

DEPARTMENT OF
**Managed
Health Care**
Help Center

**DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS**

**CAL MEDICONECT
MEDICAL SURVEY REPORT OF**

**MOLINA HEALTHCARE OF CALIFORNIA
A FULL SERVICE HEALTH PLAN**

DATE ISSUED TO DHCS: MARCH 9, 2016

Cal MediConnect Medical Survey Report
Molina Healthcare of California
A Full Service Health Plan
March 9, 2016
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EXECUTIVE SUMMARY

The Department of Health Care Services (DHCS) received authorization (CMS APPROVAL) from the federal government to conduct a Duals Demonstration Project (Cal MediConnect) to coordinate the delivery of health and long term care services to beneficiaries within California who are eligible for benefits under both Medicare and Medicaid. Starting in April 2014, DHCS began phase in enrollment of Cal MediConnect beneficiaries in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. The Department of Managed Health Care (DMHC) and the DHCS then entered into an Inter-Agency Agreement¹ whereby the DMHC will be responsible for conducting medical survey audits related to the provision of Medicaid-based services provided to Cal MediConnect enrollees. Medical Surveys pursuant to this Agreement are conducted once every three years.

On June 5, 2015, the Department notified Molina Healthcare of California (the Plan) that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department's medical survey team conducted the onsite portion of the medical survey from August 24, 2015 through August 28, 2015².

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the Cal MediConnect Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the provision of Medicaid-based services for the Cal MediConnect population. This medical survey evaluated the following elements specifically related to the Plan's delivery of care to Cal MediConnect populations as delineated by the contract between the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services in partnership with the California Department of Health Care Services, and Molina Healthcare of California (Three-Way Contract):

I. Utilization Management

The Department evaluated Plan operations related to utilization management as it relates to the provision of Medicaid-based services, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting over- and under-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

¹ The Inter-Agency Agreement (Agreement Number 13-90167) was approved on October 21, 2013.

² Pursuant to the Knox-Keene Health Care Service Plan Act of 1975, codified at Health and Safety Code section 1340, *et seq.*, Title 28 of the California Code of Regulations section 1000, *et seq.* and the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) Cal MediConnect Three-Way Contract and amendments. All references to "Cal MediConnect Three-Way Contract" or "Three-Way Contract" are to the Cal MediConnect Three-Way Contract between CMS, DHCS, and the Plan, and amendments thereto. All references to "Section" are to the Health and Safety Code unless otherwise indicated. All references to the "Act" are to the Knox-Keene Act. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

II. Continuity of Care

The Department evaluated Plan operations to determine whether Medicaid-based services are effectively coordinated both inside and outside the network. The Department also verified that the Plan takes steps to facilitate coordination of Medicaid-based services with other services delivered under the Cal MediConnect, through the enrollees' primary care physician and/or interdisciplinary team.

III. Availability and Accessibility

The Department evaluated Plan operations to ensure that its Medicaid-based services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and that the Plan addresses reasonable patient requests for disability accommodations.

IV. Member Rights

The Department evaluated Plan operations to assess compliance with internal and external complaint and grievance system requirements related to the provision of Medicaid-based services. The Department also evaluated the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

V. Quality Management

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care as it relates to the provision of Medicaid-based services.

The scope of the medical survey incorporated review of health plan documentation and files from the period of August 1, 2014 through July 31, 2015.

SUMMARY OF FINDINGS

The Department identified **four** potential deficiencies during the current medical survey.

2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT	
1	<p>For decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response:</p> <ul style="list-style-type: none">• A clear and concise explanation of the reasons for the decision;• A description of the criteria or guidelines used; and• The clinical reasons for the decision. <p>Cal MediConnect Three-Way Contract: § 2.11.4.5.; Cal MediConnect Three-Way Contract § 2.11.5.3.4; Cal MediConnect Three-Way Contract § 2.11.6.2; Section 1367.01(h)(4)</p>

