2023 Population Assessment: California

November 2023 | Quality Program Management & Performance

MOLINA® HEALTHCARE

Population Assessment

Overview

Molina Healthcare of California (Molina) strives for full integration of physical health, behavioral health, long-term services and supports (LTSS), and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. To determine the necessary structure and resources for our programs, Molina performs a population assessment to determine the appropriateness of resources and processes used to address member needs.

On an annual basis, Molina evaluates the following areas in our population assessment. We identify and assess the:

- Characteristics and needs, including social determinants of health, of member populations;
- Needs of relevant subpopulations;
- Needs of children and adolescents (2-19);
- Needs of individuals with disabilities; and
- Needs of individuals with serious and persistent mental illness.

The population assessment informs updates to Molina's Population Health Management activities and resources (including community-based resources) to address member needs. We conduct this analysis on an ongoing basis to determine the appropriateness of our programs.

Population Health Management Data Integration

Population Assessment

Methodology

The population assessment is completed using data that is integrated from multiple systems that includes but is not limited to enrollment, medical and behavioral health claims, and encounters data. The review of this data assists Molina to identify members for various Population Health Management programs and initiatives. The assessment includes an evaluation of population mix, member service and community needs, as well as demographic factors such as race, ethnicity, and preferred language. The assessment includes an evaluation of the prevalence of conditions specific to the populations served.

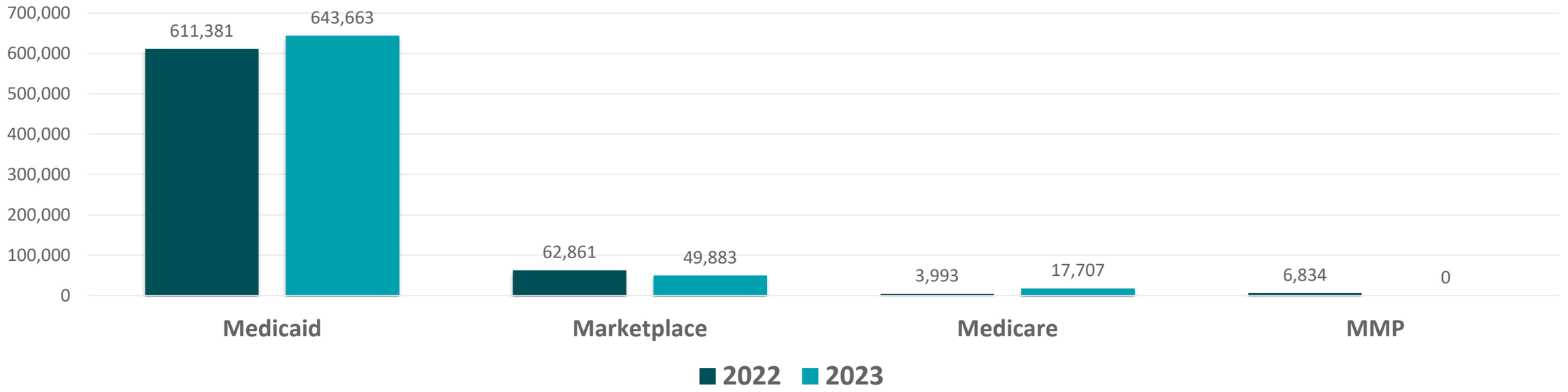
Molina identifies at-risk members who may benefit from care management through an analysis of integrated data which may include the following:

- encounter forms,
- medical and behavioral claims or encounter data,
- hospital discharge data,
- member health risk assessments,
- pharmacy claims, if applicable,
- laboratory data and results,
- data collected through the UM management process, such as case management, daily hospital census and/or ER utilization data and authorizations, etc. if applicable,
- data supplied by practitioners, including electronic health records,
- data supplied by members or caregivers,
- data provided by CMS and/or the local state health departments,
- data supplied by vendors such as vision and dental, if applicable,
- data supplied from any contracted health information exchanges (HIE), if applicable,
- state or region-wide immunization registries, if applicable, and/or
- data collected through internal and external referrals, including referrals from nurse advice line and disease management programs.

Characteristics and Needs of Member Population

- Demographics and Social Determinants of Health
- Relevant Member Populations
  - Children and Adolescents (2-19)
  - Members with Disabilities
  - Members with Serious and Persistent Mental Illness
- Diagnosis Specific Analysis
  - Children and Adolescents (2-19)
  - Members with Disabilities
  - Members with Serious and Persistent Mental Illness

Demographic Analysis – Overall Membership

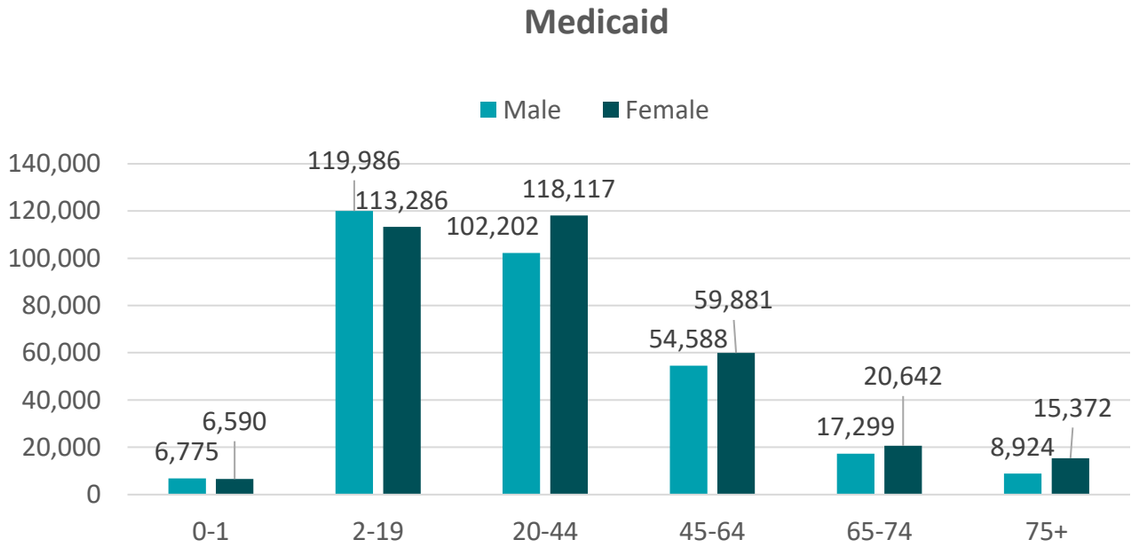


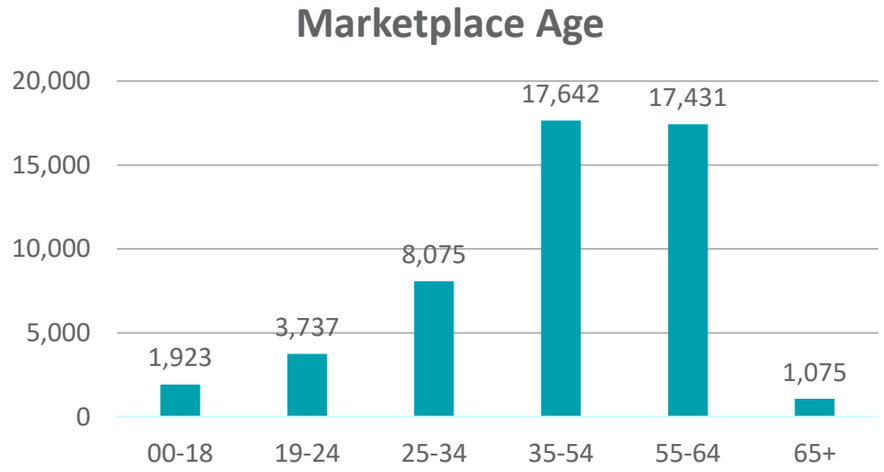
- In 2023, Molina Healthcare of California had a total membership of 711,253 members, which is a 4% increase compared to total membership last year.
- Most Molina's members (90%) in 2023 are in the Medicaid line of business (643,663). Medicaid membership increased 5% compared to last year.
- Marketplace members comprise 7% of the plan's membership which is smaller compared to last year (10%).
- Medicare members comprise 2.5% of the plan's membership which is larger compared to last year (0.5%).
- MMP members comprise 0% of the plan's membership which is smaller compared to last year (0.1%).

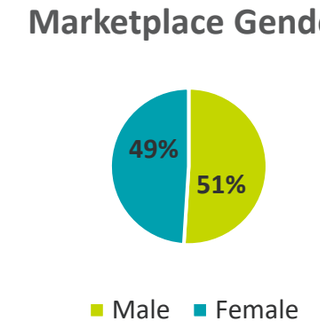
**Membership Data as of 10/10/2023*

California

Demographic Analysis – Gender and Age





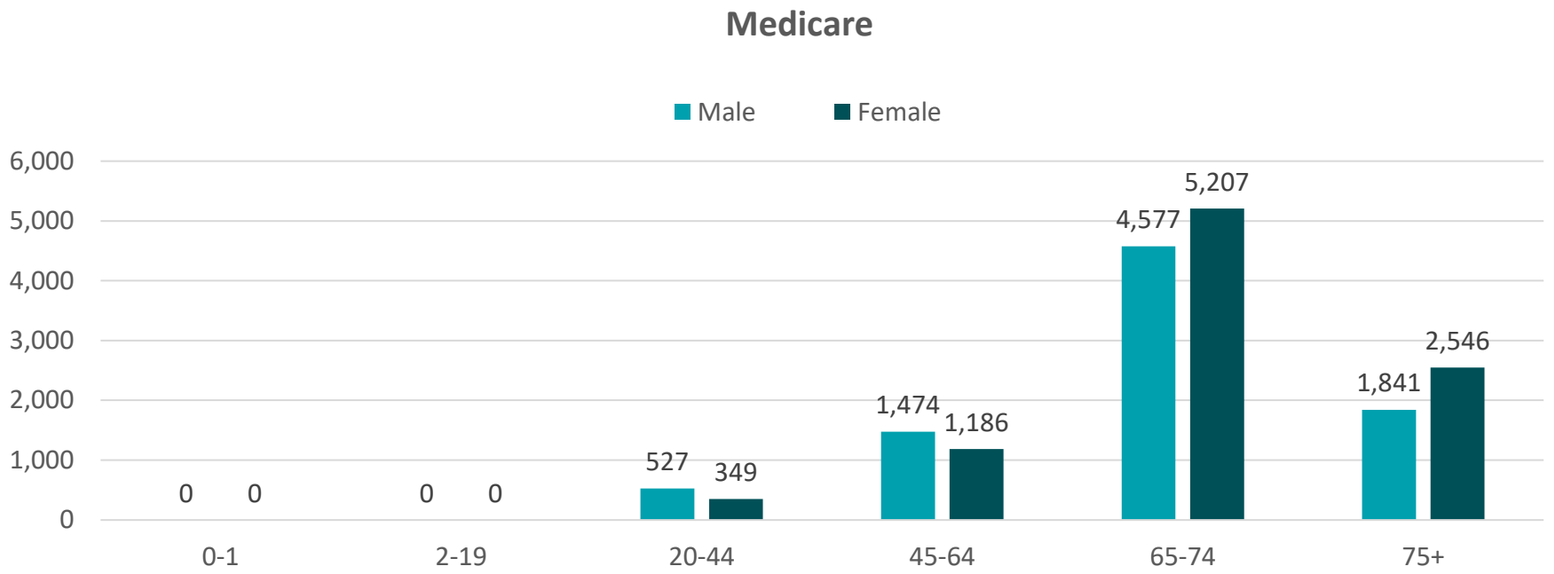


- Members 2-44 years of age represent 70% of Molina's Medicaid membership.
- Medicaid member composition is 52% female and 48% male; all age groups, except 0-19 have a larger proportion of women compared to men.
- Members aged 35-64 represent 70% of Molina's Marketplace membership.
- Marketplace member composition is 51% female and 49% male.

**Membership Data as of 10/10/2023*

California

Demographic Analysis – Gender and Age



- Molina's Medicare population is generally older with 80% of Medicare members 65 years and older.
- Medicare membership is comprised of a larger proportion of female members (52%) compared to male members (48%).

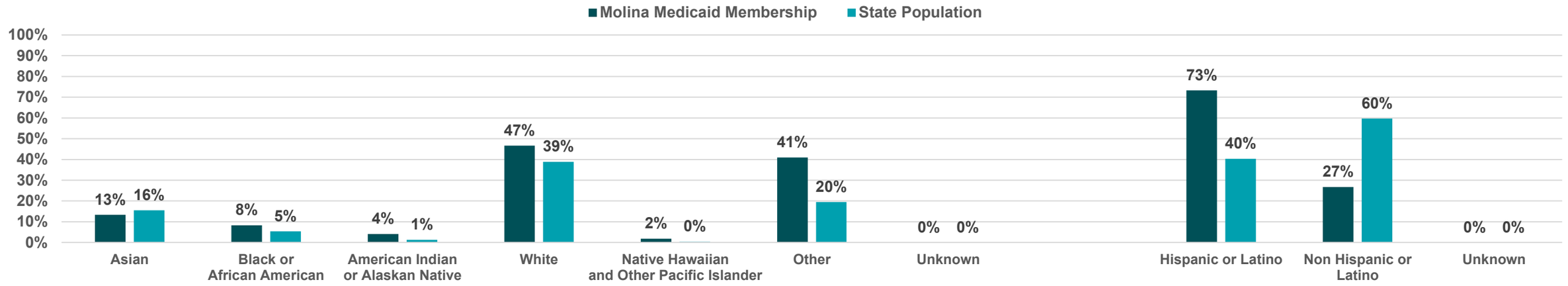
**Membership Data as of 10/10/2023*

California

Demographic Analysis – Race/Ethnicity

Molina assesses membership race and ethnicity at least annually to ensure that care and services meet the needs of the population. Race/ethnicity and language data is used to assess the existence of disparities and to focus quality improvement efforts towards improving the provision of culturally and linguistically appropriate services and decreasing health care disparities. Race and ethnicity is further analyzed by county to assess the areas where the plan should be concentrating and expanding its network. CAHPS® demographic data is used if internal data shows a high proportion of Unknown or Other membership.

