholesterol level to overall health and control of diabetes.
- Language barriers with providers.
- Lack of transportation.
- Lack of knowledge regarding health benefits and that the screening is a covered benefit.
- Lack of time to schedule an appointment for the screening.

Providers

- No availability of evening and weekend appointment times.
- Lack of child care services for patients with children.
- Misperceptions about the willingness of minority patients following through on getting screenings.

MCP

- Not having updated addresses and telephone numbers for transient members.
- Members changing their MCP and/or primary care provider and services being interrupted (i.e., care coordination and follow-up).

To address the barriers and challenges, Molina implemented several interventions, including:

- Implementing a pay-for-performance program that rewards physicians for performance that meets or exceeds the MPL.

- Targeting member outreach efforts to members with none or the least amount of physician encounters and health screenings/examinations.
- Mailing a birthday card to members with diabetes that includes a health care screening insert.

Molina's efforts were not successful at improving the rate on this measure to above the MPL in 2013, and the MCP will need to continue this IP in Sacramento County.

Childhood Immunization Status—Combination 3

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

Molina indicated that the MCP analyzed the 2012 final sample size administrative and medical record data to determine why the rate for this measure did not improve to above the MPL in Riverside/San Bernardino and Sacramento counties from 2011 to 2012. Despite the MCP's efforts to improve the integrity of the administrative data, the rates in these counties remained below the MPLs in 2012. The MCP conducted additional analyses and identified system, provider, and patient (parent) barriers, including:

System

- Poor access to immunization registry for MCPs or other health care entities.
- Insufficient and incomplete immunizations records in the registry.
- Incomplete, untimely, inconsistent, and underreported immunization encounters/claims data from network entities.

Providers

- Lack of reminder systems.
- Missing immunization opportunities when children visit for other reasons, such as well-child visits.
- Poor utilization of immunization registry to record and document immunizations, resulting in incomplete documentation in the registry.
- Reluctance to administer multiple injections concurrently.

Patients (Parents)

- Lack of recall on which immunizations have been given and not given.
- Difficulty understanding the complex vaccination schedule and the number of required doses.
- Personal barriers, including lack of transportation and scheduling challenges.

Molina implemented the following interventions to address the barriers:

- Paying bonuses to providers who submit complete, accurate, and timely data on wellness services, including immunizations.
- Improving the MCP's Needed Services Report process by upgrading the provider Web portal to allow providers to retrieve information on the services needed by members.
- Calling members to remind them about scheduling immunization appointments and assisting members with making the appointments and arranging transportation.
- Offering incentives to members with missing immunizations.

Although the rate in Riverside/San Bernardino counties improved by more than 4 percentage points and the rate in Sacramento County improved by more than 3 percentage points, the improvement was not statistically significant and did not result in the rates being above the MPLs in 2013. Molina will be required to continue the IP for this measure in these counties, which will be the fourth year the MCP has been required to do so for this measure in these counties. Molina's efforts on this measure appear to be moving performance in a positive direction; however, the MCP will need to continue to assess the factors that are leading to continued poor performance on this measure and modify the MCP's strategies to improve the rates.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Molina was required to continue its IP for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in Riverside/San Bernardino counties. The MCP identified the following new member-related barriers that resulted in the rate continuing to be below the MPL:

- Lack of transportation.
- Lack of understanding about the importance of prenatal care.

To improve the rate on this measure, Molina implemented the following new interventions:

- A pay-for-performance program as an incentive for providers to provide all recommended health care services to members.
- Member education on the importance of prenatal care through the MCP's Health and Family Newsletter and through a targeted mailing.

Despite the MCP's efforts, the rate for this measure declined significantly from 2012 to 2013 and remained below the MPL in Riverside/San Bernardino counties. Additionally, although the rate for this measure in Sacramento County improved to above the MPL in 2012, the rate declined significantly from 2012 to 2013, resulting in it being below the MPL in 2013. Finally, San Diego County, which historically has performed above the MPL on this measure, saw a statistically significant decline on the rate for this measure from 2012 to 2013, resulting in the rate being

below the MPL for the first time in this county. Molina will need to continue the IP for this measure in 2013 in Riverside/San Bernardino counties and include Sacramento and San Diego counties. It will be important for the MCP to determine the factors leading to continued decline on the rate for this measure, despite the MCP working for several years on improving the rate.

Prenatal and Postpartum Care—Postpartum Care

Molina was required to continue its IP for the *Prenatal and Postpartum Care—Postpartum Care* measure in Riverside/San Bernardino and Sacramento counties. The MCP focused efforts on the following barriers:

- Member lack of knowledge about the importance of timely postpartum care within the recommended time frame.
- Lack of member motivation to arrange a postpartum care appointment after delivery.
- Member lack of reliable transportation.
- Lack of reinforcement from providers of the importance of scheduling the postpartum care appointment within the recommended time frame.

After conducting data analyses, Molina identified several new interventions, including:

- Conducting outreach calls to pregnant and postpartum members to educate them on the importance of making appointments; assist with transportation; and provide interpreter services, if needed.
- Conducting provider education visits specifically focused on the *Prenatal and Postpartum Care* measures and other measures on which the providers are performing poorly.
- Implementing a pay-for-performance program as an incentive to providers and network groups to submit accurate, timely, and consistent postpartum care data information on Molina's members.

In addition to the information in the MCP's IP for this measure, HSAG reviewed information Molina provided as part of the MCP's response to recommendations included in Molina's 2011–12 MCP-specific evaluation report. Molina's self-report indicates that the MCP is considering selecting a formal quality improvement project (QIP) that focuses on this measure since the MCP has performed poorly on this measure for several years.

Molina's interventions were not successful in bringing the rates in Riverside/San Bernardino and Sacramento counties above the MPLs. Conversely, the rates declined significantly in these counties from 2012 to 2013. Additionally, the rate for this measure in San Diego County declined significantly from 2012 to 2013, and the rate moved from above the MPL to below the MPL for the first time since 2010. Molina will be required to continue the IP in Riverside/San Bernardino and Sacramento counties and include San Diego County. As with the *Timeliness of Prenatal Care*

measure, it will be important for Molina to determine the factors leading to continued decline in the rate on this measure, despite the MCP working for several years on improving the rate.

Use of Imaging Studies for Low Back Pain

In 2012, Molina was required to submit an IP for the *Use of Imaging Studies for Low Back Pain* measure for the first time in San Diego County. The MCP identified several barriers and challenges to the rate on this measure being above the MPL, including:

- Many inappropriate imaging studies being done during an emergency or urgent care visit.
- Emergency room physicians being focused on rapid and immediate care.
- Practitioners being unaware of the importance of avoiding imaging studies during the first 28 days after the initial diagnosis of low back pain.
- Some prescribers at the FQHC being mid-level physician assistants and nurse practitioners who may be unaware of the importance of avoiding imaging studies during the first 28 days after the initial diagnosis of low back pain.
- Members seeking treatment for low back pain at emergency rooms rather than with their primary care physician.
- Lack of member understanding of the importance of avoiding imaging studies during the first 28 days after the initial diagnosis of low back pain.