MEMBER RIGHTS	
2	<p>The Plan does not maintain an adequate system to identify and address all enrollee grievances.</p> <p>Cal MediConnect Three-Way Contract: § 2.14.2.1.1.; Section 1368(a)(1); Section 1368(a)(4)(B); Rule 1300.68(a)(1)(2).</p>
3	<p>The Plan’s written acknowledgments and resolutions of enrollee grievances do not consistently display the Department’s telephone number, TDD line, and Internet address in 12-point boldface type as required.</p> <p>Cal MediConnect Three-Way Contract: § 2.14.3.1.; Section 1368.02(b).</p>
QUALITY MANAGEMENT	
4	<p>The Plan’s Quality Improvement Program does not identify problems with the provision of Medicaid-based services and implement effective corrective actions and conduct follow-up where needed.</p> <p>Cal MediConnect Three-Way Contract: § 2.16; Cal MediConnect Three-Way Contract § 2.16.3; Rule 1300.70(a)(1).</p>

OVERVIEW OF THE PLAN’S EFFORTS TO SUPPORT CAL MEDICONNECT ENROLLEES

The Plan has designated staff to work specifically with the Cal MediConnect population. The Plan uses staff called Care Connectors who are local to members’ areas and make home visits and report concerns to the care team. In addition to the services provided that are required by the Three-Way Contract, the Plan offers additional Care Plan Option services such as a \$20.00 over the counter item allowance and additional non-medical transportation benefits (the Plan pays for 60 one-way trips per year instead of the required 30.)

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Potential Deficiency # 1: For decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response:

- **A clear and concise explanation of the reasons for the decision;**
- **A description of the criteria or guidelines used; and**
- **The clinical reasons for the decision.**

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.11.4.5.; Cal MediConnect Three-Way Contract § 2.11.5.3.4; Cal MediConnect Three-Way Contract § 2.11.6.2; Section 1367.01(h)(4)

Cal MediConnect Three-Way Contract

2.11.4.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

2.11.4.5.1. Be produced in a manner, format, and language that can be easily understood;

Cal MediConnect Three-Way Contract

2.11.5.3. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

2.11.5.3.4. Reasons for decisions are clearly documented

Cal MediConnect Three-Way Contract

2.11.6.2. Concurrent review of authorization for treatment regimen already in place: Within five (5) business days or less, consistent with urgency of the Enrollee's medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.6.3. Retrospective review: Within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

Section 1367.01(h)(4)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or

modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity....”

Documents Reviewed:

- MHC Policy CA-HCS-CAM-351: Notification of Denial, Deferral or Modification Request for Plan Authorization of Services
- Three Cal MediConnect Utilization Management (UM) Denial Files (08/18/14 – 06/04/15)

Assessment: The Plan's notices of denials failed to provide an explanation of the denial in a manner, format, and language that can be easily understood and failed to include an adequate description of the criteria or guidelines used to make the decision. These requirements are outlined in the Cal MediConnect Three Way Contract Sections 2.11.4.5, 2.11.5.3, and 2.11.6.2, which reference Section 1367.01. The Plan's Policy titled "Notification of Denial, Deferral or Modification Request for Plan Authorization of Services" (Plan Policy CA-HCS-CAM-35) confirms these contractual requirements and requires that the denial notification letters include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

The Department reviewed three Plan denial files, representing the universe of denial files for Medicaid-based services during the survey review period³. The plan's denial letters in File #2 and File #10 do not include a detailed explanation of the denial that can be easily understood, nor do they include the clinical reasons for the decisions regarding medical necessity. The denial letter is missing from File #1; therefore, the Department determined that the file was non-compliant in all aspects.

The Plan's notices of denials fail to provide an explanation of the denial in a manner, format, and language that can be easily understood. The explanation of the denial in the letters from File #2 and File #10 state "You would have to meet all of the rules before this could be approved." Though there was no denial letter included in File #1, physician reviewer notes in File #1 include a similar statement, "You would have to meet all of the rules before this could be approved." The statement itself is easy to understand, however there is no detailed description or explanation of what rules pertain to the denial.

The Plan also failed to adequately describe the criteria used to make its denial decisions. File #2 simply states "(CRITERIA USED FOR DECISION: Title 22 criteria)." In File #10, the criteria is stated as "(Criteria used for decision: interqual criteria, LOC: Acute Adult – InterQual 2014 General Medical)." Aside from these statements, the letters do not include detailed and easily understood description of the criteria used to make the decisions.

³ The Plan provided a list of 10 utilization management (UM) denial files; 7 of which were related to Medicare-Based services and therefore excluded.

