



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

Richard Chambers, President
Molina Healthcare of California Partner Plan, Inc.
200 Oceangate, Suite 200
Long Beach, CA 90802

RE: Department of Managed Health Care 1115 Waiver Seniors and Persons with
Disabilities Enrollment Survey

Dear Mr. Chambers:

The Department of Managed Health Care conducted an on-site enrollment survey of Molina Healthcare of California, a Managed Care Plan (MCP), from September 16, 2013 through September 19, 2013. The survey covered the review period of June 1, 2012, through May 31, 2013.

On March 3, 2014, the MCP provided the Department of Healthcare Services (DHCS) with a response to its Corrective Action Plan (CAP) originally issued on January 27, 2014.

All remaining open items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS's final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, contact Mr. Edgar Monroy, Chief, Plan Monitoring Unit, at (916) 449-5233 or CAPMonitoring@dhcs.ca.gov.

Sincerely,

Originally Signed by Nathan Nau

Nathan Nau, Chief
Medical Monitoring and Program Integrity Section

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Enclosure:

cc: Emily-Crescenciana Bautista, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

bcc: Edgar Monroy, Chief
Plan Monitoring Unit
MS 4417

Michael Pank, Analyst
Plan Monitoring Unit
MS 4417

CORRECTIVE ACTION PLAN

1. Plan Name: Molina Healthcare of California

2. Review Type: SPD Enrollment Survey

3. Review Period: 6/1/12 – 5/31/13

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	7. DHCS Comments
I. UTILIZATION MANAGEMENT			
<p>Deficiency #1 The Plan does not have utilization review mechanisms in place that allow for monitoring of its delegates for potential under and over-utilization of services. <i>Rule 1300.70(b)(2)(H); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 5, Utilization Management, Provision 1(F) – Utilization Management Program.</i></p>	<p>Molina will establish the following utilization review process to monitor delegates for potential over/underutilization of services: The monthly Denial Report submitted by the delegated medical group will be modified to expand review of denial by category. The two categories will be Administrative Denials and Medical Necessity Denials. Medical Necessity Denials will be reviewed and analyzed quarterly for appropriateness by a Molina Medical Director using a 10 or 10% sampling methodology. Administrative denials will be reviewed in the same fashion for appropriateness. A benchmark for rate of overturn will be established, and the findings will be analyzed for over and underutilization based on overturn rate of denials.</p> <p>The monthly Unused Authorization Report will be modified to analyze unused authorizations by specialty type. A benchmark will be established for unused authorizations. In addition, the delegated group will be required to include documentation of their efforts to reach out to the member and ensure completion of the requested service.</p> <p>The Utilization Management (UM) Delegation team, in collaboration with a Molina Medical Director, will review the data collected and identify possible over/underutilization issues, deficiencies in coordination of care, or barriers to access to care. A corrective action plan CAP will be developed and issued to the delegated group. The findings and CAP progress will be reported quarterly at the UM Committee meeting, and the Quality Improvement (QI) committee meeting for review and possible escalation if the delegated group is not meeting requirements.</p> <p>Supporting Documentation:</p> <p>1.1 Final 2014 UM Audit Tool 1214 1.1 Final 2014 Monthly Tracking Log</p>	<p>By 4/15/14: Identified Reporting logs and the reporting format of data will be developed and submitted to the MALT and UM/QI committee for approval.</p> <p>By 5/1/14: Benchmarks for rate of denial over turn and unused authorizations will be established and approved by the UM and QI committee.</p> <p>Responsible Party: Dr. James Cruz, CMO</p> <p>By 5/1/14: UM tracking logs, UM audit tools, the Monthly Report Submission Matrix, and the reporting format of data will be modified and submitted to the UM/QI committees for approval on or before 6/1/14. A review of industry or state data for high performing medical groups will be used to establish benchmarks for denial rate, rate of denial over turn, and rate of unused authorizations. The recommended benchmarks</p>	<p>This deficiency remains open. To achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> • Copy of the latest monthly unused authorization report that incorporates noted modifications. <p>Update 6/20/14;</p> <p>The MCP submitted a modified unused authorization report that includes specialty type. However, there is no indication that the MCP has established benchmarks for unused authorizations or documentation of efforts to reach out to members to ensure completion of requested services.</p> <p>DHCS requests the MCP submit an example of a modified monthly denial report that includes administrative denials and medical necessity denials. MCP to include the established benchmark for rate of overturn and resultant</p>