In 2022, California state's population was comprised of 39,029,342 residents. In 2023, Molina Healthcare of California's Medicaid membership consisted of 643,209 individuals. Compared to the overall state population, Molina's Medicaid member population has a similar proportion of Black or African American individuals (8% Molina members compared to 5% statewide) and a larger proportion of White individuals (47% Molina members compared to 39% statewide). Molina's Medicaid Hispanic or Latino members comprises 73% of the overall membership, which is a larger proportion compared to state overall (40%). *Note: CAHPS® Survey demographic data was used for this comparison because internal data shows that Unknown and Other race/ethnicity categories comprise 30% or more of the total membership.*



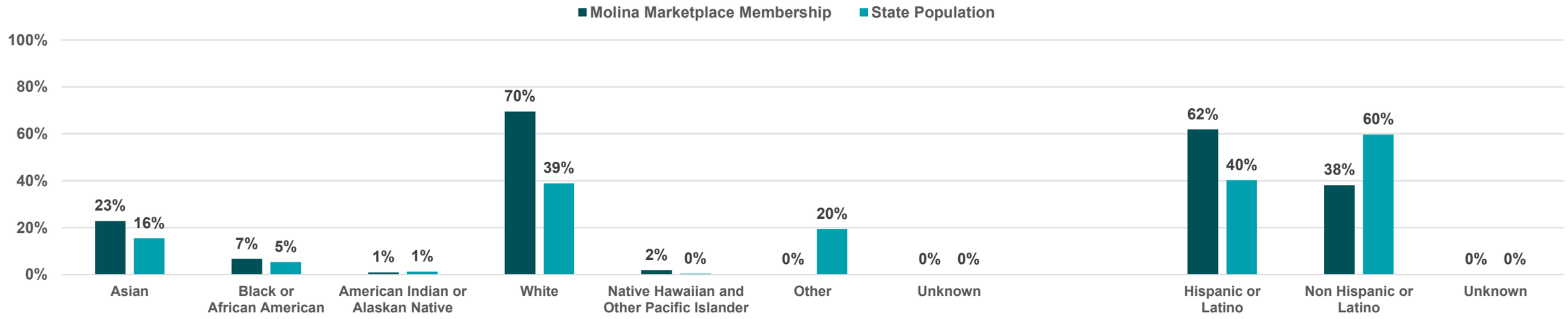
***Sum of percentages may be greater than 100% due to rounding.**
Additionally, CAHPS® respondents can select more than one race/ethnicity category.

**2023 Child CAHPS® Survey (SPH Final Report)*

California

Demographic Analysis – Race/Ethnicity

In 2023, Molina Healthcare of California's Marketplace membership consisted of 49,938 individuals. Compared to the overall state population, Molina's Marketplace member population has a similar proportion of Black or African American individuals (7% Molina members compared to 5% statewide) and a larger proportion of White individuals (70% Molina members compared to 39% statewide). Hispanic or Latino Marketplace members comprised 62% of membership, which is a larger proportion compared to the state overall (40%). *Note: Qualified Health Plan Enrollee Survey demographic data was used for this comparison because internal data shows that Unknown and Other race/ethnicity categories comprise 30% or more of the total membership.*

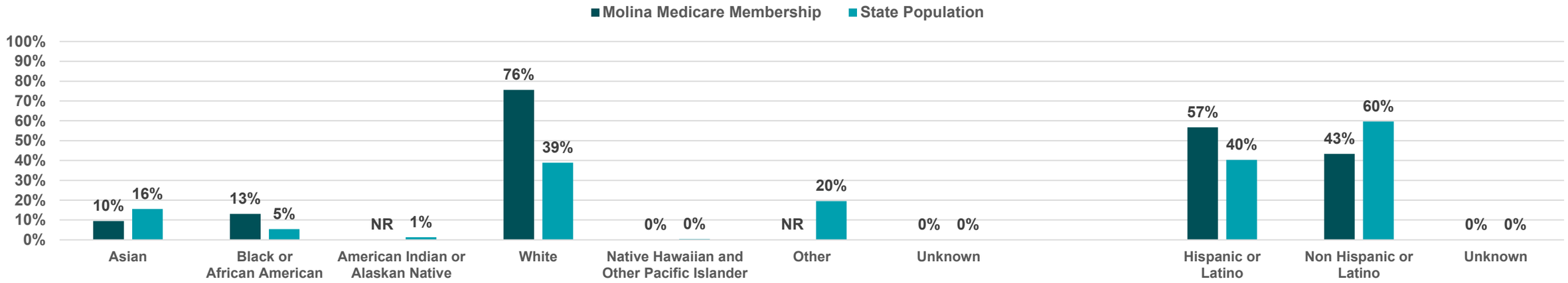


***Sum of percentages may be greater than 100% due to rounding.**
Additionally, CAHPS® respondents can select more than one race/ethnicity category.

California

Demographic Analysis – Race/Ethnicity

In 2023, Molina Healthcare of California's Medicare membership consisted of 17,917 individuals. Compared to the overall state population, Molina's Medicare member population has a larger proportion of Black or African American individuals (13% Molina members compared to 5% statewide) and White individuals (76% Molina members compared to 39% statewide). Hispanic or Latino Medicare members comprised 57% of membership, which is a larger proportion compared to the state overall (40%). *Note: MCAHPS Survey demographic data was used for this comparison because internal data shows that Unknown and Other race/ethnicity categories comprise 30% or more of the total membership.*



***Sum of percentages may be greater than 100% due to rounding.**

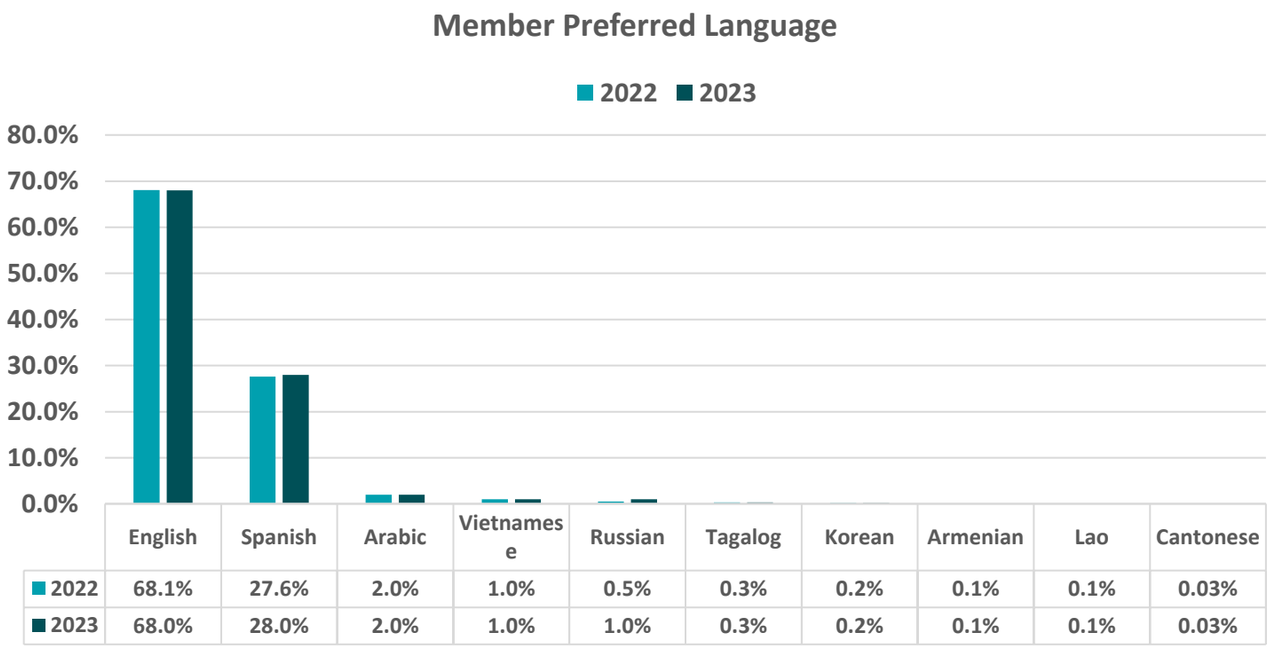
Additionally, CAHPS® respondents can select more than one race/ethnicity category.

'NR' is displayed in place of any percentage that is representative of 10 or fewer respondents .

2023 MCAHPS Survey (SPH Final Report)

California

Demographic Analysis – Language - Medicaid



	English	Spanish	Arabic	Vietnamese	Russian	Tagalog	Korean	Armenian	Lao	Cantonese
2022	68.1%	27.6%	2.0%	1.0%	0.5%	0.3%	0.2%	0.1%	0.1%	0.03%
2023	68.0%	28.0%	2.0%	1.0%	1.0%	0.3%	0.2%	0.1%	0.1%	0.03%

LOB	Language	2022 Requests Percentage of Calls	Language	2023 Requests Percentage of Calls
Medicaid	Spanish	67%	Spanish	69%
	Arabic	13%	Arabic	9%
	Vietnamese	2%	Russian	4%
	Russian	2%	Vietnamese	3%
	Farsi	2%	Haitian Creole	2%
	Pashto	2%	Mandarin	2%
	Mandarin	2%	Dari	2%
	Dari	2%	Pashto	2%
	Haitian Creole	1%	Farsi	1%
	Cantonese	1%	Cantonese	1%

- Most Medicaid members specified English as their preferred language. Spanish as a preferred language was identified by 28% of Medicaid members. Statewide, 28% of residents indicate that they speak Spanish at home.
- Between January 1 through October 31st, 2023, **61,031** interpreter services were requested by Molina Healthcare of California Medicaid members which represents 9% of the plan's Medicaid members and 30% of members whose preferred language is not English. Spanish was the top language requested followed by Arabic and Russian.

**Preferred Language Membership Data as of 10/10/2023; Language Services percentages based off internal data Jan-Oct 2023*

California

Demographic Analysis – Language - Marketplace

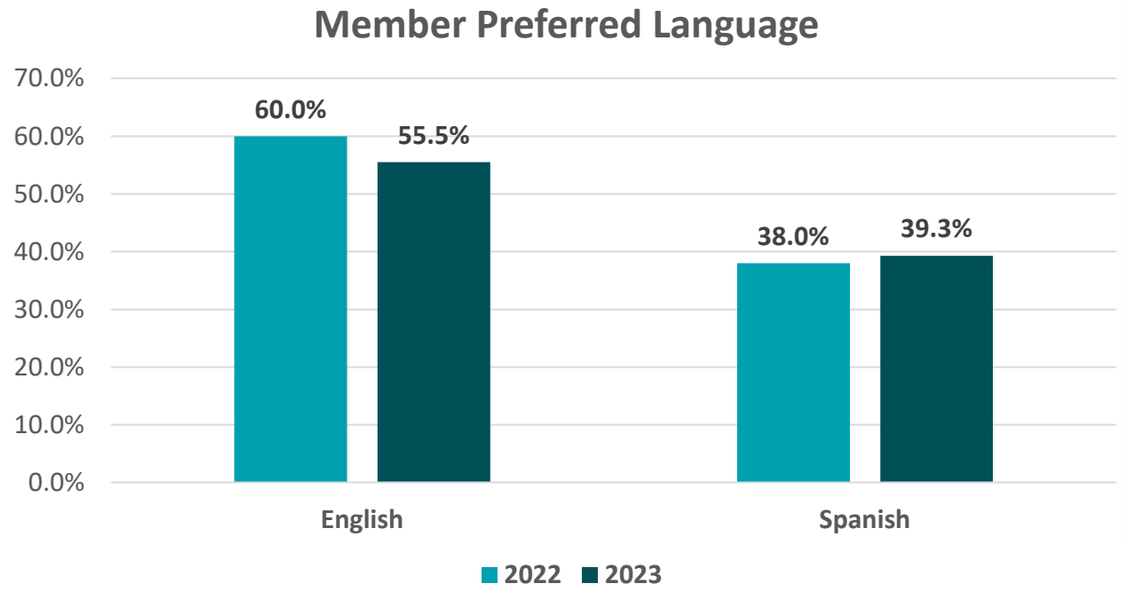
LOB	Language	2022 Requests Percentage of Calls	Language	2023 Requests Percentage of Calls
Marketplace	Spanish	86%	Spanish	78%
	Vietnamese	3%	Mandarin	5%
	Mandarin	3%	Vietnamese	4%
	Arabic	2%	Arabic	3%
	Russian	1%	Haitian Creole	1%
	Cantonese	1%	Russian	1%
	Korean	1%	Cantonese	1%
	Farsi	0.4%	Korean	1%
	Tagalog	0.3%	Farsi	1%
	Haitian Creole	0.3%	Burmese	0.5%

- Between January 1 through October 31st, 2023, **10,642** interpreter services were requested by Molina Healthcare of California Marketplace members. The top three languages requested in 2022 were Spanish, Vietnamese, and Mandarin. There was no significant year over year change in the top languages requested via interpreter services.

**2023 percentages are based off of internal data from Jan-Oct 2023*

California

Demographic Analysis – Language - Medicare



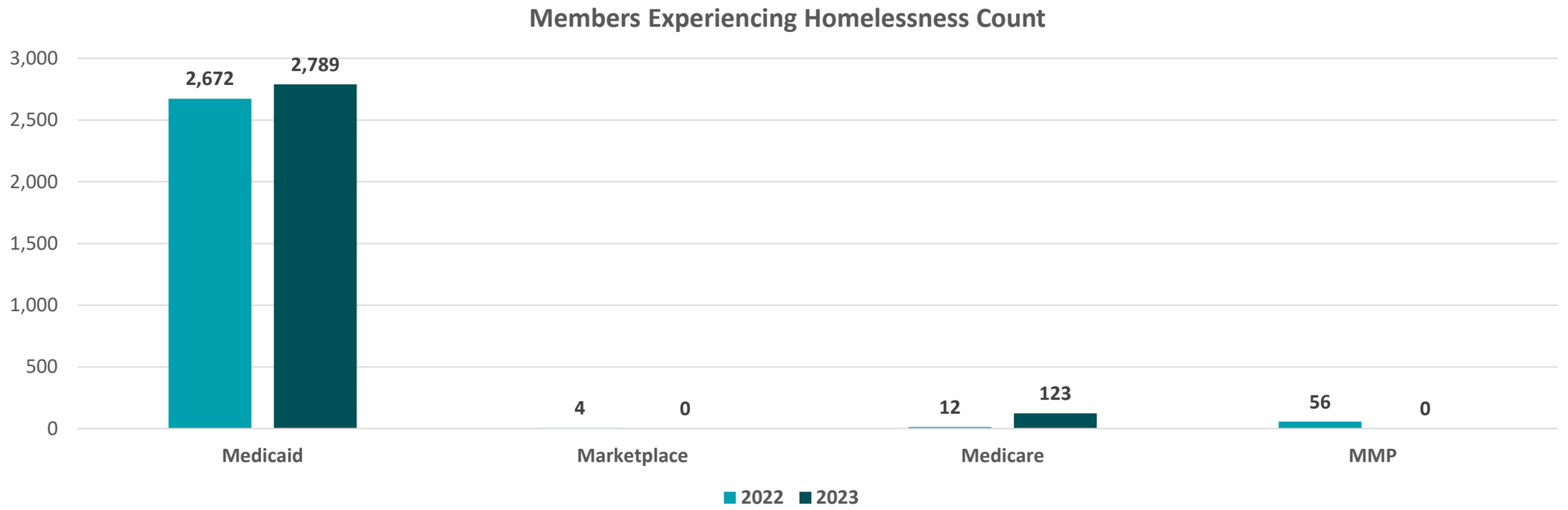
LOB	Language	2022 Requests Percentage of Calls	Language	2023 Requests Percentage of Calls
Medicare	Spanish	74%	Spanish	75%
	Vietnamese	6%	Vietnamese	7%
	Arabic	4%	Arabic	3%
	Russian	3%	Mandarin	3%
	Mandarin	3%	Cantonese	3%
	Cantonese	1%	Russian	1%
	Korean	1%	Tagalog	1%
	Cambodian	1%	Korean	1%
	Tagalog	1%	Farsi	1%
	Farsi	1%	Cambodian	1%

- Most Medicare members specified English as their preferred language. Spanish as a preferred language was identified by 38% of Medicare members. Statewide, 28% of residents indicate that they speak Spanish at home.
- Between January 1 through October 31st, 2023, **32,183** interpreter services were requested by Molina Healthcare of California Medicare members which represents 60% of the plan's Medicare members and over 100% of members whose preferred language is not English. Spanish was the top language requested followed by Vietnamese and Arabic. The top three languages requested in 2022 were Spanish, Vietnamese, and Arabic.