To address the identified barriers and challenges, Molina implemented several interventions, including:

- Adopting low back pain clinical practice guidelines, posting the guidelines on Molina's provider Web site, and faxing the guidelines to primary care physicians and hospitals.
- Conducting provider education sessions that include independent practice association and FQHC leadership.
- Member education on the appropriate use of imaging studies for low back pain through the MCP's Health and Family Newsletter.

The MCP's rate for this measure in San Diego County was 0.3 percentage points from the MPL in 2012; in 2013, the rate moved to within 0.04 percentage points of the MPL. Unfortunately, since the rate for this measure remained below the MPL in 2013, Molina will be required to continue the IP for this measure in San Diego County.

2013 Improvement Plans

In addition to the IPs above that will need to continue and the new counties that will need to be added to existing IPs, Molina will be required to submit IPs for the following measures in Sacramento County that had rates below the MPLs in 2013:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Although Molina's rates on all four *Children and Adolescents' Access to Primary Care Practitioners* measures in Riverside/San Bernardino and Sacramento counties and the *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure in San Diego County were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

The rate for the *Use of Imaging Studies for Low Back Pain* measure was above the HPL for the second year in a row in Sacramento County, and San Diego County had two *Comprehensive Diabetes Care* measures with rates above the HPLs—*LDL-C Control (<100 mg/dL)* and *LDL-C Screening*. Across all counties, 11 measures had rates with statistically significant improvement from 2012 to 2013.

Opportunities for Improvement

As in previous years, the opportunities for improvement on performance measures impact all three domains of care—quality, access, and timeliness. MCP will need to submit new IPs for two measures in Sacramento County, continue all IPs from 2012 (except the *Cervical Cancer Screening* IP as noted above), and add counties to three existing IPs. The MCP has the opportunity to continue to have technical assistance calls with DHCS and the EQRO to discuss strategies for addressing Molina continuing to have consecutive years of poor performance on measures, including a decline in performance on some measures, despite efforts to make improvements.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

Molina participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

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

Table 4.1—Quality Improvement Projects for Molina
July 1, 2012, through June 30, 2013

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

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

Prior to initiation of the statewide collaborative QIP, Molina had a 30-day readmission rate of 12.5 percent among Medi-Cal beneficiaries. Molina also found that the readmission rate for the SPD population was 16.3 percent, which was higher than the 10.5 percent rate for the non-SPD population.

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

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

Table 4.2—Quality Improvement Project Validation Activity
Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—Riverside/San Bernardino, Sacramento, and San Diego	Study Design Submission	90%	100%	*Met*
Internal QIPs					
Improving Hypertension Control	Riverside/San Bernardino	Annual Submission	94%	100%	*Met*
	Sacramento	Annual Submission	94%	100%	*Met*
	San Diego	Annual Submission	91%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by Molina of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. Molina also received an overall validation status of *Met* for its *Improving Hypertension Control* annual submission with 100 percent of the critical elements and between 91 percent or 94 percent of the evaluation elements being met based on the county.

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

Table 4.3—Quality Improvement Project Average Rates*
Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	0%	10%
Design Total		**96%**	**0%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	42%	0%	58%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**42%**	**0%**	**58%**

*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.

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

Molina demonstrated a thorough application of the Design stage, meeting 96 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. Molina did not describe the MCP's data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. Molina met 100 percent of the requirements for all applicable evaluation elements for the *Improving Hypertension Control* QIP for the Design stage.

Only the *Improving Hypertension Control* QIP progressed to the Implementation and Outcomes stages during the reporting period. Molina demonstrated a thorough application of the Implementation stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage. The QIP received a lower score for San Diego County in Activity IX because there was no improvement in the study indicator's rate from Remeasurement 1 to

Remeasurement 2. The QIP received a lower score in all counties for Activity IX because the study indicator did not demonstrate statistically significant improvement over baseline. Activity X was not assessed for this QIP since sustained improvement cannot be assessed until the study indicator has achieved statistically significant improvement over baseline and reported a rate in a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

The *All-Cause Readmissions* QIP did not progress to the implementation or outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report for this QIP.

Table 4.4—Quality Improvement Project Outcomes for Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2012, through June 30, 2013

QIP #1—Improving Hypertension Control				
Study Indicator: Percentage of members 18 to 85 years of age who had both a systolic and diastolic blood pressure of <140/90				
County	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
Riverside/San Bernardino	59.6%	42.6%*	53.7%*	‡
Sacramento	56.6%	50.8%	53.1%	‡
San Diego	66.4%	58.3%*	55.0%	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.
* A statistically significant difference between the measurement period and prior measurement period (*p* value < 0.05).
‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Improving Hypertension Control QIP

In 2012, Molina submitted Remeasurement 2 results for the *Improving Hypertension Control* QIP. The study indicator rates in Riverside/San Bernardino counties significantly improved from Remeasurement 1 to Remeasurement 2; however, the rates were still below the baseline rate. Although not statistically significant, the study indicator rate in Sacramento County improved by more than 2 percentage points. The study indicator rate in San Diego County significantly declined

from Remeasurement 1 to Remeasurement 2. A review of the MCP's QIP Summary Form and QIP Validation Tools revealed the following observations:

- For Riverside/San Bernardino and Sacramento counties, the interventions were successful, and the MCP documented the need to continue the interventions in order to evaluate the overall effectiveness of the interventions.
- Although the interventions were not successful in San Diego County, Molina documented the need to continue the interventions to enable the MCP to evaluate the overall effectiveness of the interventions.
- For San Diego County, Molina described problem-solving techniques using data analysis to identify possible causes and solutions; however, the MCP did not determine if county-specific interventions are needed based on subgroup analysis results for each county.

Strengths

Molina demonstrated an excellent application of the QIP process for the Design and Implementation stages. The MCP achieved an overall *Met* validation status on both QIP submissions without having to resubmit, indicating proficiency with the QIP validation process.

In Molina's 2011–12 MCP-specific evaluation report, HSAG recommended that the MCP perform barrier analyses to identify barriers to making improvements on QIP study indicators. As part of the QIP validation process for the MCP's 2012 QIP submissions, HSAG determined that for its *Improving Hypertension Control* QIP, Molina completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. Additionally, in the documentation provided by Molina for HSAG to review when producing this report, the MCP provided documentation from the causal/barrier analysis conducted for the *All-Cause Readmissions* QIP.