	<p>1.1 Report Submission Matrix 2013</p> <p>Plan Response 9/12/14:</p> <p>Molina Healthcare Corporate leadership has extensive Medicaid managed care experience which was used to establish targets that they believe should be achievable by a well-managed health plan. The corporate targets were customized to reflect the specific Molina Healthcare of California member risk profile (age/sex and the acuity as measured by the Chronic Illness and Disability Payment System (CDPS) for the ABD population).</p> <p>In addition, for the TANF population only, actual utilization was compared to Milliman benchmarks. Milliman benchmarks reflect the collective experience of multiple Medicaid managed care plans operating in multiple states. They are presented as a range –the low end is referred to as “well managed” and is designed to reflect the highest levels of care management observed in the US; the high end is referred to as “loosely managed” and represents results expected without health plan management of provider utilization practices. For the purpose of this comparison, the benchmarks were adjusted to reflect the Molina Healthcare of California member risk profile (age/sex). These reports are updated quarterly.</p> <p>August authorization report submitted via separate secure email</p>	<p>will be submitted for approval at the UM committee and QI committee by 6/1/14.</p> <p>Responsible Party: Dr. James Cruz, CMO</p>	<p>analysis.</p> <p>9/22/14:</p> <p>The MCP has submitted established benchmarks adjusted to reflect the MCP’s California member risk profile. The MCP also submitted the August Enrollment Survey.</p> <p>This deficiency is closed.</p>
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<p>Deficiency #2 The Plan does not consistently ensure that denial letters include a clear and concise explanation of the reasons for the plan's decision. <i>Section 1367.01(h)(4); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorization and Review Procedures; and DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 13, Member Services, Provision 4(C) – Written Member Information.</i></p>	<p>To ensure that denials are appropriate or represent consistently applied criteria, Medical Directors were re-trained on denial language. The training covered National Committee Quality Assurance (NCQA) criteria for denial language to include: Simplifying denial language, citing the correct decision criteria, providing detail around why criteria were not met, and reminding patients about consulting with their physicians about other healthcare options. Quarterly audits were completed. These included 10 approved and denied cases per Medical Director to ensure appropriate selection and application of criteria. The 2014 Inter-rater reliability testing will be completed March 31, 2014 and reported to the quarterly Utilization Management Committee (UMC) and Quality Improvement Committee (QIC) meetings.</p> <p>Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include process and policy revisions include: P&P: QM 50</p> <p>Corrective action includes process improvements developed to ensure that all denial letters include a clear and concise explanation of the reasons for the plan's decision.</p> <p>The new QI Policy, QM - 50 Quality Improvement Monitoring, defines semiannual interdepartmental monitoring of compliance with MHC policies that will ensure adherence to standards and guidelines, including, but not limited to, the appropriate handling of the following: UM Denials, UM Appeals, Accepted PQOC's and Grievances MHC Focused Medical Record Review Audits</p> <p>The audit will review a sample based on the 8/30 NCQA Sampling Methodology rule.</p> <p>A sample size of 30 is a valid sample size when trying to determine if the null hypothesis can or cannot be rejected. In this case, we are looking to determine if the physician is or is not in compliance. The null hypothesis is that they ARE in compliance. A sample size of 30 is sufficient to prove or disprove this hypothesis. When testing the null hypothesis, a sample of 8 is a valid sample size when the 8 pieces of sample are randomly selected and are the initial 8 surveys completed. The results for those 8 must be identical either proving or disproving the null hypothesis.</p>	<p>Medical Director retraining completed in August 2013.</p> <p>Quarterly audit completed in December 2013 by Dr. Baharieva</p> <p>Next quarterly audit scheduled for 3/31/14</p> <p>The Inter-rater reliability testing will be completed by 3/31/14.</p> <p>Responsible Party: Dr. James Cruz, CMO</p> <p>Initiated remedial action: Developed P&P 2/10/14.</p> <p>Long Term ongoing monitoring of corrective action includes: Develop QM Audit Tool 2/25/14.</p> <p>Present to Senior Leadership Team and stakeholders 3/4/14.</p> <p>Acceptable level process implementation 4/1/14.</p> <p>Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency utilizing the 8/30 sampling methodology.</p>	<p>Medical Directors were re-trained on denial language and the training covered NCQA criteria for denial language. The MCP has begun to implement quarterly audits to ensure appropriate language was applied.</p> <p>This deficiency remains open. To achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> • The results of the quarterly audit scheduled for 3/31/14. • Submit five sample initial denial letters utilizing NCQA criteria for denial language. <p>Update 6/20/14;</p> <p>The MCP submitted five sample denial letters utilizing NCQA criteria for denial language that provided clear and concise explanations for the reasons for the decisions.</p> <p>DHCS requests that the MCP submit the results of the quarterly audit of 3/31/14.</p> <p>Update 9/22/14:</p> <p>The MCP submitted quarterly medical director audit – see attachment.</p> <p>This deficiency is closed.</p>
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A sample size of 30 is valid using the appropriate formula and the critical value of K is $1.36/\sqrt{30}=.248$. Because the calculated value of K is smaller than the critical value, the null hypothesis cannot be rejected. Alternatively, the probability of observing a K value of .222, as determined by the normalized z statistics, is .103. Because this is more than the significance level of .05, the null hypothesis cannot be rejected, leading to the same conclusion. (Source: Malhotra, Naresh K and David F. Birks, Third European Edition Marketing Research an Applied Approach. Pearson Education Company. Prentice Hall Inc. 2007.)