**Preferred Language Membership Data as of 10/10/2023; Language Services percentages based off internal data Jan-Oct 2023*

California

Social Determinants of Health: Homelessness

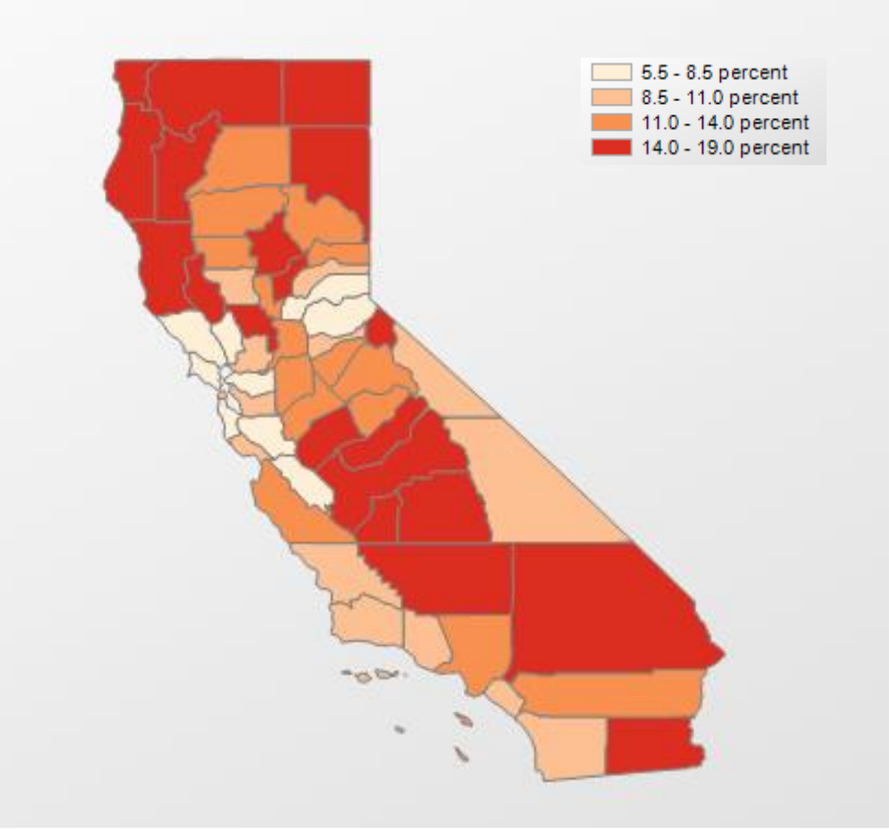


- Between 2022 and 2023, the number of members who are experiencing homelessness increased by 117 individuals among Medicaid members and by 111 individuals among Medicare members. Marketplace and MMP member count decreased.
- About 97% of Molina's members experiencing homelessness are covered by Medicaid.
- Please note: the increase in members experiencing homelessness may be attributed to increased data collection.

**Membership Data as of 10/10/2023*

Social Determinants of Health: Poverty

The Census Bureau provides data using ratios that compare the income levels of people or families with their poverty threshold: Households with incomes at or below 100% are considered “in poverty.”



U.S. Poverty Thresholds:

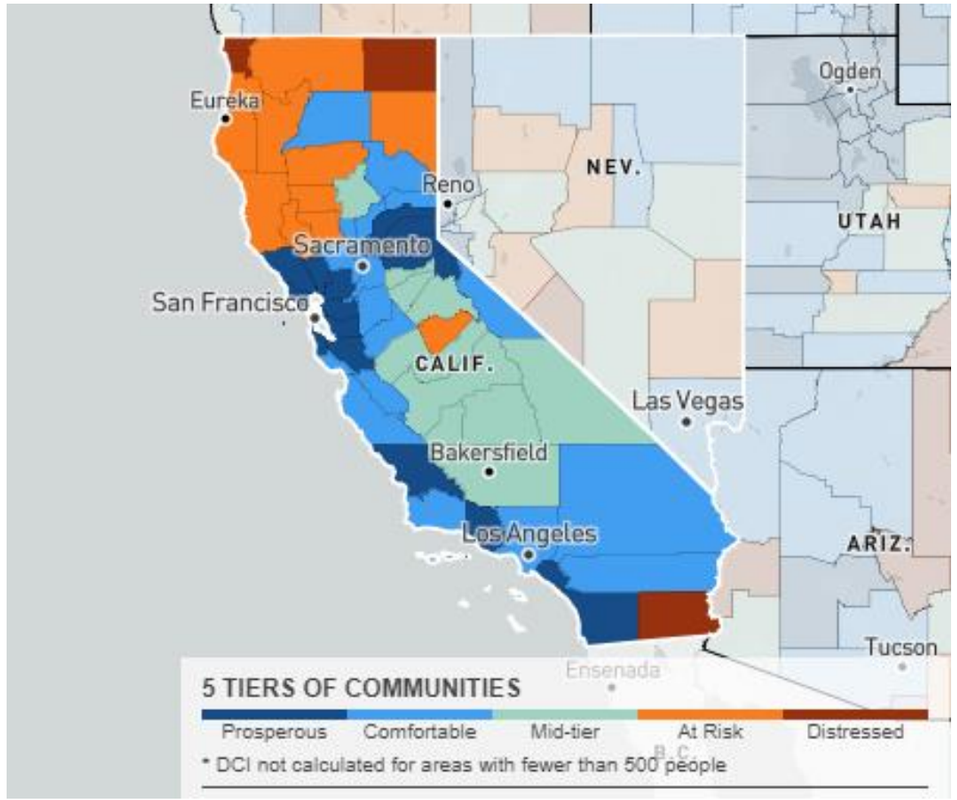
- $14,097 for a single individual under age 65
- $18,145 a household of two people (65+) with a household with no children
- $27,479 for a family of four with two children under age 18

Counties with the highest poverty rate	
County	**Poverty Rate**
Del Norte	18.5%
Kern	18.3%
Imperial	18.1%
Trinity	18.0%
Modoc	17.9%

Source(s): USDA ERS Data; U.S. Census Bureau

MOLINA HEALTHCARE

Social Determinants of Health: Distressed Communities Index



Distress scores are calculated based on seven well-being variables

1. No high school diploma
2. Housing vacancy rate
3. Adults not working
4. Poverty rate
5. Median income ratio
6. Change in employment
7. Change in business establishment

A community with a score of 80 or higher is considered to be in distress, indicated by shades of deep orange. Communities with a score of 20 or lower are considered to be prosperous and are shown in shades of dark blue.

Economic Indicators for California

Population living in distressed communities	**6.7%**
Population living in prosperous communities	**24.1%**

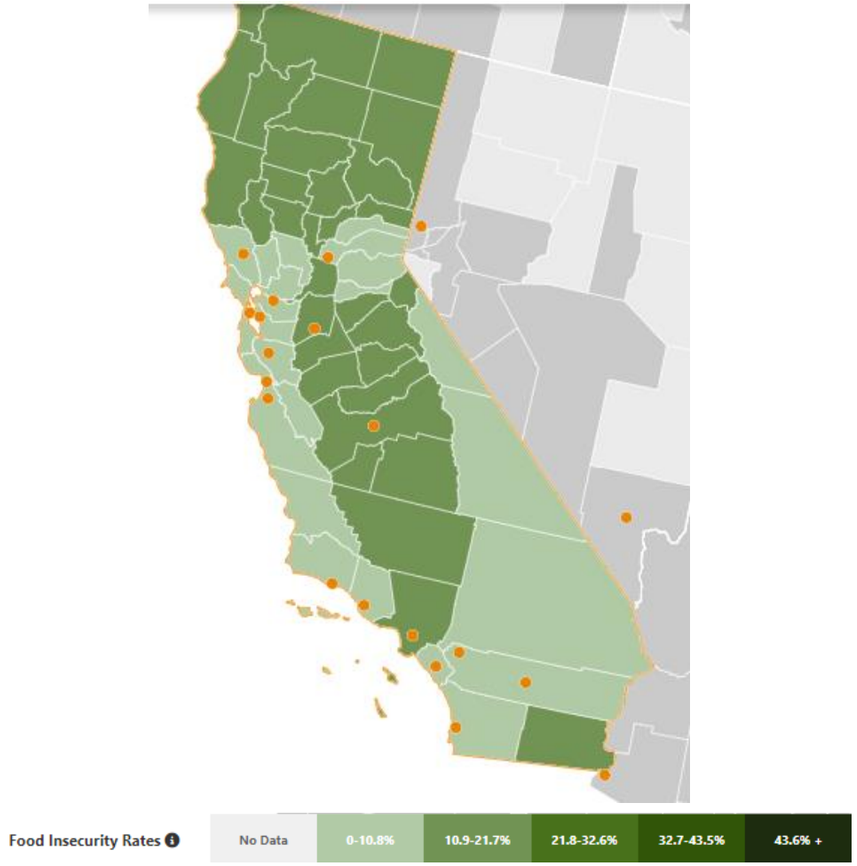
Source(s): Economic Innovation Group

MOLINA HEALTHCARE

California

Social Determinants of Health: Food Insecurity

According to the United States Department of Agriculture (USDA), food insecurity is a “household-level economic and social condition of limited or uncertain access to adequate food for a healthy diet.”



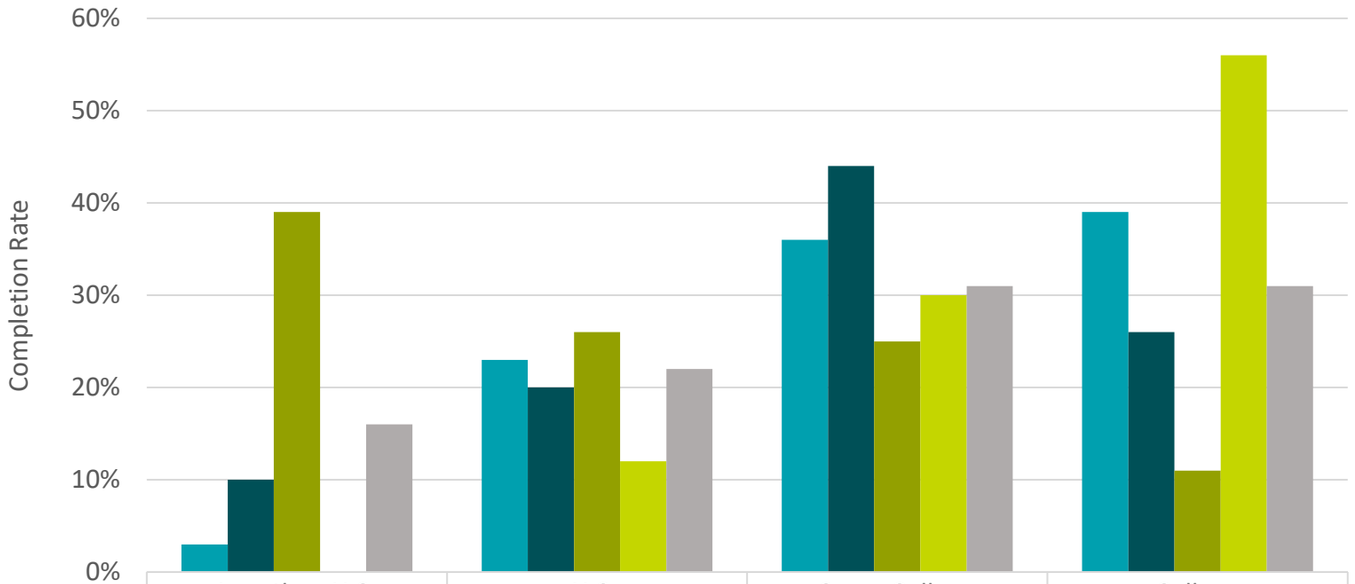
Number of Food Insecure People	**3,571,920**
Rate of Food Insecurity	**9.1%**
Number of Feeding America Foodbanks	**17**

Top 5 Most Food Insecure Counties		
County	**Rate**	**Number of People**
Imperial	19.0%	34,143
Siskiyou	15.0%	6,611
Humboldt	15.0%	20,470
Lake	15.0%	10,225
Tehama	14.5%	9,545

Source(s): Feeding America

California

Social Determinants of Health: Educational Attainment



	Less than H.S.	H.S.	Some College	College
White	3%	23%	36%	39%
Black	10%	20%	44%	26%
Hispanic	39%	26%	25%	11%
Asian		12%	30%	56%
Overall	16%	22%	31%	31%

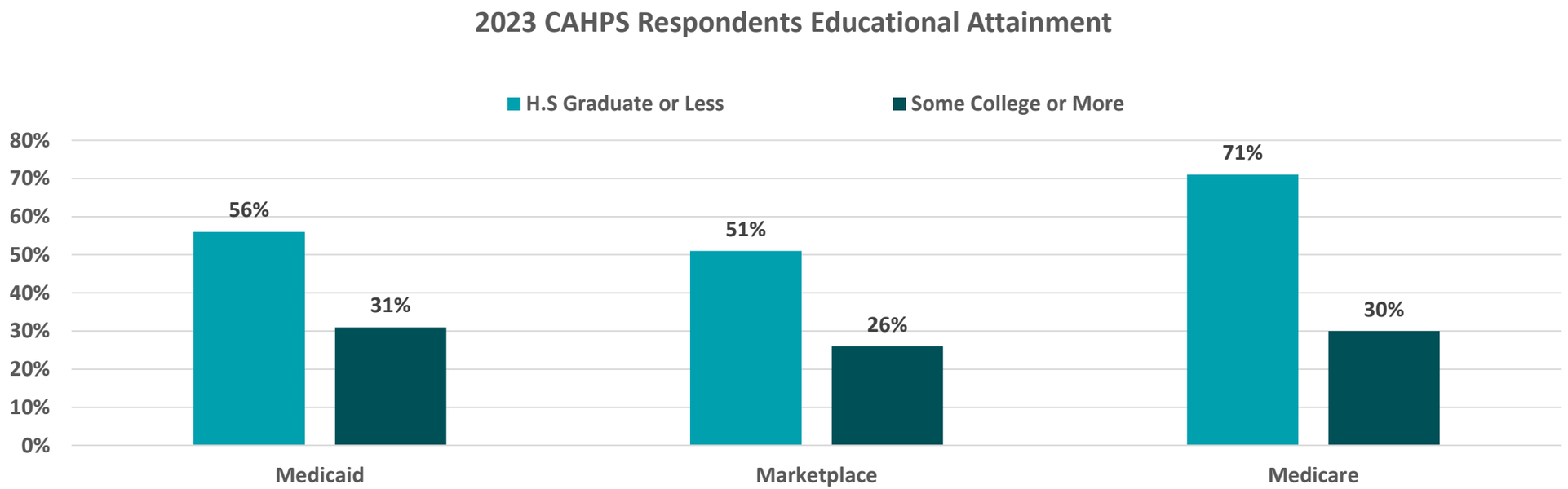
Graduation Rates in the Most Populated Counties		
County	**H.S. Graduation Rate**	**% Molina Membership in Co. (All LOBs)**
Los Angeles	80%	14%
San Diego	88%	39%
Orange	85%	0.1%
Riverside	82%	18%
San Bernardino	80%	17%
California	83%	
U.S.	89%	