Opportunities for Improvement

Although Molina understands the QIP process, Molina has not achieved statistically significant improvement over baseline for the *Improving Hypertension Control* QIP study indicator in any of the counties. Although the rate is moving in a positive direction in Riverside/San Bernardino and Sacramento counties, the rate in San Diego County continues to decline. Molina has the opportunity to build on the successes from the interventions being implemented in Riverside/San Bernardino and Sacramento counties and apply applicable strategies in San Diego County that will hopefully result in the rate for the study indicator achieving statistically significant and sustained improvement over baseline.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Molina's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about Molina's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 through Table 5.6 present the star ratings for the global ratings and composite measures for Molina's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care Adult County-Level Global Ratings
Molina—Sacramento, San Bernardino/Riverside, and San Diego Counties

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

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care Child County-Level Global Ratings
Molina—Sacramento, San Bernardino/Riverside, and San Diego Counties

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

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.5—Medi-Cal Managed Care Adult County-Level Composite Measures
Molina—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Sacramento	★+	★+	★+	★★+
Riverside/San Bernardino	★+	★+	★+	★★★★+
San Diego	★+	★+	★★+	★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.6—Medi-Cal Managed Care Child County-Level Composite Measures
Molina—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Sacramento	★+	★+	★+	★★+
Riverside/San Bernardino	★+	★+	★	★★★+
San Diego	★	★	★	★★★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

For the child population, San Diego County received an *Excellent* rating for the *Rating of Specialist Seen Most Often* and *Customer Service* measures, and Riverside/San Bernardino counties received an *Excellent* rating on the *Rating of Specialist Seen Most Often* measure for the child population. Additionally, Riverside/San Bernardino counties received a *Very Good* rating for the adult *Customer Service* measure. Please note that across all counties, Molina had fewer than 100 respondents for most measures so caution should be exercised when evaluating these results.

The following measures received a *Good* rating:

- *Rating of Personal Doctor*—San Diego County for both the adult and child populations
- *Rating of Specialist Seen Most Often*—Sacramento County for the adult population
- *Customer Service*—Riverside/San Bernardino counties for the child population

Molina improved its ratings in Sacramento County on the following measures from 2010 to 2013:

- *Rating of Specialist Seen Most Often*—adult population
- *Customer Service*—adult and child populations

Molina improved its ratings in Riverside/San Bernardino counties on the following measures from 2010 to 2013:

- *Rating of Specialist Seen Most Often*—child population
- *Customer Service*—adult and child populations

Molina improved its ratings in San Diego County on the following measures from 2010 to 2013:

- *Rating of Personal Doctor*—adult population
- *Rating of Specialist Seen Most Often*—child population
- *How Well Doctors Communicate*—adult population
- *Customer Service*—child population

Opportunities for Improvement

Molina's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Molina's highest priorities: *Rating of Health Plan, Rating of Personal Doctor,* and *Rating of All Health Care*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 Molina CAHPS MCP-Specific Report.* Areas for improvement spanned the quality domain of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Molina's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

Overall, the information provided in Molina's Roadmap and questionnaire indicates that the MCP has established operational policies and practices for the creation, validation, correction, and ongoing monitoring of encounter data submission. Approximately 90 percent of Molina's contracted providers are capitated, and approximately 95 percent of claims are received electronically. While providers have 365 days from the date of service to submit new claims, the reimbursement amount for claims received in excess of 180 days from the date of service are reduced. Molina's pharmacy benefit manager (PBM) and vision claims are received monthly and processed for submission to DHCS.

In September 2012, Molina's redesigned its inbound encounter processes to streamline them and increase data quality. The Claims Encounter Management System (CEMS) was developed to provide Molina's staff with improved access to detailed claims and encounter views and support encounter error correction and resubmission to DHCS. Molina reported that fewer than 0.009 percent of encounters are initially rejected by DHCS, although the MCP indicated that error rates have increased due to changes in DHCS's submission requirements and delays and gaps in guidance from DHCS. The submission requirement changes, along with Molina not requiring providers to submit encounters within a specific time frames , may impact the reconciliation of encounters between Molina and DHCS.

Record Completeness

Overall, Molina had fairly low record omission and record surplus rates for the Medical/Outpatient and Hospital/Inpatient claim types, indicating fairly complete Medical/Outpatient and Hospital/Inpatient data when comparing DHCS's data and the encounter data extracted from Molina's system for this study. However, the Pharmacy claim type had relatively incomplete data due to the fairly poor record omission rate of 22.6 percent and record surplus rate of 13.6 percent. For the Pharmacy records omitted from DHCS's data, Molina's records indicated that more than 98 percent were submitted to DHCS on March 4, March 10, or April 11, 2011. The main cause for the surplus Pharmacy records was due to the MCP's data not containing records with dates of service in June 2011. Molina's record omission rate for the Pharmacy claim type was 9.3 percentage points worse than the statewide rate, while all of the remaining record omission and surplus rates were better than the statewide rates. The county-level variation was minimal for both record omission and surplus rates, with the exception of the record omission rates for the Pharmacy claim type. The difference between the highest Pharmacy record omission rate (29.0 percent) from San Diego County and the lowest omission rate (10.5 percent) from Sacramento County was 18.5 percentage points.

Data Element Completeness

Molina had fairly good performance for data element completeness, with element omission and element surplus rates of 2.1 percent or less for all key data elements across the three claim types. Molina's element omission rates and surplus rates were generally similar to or better than the respective statewide rates. The data elements *Provider Specialty* and *Procedure Code Modifier* in the Medical/Outpatient claim type were the only data elements that had element surplus rates slightly worse than the statewide rates by 0.8 percentage points and 1.6 percentage points, respectively. There was minimal county variation for the element omission and surplus rates.

Data Element Accuracy

Molina had element accuracy rates that were greater than 95 percent for all key data elements across the three claim types except the three elements listed below.

- For the Medical/Outpatient claim type, the *Provider Type* had an element accuracy rate of 76.9 percent, which was below the statewide rate by 17.6 percentage points. Approximately 86 percent of the inaccuracies for this data element were attributed to a value of "27" (Podiatrists) in the MCP's data and a value of "10" (Group Certified Pediatric Nurse Practitioner and Certified Family Nurse Practitioner) in DHCS's data file. At the county level, the data element *Provider Type* had a 24.3 percentage point spread between the highest element accuracy rate (93.2 percent for Sacramento County) and the lowest rate (68.9 percent for Riverside County).

- For the Medical/Outpatient claim type, the *Rendering Provider Number* had an element accuracy rate of 83.4 percent, which was below the statewide rate by 12.1 percentage points. Approximately 56 percent of the inaccuracies for the *Rendering Provider Number* were from the records with a provider type of "15" (Community Hospital Outpatient Departments).
- For the Hospital/Inpatient claim type, the *Revenue Code* had an element accuracy rate of 94.7 percent, which was slightly below the statewide rate by 0.4 percentage points. More than 98 percent of the records with mismatched revenue code values had the first two digits of the revenue codes in the MCP's data matching the last two digits of the revenue codes in DHCS's data. At the county level, Sacramento County had the highest accuracy rate of 100 percent, while San Diego County had the lowest rate of 91.2 percent.

The remaining element accuracy rates met or exceeded the statewide rates and did not have notable county-level variation.

The all-element accuracy rates for the Hospital/Inpatient and Pharmacy claim types were above the statewide rate by 25.4 percentage points and 21.2 percentage points, respectively. However, due to the low element accuracy rates for a few data elements, the Medical/Outpatient claim type underperformed the statewide rate by 4.7 percentage points. There was no county variation for the Pharmacy claim type. For the Medical/Outpatient claim type, Sacramento County had an all-element accuracy rate of 77.4 percent, which was more than 18 percentage points higher than the rates for the other three counties. For the Hospital/Inpatient claim type, San Diego County had the lowest rate of 81.5 percent, which was more than 12 percentage points below the other counties' all-element accuracy rates.