NCQA provides the following explanation for the sampling methodology in its May 1, 2001 memo titled "Explanation of '8 and 30' File Sampling Procedure" <http://www.ncqa.org/tabid/125/Default.aspx>

"The statistical test underlying the ["8/30"] classification decision is based on the binomial distribution, the characteristics of which are very well known. This fact allows the classification decision to be based on a very small sample of 30 files, regardless of the size of the population of eligible records. The use of the binomial distribution is possible because the decision based on the 8 and 30 file sampling methodology is BINARY. That is, the decision based on the file review falls into one of two possible categories ("in compliance"/"out of compliance")." As such, there is no statistical difference between an outcome using the 8/30 sample methodology vs. a 50 sample size.

An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported to Quality Improvement Committee (QIC) quarterly.

- Supporting Documentation:
- I.2: QM 50
 - I.2: 8/30 Methodology NCQA
 - 1.2 MD Denial Training
 - 1.2 MD audit tool
 - 1.2 2014 IRR training

Plan Response 9/12/14:

Molina submits the Q1 Medical Director Audits

II. CONTINUITY OF CARE

Deficiency #3
The Plan does not ensure that its primary care providers review the individual health education behavioral assessment tool (IHEBA) at least annually with each member.

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 10, Scope of Services, Provision 8(A) (10) – Services for All Members.

Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include:
 Implementation of a Focused Medical Record Review (MRR) Audit and Monitoring Process.

MRR tool is inclusive of the elements to address medical records deficiencies such as documentation of IHEBA or Staying Healthy Assessment (SHA), a critical criteria for both child and adult preventive care. A subsequent assessment and annual SHA re-administration according to updated SHA policy will be recorded in the tool. These audits will be tracked and reported.

The MRR audit will be executed through a random medical record review process stratified by high volume providers based on enrollment of Molina Healthcare Members. The audit will review a sample based on the 8/30 National Committee Quality Assurance (NCQA) Sampling Methodology rule. See methodology description: 8/30 Methodology.

If a provider office is found to be out of compliance based on the 8/30 review, a corrective action plan CAP will be given to the provider office. The provider/provider office will have 30 business days to submit the CAP to the QI Department.

Upon acceptance of the CAP, the provider will be entered back into the random sample pool for further review by the QI Compliance team.

The audit will be conducted by Facility Site Review (FSR) nurses who are trained and certified by DHCS.

An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported quarterly to Professional Review Committee (PRC).

Providers failing to comply with the completion of the CAP will be reported to the PRC for recommended action.

Molina ensures that all contracted primary care providers are properly trained with the updated DHCS SHA policy and monitor their compliance.

Molina will provide a comprehensive SHA provider training via webinar to demonstrate how to use the new SHA form.

Initiated remedial action:
 Developed P&P 2/10/14.
 Develop Audit Tool 2/14/14.

Long Term ongoing monitoring of corrective action includes:
 Approval of audit tool 4/9/14 at the Clinical Quality Management Committee.

Training of QI staff 3/3-14/14.

Pilot audit tool 3/17 - 3/31/14.

Acceptable level process implementation 4/1/14.

Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency utilizing the 8/30 sampling methodology.

Responsible Party:
 Dr. James Cruz, CMO

The MCP has implemented a focused medical record review auditing process. The audit will address medical record deficiencies.

This deficiency remains open. To achieve compliance, the MCP must submit:

- A copy of the audit tool as approved by the Clinical Quality Management Committee.
- A copy of the latest MMR Audit results.

Update 6/20/14;

The MCP submitted a copy of the Medical Record Review (MRR) audit tool attached to revised P&P QM 53.

DHCS requests MCP to submit latest MMR audit results that addresses whether PCPs are reviewing IHEBA with members annually.

9/22/14:

MCP submitted MMR audit addressing PCPs and the review of IHEBA.

This deficiency is closed.