Source(s): U.S. Census Bureau; CDC BRFSS

MOLINA HEALTHCARE

California

Social Determinants of Health: Educational Attainment among Molina Members

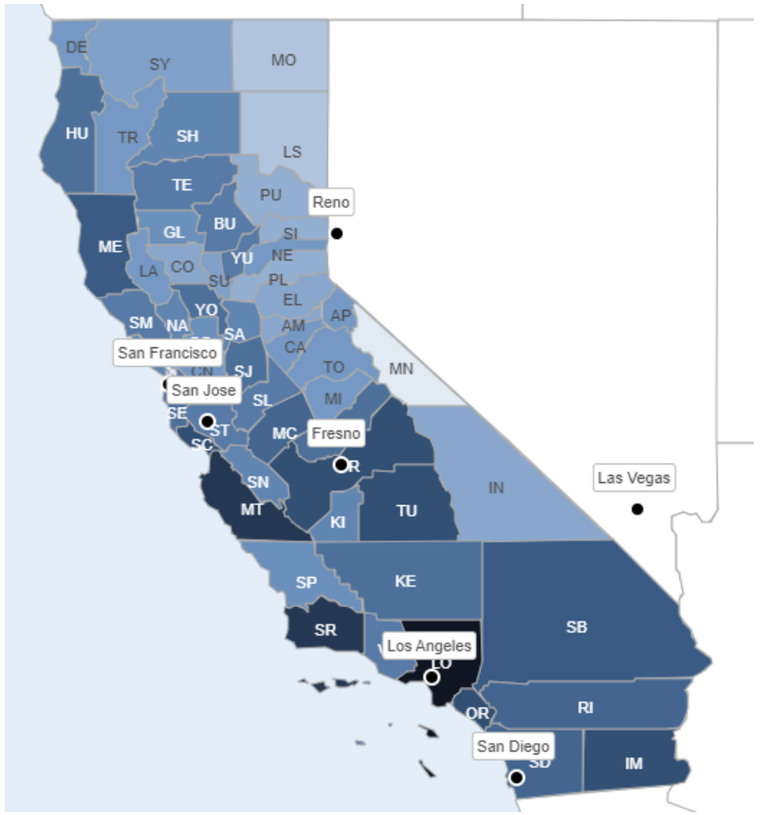


- Most Medicaid CAHPS Survey respondents specified high school or less as their highest level of education (56%), followed by some college or more (31%).
- A smaller proportion of Marketplace QHP Survey respondents specified high school or less as their highest level of education (51%) compared to other lines of business, while Medicare CAHPS Survey respondents had larger proportion of members indicating high school graduate or less (71%).

**2023 Adult CAHPS , QHP and MCHAPS Survey (SPH Final Report)*

Social Determinants of Health: Severe Housing Problems

Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities.



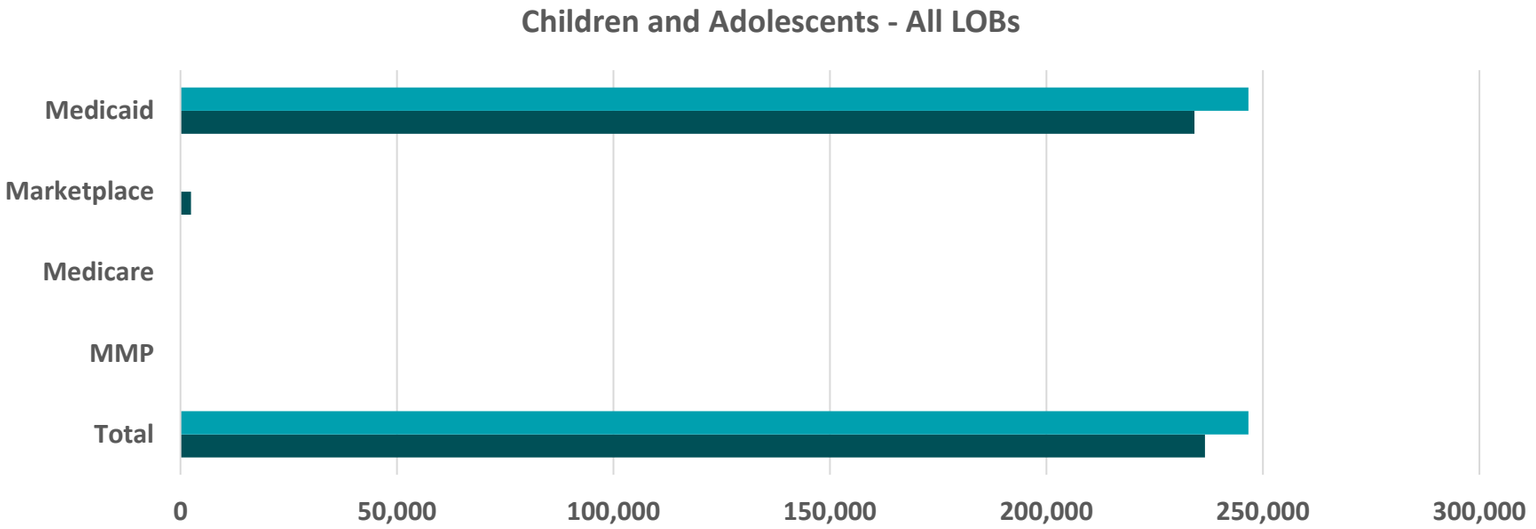
Rates in the Most Populated Counties			
County	**Prevalence of Severe Housing Problems**	**Number of Households with Severe Problems**	**% Molina Membership in County (All LOBs)**
Los Angeles	32%	1,066,401	14%
San Diego	25%	127,916	39%
Orange	25%	284,742	0.1%
Riverside	25%	184,103	18%
San Bernardino	25%	183,995	17%
California	26%	3,406,810	
U.S.	16%	20,572,800	

Source(s): Robert Wood Johnson Foundation

MOLINA HEALTHCARE

California

Demographic Analysis – Children and Adolescents (2-19)

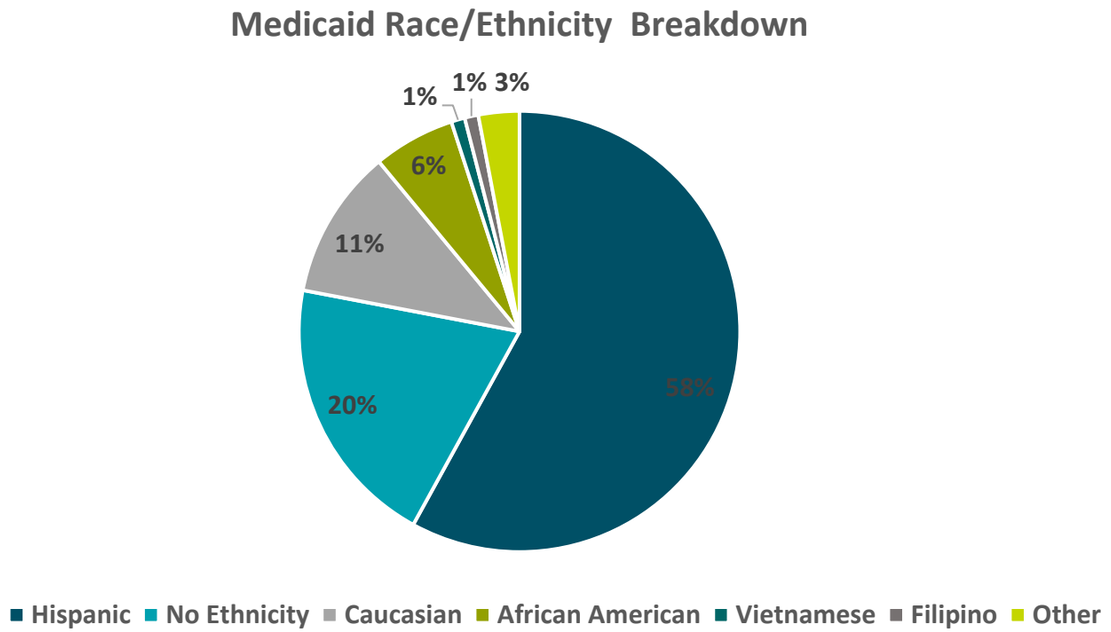


	Total	MMP	Medicare	Marketplace	Medicaid
2023	246,637	0	0	0	246,637
2022	236,593	0	0	2,389	234,204

- Due to data limitations, a year over year analysis of marketplace children and adolescents (2-19) membership counts could not be completed.
- Between 2022 and 2023, overall children and adolescent Medicaid membership increased by 5%.

**Membership Data as of 10/10/2023*

Demographic Analysis – Children and Adolescents (2-19)

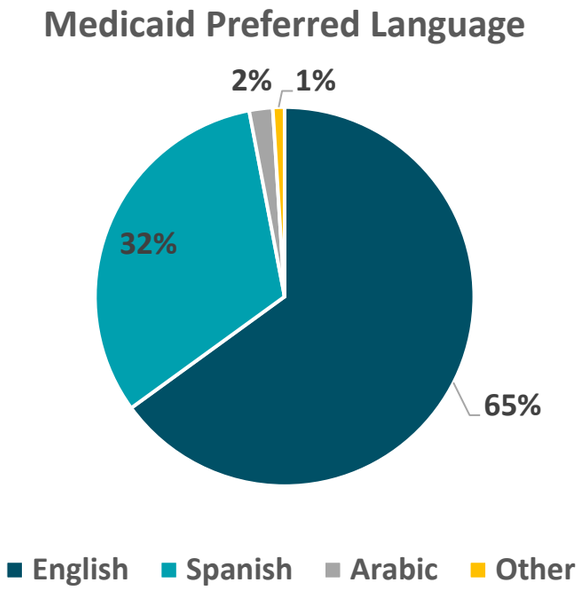


- Due to data limitations, a complete Marketplace race/ethnicity demographic analysis for children and adolescents (2-19) could not be completed.
- 58% of Medicaid children and adolescents (2-19) are Hispanic, 20% have No Ethnicity listed,11% are Caucasian and 6% are African American.

**Membership Data as of 10/10/2023*

California

Demographic Analysis – Children and Adolescents (2-19)

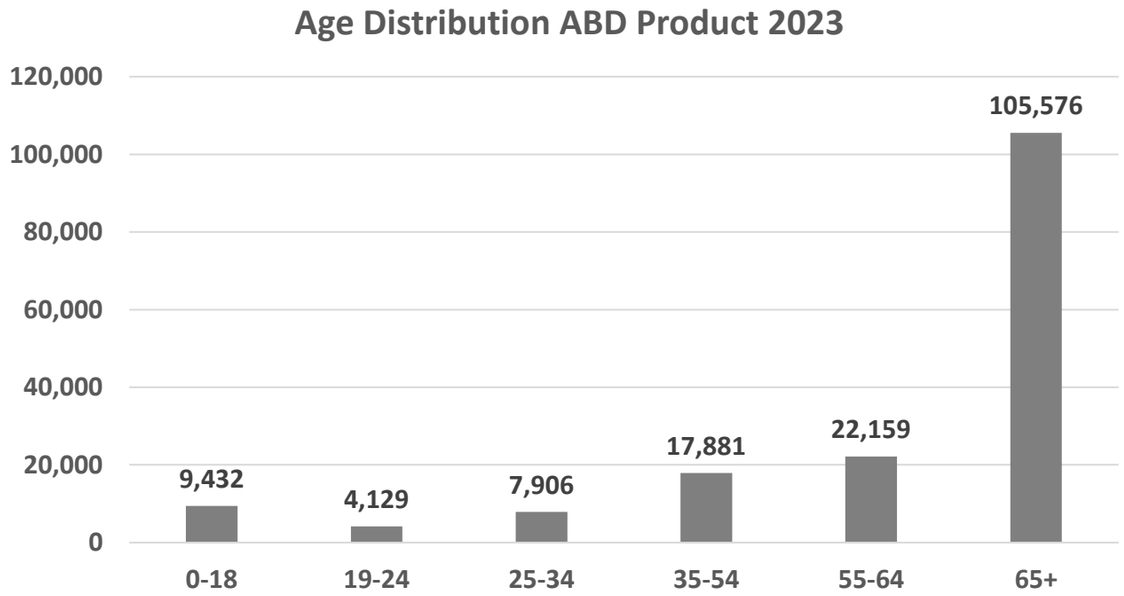


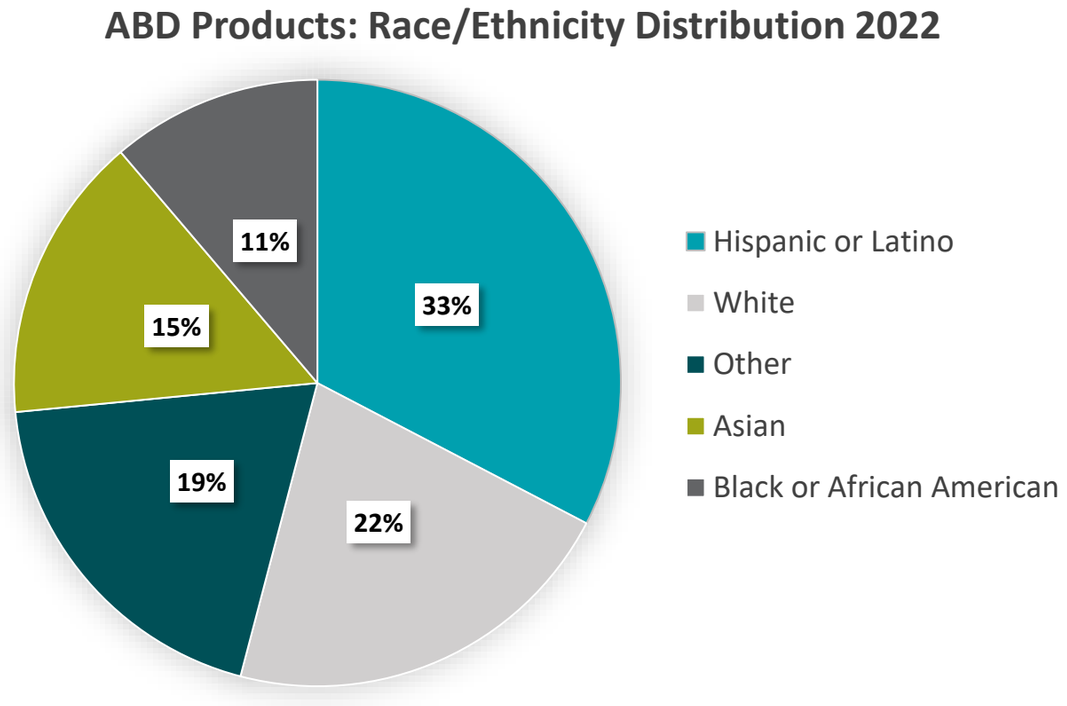
- Due to data limitations, a complete Marketplace preferred language analysis for children and adolescents (2-19) could not be completed.
- 65% of Medicaid children and adolescents (2-19) list English as their preferred language, 32% list Spanish and 2% list Arabic as their preferred language.