Recommendations

Based on its review, HSAG recommends the following:

- Molina should investigate the reasons for the relatively poor record omission rate and record surplus rate for the Pharmacy claim type and create strategies for improvement.
- Nearly all Medical/Outpatient records in the MCP's data and DHCS's data were missing values for the data element *Referring/Prescribing/Admitting Provider Number*. The percentage of records without values for this data element was high compared to the other MCPs in the study. Molina should consult with DHCS about whether the *Referring/Prescribing/Admitting Provider Number* is a data element for which Molina should be collecting values for the Medical/Outpatient records. If so, Molina should modify its processes and procedures so that the values for the data element *Referring/Prescribing/Admitting Provider Number* can be submitted to DHCS in the future.

- Molina should investigate the low element accuracy rates for the data elements *Provider Type* and *Rendering Provider Number* in the Medical/Outpatient claim type so that it can improve the accuracy rates for these two data elements.
- Despite having a fairly high element accuracy rate of 94.7 percent for the *Revenue Code* in the Hospital/Inpatient claim type, Molina should work with DHCS to investigate the reasons(s) and take necessary actions for improvement.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

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

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

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

HSAG reviewed Molina's quality improvement program documents, which describe the processes the MCP uses and the organizational structure the MCP has in place to ensure quality services are provided to the MCP's Medi-Cal members.

The rates for 10 quality measures improved significantly from 2012 to 2013, and the following three quality measures had rates above the HPLs in 2013:

- *Use of Imaging Studies for Low Back Pain* in Sacramento County
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in San Diego County
- *Comprehensive Diabetes Care—LDL-C Screening* in San Diego County

Across all counties, 16 quality measures had rates below the MPLs, and 15 quality measures had rates that declined significantly from 2012 to 2013. The MCP implemented IPs for 10 quality measures with rates below the MPLs in 2012, and none of the IPs were successful at bringing the rates above the MPLs in 2013. The MCP will be required to add counties to two of the IPs for 2013 and submit new IPs for two quality measures in 2013. Note: As indicated in the Improvement Plans section of this report, although the IP for the *Cervical Cancer Screening* measure was not successful at bringing the rate above the MPLs in Riverside/San Bernardino and Sacramento counties in 2013 and the rate for this measure was below the MPL in San Diego County, the MCP will not be required to continue the IP for this measure.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. The following quality measures had SPD rates that were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* in Sacramento and San Diego counties
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in San Diego County
- *Comprehensive Diabetes Care—LDL-C Screening* in San Diego County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Sacramento and San Diego counties
- *Annual Monitoring for Patients on Persistent Medications—ACE* in Riverside/San Bernardino counties
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Riverside/San Bernardino and San Diego counties

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

Across all counties, the SPD rates for the following quality measures were significantly worse than the non-SPD rates:

- *All-Cause Readmissions* in Riverside/San Bernardino, Sacramento, and San Diego counties
- *Children and Adolescents' Access to Primary Care Physicians (12–24 Months)* in San Diego County
- *Children and Adolescents' Access to Primary Care Physicians (12–19 Years)* in Sacramento County
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* in Riverside/San Bernardino counties
- *Comprehensive Diabetes Care—LDL-C Screening* in Riverside/San Bernardino counties

The SPD rates in all counties for the *All-Cause Readmissions* measure being significantly higher than the non-SPD rates means that in all counties, the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

All CAHPS measures fall into the quality domain of care. Across all counties most of the measures had a *Poor* rating. The following measures received an *Excellent* rating:

- *Rating of Specialist Seen Most Often* in Riverside/San Bernardino and San Diego counties for the child population
- *Customer Service* in San Diego County for the child population

Riverside/San Bernardino County received a *Very Good* rating for the CAHPS *Customer Service* measure for the adult population, and the following CAHPS measures received a *Good* rating:

- *Rating of Personal Doctor* in San Diego County for both the adult and child populations
- *Rating of Specialist Seen Most Often* in Sacramento County for the adult population
- *Customer Service* in Riverside/San Bernardino counties for the child population

Both of Molina's QIPs fall into the quality domain of care. The *All-Cause Readmissions* QIP did not progress to the Outcomes stage, so HSAG was not able to assess the QIP's success at improving the quality of care delivered to the MCP's members. Although the *Improving Hypertension Control* QIP is showing some positive results in Riverside/San Bernardino and Sacramento counties, the QIP study indicator has not yet achieved statistically significant improvement over baseline. Additionally, the study indicator rate declined in San Diego County at Remeasurements 1 and 2.

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

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed Molina's quality improvement program documents and found descriptions of several activities focused on ensuring member access to services. The MCP's 2012 program evaluation describes results of all quality improvement activities and shows that Molina met or exceeded most access-related goals.

Although Molina reports meeting or exceeding access-related quality improvement goals, the MCP continues to struggle with performance on access measures. While the rate for one access measure in San Diego County, *Comprehensive Diabetes Care—LDL-C Screening*, improved significantly from 2012 to 2013, resulting in the rate for this measure being above the HPL in 2013, across all counties 21 access measures had rates below the MPLs. Across all counties, the rates for six access measures improved significantly from 2012 to 2013; however, the rates for nine access measures declined significantly from 2012 to 2013.

The MCP implemented IPs for eight access measures with rates below the MPLs in 2012, and none of the IPs were successful at bringing the rates above the MPLs in 2013. Additionally, the MCP will be required to add counties to two of the IPs for 2013. Note: As indicated in the Improvement Plans section of this report, although the IP for the *Cervical Cancer Screening* measure was not successful at bringing the rate above the MPLs in Riverside/San Bernardino and Sacramento counties in 2013 and the rate for this measure was below the MPL in San Diego County, the MCP will not be required to continue the IP for this measure.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rates for the following access measures were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—LDL-C Screening* in San Diego County

- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Sacramento and San Diego counties

The SPD rates for the following access measures were significantly worse than the non-SPD rates:

- *All-Cause Readmissions* in Riverside/San Bernardino, Sacramento, and San Diego counties
- *Children and Adolescents' Access to Primary Care Physicians (12–24 Months)* in San Diego County
- *Children and Adolescents' Access to Primary Care Physicians (12–19 Years)* in Sacramento County
- *Comprehensive Diabetes Care—LDL-C Screening* in Riverside/San Bernardino counties

Molina performed below average on the access-related CAHPS measure, *Getting Needed Care*, receiving a *Poor* rating in all counties for both the adult and child populations.

Both of Molina's QIPs fall into the access domain of care. As indicated above, the *All-Cause Readmissions* QIP did not progress to the Outcomes stage; therefore, HSAG was not able to assess the QIP's success at improving access to care for the MCP's Medi-Cal members. Also, as indicated above, although the *Improving Hypertension Control* QIP is showing some positive results in Riverside/San Bernardino and Sacramento counties, the QIP study indicator has not yet achieved statistically significant improvement over baseline. Additionally, the study indicator rate declined in San Diego County at Remeasurements 1 and 2.