	<p>Training attestation and signature is required for all attendees.</p> <p>Ongoing provider education and reinforcement SHA completion by Provider Services during quarterly provider on site visit.</p> <p>Ongoing provider education is conducted by FSR review nurses during focused reviews, periodic and initial scheduled audits.</p> <p>Provider communication (Just the Fax) will be sent out on an annual basis reminding providers of this contractual obligation.</p> <p>Supporting Documentation: II.3: QM 50 II.3: HE-17 II.3: Focused MRR Tool II.3: 8/30 Methodology NCQA II.3: IHA Timeline Clarification II.3: SHA Provider Training II.3: SHA Attestation/Sign-in Form</p> <p>Plan Response 9/12/14</p> <p>Molina submits the Q3 Interim July/ August MRR Audit</p>		
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III. AVAILABILITY & ACCESSIBILITY OF SERVICES

<p>Deficiency #4 The Plan does not have a mechanism to ensure that the first prenatal visit for a pregnant member will be available within two weeks of request. <i>Rule 1300.67.2(f); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provision 3(B) – Access Requirements.</i></p>	<p>Actions taken by the Quality Improvement QI Department to ensure correction of the deficiency include: The annual Provider Access and Availability Survey and policy and procedure (P&P) QM 09 Access to Health Care have undergone revision. Custom questions for high volume OB/GYNs have been developed to assess the availability of the first prenatal appointment within two weeks of the request.</p> <p>Providers failing to comply with availability of the first prenatal appointment within two weeks of the request will be reported to the Professional Review Committee (PRC) for recommended action.</p>	<p>Initiated remedial action: Developed P&P 2/10/14.</p> <p>Long term ongoing monitoring of corrective actions includes: Draft Provider Access survey tools due from NCQA accredited vendor 2/19/14.</p> <p>Approval of policies 2/27/14 at the QI Committee meeting.</p>	<p>The MCP submitted a revised P&P QM-09 that indicates the first prenatal care visit is within five business days of the request.</p> <p>This deficiency remains open. To achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> Initial results of the provider access and
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	<p>The new Motherhood Matters Healthy Baby & Me program initial assessment will include a question to confirm the availability of the first prenatal appointment within two weeks of the request.</p> <p>Supporting Documentation: III.4: QM-09 III.4: Motherhood Matters Description</p> <p>Plan Response 9/12/14:</p> <p>The complete 2014 Provider Access Appointment Availability and After Hours Survey is submitted for review. Additionally, a 2014 Access Survey Report – OB/GYN First Prenatal Appointment Availability is submitted for review. 95.52% (128/134) of OB/GYN practitioners surveyed were in compliance with the Access standard addressing access to availability of the first pre-natal visit within two weeks of request. This rate met the goal rate of 85%.</p> <p>The results of the 2014 Access Survey Report – OB/GYN First Prenatal Appointment Availability will be presented at the September 22nd Professional Review Committee.</p> <p>The 6 practitioners who failed to meet this standard will be sent individually tailored corrective action plan (CAP) letters to include evaluation findings and necessary implementations for improvement and compliance with availability of the first pre-natal visit within two weeks of request. CAPs require signature from the applicable practitioner/provider or office representative/manager acknowledging and agreeing to adhere to MHC’s Access Standards.</p>	<p>Acceptable level process implementation: Provider Access & Availability/After Hours Survey administered 3/15 - 5/15/14.</p> <p>Final Survey Report to plan 6/15/14.</p> <p>Final Survey Report analysis and comparison with CAHPs and grievance data completion by 6/30/14.</p> <p>Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency through analysis and CAP provider monitoring.</p> <p>Responsible Party: Dr. James Cruz, CMO</p>	<p>availability /after-hours survey administered 3/15/14-5/15/14.</p> <ul style="list-style-type: none"> • P&P QM-09 must be revised to reflect contractual requirements in Exhibit A, Attachment 10, Provision 5.A (1) and (2) which outlines the provisions for IHAs for members under the age of 18 months and for members 18 months of age and older. <p>Update 6/20/14;</p> <p>P&P QM-09 reflects the contractual requirements regarding the provision of IHAs for members 18 months old and younger.</p> <p>DHCS requests the MCP to submit results of latest provider access and availability survey addressing access to availability of the first pre-natal visit within two weeks of request and status of any providers reported to the Professional Review Committee for failing to comply.</p> <p>Update 9/22/14:</p> <p>MCP submitted provider access and availability survey. 95% of providers audited met</p>
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			<p>the stated goal of a pre-natal visit within two weeks. The providers who did not meet the standard were given individual CAPs.</p> <p>This deficiency is closed.</p>
<p>Deficiency #5 The Plan does not take appropriate and effective corrective action to ensure that individual physicians and/or provider groups meet appointment availability and after-hours standards. <i>Rule 1300.67.2.2(d)(2)(A); Rule 1300.70(a)(1) and (3); and DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provisions 3 – Access Requirements, and 4 – Access Standards.</i></p>	<p>Actions taken by the Quality Improvement Department to ensure correction of the deficiency including process and policy revisions include:</p> <p>Revisions to Policy and Procedure P&P QM 09 Access to Health Care</p> <p>Revisions to P&P: QM 01 Potential Quality of Care (PQOC)</p> <p>Revisions to Annual Provider Access and Availability Survey</p> <ul style="list-style-type: none"> o The survey revisions include custom questions which will allow the QI team to accurately assess the availability of appointments and after hours care. o Corrective action and ongoing monitoring of the deficiency will include the use of the annual Provider Access and Availability Survey (conducted by NCQA accredited vendor) results. o Results will be reviewed by QI Staff and presented to all functional health plan areas during the Clinical Quality Improvement Committee (CQIC)/ Quality Improvement Strategic Committee (QISC) and reported to Quality Improvement Committee (QIC). o The review will analyze and compare the results of the annual Provider Access and Availability Survey with these additional monitors: <ul style="list-style-type: none"> Annual CAHPs member survey, Mid-year Mini-CAHPS results, New Post Appointment Survey (member experience with recent appointment), Access related Grievances, and Access related PQOC issues as noted in the revision of P&P: QM 01 Potential Quality of Care. <p>Ongoing monitoring will be through administering a Corrective Action Plan (CAP) process described in policy and procedure QM-09. This process has been implemented as of Q4 2013.</p>	<p>Initiated remedial actions which include: Implemented CAP to providers who did not meet contractual requirements Q4 2013.</p> <p>CAP implementation as of 12/15/13.</p> <p>Revised P&Ps 2/10/14.</p> <p>Long term ongoing monitoring of corrective actions includes: Draft Provider Access survey tools due from NCQA accredited vendor 2/19/14.</p> <p>Approval of P&Ps 2/27/14 at the QI Committee meeting.</p> <p>Acceptable level process implementation: Provider Access & Availability/After Hours Survey administered 3/15 - 5/15/14.</p> <p>Final Survey Report to plan 6/15/14.</p> <p>Final Survey Report analysis and</p>	<p>The MCP utilizes a vendor to conduct annual provider appointment and after-hour availability surveys.</p> <p>Revisions to P&P QM 09 indicate providers identified as non-compliant are issued a corrective action plan with detailed information about the elements that they failed to meet and how to make corrections.</p> <p>This deficiency remains open. To achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> • Documentation of providers not meeting contractual requirements and initiated CAPS – Q4 2013. • Documentation of a CAP and subsequent follow up on a provider who did not meet the contractual requirements Q4 2013.