Conclusion: The Plan’s Cal MediConnect Three-Way Contract and Section 1367.01(h)(4) require that the Plan’s denial letters be written in a manner that can be easily understood and that provide a description of the criteria used in making the denial decision. The Department’s review of the Plan’s utilization management denial files found that the Plan did not provide written denials which met these requirements. Therefore, the Department finds the Plan in violation of this contractual requirement.

TABLE 1
Utilization Denial Deficiencies

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	
UM denials for Medicaid-Based Services	3	Denial letter has a clear and concise explanation for denial	0 (0%)	3 (100%)
		Denial letter includes description of the criteria or guidelines used for the decision	0 (0%)	3 (100%)
		Denial letter specifies the clinical / medical reasons for the denial	0 (0%)	3 (100%)

MEMBER RIGHTS

Potential Deficiency #2: The Plan does not maintain an adequate system to identify and address all enrollee grievances.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.14.2.1.1.; Section 1368(a)(1); Section 1368(a)(4)(B); Rule 1300.68(a)(1)(2).

Cal MediConnect Three-Way Contract

2.14. Enrollee Grievances

2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which Enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975 and the regulations promulgated thereunder, WIC Section 14450 and CCR, Title 22, Section 53260.

Section 1368(a)(1)

(a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Section 1368(a)(4)(B)

(a) Every plan shall do all of the following:

(4) (B) Grievances received by telephone, by facsimile, by e-mail, or online through the plan's website pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

- (i) The date of the call.
- (ii) The name of the complainant.
- (iii) The complainant's member identification number.
- (iv) The nature of the grievance.
- (v) The nature of the resolution.
- (vi) The name of the plan representative who took the call and resolved the grievance.

Rule 1300.68(a)(1)(2)

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:

- (1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
- (2) "Complaint" is the same as "grievance."

Documents Reviewed:

- Pre-Onsite Plan Document: Memo to DMHC – DMHC Cal MediConnect Exempt Survey Log (Item 2c) (06/24/15)
- Plan Policy PO-19: Member Grievance Process (revised 04/18/14)

Assessment: The Plan does not maintain an adequate system to identify and address all enrollee grievances by failing to maintain a log of exempt grievances and failing to maintain inquiry logs specific to for the Plan’s Cal MediConnect line of business. The Plan’s Cal MediConnect Three-Way Contract 2.14.2.1.1 requires the Plan to “establish and maintain a grievance process under which Enrollees may submit their grievances regarding all benefits and services. This process must be established pursuant to the Knox-Keene Health Care Services Plan Act of 1975, WIC Section 14450 and CCR, Title 22, Section 53260 ... ” Section 1368(a)(1) confirms the contractual requirement to maintain a grievance process. Section 1368(a)(4)(B) requires the Plan to maintain a log of grievances that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt, (sometimes referred to as “one-day grievances” or “exempt grievances” because these grievances are exempt from the requirement to send written acknowledgment and response letters.) Rule 1300.68(a)(1)(2) defines a grievance as “a written or oral expression of dissatisfaction regarding the plan and/or provider,” and states that a “complaint” is the same as a “grievance.”

Plan Policy *PO-19, Member Grievance Process*, confirms these contractual, statutory, and regulatory requirements, stating that a grievance is:

“... a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and all include a complaint, dispute, and a request for reconsideration or appeal made by an enrollee of the enrollee’s representative and remains unresolved to the member’s satisfaction. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance ... a grievance may be presented in person, telephone, fax, e-mail, or in writing to MHC or at any office of a MHC provider and can require an expedited or standard resolution.”

The Department requested inquiry logs for the Plan’s Cal MediConnect line of business specific to Medicaid-based services. However, Plan staff stated that they were unable to isolate a list of inquiries specific to Medicaid-based services and did not provide the inquiry logs as requested. Further, the Plan could not provide the Department with the log required by Section 1368(a)(4)(B) containing exempt grievances. Due to the lack of documentation provided, the Department was unable to assess whether the Plan adequately classifies all statements of dissatisfaction as grievances or that it addresses such grievances. As a result of its failure to properly document and classify such grievances, the Plan’s reporting to the Department and other entities is inaccurate.