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

Timeliness

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

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

Molina's quality improvement program description includes descriptions of activities related to member rights, grievances, continuity and coordination of care, and utilization management, which all impact the timeliness of care delivered to members.

Molina had no timeliness measures with rates above the HPLs. The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, had statistically significant improvement from 2012 to 2013 in all counties. Eight timeliness measures had rates below the MPLs in 2013, and six timeliness measures had rates that declined significantly from 2012 to 2013.

The MCP implemented IPs for five timeliness measures with rates below the MPLs in 2012, and none of the IPs were successful at bringing the rates above the MPLs in 2013. Additionally, the MCP will be required to add counties to two of the IPs for 2013.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating in all counties for both the adult and child populations.

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

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-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 MCP:

- Since Molina had 25 measures with rates below the MPLs in 2013 and 16 measures with rates that were significantly lower in 2013 when compared to 2012, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.
- Since the SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate in all counties, assess the factors that are leading to a higher rate of readmissions for the SPD population and identify strategies to ensure the MCP is meeting the needs of the SPD population.
- For its *Improving Hypertension Control* QIP, build on the successes from the interventions being implemented in Riverside/San Bernardino and Sacramento counties and apply applicable strategies in San Diego County that will hopefully result in the rate for the QIP study indicator achieving statistically significant and sustained improvement over baseline.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of Health Plan, Rating of Personal Doctor,* and *Rating of All Health Care* priority areas.

- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Tables 3.2 through 3.4)

Quality Domain

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

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

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.6)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for Molina Healthcare of California Partner Plan, Inc.

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with Molina's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—Molina's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
To ensure successful improvement plans (IPs) for measures that performed below the MPLs in 2012:	
1. 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.	Molina Healthcare of California Partner Plan, Inc., arranged and participated in Technical Assistance calls with Health Services Advisory Group (HSAG), DHCS' external quality review organization, to discuss Improvement Plans for HEDIS measures that performed below the MPLs in 2012. • Meeting: Technical Assistance call with HSAG and DHCS for all plans required to submit IPs Date: January 23, 2013 Meeting & Discussion Topics: 2012 HEDIS IP Submission Form (updated form since 2011); HEDIS IP Evaluation Checklist to understand the criteria that will be applied to each IP. Molina Attendees: Shirley Kim, Rick VanGorder, Carol Pranis, Camille Morris, Deborah Clancy, and Erlinda Castillo • Meeting: Technical Assistance call requested by Molina held with DHCS and HSAG Date: February 6, 2013 Meeting & Discussion Topics: Discussed Molina's barrier analysis and interventions for HEDIS measures that have consecutive years of performance below the MPLs without improvement, CIS-3, PPC, and CDC. Discussed in detailed analysis of the negative numerators and positive numerators to identify differences in the sample population. Discussed targeting primary causal barriers with data information to support the findings, instead of anecdotal barriers that are theoretical in nature. Molina Attendees: Shirley Kim, Rick VanGorder, Erlinda Castillo, Carol Pranis, Camille Morris, Deborah Clancy • Meeting: 30 Day All-Cause Readmission Statewide

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	Collaborative technical assistance calls Dates: August 2, 2012, October 18, 2012, November 8, 2012, and February 7, 2013 Meeting & Discussion Topics: appropriate analyses, including causal barrier, data analysis, and intervention evaluation analysis to implement effective interventions for improvement. Molina Attendees: Rick VanGorder, Carol Pranis, Camille Morris, Deborah Clancy, Erlinda Castillo and Shirley Kim
2. 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.	Among the HEDIS measures that performed below the MPLs in 2012 for Molina, postpartum care (PPC-Pst) measure has the greatest need of improvement based on continued performances below the MPL in the past years. Molina is considering selecting PPC-Pst measure as the topic for a formal QIP. PPC-Pst QIP will be implemented to assess root causal barriers with data information; to identify and prioritize barriers and opportunities for improvement; to plan, design, and implement effective intervention; and to evaluate and validate the effectiveness of implemented interventions through process and outcome evaluations.
3. 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.	As delineated in Molina's 2012 HEDIS *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* (AAB) Improvement Plan (IP) document for San Diego County, appropriate interventions were prioritized and implemented based on detailed analysis of causal barriers. Implementation of interventions in late 2012 and during 2013 did not impact the HEDIS 2013 rates (measurement period from 1/1/12–12/31/12). However, existing interventions are evaluated to either modify or add new interventions to bring the rate above the MPL in the subsequent year. YTD 2014 HEDIS rate for *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* (AAB) in San Diego as of June 2013 is 29.71 percent, above the MPL of 18.98 percent. • **9/24/12–10/8/12:** Molina Provider Service representatives received training on A "Provider's Guide to HEDIS and Star" prior to their distribution to PCPs. This guide contains specific criteria and coding information for all critical HEDIS measures, *including Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*, to assist providers with meeting HEDIS requirements. • **10/8/12–12/31/12:** A "Provider's Guide to HEDIS and Star" was distributed to PCPs by Molina Provider Service representatives during provider office visits. • **2/8/13:** Analysis of HEDIS 2012 AAB measure findings for numerator negative cases identified FQHC and ER practitioners as most common prescribers of antibiotics for a diagnosis of acute bronchitis. Few PCPs were prescribing inappropriately. • **2/12/13:** San Diego MHC medical director and chief medical