	<p>All noncompliant providers (those who failed the Access and Availability Survey) are faxed detailed information about the elements that they failed to meet. They are provided with information about how to make corrections.</p> <ul style="list-style-type: none"> o CAPs must be completed and returned to the Plan within 30 business days. o Providers failing to comply with the completion of the CAP will be reported to the Professional Review Committee PRC for recommended action. <p>Ongoing monitoring will be conducted during Focused Medical Record Review (MRR) Audit and the Quality Improvement Monitoring Audit Process.</p> <p>Other functional areas are working with QI staff include Provider Services.</p> <ul style="list-style-type: none"> o Provider Services is assisting in follow-up of providers who received CAPs. <p>Supporting Documentation: III.5: QM-09 III.5 QM 01 PQOC III.5: QM 01 PQOC Redline III.5: QM 50</p>	<p>comparison with CAHPs and grievance data completion by 6/30/14.</p> <p>Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency.</p> <p>Responsible Party: Dr. James Cruz, CMO</p>	<p>Update 6/20/14;</p> <p>The MCP submitted documentation depicting the number of provider surveys conducted and CAPs initiated; along with number of outstanding CAPs.</p> <p>The MCP submitted a sample CAP and subsequent follow up relating to a provider that failed access to specialists within 24 hrs.</p> <p>This deficiency is closed.</p>
<p>Deficiency #6 The Plan does not have sufficient specialists to serve its Medi-Cal members, including its SPD members, in Sacramento County. <i>Rule 1300.67.2 (e); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provision 1 – General Requirement.</i></p>	<p>Although the reviewers did not provide evidence that the members couldn't access services, the Plan does arrange for necessary specialists on a case-by-case basis through individual Letters of Agreement in cases where contracted specialists are not available. Furthermore, the Plan has since contracted with a Colon-Rectal Surgeon and Rheumatologist; and is in the midst of contracting with an Oral Surgeon, and a second Colon-Rectal Surgeon. The Plan already had a contracted with a Therapeutic Radiologist but the Q1 2013 report reviewed by the auditors was incorrect and subsequently corrected for the Q3 2013 Access and Availability Committee meeting.</p>	<p>Responsible Party: James Novello, COO</p>	<p>DMHC reported that the MCP did not have any contracts with the following specialists: oral surgeons, colorectal surgeons, radiology, therapeutic or geriatricians and the MCP only had one specialist for each of the following specialties: dermatology, rheumatology, genetics and emergency medicine.</p> <p>The MCP has since contracted with multiple new specialists for the service area and has letters of agreement to arrange for necessary specialists on a case-by-case</p>