During interviews, Plan staff acknowledged that they have been experiencing challenges with coding exempt grievances. Staff explained that they are currently “building a process to get inquiries over to Grievances and Appeals so grievances can kick in if it will go over 24 hours,” although they do not yet have any aspect of the process in place.

Conclusion: The Cal MediConnect Three-Way Contract 2.14.2.1.1 requires the Plan to establish and maintain a grievance process. Both the Plan's policy and Rule 1300.68(a)(1)(2) require that an expression of dissatisfaction be treated as a grievance, and Section 1368(a)(4)(B) requires that the Plan keep a log of all exempt grievances. By its own admission, the Plan does not maintain a separate inquiry log for Medicaid services, or of exempt grievances for Medicaid-Based services. As a result, the Plan does not maintain an adequate grievance process. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

Potential Deficiency # 3: The Plan's written acknowledgments and resolutions of enrollee grievances do not consistently display the Department's telephone number, TDD line, and Internet address in 12-point boldface type as required.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract §2.14.3.1.; Section 1368.02(b).

Cal MediConnect Three-Way Contract 2.14.3.1.

Pursuant to Health & Safety Code Section 1368(b), Contractor shall inform Enrollees that they may file an external grievance for Medi-Cal only covered benefits and services (not including IHSS) through DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free number, the DMHC's TDD line for the hearing and speech impaired, and the DMHC's website address pursuant to Health & Safety Code Section 1368.02.

Section 1368.02(b)

Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by

your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site **<http://www.hmohelp.ca.gov>** has complaint forms, IMR application forms and instructions online.

Documents Reviewed:

- Plan Policy PO-19: Member Grievance Process (revised 04/18/14)
- Three Standard Grievance Files (08/01/14 – 07/31/15)

Assessment: The Cal MediConnect Three-Way Contract 2.14.3.1 requires the Plan to inform Enrollees that they may file an external grievance for Medi-Cal only covered benefits and services through DMHC's consumer complaint process. As part of this notification, the Plan "shall inform Enrollees of the DMHC's toll-free number, the DMHC's TDD line for the hearing and speech impaired, and the DMHC's website address" Section 1368.02(b) confirms this contractual requirement and further instructs the Plan on how the Department's telephone number, TDD line, and website address, as well as the Plan's telephone number, should be displayed.

Plan Policy *PO-19, Member Grievance Process*, commits the Plan to the following statement, which refers to, but does not properly outline, all of the statutory requirements. Specifically, it does not indicate that the information must be displayed in 12-point boldface type:

Written notification to the member of MHC's proposed resolution of the grievance, including: The right to contact the Department of Managed Health Care (DMHC), with appropriate language and toll-free telephone number (1-888-HMO-2219) and TDD line (1-877-688-9891), as provided in Health and Safety Code Section 1368.02, subparagraph (b).

The Department reviewed three standard grievance files, which represent the universe of such files for the survey review period, and determined that the Plan did not appropriately format the statement as required by Section 1368.02(b) in the acknowledgement and resolution letters in all three (100%) of the files. Specifically, not all of the required information was formatted correctly in boldface type.

Conclusion: The Plan's Cal MediConnect Three-Way Contract 2.14.3.1 requires that the Plan inform enrollees of DMHC's toll-free number, DMHC's TDD line for the hearing and speech impaired, and DMHC's website address pursuant to Health and Safety Code Section 1368.02. Section 1368.02(b) requires that written grievance communications include the following

information in boldface type: the Department’s telephone number, the Department’s TDD line, the Plan’s telephone number, and the Department’s Internet Web site address. The Department determined that the Plan failed to include the appropriate format of the statement in its acknowledgment letters and resolution letters. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

TABLE 2
Grievance Acknowledgment and Resolution Letters
Include Required Language Required by 1368.02(b)

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	
Standard Grievance	3	Acknowledgment letter includes language as required by 1368.02(b) in boldface type	0 (0%)	3 (100%)
		Resolution letter includes language as required by 1368.02(b) in boldface type	0 (0%)	3 (100%)

QUALITY MANAGEMENT

Potential Deficiency # 4: The Plan’s Quality Improvement Program does not identify problems with the provision of Medicaid-based services, implement effective corrective actions, and conduct follow-up where indicated.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.16; Cal MediConnect Three-Way Contract §2.16.3; Rule 1300.70(a)(1).