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	officer (CMO) notified of HEDIS 2012 AA findings—intervention developed to educate FQHC practitioners about the HEDIS AAB specifications and HEDIS 2012 findings. • **4/2/13:** San Diego MHC medical director presented FQHC-specific HEDIS results/scorecards and a review of HEDIS specifications to FQHC leadership at quarterly Health Plan-FQHC meeting. • **4/10/13:** Monthly monitoring of HEDIS 2014 administrative rates initiated. • **5/3/13:** First quarterly analysis of claims and pharmacy data for a diagnosis of acute bronchitis where prescriptions were filled for an antibiotic. • **5/10/13:** Monitoring of May HEDIS 2014 data identified ER MDs as high prescribers of antibiotics for acute bronchitis. • **5/13/13:** 89 Letters sent to PCP, Clinic, and FQHC practitioners who prescribed antibiotics for the diagnosis of acute bronchitis. Letters indicated if the prescription was related to an ER or urgent care center (UCC) visit. Letter provided a link to the Acute Bronchitis Clinical practice guidelines and to the AWARE (Alliance Working for Antibiotic Resistance Education) Web site for patient education materials to support practitioners' efforts to educate members about appropriate antibiotic use. • **5/14/13:** Just the Fax (JTF) provider bulletin notice sent to all contracted hospital ER medical directors with HEDIS 2012 rates and reminder of HEDIS AAB requirements. • **6/5/13:** First quarterly educational postcard mailing to 89 members who filled an antibiotic prescription as treatment of acute bronchitis. The postcard included the messages that antibiotics will not cure a virus, most bronchitis is caused by a virus, and the risk of antibiotic resistance from inappropriate use of antibiotics. • **6/10/13:** Molina San Diego-based medical director conducted educational sessions about antibiotic avoidance for treatment of acute bronchitis in adults during meetings with independent practice associations (IPAs) and FQHC leadership, including medical directors. • **6/10/13:** Emergency physicians identified from the 2012 HEDIS data analysis added to the 2013 AWARE annual toolkit mailing to remind them of the current guidelines. • **6/14/13:** Monitoring of June HEDIS 2014 AAB data showed San Diego rate YTD to be 29.71 percent (MPL 18.98 percent). Interventions will continue as planned.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
4. 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.	As delineated in Molina's 2012 HEDIS *Cervical Cancer Screening* (CCS) Improvement Plan (IP) document for Riverside/San Bernardino and Sacramento counties, appropriate interventions were prioritized and implemented based on detailed analysis of causal barriers. Barriers are prioritized based on the magnitude of challenge, and appropriate interventions that address the identified barriers are also prioritized based on available resources and the impact for improvement. Although, Sacramento failed to meet the MPL of 64.0 percent, Sacramento County demonstrated an increase in the rate for 2012 (63.1 percent) when compared to 2011 rate of 60.1 percent, an increase of 3 percentage points. BARRIERS • Increase in female membership which may result in higher demand of female practitioners for women's health. • Providers with high membership not performing screening • Members are not aware of and/or utilizing the free transportation services • Younger members are not getting the screening • Burden on providers' staff for on-site chart review processes and collections of medical records INTERVENTIONS • **CONTINUOUS—Quarterly 2012–2013 and ongoing**—Needed Services Reports listing providers' assigned members that are in need of HEDIS-related measures, preventive health provider informational mailings and faxes (i.e., JTF provider bulletins, Clinical Practice Guidelines, Preventive Health Guidelines) are disseminated. The Member Services Department, when speaking to a member, will also see alerts that identify missing preventive services for members and are trained to educate the members about their needed services. Member information mailings (i.e., member newsletters, brochures, reminder postcards, Evidence of Coverage, CCS bracelet) are sent to applicable members. • **NEW—2012–2013**—Implementation of electronic document storage in some of the Molina Medical Group clinics in Sacramento and Riverside/San Bernardino County to catalogue paper documents that are exchanged between Molina and the clinics. Information will be readily available as needed for hybrid abstractions. • **NEW—9/24/12–10/8/12**—A "Provider's Guide to HEDIS & STAR": written by MHC's Quality Improvement (QI) Department. The QI Department nurses trained all of the Provider Services field staff in its use with guidance on how to present the book to primary and specialty care physicians in each county. The book includes CCS guidelines and requirements. • **NEW—10/8/12–12/31/12**—A "Provider's Guide to HEDIS and STAR" was distributed to PCPs by MHC's Provider Service representatives during provider office visits.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• **NEW—Quarter 1 2013**—Hiring of more female nurse practitioners and female physician assistants to perform female invasive screenings and help with patient overload in Molina Medical Group clinics located in Riverside/San Bernardino County. • **NEW—Quarter 1 2013**—Kids Corner: a free child care on-site service at MMG sites in Sacramento and Riverside/San Bernardino counties for patients who have medical appointments at the clinics. Now, instead of missing or cancelling appointments, parents can have peace of mind their child is safe while they attend to their own health. • **NEW—Quarter 1 2013**—Neighborhood Shuttle, a free Van Service: The Molina Healthcare Neighborhood Shuttle is a free transportation service that travels on a designated route stopping at Molina Medical clinics, grocery stores, Laundromats and at other convenient stops. The Neighborhood Shuttle is offered in North Long Beach, San Bernardino, Fontana, and North Sacramento. No need to contact the health plan to set up an appointment. The Neighborhood Shuttle travels a designated route five days a week, from 8:30 a.m.–5:00 p.m. to and from a variety of both medical and non-medical locations. • **NEW—4/11/13**—MHC member incentive program targeting Sacramento County members to aid in obtaining their cervical cancer screenings. The members' PCP completes the form once services are rendered and returns the form to the health plan for gift incentive distribution to the member.
5. 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.	Below are identified causal/barriers factors that are attributable to declined performance on the *Comprehensive Diabetes Care, LDL-C Screening* measure in Sacramento County. MEMBER BARRIERS: Require child care services, distrust health care providers, only seeks care when ill, has no time to see health care providers due to work, school, family obligations, fear of pain from health care procedures, unable to schedule appointments due to provider time constraints, misperceptions about various health care topics, lack of knowledge about test parameter, lack of privacy and comfort at health care site, discourteous staff at health care site, language and cultural barriers at health care site, needs transportation to health care, testing is inconvenient due to preparation, depression hinders acquisition of health care. PROVIDER BARRIERS: Lacks convenient appointment times/hours, no child care services, less likely to recommend testing to minority patients due to misperceptions and biases, forgets to tell patients they need testing, discourteous staff, long wait times for patients, heavy workload impedes optimal health care practice, does not use translator service for non-English-speaking patients,

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	provider overwhelmed by multiple treatment guidelines and protocols, sends patients to lab for tests to be performed. HEALTHPLAN BARRIERS: Members move frequently and cannot be located; health plan members are allowed to change plans frequently, which interrupts continuity of care and service; plan does not continually remind members and providers of availability of translator and transport services. INTERVENTIONS: A "Needed Services Report" for each provider's patients is sent to PCPs three times a year that highlights recommended HEDIS testing. Soft interventions of provider and member informational mailings and notices continue: JUST THE FAX (JTF) provider bulletin regarding county diabetes data to respective physicians and physician specific 2012 diabetes performance data; HEAD TO TOE postcards sent to members. MHC initiated a new member telephone outreach program that informs the member of services available and recommended plus performs an initial assessment for case management services. Interventions were implemented for calendar year 2012, and the CDC LDL-Cholesterol testing rate for Sacramento increased from 69.3 percent to 70.33 percent, 0.01 percent less than the MPL of 70.34 percent.
6. 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.	As delineated in Molina's 2012 HEDIS *Childhood Immunization Status—Combination 3* (CIS-3) Improvement Plan (IP) document, a detailed causal/barrier analyses were conducted using data mining activities. The positive and negative numerators of the CIS-3 sample size population (subgroups) were analyzed to compare and contrast the differences and characteristics of the groups. Furthermore, an intensive analysis of the seven types of immunizations in CIS Combination 3 resulted in identification of new barriers. Findings interpret that PCV, DTaP, and HepB are highly accountable for the overall negative numerator proportion and ultimately weigh down the potential positive hits in the final sample size. Findings also interpret that when individual immunization rate is observed, the completion rate is relatively higher than the final CIS-3 rate. This is due to CIS-3 measure's high sensitivity, specificity, and inclusive criteria that require members who completed the entire seven different types of immunizations within two years. Detailed analysis by county and by type of immunizations inferred the following barriers. Although particular barriers that were previously identified are still existing, intensive analysis and diverse segmentation analysis of the positive and negative numerators of the final sample size in each county have identified new barriers. System-driven barriers:

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• Sensitivity and specificity to data exchange format and processes between the health plan and immunization registry. • Poor access to immunization registry for health plans or other health care entities. • Insufficient and incomplete records of immunization in the registry. • Incomplete, untimely, inconsistent, and underreported immunization encounters/claims data from network entities. Provider-related Barriers: • Practitioners'/providers' lack of incorporating system in their offices to record, remind, and recall patients for vaccinations. • Practitioners/providers may miss immunization opportunities when children visit for other reasons, such as well-child visits. • Poor utilization of immunization registry to record and document, resulting in incomplete documentation. • Incomplete, untimely, inconsistent, and under-submission of immunization encounter data from providers who are on capitation payment arrangement. • Reluctance to administer multiple injections concurrently. Patient (Parent) Barriers: • Lack of recall on what immunizations are given and not given. • Difficulty understanding the complex vaccination schedule and the number of required doses. • Personal barriers (no transportation, inconvenient clinic hours or locations). • Fear of side effects. Interventions implemented: • Internal investigation to validate completeness and accuracy of data receipt and extraction: Immunization data collected in the encounter system, interface and transfer of data between Molina system and the immunization registry and electronic health record system. • Needed Service Reports via provider e-portal. • Immunization Incentives for Members. Comparison between HEDIS 2012 and 2013 rates interpret that implemented interventions are being effective, since the CIS-3 rates for Riverside/San Bernardino increased from 59.6 percent to 63.86 percent and Sacramento increased form 50.1 percent to 54.06 percent.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
7. 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.	The causes/barriers must be accurately identified and defined with data information, and interventions must be planned to specifically address and target the identified barriers. Effective interventions cannot be designed and planned if the causes/barriers are not objectively identified through data. Moreover, intermittent monitoring and analysis are needed to evaluate the effectiveness of the implemented intervention in addition to the outcome evaluation. It is critical to continuously analyze the findings with data. Our members in general do not realize the importance of the visit and simply forgo prenatal and postpartum care visit appointments unless they find it necessary. Molina's improvement plan and interventions will target patient education and provider engagement to reinforce patient compliance. Since member's health perception is highly influenced by providers, engaging physicians and clinicians to be accountable in providing optimized evidence-based quality care is equally important.
8. Evaluate effectiveness of existing interventions for the *Prenatal and Postpartum Care—Postpartum Care* measure in Sacramento County and Riverside/San Bernardino counties.	All interventions are monitored and evaluated intermittently to determine effectiveness of each intervention implemented. Process measure indicators are collected and monitored to evaluate the work progress and to evaluate the effectiveness of intervention against the outcome measure. 1. Pregnancy Notification Report (PNR) Outreach Calls (this is an ongoing intervention through postpartum)—assess and track the number of PNR that received monthly, monitor the outcome of each call such as the number of members successfully contacted, confirmed appointments, members who had seen an obstetrician (OB), volume of medical records collected, unable to contact letters sent, and call-back received). A scorecard is used to track and demonstrate the effectiveness of the intervention. 2. Molina Medical Group Prenatal and Postpartum Pilot Project—review outcomes, monitor patient volume seen for prenatal and postpartum care visits, provider claims, and encounter data. 3. Provider Education Strategy Visit (FSR)—review process and outcomes, monitor volume of provider offices who received HEDIS postpartum care measure education, medical records received, provider claims and encounter data of providers who were educated. A scorecard is used to assess performance level and track quarterly progress. 4. Review of transportation services for availability, timeliness, and member satisfaction.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
9. 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.	Implementation of interventions in late 2012 and during 2013 did not impact the HEDIS 2013 rates (measurement year 1/1/12–12/31/12). Factors that lead to the decline in rates in 2012 included high inappropriate ordering of x-rays for a new diagnosis of low back pain by FQHC and ER providers. The YTD 2014 HEDIS rate for *Use of Imaging Studies for Low Back Pain* (LBP) in San Diego as of June 2013 is 68.35 percent, below the MPL of 72.04 percent. Along with the interventions completed though June 30, 2013, additional interventions targeting ER physicians, including San Diego-based medical director meetings with hospital-based ER groups will be developed for the latter half of 2013. • **9/24/12–10/8/12:** Molina Provider Service representatives received training on A "Provider's Guide to HEDIS and Star" prior to their distribution to PCPs. This guide contains specific criteria and coding information for all critical HEDIS measures, including *Use of Imaging Studies for Low Back Pain*, to assist providers with meeting HEDIS requirements. • **10/8/12–12/31/12:** A "Provider's Guide to HEDIS and Star" was distributed to PCPs by Molina Provider Service representatives during provider office visits. • **2/8/13:** Analysis of HEDIS 2012 LBP measure findings for numerator negative cases identified FQHC and ER practitioners as most common prescribers of x-rays during the first 28 days after diagnosis of low back pain. Few PCPs were ordering x-rays inappropriately. • **2/12/13:** San Diego MHC medical director and CMO notified of HEDIS 2012 LBP findings—intervention developed to educate FQHC practitioners about the HEDIS LBP specifications and HEDIS 2012 findings. • **4/2/13:** San Diego MHC medical director presented FQHC-specific HEDIS results/scorecards and a review of HEDIS specifications to FQHC leadership at quarterly Health Plan-FQHC meeting. • **4/10/13:** Monthly monitoring of HEDIS 2014 administrative rates initiated. • **5/3/13:** First quarterly analysis of claims data for a diagnosis of low back pain where x-rays were prescribed during the first 28 days after diagnosis. • **5/10/13:** Monitoring of May HEDIS 2014 data identified FQHC and ER MDs as high prescribers of x-rays for a diagnosis of low back pain. • **5/13/13:** Eighty-nine letters sent to San Diego PCP, Clinic, and FQHC practitioners who ordered x-rays for the diagnosis of lower back pain. Letters indicated if the x-rays were related to an ER visit. Letter provided a link to the low back pain clinical practice guidelines. • **5/14/13:** Just the Fax (JTF) provider bulletin notice sent to all contracted hospital ER medical directors with HEDIS 2012 rates and reminder of HEDIS LBP requirements.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• **6/10/13:** Molina San Diego-based medical director conducted educational sessions about avoidance of x-rays during the first 28 days after diagnosis of low back pain during meetings with IPAs and FQHC leadership, including medical directors. • **6/14/13:** Monitoring of June HEDIS 2014 LBP data showed San Diego rate YTD to be 68.35 percent (MPL 72.04 percent). • **6/25/13:** Discussion with San Diego- based Molina medical director regarding the development of stronger interventions targeting Emergency physicians identified as prescribing x-rays for the diagnosis of lower back pain during the first 28 days after diagnosis.
To ensure successful QIPs:	
1. 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.	**<u>Statewide Collaborative QIP: All-Cause Readmission</u>** Prioritized barriers to improving 30 Day All-Cause Readmissions include: 1. Failed or unsafe discharges 2. Inadequate discharge plan from hospital 3. Poor medication reconciliation 4. Member/caregiver unaware of discharge instructions from hospital Health Plan Barriers: 1. Finite funding 2. Emphasis on short inpatient length of stay with member discharged before condition is stable 3. Inadequate care coordination 4. Inadequate follow-up of member once discharged from inpatient setting 5. Inadequate discharge planning 6. Workforce shortage 7. Late assignment of discharged members to case managers 8. PCP unaware of patient issues and case management care plan Hospital Barriers: 1. Workforce shortage: Inadequate discharge planning staff in numbers and quality 2. Finite funding 3. No consequences for readmissions: Medi-Cal & Medicare pay for unlimited inpatient stays 4. Discharge planning not a hospital priority 5. Hospital does not notify the PCP of patient's admissions & discharge 6. Inadequate health teaching of patient prior to inpatient discharge 7. Patient has no pharmacist contact for medication education prior to discharge 8. Lack of communication between hospital and health plan