**Membership Data as of 10/10/2023*

California

Demographic Analysis – Individuals with Disabilities

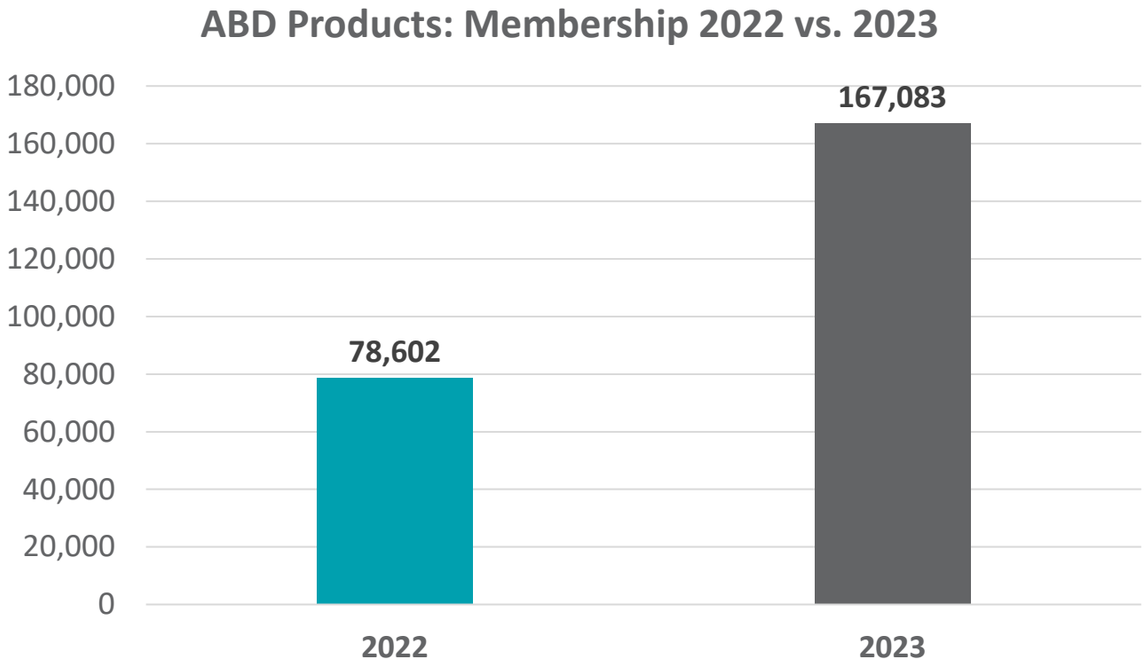


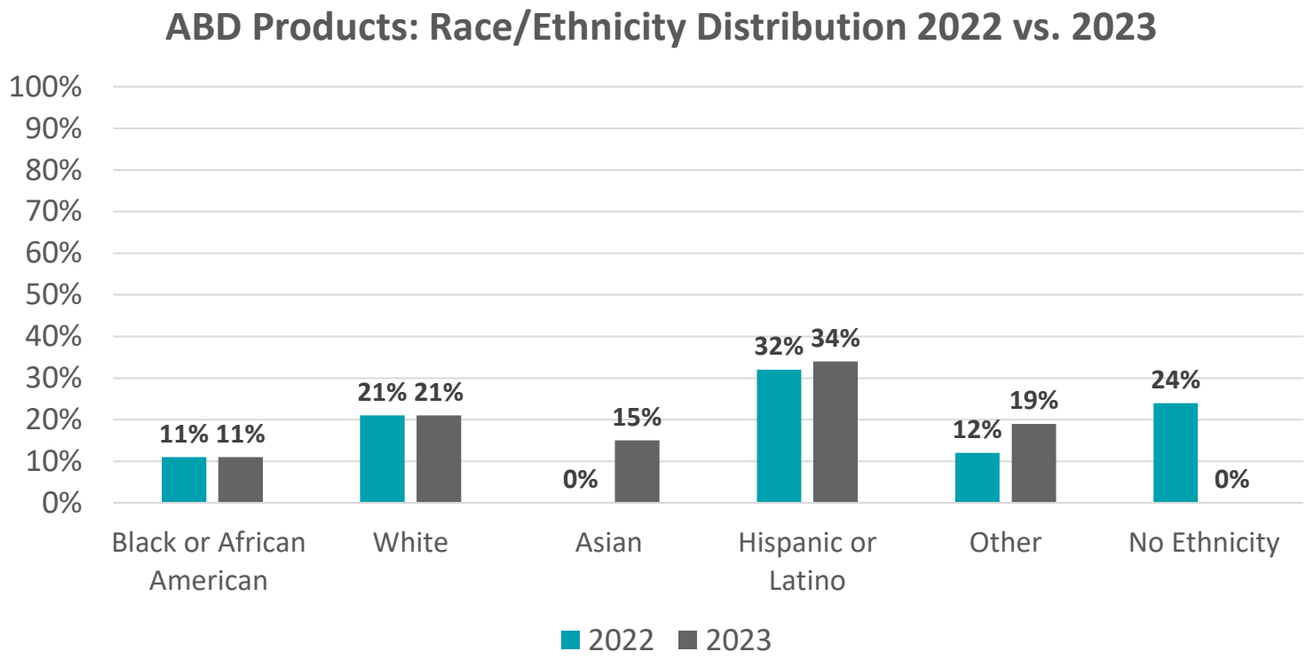


- Molina Healthcare of California has 167,083 members enrolled in ABD products representing 23% of the total membership (ABD Products = ABD Dual, ABD LTC Dual, ABD LTC Non-Dual, ABD Non-Dual, ABD Kids, and ABD BH).
- Among the members with disabilities, 53% are female and 47% are male.
- The largest group of members with disabilities are age 65+ (63%).
- The Hispanic (32%) and White (21%) groups are the largest race/ethnic groups of ABD members.

California

Year Over Year Demographic Trends – Individuals with Disabilities





- In the past year, individuals with disabilities membership has increased by 113% (88,481) members.
- Majority of members with disabilities during 2022 and 2023 identified as Hispanic or Latino (32% and 34% respectively) or White (21%).

California

Demographic Analysis – Individuals with Serious and Persistent Mental Illness

Medicaid	Marketplace	Medicare	MMP	Total
7,455	80	1,384	841	9,760

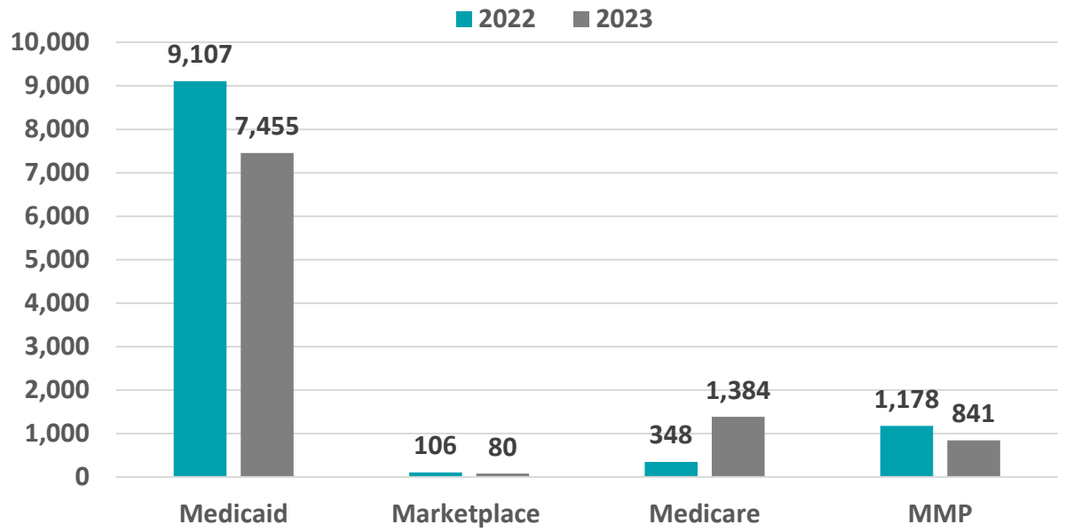
Molina defines individuals with serious and persistent mental illness (SPMI) as members with the following diagnosis codes:

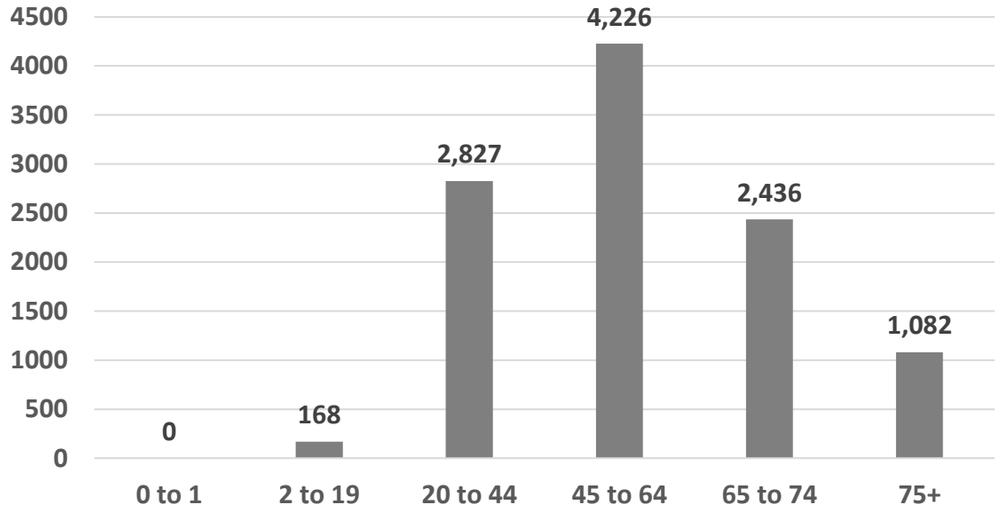
Description	ICD-10
Schizophrenic Disorders	F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9
Schizoaffective Disorders	F25.0, F25,1, F25.8, F25.9
Episodic Mood Disorders	F30.XX, F31.XX, F32.XX, F33.XX, F34.8, F34.9, F39
Delusional Disorders	F22, F24
Other Nonorganic Psychoses	F23, F28, F29, F44.89

**Membership Data as of 10/10/2023*

California

Demographic Analysis – Individuals with Serious and Persistent Mental Illness



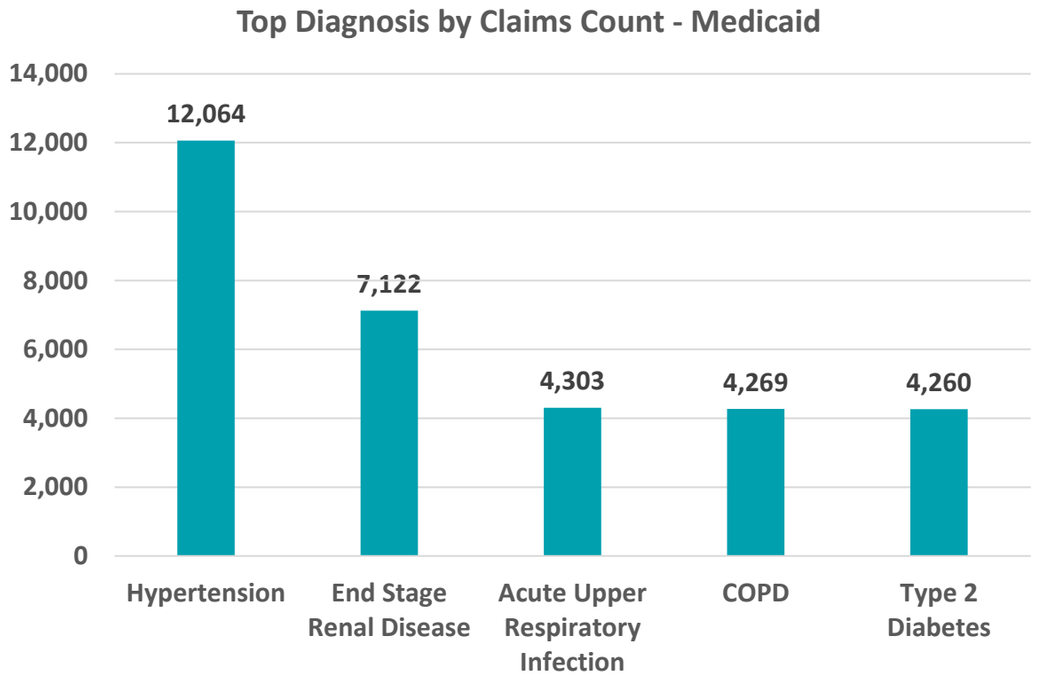


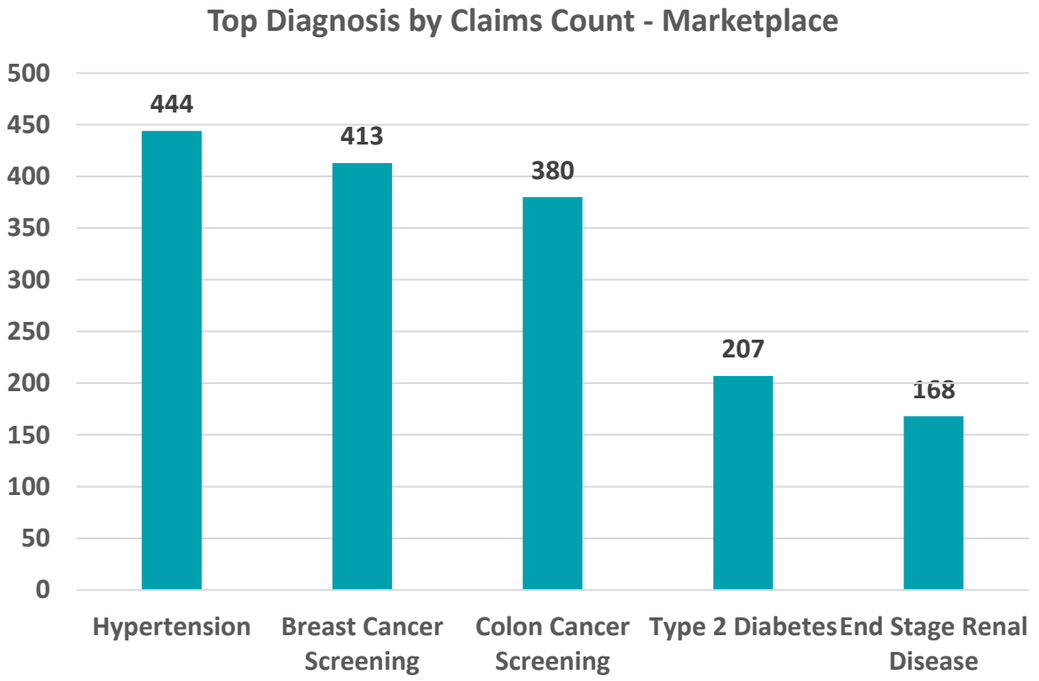
- Most Molina's members with serious and persistent mental illness (SPMI) are enrolled in the Medicaid line of business (76%); however, Medicare members have the highest prevalence of SPMI (8%) compared to Medicaid (1%) and Marketplace (0.1%).
- Compared to the previous year, Medicaid members with serious and persistent mental illness decreased by 1,652 members.
- The number of Marketplace, Medicare and MMP members with serious and persistent mental illness also decreased.
- Members aged 45-64 comprise the largest age group among members with SPMI.