Cal MediConnect Three-Way Contract

2.16. Quality Improvement Program

2.16.1. Quality Improvement (QI) Program. The Contractor shall:

2.16.2. Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.16.2.5 Issues identified by the Contractor, DHCS and/or CMS; and

2.16.2.6. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

Cal MediConnect Three-Way Contract

2.16.3 QI Program Structure

2.16.3.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438., including Subpart D, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA health plan accreditation requirements in 28 CCR Section 1300.70.

Rule 1300.70(a)(1)

The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Documents Reviewed:

- Plan Policy QM-01: A Potential Quality of Care (PQOC), Serious Reportable Adverse Events and Never Events P/P (05/07/15)
- Molina Healthcare of California, Inc. Quality Improvement Program Description 2014
- Molina Healthcare of California, Inc. Quality Improvement Program Description 2015
- QM 0027 Memo QI CAP (08/24/15)
- QIC Meeting Minutes (12/16/14 and 02/24/15)
- CQIC Peer Review Minutes (12/10/14 and 03/11/15)
- Five PQIs (08/01/14 – 07/31/15)
- QM-01 A Potential Quality of Care (PQOC), Serious Reportable Adverse Events and Never Events Policy and Procedure 05/07/2015
- Cal MediConnect PQI Log (08/01/14-07/31/15)
- QM Cal MediConnect Potential Quality Issue (PQI) Track and Trend Report, by Provider, Issue, Severity Level
- Potential Quality of Care-Issues Codes-Severity Codes

Assessment: The Plan's Quality Improvement Program does not identify problems with the provision of Medicaid-based services, implement effective corrective actions, and conduct follow-up where indicated. The Plan failed to assign an appropriate level of severity and, therefore, to elevate the case for corrective actions. The Cal MediConnect Three-Way Contract 2.16, Quality Improvement Program, requires the Plan to "[a]pply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements," including "the delivery of primary and specialty health care services, Behavioral Health services and LTSS." Section 2.16.3.1 further requires plans to "... maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI" and to meet the quality management and improvement criteria described in Section 1300.70. Section 1300.70 requires

plans to "... document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated."

According to Plan Policy *QM-01, A Potential Quality of Care (PQOC), Serious Reportable Adverse Events and Never Events P/P*, the Plan's Quality Improvement (QI) Department evaluates and reviews all clinical grievances involving enrollees, practitioners, and other health care professionals from all sources. If a PQI is identified, the case is referred to the Plan's Chief Medical Officer (CMO) to review the file, assign a severity level, and initiate follow-up if appropriate. The policy states:

Molina staff who identifies [sic] a potential quality issue shall complete a referral form and forwards to the QI Department.

C. Review Process

II. Level 2 Review: Medical Director

1. The Medical Director reviews the case summary and all documents of grievances related to medical quality of care issues. Upon completion an appropriate severity level is assigned.

The severity level is a numerical system.

The QI severity level system is categorized as follows:

Level 0: No Quality of Care Issue

Level 1: Potential Quality Issue

Level 2: Quality of Care Issue without negative outcome

Level 3: Quality of Care Issue with negative outcome

Level 4: Gross and flagrant violation of acceptable medical practice or service

Standard

2. The Medical Director documents his findings, final assessment and signs-off case.

3. If the Medical Director determines a quality of care issue exists, one or more of the following corrective actions including but not limited to:

a. Off-cycle review by Professional Review Committee (PRC)

b. Counseling or education by the Medical Director or designee via written or verbal communication

c. Staff education by Provider Services Department or other department as appropriate

d. Policy and procedure improvement or protocol submission

e. Other

According to Plan Policy *QM-01*, Level 0 or 1 cases are not referred for further action. Level 2, 3, or 4 cases receive corrective/educational actions.

In its review of the Plan's five (5) PQIs from the survey review period, the Department determined that all five PQI files were properly identified as PQIs. However, in three (3) of the five (5) cases, the Plan failed to assign an appropriate level of severity and, therefore, to elevate

the case for corrective actions. Therefore, the Department found that the Plan does not “[a]pply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements...” as required by Section 2.16.2.