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	regarding discharge plan 9. Weekend discharge of patient without health plan involvement PCP Barriers: 1. Unable to see discharged patients in a timely manner 2. Unable to devote sufficient time to members during post-discharge visits Member Barriers: 1. Lack of funds to afford medications and/or costs of services 2. Lack of caregiver and/or social support in home 3. Lack of transportation for health care purposes: Members don't realize service is a covered benefit 4. Member non-compliance: Lack of knowledge, cultural barriers, language barrier, member preferences. Community Barrier: 1. Lack of or inadequate community support resources. **Internal QIP: Improving Hypertension Control** In order to identify specific factors and steps from the two external types of audiences (practitioners and members) that are attributable to controlling high blood pressure, a brainstorming process by the QI team was first used to list the factors, followed by the fishbone diagram. Upon identification of the factors derived from practitioner- and member-related barriers to improving hypertension control, interventions were developed. Barriers were prioritized based on the level of impact and the likelihood of achieving positive results, if targeted. Appropriate interventions were prioritized based on data accessibility, data availability, and feasibility with given resource to implement. Year 2013 is the Remeasurement 3 submission with 2012 measurement year. Prioritization of the practitioner-related barriers: 1. Ineffective or lack of pharmacological regimen to control high blood pressure 2. Failure to increase or change therapy to achieve BP goals 3. Disagreement with clinical practice guidelines 4. Lack of knowledge about clinical practice guidelines 5. Inadequate or no patient education Prioritization of the member-related barriers: 1. Noncompliance with medication therapy 2. Complicated medication regimen, side effects of medication, and inconvenient dosing schedule that further lead to noncompliance 3. Lack of awareness to hypertension, including the blood pressure measure and its category 4. Clinical instruction on how to control and manage high blood pressures is not clear and/or not given to the

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	patients in writing 5. Individual lifestyle and diet that affect blood pressure
2. 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.	**Statewide Collaborative QIP: All-Cause Readmission** For the 30 Day All-Cause Readmission Statewide Collaborative, we identified these two high-priority hospital barriers with the respective interventions: BARRIER: Workforce Shortage: Inadequate discharge planning staff in numbers and quality to affect efficient, thorough, and safe patient discharges with patient's lacking knowledge and their physicians not receiving adequate hospitalization information. INTERVENTION: The MHC Transition of Care Coach assumes responsibility for communication and collaboration with inpatient and community-based providers as well as the patient and caregiver to ensure adequate knowledge of matters related to the hospital stay and post-hospital care needs. BARRIER: Finite Funding: Limited hospital budgets result in inadequate staffing to ensure safe, efficient, and thorough patient discharges. INTERVENTION: Renegotiate hospital contracts at time of renewal with emphasis on bundled payments and value-based purchasing. **Internal QIP: Improving Hypertension Control** Below are the prioritized barriers and their corresponding interventions to address those barriers: Prioritized barriers: 1. Insufficient antihypertensive treatment to improve BP control through appropriate and effective pharmacological regimen and to reduce drug-related barriers. 2. Lack of PCP awareness of their assigned members' hypertension diagnosis and their need for an annual visit and appropriate treatments. 3. Lack of patient/member understanding of the importance of controlling hypertension and taking prescribed medications. Prioritized Interventions: • Hypertension Pharmacy Profile (quarterly report) Date Implemented: 04/10; 07/10; 10/10; 01/11; 04/11; 10/11; 12/11; 4/12; 7/12; 10/12 Category of the Intervention: Provider Targeted population: Direct target to providers and indirect target to members through providers. Targeted Barrier: Ineffective or lack of pharmacological regimen to control high blood pressure; failure to increase or change therapy to achieve BP goals; inadequate or no patient education.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• Member Postcards: Date Implemented: 04/10; 07/10; 10/10; 01/11; 04/11; 10/11; 12/11; 4/12; 7/12; 10/12 Category of the Intervention: Member Targeted population: Member Targeted Barrier: Lack of patient/member understanding of the importance of controlling hypertension and taking prescribed medications; patient noncompliance to prescribed medication therapy. • Member Outreach Calls: Date Implemented: Monthly member calls with start date of 10/11 and end date of 11/12 during the QIP period Category of the Intervention: Member Targeted population: Member Targeted Barrier: Lack of patient/member understanding of the importance of controlling hypertension and taking prescribed medications; patient noncompliance to prescribed medication therapy. • Needed Services Report: Date Implemented: 1/11; 7/11; 10/11; 1/12; 7/12; 11/12 Category of the Intervention: Provider Targeted population: Direct target to providers and indirect target to members through providers. Targeted Barrier: Lack of PCP awareness of their assigned members' hypertension diagnosis and their need for an annual visit and appropriate treatments.
3. 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.	**Statewide Collaborative QIP: All-Cause Readmission** For the 30 Day All-Cause Readmission Statewide Collaborative QIP, MHC proposed the following evaluation methods to determine the effectiveness of the Case Management and Transition of Care program for Riverside, San Bernardino, Sacramento, and San Diego counties and by payer type (Medi-Cal, SPD, Non-SPD): • For Complex Case Management staff, evaluate performance by: • Total number of members managed by each case manager • Total number of members with emergency room encounters. Differentiate those sent home vs. those with hospital admissions • Total number of members per case manager hospitalized: Differentiate planned vs. unplanned encounters • Total number of members per case manager with planned and unplanned 30 day readmissions.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• For Transition of Care staff evaluate performance by: • Total number of hospitalized members managed • Total number of hospitalized and discharged members with phone vs. face-to-face contact • Total number of discharged members with planned and unplanned 30 day readmissions and further differentiated by phone contact only vs. phone and face-to-face contact • Total number of discharged members referred to the Case Management program for the first time vs. the number previously in the program and returning to it vs. those that no longer require case management. **Internal QIP: Improving Hypertension Control** During the period of July 1, 2012, through June 30, 213, Molina's internal QIP (IQIP) has completed its project cycle with Remeasurement 3 period of 1/1/2012–12/31/2012. During the IQIP lifecycle, the baseline and subsequent remeasurements were analyzed and evaluated by the study outcome indicator, HEDIS Controlling High Blood Pressure (CBP). Moreover, implemented interventions were observed and evaluated in conjunction to the result of the statistical analysis and finding of the study outcome: The number of members who did not fill any type of antihypertensive class medications; the number of distinct PCPs who received quarterly data reports on their assigned hypertensive members without indication of filling an antihypertensive medication were observed and evaluated