**Membership Data as of 10/10/2023*

California

Diagnosis-Specific Analysis



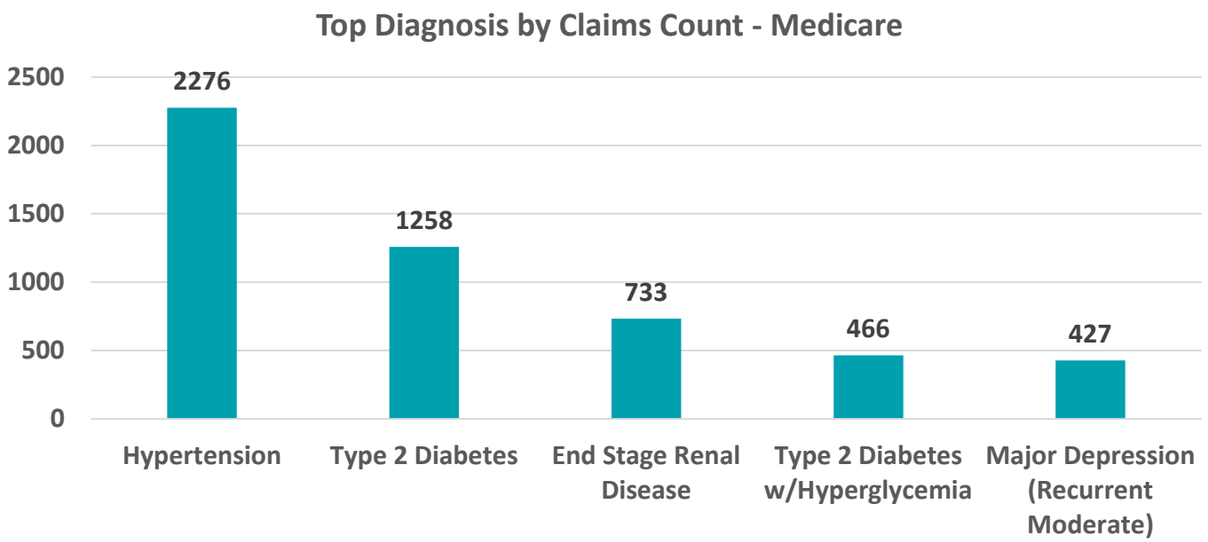


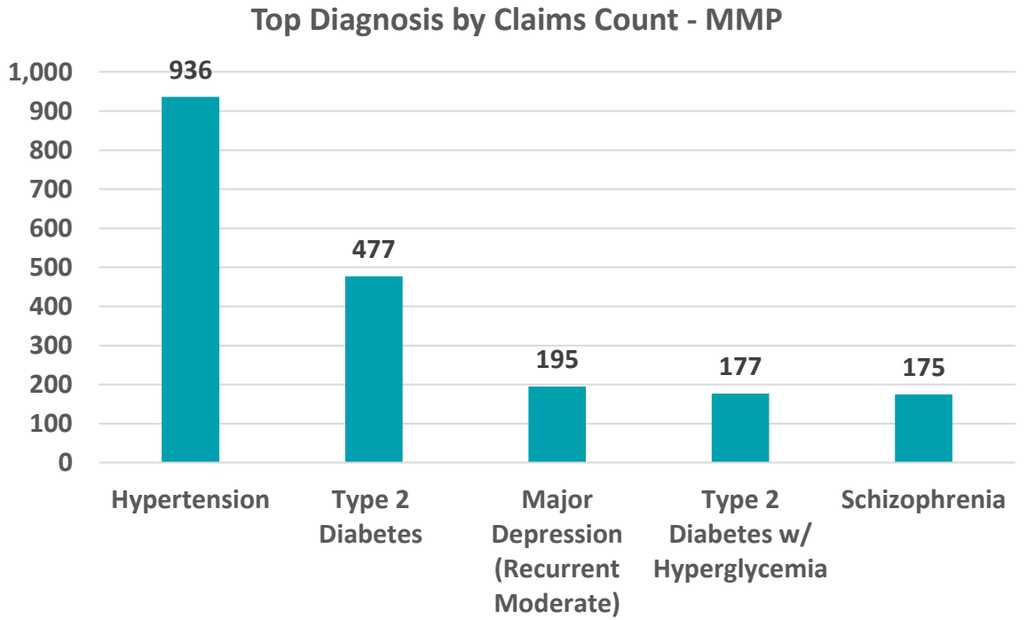
- Among Medicaid members, hypertension was the top diagnosis in 2023, followed by end state renal disease and acute upper respiratory infection. In 2022, the top diagnosis among Medicaid members were: Hypertension, COVID-19 and end stage renal disease.
- In 2023, the top diagnosis among Marketplace members was hypertension followed by breast cancer screening and colon cancer screening. In 2022, the top diagnosis among Marketplace members were: Hypertension, malignant neoplasm and COVID-19.

**Membership Data as of 10/10/2023*

California

Diagnosis-Specific Analysis



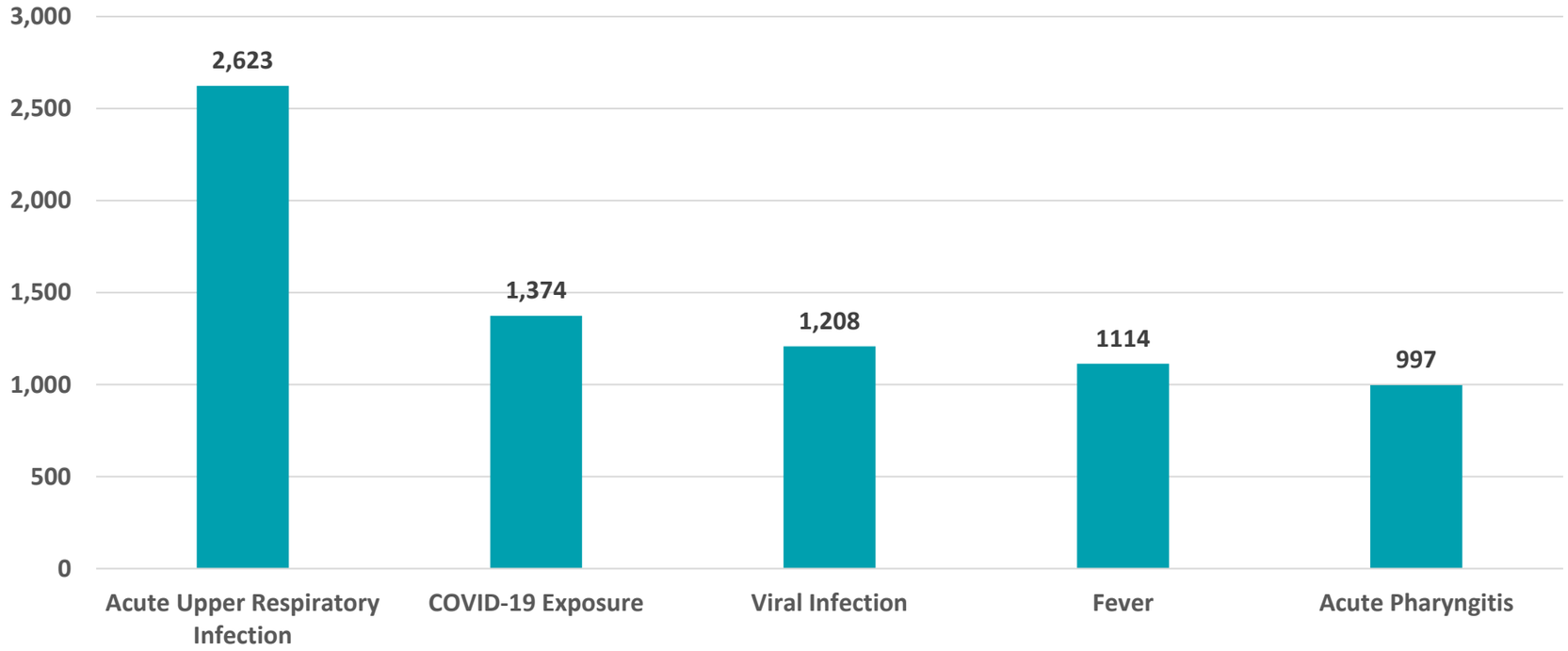


- In 2023, hypertension was the top diagnosis among Medicare members, followed by type 2 diabetes and end stage renal disease. The top three diagnoses in 2022 were: hypertension, type 2 diabetes and end stage renal disease.
- In 2023, hypertension was the top diagnosis among MMP members, followed by type 2 diabetes and major depression (recurrent moderate). The top three diagnoses in 2022 were: Hypertension, type 2 diabetes and type 2 diabetes with hyperglycemia.

**Membership Data as of 10/10/2023*

California

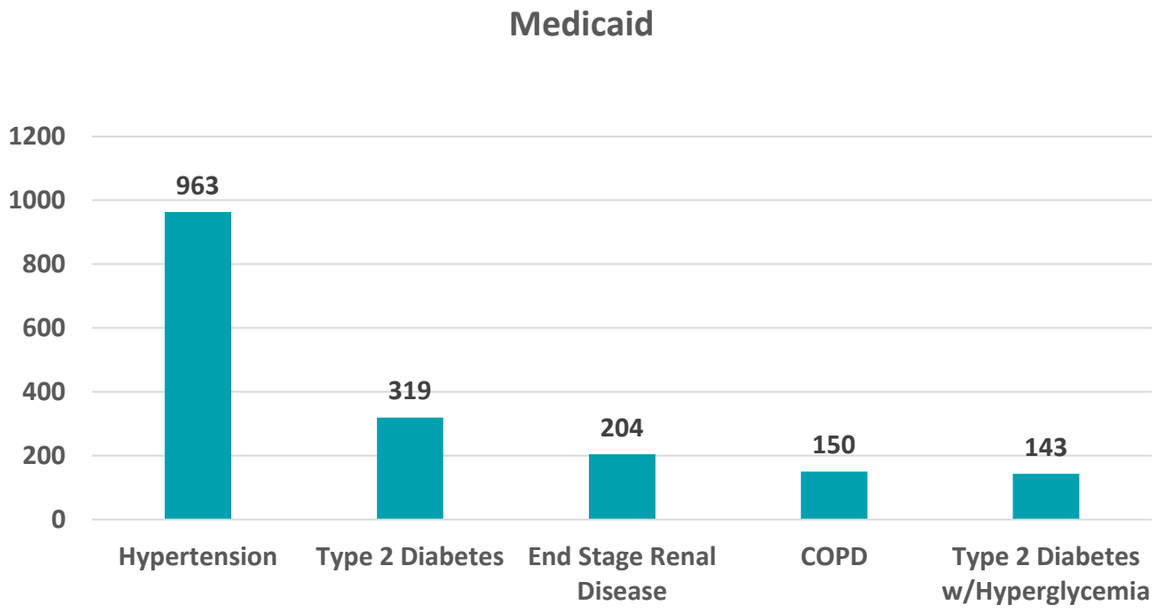
Diagnosis-Specific Analysis – Children and Adolescents 2-19 years of age

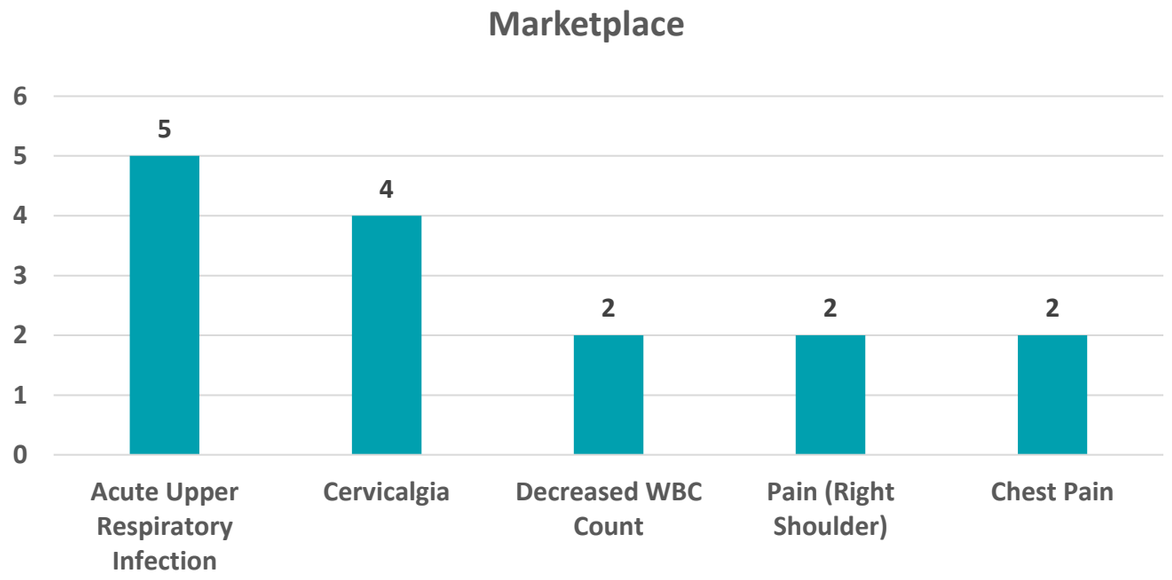


- In 2023, acute upper respiratory infection was the top diagnoses based on claims count among children and adolescents followed by COVID-19 and viral infection.
- The top three diagnoses in 2022 were: Acute upper respiratory infection, COVID-19 and viral infection.