			<p>basis where contracted specialists are not available.</p> <p>This deficiency is closed.</p>
<p>IV. MEMBER RIGHTS</p>			
<p>Deficiency #7 The Plan does not implement and maintain a grievance system that consistently includes: - an adequate appeals process to ensure that clinical issues are resolved by an identified licensed health care professional who has not participated in any other prior decisions related to the grievance, and that the rationale for the decision is clearly documented; and - an adequate intake process to ensure that inquiries and expressions of dissatisfaction are appropriately documented and identified. <i>Section 1367.01(e); Section 1368(a)(1); Rule 1300.68(a)(1); Rule 1300.68(d)(8); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 2(D) and (G)(1)(2)(3) – Grievance System Oversight.</i></p>	<p>The following actions have been taken by the Quality Improvement (QI) Department to ensure correction of the deficiency: Potential Quality of Care (PQOC) tools and resources to be used for training Customer Support Center (CSC) staff, Healthcare Services, Appeals and Grievance (A&G) unit and other Molina departments is currently in development.</p> <p>QI Department will collaborate and work with Directors in every department to provide a PQOC presentation and ongoing training.</p> <p>Revised policy and procedure P&P QM 01- Potential Quality of Care to improve process and ensure that grievances are accurately and consistently identified.</p> <p>Restructured severity level system to provide category guidelines for each severity level that will effectively track and trend all individual cases and systemic trends including severity levels, case categories and review timeframes which are reported to Clinical Quality Improvement Committee CQIC.</p> <p>QI established a two-tiered review process to ensure that all PQOC issues and grievances are appropriately identified and investigated. The LVN reviews 100% of grievances at the 1st level. The 2nd level RN reviews and validates all grievances reviewed at the 1st level.</p> <p>Additional action items: The Plan's P&P UM 67 was revised on 2/19/14 to state: "The MHC Medical Director's designee, a board certified specialist of the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment that was denied and who was not involved in the original adverse decision and who is not a subordinate of the reviewer who made the original adverse decision reviews each member appeal of a Utilization Management (UM) decision and determines whether to uphold or overturn the initial denial or modification decision."</p>	<p>Develop PQOC tools and resources 2/25/14.</p> <p>P&P Revision 2/10/14.</p> <p>Long term ongoing monitoring of corrective action includes: Approval of PQOC tools and resources 4/17/14 at the QI Committee. Print and Fulfillment 4/23/14. Acceptable level process implementation 6/2/14.</p> <p>Responsible Party: Dr. James Cruz, CMO</p>	<p>The MCP revised P&P UM 67 to indicate that final resolution of appeals will be made by someone who has not participated in any prior decisions related to the grievance.</p> <p>This deficiency remains open. To achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> Supporting documentation that appeals files include the name of the clinician responsible for making a final determination, as well as, documentation of the basis or rationale for the decision. Supporting documentation that demonstrates member services call logs identify all cases involving an expression of dissatisfaction as grievances and are appropriately handled.

Molina Health Plan has a contract with an outside vendor, Advanced Medical Review (AMR), which performs independent medical review using board certified physicians. AMR will be used in situations where the Plan is experiencing a high volume of appeals or the medical necessity decision is outside the specialty scope of experience of Molina Medical Directors.

A "Member Appeal Work Flow" has been created as a training tool for all staff involved in the Appeals process and is an attachment to P&P UM 67.

Molina's Chief Medical Officer (CMO) has reviewed P&P UM 67 and UM 41 (Expedited Appeals Process) with the Medical Director staff individually. The CMO will review UM 67 and UM 41 again with all Plan Medical Directors by the end of February, 2014. P&Ps UM 67 and UM 41 were reviewed and approved by the Utilization Management UM Committee on February 19, 2014

A new Manager was hired to oversee the Healthcare Services (HCS) business unit staff responsible for processing appeals including medical necessity reviews. The Manager reviewed P&P UM 67 and work flow and UM 41 with staff on February 19, 2014. The Manager's responsibilities include improving the appeals process. The Manager has made two key improvements in the management of appeals. The first is the creation of an appeals checklist that lists all steps that must be completed to result in an appeal that meets regulatory requirements. The Manager conducts 100% audit on appeals files using the checklist as a guide. The second improvement was the creation of an electronic appeals log to document the progression, aging and location of all open appeals in various stages of work-up and determination. The log is key to maintaining compliance with regulatory standards for DHCS, DMHC and NCQA. The Manager reviews the log several times a day to look for barriers to the process and location of the appeals file. The log and checklist are in use now. P&P UM 67 will be revised further to include a procedure for use of the checklist and the log. The goal for policy revision is February 28, 2014 followed by UM Committee approval. Currently, there is two staff trained to process appeals in the HCS business unit. They are responsible for preparing the appeals case for review by the Medical Director and ensuring timely processing of the appeal in accordance with regulations regarding timeliness of appeal decision making. Three additional employees were hired, one is in training and the other two will begin employment on February 24, 2014.