**Membership Data as of 10/10/2023*

Diagnosis-Specific Analysis – Individuals with Disabilities



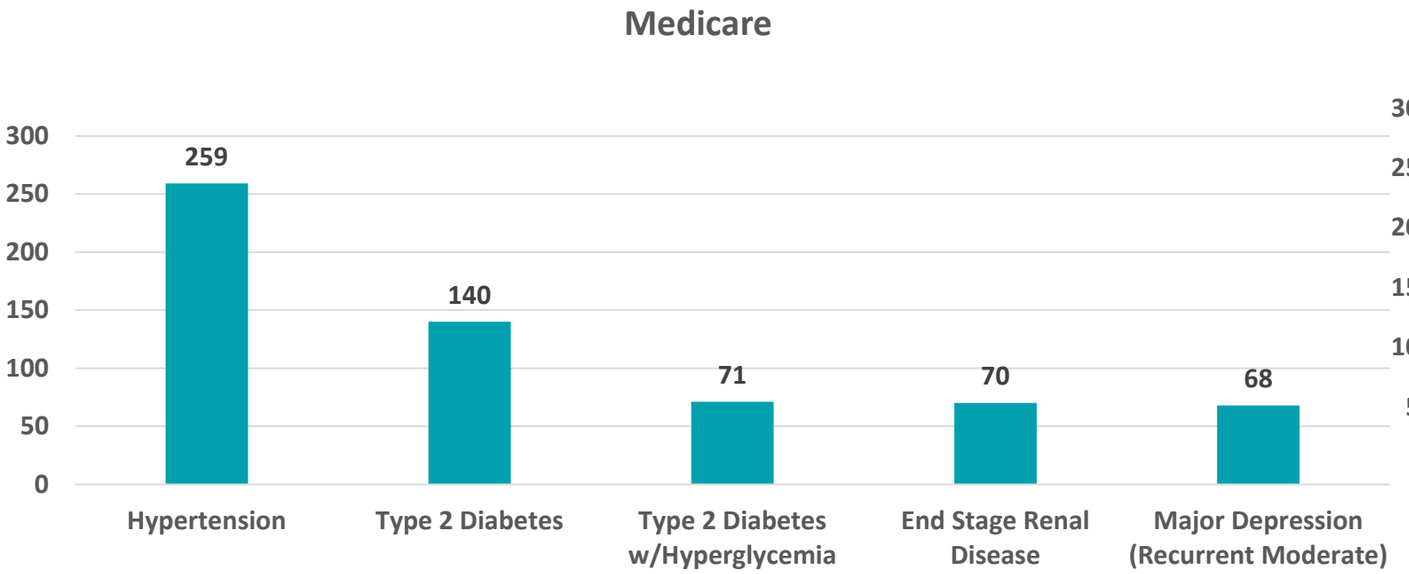


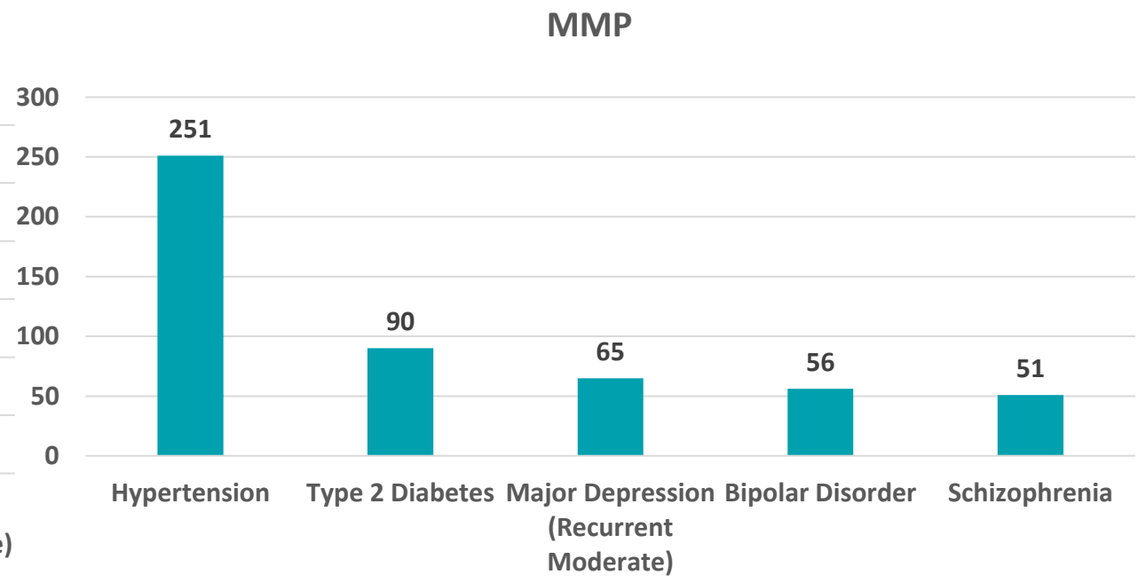
- In 2023, the top diagnoses among Medicaid individuals with disabilities were hypertension followed by type 2 diabetes and end stage renal disease.
- Acute upper respiratory infection, cervicalgia, and decreased white blood count were the top three diagnoses among Marketplace members in 2023.
- In 2022, the top three diagnosis among all members with disabilities were hypertension, type 2 diabetes and COVID-19.

**Membership Data as of 10/10/2023*

California

Diagnosis-Specific Analysis – Individuals with Disabilities





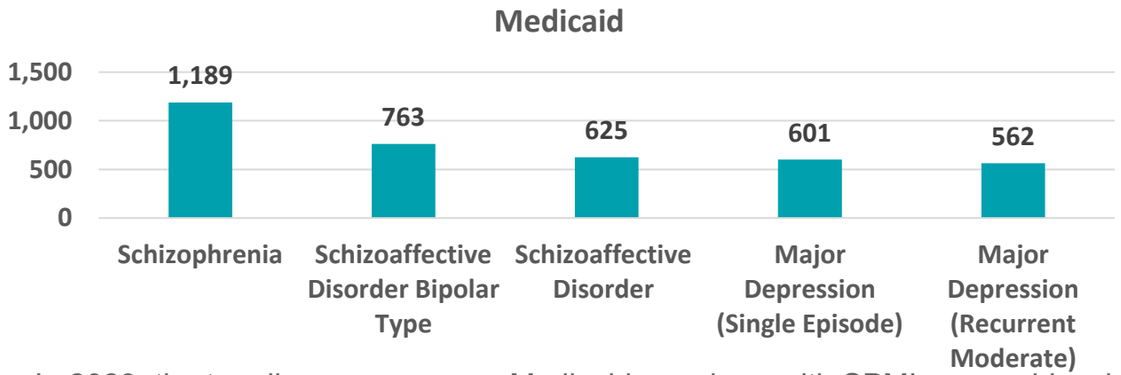
- In 2023, the top diagnoses among Medicare individuals with disabilities were hypertension followed by type 2 diabetes and type 2 diabetes with hyperglycemia.
- Hypertension, type 2 diabetes, and major depression (recurrent moderate) were the top three diagnoses among MMP members in 2022.
- In 2022, the top three diagnosis among all members with disabilities were hypertension, type 2 diabetes and COVID-19.

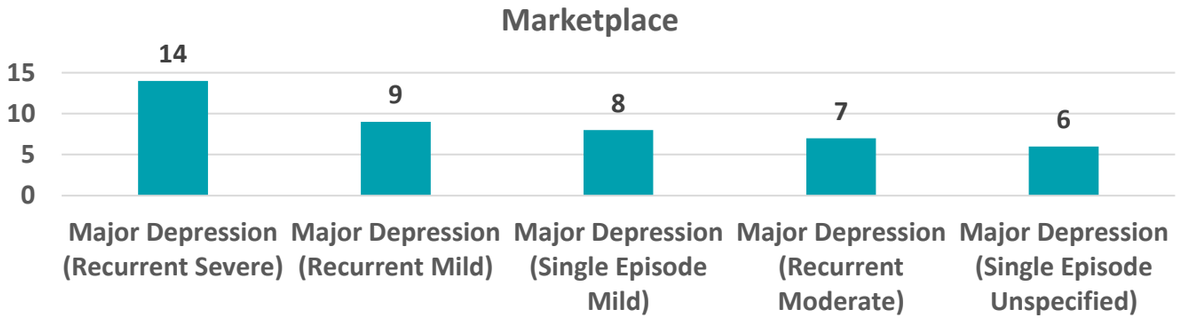
**Membership Data as of 10/10/2023*

MOLINA® HEALTHCARE

California

Diagnosis-Specific Analysis – Individuals with Serious and Persistent Mental Illness (SPMI)





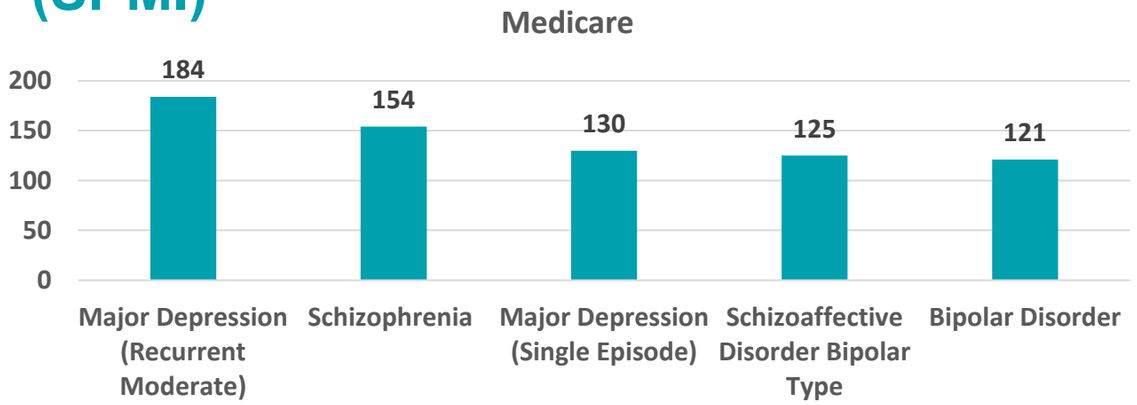
- In 2023, the top diagnoses among Medicaid members with SPMI were schizophrenia, schizoaffective disorder bipolar type and schizoaffective disorder unspecified.
- Top three diagnoses among Marketplace members with SPMI were acute major depression (recurrent severe), major depression (recurrent mild) and major depression (single episode mild).
- In 2022, the top three diagnosis among all members with SPMI were schizophrenia, major depression (single episode) and schizoaffective bipolar type.
- Additionally, Molina collects and monitors data related to members who have behavioral disorders and other chronic conditions. Using HEDIS methodology, Molina analyzes the results for the following measures with the goal of achieving the 67th percentile for Medicaid and 75th percentile for Marketplace based on NCQA's Quality Compass and developing interventions when the goal is not met:

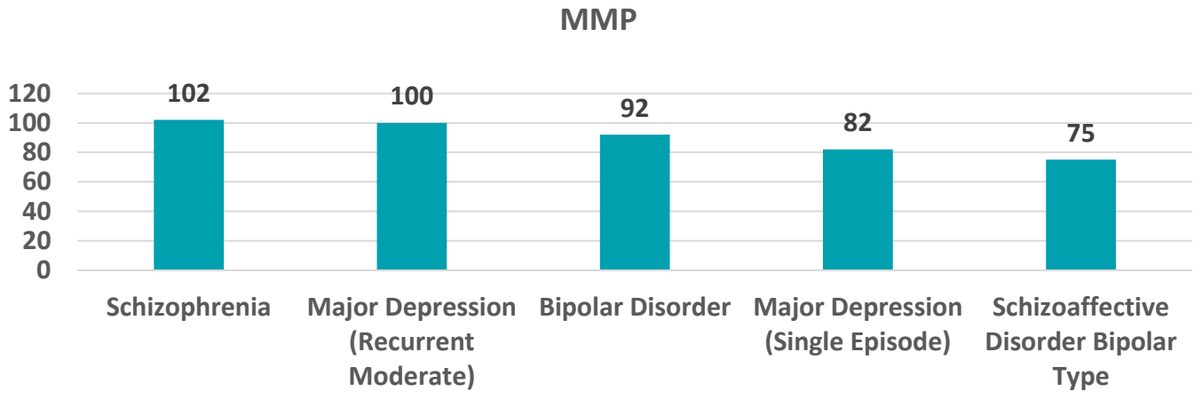
Medicaid and Marketplace HEDIS Measures	Medicaid					Marketplace				
	Numerator	Denominator	Rate	67th Percentile	Goal Met	Numerator	Denominator	Rate	75th Percentile	Goal Met
Antidepressant Medication Management (AMM) – Effective Acute Phase Treatment	2,521	3,632	69.41%	64.17%	Y	263	381	69.03&	81.36%	N
Antidepressant Medication Management (AMM) – Effective Continuation Phase Treatment	1,832	3,632	50.44%	46.74%	Y	198	381	51.97%	63.32%	N

**Membership Data as of 10/10/2023 *MY 2023 Retrospective HEDIS Refresh Date 02/21/2024*

California

Diagnosis-Specific Analysis – Individuals with Serious and Persistent Mental Illness (SPMI)





- In 2023, the top diagnoses among Medicare members with SPMI were major depression (recurrent moderate), schizophrenia, and major depression (single episode).
- Top three diagnoses among MMP members with SPMI were schizophrenia, major depression (recurrent), and major depression (single episode).
- In 2022, the top three diagnosis among all members with SPMI were schizophrenia, major depression (single episode) and schizoaffective bipolar type.
- Additionally, Molina collects and monitors data related to members who have behavioral disorders and other chronic conditions. Using HEDIS methodology, Molina analyzes the results for the following measures with the goal of achieving the 75th percentile based on NCQA's Quality Compass and developing interventions when the goal is not met:

Medicare and MMP HEDIS Measures	Medicare					MMP				
	Numerator	Denominator	Rate	75th Percentile	Goal Met	Numerator	Denominator	Rate	75th Percentile	Goal Met
Antidepressant Medication Management (AMM) – Effective Acute Phase Treatment	141	189	74.60%	84.39%	N	8	12	66.67%	84.39%	N
Antidepressant Medication Management (AMM) – Effective Continuation Phase Treatment	80	189	57.67%	70.21%	N	6	12	50.00%	70.21%	Y

*Membership Data as of 10/10/2023 *MY 2023 Retrospective HEDIS Refresh Date 02/21/2024*

MOLINA HEALTHCARE

California

Diagnosis-Specific Analysis – Members of Racial or Ethnic Groups and Members with Limited English Proficiency

As described in the 2023 CLAS Analysis, Molina annually analyzes clinical performance and member experience measures by race, ethnicity, language, gender and SDOH risk level (as applicable and based on data availability) to determine if health care disparities exist among members. Key findings are included below, and additional detail can be found in the 2023 Molina CLAS Analysis – Health Care Disparities Assessment.

Medicaid

- Compared to English speaking Medicaid members, non-English speaking members had lower rates for Controlling Blood Pressure, Prenatal and Postpartum Care – Timeliness of Prenatal Care and HbA1c Control (<8.0%).
- Compared to White Medicaid members, Black or African American Medicaid members had lower rates for Prenatal and Postpartum Care (PPC) – Postpartum Care, HbA1c Control (<8.0%) and Colorectal Cancer Screening. Compared to White Medicaid members, Black or African American Medicaid members had a higher rate for HbA1c (>9.0%); this is an inverse measure, higher rate indicates lower performance.
- Compared to Not Hispanic or Latino Medicaid members, Hispanic or Latino members had lower rate for Prenatal and Postpartum Care (PPC) – Timeliness of Care.
- Compared to female Medicaid members, Male Medicaid members had lower rates for Controlling Blood Pressure, HbA1c Control (<8.0%), Child and Adolescent Well-Child Visits, Colorectal Cancer Screening and Rating of Health Plan. Additionally, male Medicaid members had a higher rate for HbA1c Poor Control (>9.0%), indicating lower performance compared to female Medicaid members.

Marketplace

- Compared to English speaking Marketplace members non-English speaking members had lower rates for Prenatal and Postpartum Care – Timeliness of Prenatal Care and Colorectal Cancer Screening.
- Compared to White Marketplace members, Black or African American Marketplace members had lower rates for Controlling Blood Pressure, Prenatal and Postpartum Care (PPC) – Timeliness of Care and Postpartum Care, HbA1c Control (<8.0%) and Rating of Health Plan.
- Compared to Not Hispanic or Latino Marketplace members, Hispanic or Latino members had lower rate for Prenatal and Postpartum Care – Timeliness of Prenatal Care, Postpartum Care, HbA1c Control (<8.0%) and Colorectal Cancer Screening.
- Compared to female Marketplace members, Male Marketplace members had lower rates for Controlling Blood Pressure, HbA1c Control (<8.0%), Colorectal Cancer Screening and Rating of Health Plan.

California

Diagnosis-Specific Analysis – Members of Racial or Ethnic Groups and Members with Limited English Proficiency

As described in the 2023 CLAS Analysis, Molina annually analyzes clinical performance and member experience measures by race, ethnicity, language, gender and SDOH risk level (as applicable and based on data availability) to determine if health care disparities exist among members. Key findings are included below, and additional detail can be found in the 2023 Molina CLAS Analysis – Health Care Disparities Assessment.

Medicare

- Compared to English speaking Medicare members non-English speaking Medicare members had lower rate for Controlling Blood Pressure.
- Compared to White Medicare members, Black or African American Medicare members had lower rate for Colorectal Cancer Screening.
- Compared to female Medicare members, Male Medicare members had lower rates for Controlling Blood Pressure, HbA1c Control (<8.0%), Colorectal Cancer Screening and Rating of Health Plan.

Population Assessment Analysis

Summary

In 2023, Molina Healthcare of California's membership was comprised of 643,663 Medicaid (90%), 17,707 Medicare (3%) and 49,883 Marketplace (7%) members. A large proportion of Molina's Medicaid members are between the ages of 2-44 (70%). Members 65 years and older comprise 80% of Medicare membership. Among Marketplace members, 70% are between 35 and 64 years. The largest age group among members with disabilities are females aged 65 or older (63%).

Molina observed that there is a larger proportion of women (52%) compared to males (48%) in the overall member distribution. Medicaid member composition is 52% female and 48% male; the 20+ age groups have a higher proportion of women compared to men. Among the individual subpopulations, there are more Medicaid male children and adolescent (2-19) members (51%) compared to females (49%), while there are more female members with disabilities (53%) compared to males (47%).

According to 2023 CAHPS and QHP data, a larger proportion of Medicaid (73%), Medicare (57%) and Marketplace (62%) members are Hispanic compared to the state overall (40%). Among Medicaid children and adolescents (2-19 years) 58% are Hispanic or Latino and 32% report Spanish as their preferred language. Additionally, a similar proportion of Medicare (40%) report Spanish as their preferred language compared to the state overall (28%).

The top diagnosis by claims count results shows that hypertension end stage renal disease are the most common diagnosis among all lines of business. Additionally, Medicare members have the highest prevalence of SPMI (8%) compared to Medicaid (1%) and Marketplace (0.1%).

Population Health Management Review

Population Assessment Analysis

Impacting Program

Population Health Management Activities and Resources Review

Molina's Integrated Care Management program incorporates condition specific coaching and motivational interviewing to address physical health (hypertension, diabetes and hyperlipidemia), behavioral health needs and other social support services to eliminate fragmentation of care. This integration is achieved by implementing a member directed and, individualized plan of care that is shared amongst all providers active in a member's care. These targeted interventions take into account the member's age, linguistic, and education needs and preferences. The interventions are also aimed at assisting members with navigating care, understanding treatment options, potential interventions, assisting members with self-management and avoiding adverse health outcomes.

Molina has a Health Care Services (HCS) program description that is reviewed annually by an interdisciplinary Healthcare Services Committee. The Healthcare Services Committee is led by a dedicated Medical Director and the Vice President, Healthcare Services, and includes representation from Quality Improvement, Provider Services, Healthcare Services, Operations, and external providers. The committee focuses on reviewing applicable and meaningful programs and reports and assessing programs along with implementing consistent policies and procedures.

Molina conducted extensive research of current literature to identify the factors that increase the likelihood of hospitalization, costly medical expenses, or poor health outcomes for members. Based on this information, Molina updated the criteria that trigger member placement into case management.

Population Assessment Analysis

Impacting Program

Care Coordination/Targeted Case Management/Enhanced Services
Molina's case management program has a program to coordinate health care services provided and/or arranged by the state, such as Targeted Case Management ("TCM"). TCM services are those that assist the member in gaining access to needed medical, educational, social and other services. Although Molina is not responsible for covering TCM services coordinating services with the state avoids service duplication and ensures the member's needs are met through a referral and management process. Referrals are made to providers and agencies for medical education, legal and rehabilitative services and information exchanged to assist in the coordination of care.

Community Connectors
Community Connectors are community health workers trained by Molina to serve as member navigators and promote health within these communities. Community Connectors serve as navigators by providing members with education, advocacy and social support. They are members of the community in which they serve and therefore understand the community's culture, language and norms. They establish relationships with community shelters, churches, adult day programs, soup kitchens, food banks and they work with these agencies to assist members with housing, food, clothing, heating, medication refills, scheduling appointments and transportation needs; obtaining durable medical equipment (DME), financial assistance and maintaining eligibility. This Population Assessment showed 2,912 Molina members experienced homelessness in 2023. Molina will continue to utilize Community Connectors and collaborate with community resource organizations and shelters to locate homeless members, provide referrals to housing resources, and assess for transition of care and other services.

Impacting Program

Health Management/Disease Management
Molina offers individualized self-management, disease management and condition specific coaching to meet the cultural, linguistic and literacy needs of the members. As identified in this report, Molina has a higher proportion of members who are Hispanic/Latino and African American/Black.

Transition of Care (ToC)
Molina's ToC Program is designed to improve the quality of care while containing utilization costs for members admitted to the hospital. The program closely follows the members most at risk for hospital readmissions by identifying specific diagnoses and other case determinants most correlated with readmissions. ToC provides a high level of support and intervention for members from the time of their identification, as early as their admission to the hospital, and follows them across transitions. Molina's ToC Coach/Case Manager identifies opportunities to conduct face-to-face visits in hospital/nursing facility settings and during each transition setting, as necessary. Assessment for face-to-face visits is based on member's clinical acuity and cultural, linguistic, literacy needs and preferences that may adversely impact their health status.

ToC Five Core elements: Assessment of Health Status, Medication Management, Follow-Up Care, Nutrition Management (including referral for access to adequate nutrition and available community resources), Coordination of post discharge services (including referral to community resources, such as shelters and housing programs).

Population Assessment Analysis

Impacting Program

BH Transition of Care and Follow-up after Hospitalization

Molina identified 9,760 members diagnosed with SPMI through the population assessment analysis. Member noncompliance with recommendations for ongoing aftercare follow-up is a major predictor of rehospitalization. To improve the likelihood that a member will initiate and continue outpatient treatment after an admission, ToC Coaches, including BH clinicians who utilize standard Molina practices, ensure members have their initial outpatient appointment within the first seven (7) days of discharge. When appropriate, more immediate outpatient follow-up is initiated. ToC Coaches visit members in the hospital whenever possible and contact members post discharge to facilitate a second follow-up visit within 30 days of discharge.

Culturally and Linguistically Appropriate Services

Molina's goal is to ensure that culturally and linguistically appropriate services (CLAS) are provided across the health care continuum to reduce health disparities and improve health outcomes. Examples of CLAS activities include:

- Language access services (oral interpreting by trained and qualified interpreters, American Sign Language, access to telephonic interpreter services, member materials translated into alternative languages and made available in alternate formats).
- Member materials written using Plain Language guidelines and content at a sixth-grade reading level or lower.
- Ongoing cultural competency staff and provider trainings.

Population Assessment Analysis

Impacting Program

Community-based Resources and Interventions

Molina's Case Managers assess for formal and informal support needs to address the cultural, linguistic, literacy needs and preferences that may adversely impact member's health status. Examples of these formal and informal resources that may be accessed include:

- Apartments for senior citizens
- Catholic Charities
- Center for Accessible Living (for home repairs, modifications & ramps)
- Community food banks, Meals on Wheels, emergency food assistance
- Community Mental Health Centers
- Community Ministries (for clothing, shelter, utilities)
- Cooper/Clayton Smoking Cessation Program
- County Health Departments (for utility assistance, food stamps, food assistance, health education classes, clinic services)
- HIV/AIDS Support Services
- Legal Aid
- LIHEAP (Low Income Home Energy Assistance Program) (subsidy and crisis assistance program for home energy assistance)
- Senior and Community Centers
- Services for the Blind
- Services for deaf & speech disabilities
- Support groups, e.g., American Lung Association; American Heart Association; American Diabetes Association; American Cancer Association
- The Homeless Coalition
- Transportation, including hearing impaired bus service

Population Health Management Activities and Resources Review

Activities/Resources	Member Needs Addressed	Additional Activities	Adequate Activities/ Resources (Y/N)
Care Coordination/ Case Management/ Enhanced Services	Top conditions such as chronic pain, hypertension and COPD; homeless members referred to housing resources, community partnership referrals - available to all age groups	N/A	Y
Community Connectors	Members in need of social supports, cultural, linguistic and literacy needs of members; available to all age groups	N/A	Y
Health Management/ Disease Management	Top conditions such as hypertension and diabetes; cultural, linguistic, literacy needs of members; available to all age groups	N/A	Y
Transition of Care	Top conditions such as hypertension and COPD; referrals to community resources and housing resources as needed; available to all age groups	N/A	Y
BH Transition of Care and Follow-up after Hospitalization	Top conditions such as major depression; referrals to community resources and housing resources as needed; available to all age groups	N/A	Y
Culturally and Linguistically Appropriate Services	Unique cultural, linguistic and literacy needs of members as identified through the population assessment	All staff will be required to complete a series of two Cultural Competency and Health Equity trainings in Q4 2021 and annually thereafter.	Y
Community Partnerships	Members with disabilities, members in all age groups with specific resources geared to older age groups, members with SPMI and substance abuse, homeless members, members with unique cultural, linguistic and literacy needs.	Molina continues to assess and identify available community partnerships based on members needs.	Y

Impacting Program (California)

Care Connections

- Care Connections is a team of nurse practitioners and social workers who can help manage member health.
- Care Connections visits members to learn about health needs. Care Connections gives members an Annual Comprehensive Exam (ACE) to take vital signs, check hemoglobin A1c and a diabetic retinal exam (if the member has diabetes), talk about current health conditions, medicines and help decide what is needed on an ongoing basis.
- Care Connections will visit in home, an assisted living facility, senior living community or nursing home. Care Connections can also do a video visit if the member has a smart phone or computer. Video assessment allows members to see and talk to a nurse practitioner in real time.
- Aunt Bertha is a resources Care Connections utilizes to connect members to community resources.
- Molina Help Finder is a one-stop shop for finding low-and no-cost community resources when you need them. Search for services using MolinaHelpFinder.com and My Molina.com. Members can search for help and services to meet basic needs like:
    - Food, Housing, Transportation, Health, Job training, Childcare, Education, Work, Legal

In 2023, Care Connections completed a total of 20,874 Medicaid, 6,998 Marketplace, 11,181 Medicare and 11 MMP member visits for the state of California.

Population Health Management Activities - Medication Adherence CCIP (California)

Project Aim:

To use a patient-centric coaching model and care coordination to improve diabetes medication adherence. Specific Star rating goals are identified for each health plan to show improvement from baseline/annual results as measured by Acumen data using the Stars Medication Adherence for Diabetes Medication measure. Achieving these goals will assist members with diabetes, those most at risk of non-adherence receive the necessary follow-up care. We also propose that successful treatment of diabetes will translate into improved health endpoints for other chronic conditions (and decreased healthcare utilization) in the intervention group.

Focus Population:

California's Medicare members with a diabetes diagnosis at risk of non-adherence.

Population Health Management Activities - Medication Adherence CCIP (California)

Interventions:

Upon eligibility for the Stars Medication Adherence for Diabetes Medication measure, the Molina Pharmacy team conducts telephonic outreach to provide a high-touch intervention with member-centric coaching aimed at barrier identification and resolution.

- Member interviews are personalized to identify unique member barriers and resolutions.
- Members receive three call attempts on different days and times.
- After successful call attempts letters are mailed to the member to summarize the call, medications, barriers, and solutions.
- The pharmacist refers interested members to the Case Management Program for additional coaching and follow-up care.
- If applicable, the pharmacist aims to get 90-day fills and/or mail order/delivery.
- Assistance with scheduling appointments, transportation, and pharmacy outreach is also provided.

The aim of this intervention is to reduce barriers to increase medication adherence.

Next Steps

The population assessment assists Molina in stratifying its entire population and the development of appropriate targeted interventions to address the needs of each of the subsets. Molina will review the analysis to identify additional needs of our members, including any potential opportunities to improve our existing programs.

- Molina will continue to collect data on and assess member characteristics and needs and adjust resources provided to members as needed.
- Molina will continue to implement population health management initiatives and provide needed resources to staff and providers.
- Molina will continue to revamp and produce new cultural competency training resources for staff and providers.

Detailed Methodology – Internal Data

Population Assessment – Internal Data Methodology

MEMBERSHIP REPORT

Membership Identification

Members are identified from the QNXT reporting database. We identified all members who were enrolled with Molina Healthcare as of October 9th, 2023, during the period the report covers. We did not remove/exclude any member for any reason.

Member Programs:

- MMP
- Marketplace
- Medicare
- Medicaid

For example:

- Los Angeles MMP – MHC → MMP
- Molina Marketplace Program → Marketplace
- Los Angeles – SPD –MHC → Medicaid
- Molina Medicare → Medicare

Population Assessment – Internal Data Methodology

MEMBERSHIP REPORT (Continued)

Hispanic Ethnicity

- If members ethnicity = 'HISPANIC', then set to 'Hispanic or Latino'.
- If member ethnicity is 'UNKNOWN', 'CHECK ETHNICITY', 'NO ETHNICITY', or 'REFER TO MEMO', then set to 'UNKNOWN'.
- Otherwise, ethnicity set to 'Not Hispanic or Latino'.

Language Spoken

- Member language was set to English, Spanish or Other. If member's primary language is other than English or Spanish, we set to 'Other'.

Member County

- If member county was blank or set to 'random' numbers, then member county was set to 'Unknown'.

Population Assessment – Internal Data Methodology

MEMBERSHIP REPORT (Continued)

Member Indicators

Multiple Moves

Identified members, in a given year, which had more than 2 unique addresses. We considered addresses with unique Street Number, Suite Number, and Zip Code.

Homeless Member

Identified members that had one of the following:

- QNXT Physical Address set to Homeless
- Member with CCA Concept of Homeless (Concept ID 504602 w/ Str 1)
- Member with CCA Case with Homeless description

Nursing Home

Identified members that had one of the following:

- Member with CCA Concept of Nursing (Concept ID 504602 w/ Str 4)
- Member with CCA Case with Nursing description

Group Home

Identified members that had one of the following:

- Member with CCA Concept of Group Home (Concept ID 504602 w/ Str 3)
- Member with CCA Case with Group Home description

Population Assessment – Internal Data Methodology

Disability

- Identified members with a CCA Concept for disability. Concepts included '503353', '503349', '508463', and '515779'.

SPMI / Mental Health / Dementia / Alzheimer's / Chronic Conditions

- SPMI / Mental Health / Dementia / Alzheimer's / Chronic Conditions are based on claim diagnoses. We reviewed all claims for the given year which were in 'OPEN', 'PAID', and 'PAY' status with no resubmission. Then cross-walked the diagnostic codes below to determine if member had any of the conditions.

PROVIDER REPORT

Provider Identification

Providers are identified from the QNXT reporting database. We identified all providers who had an active affiliation and contracted with Molina for a minimum of 1 day during the period the report covers. We only included providers with the following specialties:

- PCP – Internal Medicine
- PCP – Family Practice
- PCP – Pediatrician
- PCP – General Practice
- OB/GYNs
- Cardiologists
- Endocrinologists
- Pulmonologists
- Nephrologists
- Oncologists

Population Assessment – Internal Data Methodology

PROVIDER REPORT (Continued)

Language Spoken

- Provider language was set to English, Spanish or Other. Data collection methods may impact this percentage because many providers do not have any language loaded in QNXT, or they list only list non-English Languages. If member's primary language is other than English or Spanish, we set to 'Other'.

Claims Report

- We included all claims for the given year which were in 'PAID' and 'PAY' status with no resubmission.