DHCS acknowledges the MCP's submission for this survey finding. This finding was also identified in the DMHC non-routine survey completed on June 4, 2014. Ongoing monitoring and corrective action for this finding will be achieved through the DMHC CAP.

Update 6/20/14;

The MCP submitted an example of a member services call log that includes the identification of grievances.

MCP must still submit supporting documentation that appeals files contain the identity of the clinician making the final decision in addition to the rationale for the decision.

Update 9/22/14:

The MCP submitted supporting documentation that appeals files contain the identity of the clinician making the final decision.

This deficiency is closed.

The Manager responsible for oversight of appeals processing is also responsible for reporting the status of timeliness of appeals processing, any actual or potential barriers to meeting timeliness standards, or delays in Medical Director review of appeals cases to the VP of Health Care Services (HCS) weekly. The appeals inventory and turnaround time for each file in process is reported.

The Medical Directors are responsible for documentation of the rationale for the appeals determination decision. The Medical Director's decision is documented electronically in the QNXT (electronic medical management system) notes. The Medical Director handwrites in the appeal. The Medical Director's documentation in QNXT is used to formulate the member resolution letter. The signature in the resolution letter is signed by the appeals nurse. See attached sample letter. This process will be added to the next revision of UM 67.

With respect to documentation of first level appeals for delegated providers, paper records are received from the delegated providers. The HCS appeals staff manually extracts documents from the records for Medical Director review. The Medical Director hand writes the appeal determination for the appeal file in the appeal note section of the file. All of the supporting documentation supporting the decision is kept in the appeal file as well.

The Compliance department is conducting quarterly focused audits on the appeals process for additional oversight.

Contact Support Center (CSC) agents were retrained on the Appeals and Grievance (A&G) processes and procedures, which includes appropriate use of Call Types and Call Codes used for categorizing A&G to ensure appropriate tracking and trending of grievances.

Supporting Documentation:

IV.7 Appeal File Checklist 1-10-14
IV.7 Member Appeal Workflow- 1st Level, 2nd Level, and Expedited
IV.7 P & P UM 67
IV.7 P & P UM 41
IV.7 2014 Appeals- Member Log (sample)
IV.7 Inter-Reliability (IRR) Training
IV.7 MD Medicaid Audit Tool
IV.7 QM 50
IV.NCQA 8-30 Sampling Methodology
Member Rights IV-7 QM 01A Potential Quality of Care (PQOC)
Member Rights IV-7 QM 50: Quality Improvement Internal Monitoring

	<p>Member Rights IV-7 Quality Improvement New Employee Orientation Training Presentation Member Rights IV-7 PQOC iLearn Training</p> <p>Plan Response 9/12/14 Molina submits supporting documentation that appeals files contain the identity of the clinician making the final decision --- see separate secure email</p>		
<p>Deficiency #8 The Plan does not ensure that written member-informing materials, including grievance acknowledgment and resolution letters, are translated into identified threshold languages. <i>Section 1367.04(b)(1)(B)(iv); Section 1367.04(b)(1)(C)(i); DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 9, Access and Availability, Provision 14 (B)(2) – Linguistic Services; and DHCS Two-Plan Contract and GMC Contract, Exhibit A, Attachment 13, Member Services, Provision 4(C)(1) – Written Member Information.</i></p>	<p>The Plan offers telephonic interpreter services at any time during a member service inquiry call, while member is receiving care, and throughout the grievance intake process to ensure that there are no language barriers. If the members profile indicates a language of preference (threshold or other), correspondences will be sent in the appropriate language. Members may also verbally request that correspondence be translated in their written language of preference at any time. If the members profile does not indicate a language of preference or indicates "English," the translation insert will be provided with all correspondence. The Appeals and Grievance (A&G) unit has developed and implemented policy PO-17 to address the deficiency noted. Additionally, policy UM-67 has been revised to reflect the above processes. All grievances and appeals, including language of preference, are tracked, monitored, and reported to several committees (Quality Improvement Strategic Committee(QISC), Quality Improvement Committee(QIC), Utilization Management Committee (UMC) etc.) on a quarterly basis.</p> <p>Supporting Documentation: IV.8 PO 17 Appeals and Grievance Cultural Linguistic Services IV.8 UM 67 Member Appeal of Medical Necessity, Denial or Modification Determination. IV.8 NCQA 8-30 Sampling Methodology IV.8 QM 50 IV.8 UM-67 Redline Member Appeals of Medical Necessity Denial</p>	<p>Pending policy approval from the appropriate committees and DHCS, 100% of the letters are translated in our threshold and other languages, or if primary language unknown translation insert included starting 02/03/2014.</p> <p>Responsible Party: Dr. James Cruz, CMO</p>	<p>This deficiency remains open. To achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> An approved, signed P&P UM-67 that reflects the required process. <p>Update 6/20/14;</p> <p>The MCP submitted a revised, approved, signed P&P UM-67 that ensures written member informing materials are translated in the member’s preferred language.</p> <p>This deficiency is closed.</p>
<p>V. QUALITY MANAGEMENT</p>			
<p>Deficiency #9 The Plan’s Quality Assurance program does not ensure that effective action is taken to improve care where deficiencies are</p>	<p>Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include process and policy revisions include: Revisions to policy and procedure P&P QM 50</p> <p>Corrective action includes process improvements developed to ensure that all denial letters include a clear and concise explanation of the</p>	<p>Initiated remedial action: Developed P&P 2/10/14.</p> <p>Long Term ongoing monitoring of corrective action includes:</p>	<p>Per the MCP’s Quality Improvement Program Evaluation, the MCP’s acute bed day goal is less than or equal to 250. Actual bed days for each documented quarter</p>

<p>identified. Rule 1300.70(a) (1) and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement.</p>	<p>reasons for the plan’s decision.</p> <p>The new QI Policy, QM-50 Quality Improvement Monitoring, defines semiannual interdepartmental monitoring of compliance with Molina policies that will ensure adherence to standards and guidelines, including, but not limited to, the appropriate handling of the following:</p> <ul style="list-style-type: none"> UM Denials, UM Appeals, Accepted PQOC’s and Grievances, and MHC Focused Medical Record Review Audits. <p>An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported to Quality Improvement Committee (QIC) quarterly.</p> <p>The audit will review a sample based on the 8/30 national Committee Quality Assurance (NCQA) Sampling Methodology rule.</p> <p>A sample size of 30 is a valid sample size when trying to determine if the null hypothesis can or cannot be rejected. In this case, we are looking to determine if the physician is or is not in compliance. The null hypothesis is that they are in compliance. A sample size of 30 is sufficient to prove or disprove this hypothesis. When testing the null hypothesis, a sample of 8 is a valid sample size when the 8 pieces of sample are randomly selected and are the initial 8 surveys completed. The results for those 8 must be identical either proving or disproving the null hypothesis. A sample size of 30 is valid using the appropriate formula and the critical value of K is $1.36/\sqrt{30}=.248$. Because the calculated value of K is smaller than the critical value, the null hypothesis cannot be rejected. Alternatively, the probability of observing a K value of .222, as determined by the normalized z statistics, is .103. Because this is more than the significance level of .05, the null hypothesis cannot be rejected, leading to the same conclusion. (Source: Malhotra, Naresh K and David F. Birks, Third European Edition Marketing Research an Applied Approach. Pearson Education Company. Prentice Hall Inc. 2007.)</p> <p>NCQA provides the following explanation for the sampling methodology in its May 1, 2001 memo titled “Explanation of ‘8 and 30’ File Sampling Procedure” http://www.ncqa.org/tabid/125/Default.aspx</p> <p>“The statistical test underlying the [“8/30”] classification decision is based on the binomial distribution, the characteristics of which are very well known. This fact allows the classification decision to be based on a</p>	<p>Develop Audit Tool 2/25/14.</p> <p>Present to Senior Leadership Team and stakeholders 3/4/14.</p> <p>Acceptable level process implementation 4/1/14.</p> <p>Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency utilizing the 8/30 sampling methodology.</p> <p>Responsible Party: Dr. James Cruz, CMO</p>	<p>exceeded the goal.</p> <p>This deficiency remains open. To achieve compliance, the MCP must:</p> <ul style="list-style-type: none"> • Develop a systematic approach to identify and address over-utilization of high bed days and implement corrective action as necessary. <p>Update 6/23/14;</p> <p>The MCP submitted proposed benchmarks for detecting under and over-utilization for bed day, ER visits and readmission rates for the following populations: TANF, ABD, Medicare and Pharmacy. The MCP will conduct analysis of the benchmarks and should objective data indicate over or under-utilization, a CAP will be developed.</p> <p>These proposed benchmarks will be presented at the next UM Committee meeting 6/25/14.</p> <p>This deficiency is closed.</p>
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	<p>very small sample of 30 files, regardless of the size of the population of eligible records. The use of the binomial distribution is possible because the decision based on the 8 and 30 file sampling methodology is BINARY. That is, the decision based on the file review falls into one of two possible categories ("in compliance"/"out of compliance")." As such, there is no statistical difference between an outcome using the 8/30 sample methodology vs. a 50 sample size.</p> <p>An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported to QIC quarterly.</p> <p>Supporting Documentation: V.9: QM 50 V.9: 8/30 Methodology NCQA</p>		
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8. Submitted By: _____

Date: _____

Title: _____