The Department identified the following concerns with the Plan’s handling of PQIs:

1. Failure to identify problems and implement corresponding corrective actions

In three of the five (5) cases it reviewed, the Plan failed to identify problems that should have resulted in corrective/educational actions.

File #1: is based on a report from one of the Plan’s case managers while completing an enrollee assessment visit in a skilled nursing facility (SNF). The Case Manager reported care and cleanliness/maintenance issues, including concerns about tube feedings, an odor in rooms, a broken bed, soiled pads next to a bed, and dead roaches. The enrollee reported dissatisfaction with the facility and requested relocation. The Plan sent the issues to the CA Department of Public Health, and requested an explanation from the facility, which was received. The case was identified as a PQI at Level 1 and closed with no further follow-up. The Plan did not issue a corrective action plan (CAP), monitor the facility for correction of identified issues, or follow-up with the enrollee. Upon reviewing the case, the Department determined that the Plan should have assigned the case a higher severity level, requested a CAP, monitored the facility, and addressed the enrollee’s dissatisfaction and possible relocation. During the onsite review, Department staff discussed this case with the Plan’s Chief Medical Officer (CMO) who concurred that the enrollee’s concerns were not addressed and stated that the SNF should have received a CAP and undergone monitoring.

- *File #3:* The enrollee, who was residing in a SNF, pulled out a catheter, went to the bathroom, and fell. The enrollee was admitted to a hospital with a head injury. On another occasion approximately a week later, the enrollee fell again in the SNF and was readmitted to the hospital. After the second incident, the Plan requested and received medical records, in which there was no evidence of implementation of a fall prevention program or indication of any other modification to the enrollee’s care plan to address safety. The Plan assigned a Level 0 to the case and closed it with no further follow-up. It is unclear how the Plan arrived at a Level 0 when a negative outcome has been demonstrated with hospitalization. Given the repeat breach of patient safety in the same facility, the Department determined this was a serious case warranting correction and follow-up monitoring (e.g., monitored the facility’s fall rate and fall prevention program).
- *File #4:* This was reported by one of the Plan’s Case Managers. The enrollee sustained a fractured humerus during a staff-assisted transfer from bed to shower and was sent to a hospital. The Plan requested records from the SNF and the Plan’s CMO reviewed the case and assigned Level 0. The case was referred for tracking and trending. No further follow-up was noted. It is unclear how the Plan arrived at a Level zero when a negative

outcome – fractured humerus -- was demonstrated with hospitalization. The Department determined that this case should have been assigned a CAP and further follow-up.

2. Failure to refer identified issues to the QI Committee or other appropriate body for input when appropriate.

The Department determined that three (3) of the five (5) cases it reviewed were incorrectly leveled at a 0 or 1 by the CMO. When a case is leveled at a 0 or 1, it is not referred to a review committee. According to Plan policy, if these cases had been assigned a higher severity level as the Department determined they should have been, the cases would have been referred to a quality review committee and potentially received corrective action (e.g., counseling or education by the CMO or appropriate department; policy/procedure improvement) and follow up.

Conclusion: The Cal MediConnect Three-Way Contract 2.16 Quality Improvement Program requires the Plan to apply the principles of “Continuous Quality Improvement (CQI)” to all aspects of the service delivery. Rule 1300.70(a)(1) further requires that the quality of care is reviewed, problems are identified, effective corrective actions are taken where deficiencies are identified, and follow-up is conducted where indicated. The Plan does not consistently identify and acknowledge the severity of quality of care issues in cases reviewed as PQIs and, as a result, does not implement effective corrective actions. The Plan’s failure to implement effective corrective actions may enable problems to continue or recur among providers, negatively affecting the quality and safety of care delivered to enrollees. Therefore, the Department finds the Plan in violation of this contractual requirement.

TABLE 3
Cal MediConnect Potential Quality Issues for Medicaid-Based Services

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Potential Quality Issues	5	Failure to refer identified issues to the QI Committee or other appropriate body for input when appropriate	2 (40%)	3 (60%)

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Jennifer Friedrich	Medical Survey Team Lead
Cindy Liu	Attorney
MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS	
Elizabeth Fuhrmann, PhD., RN	Utilization Management Surveyor
Maureen Plumstead, RN	Quality Management, and Continuity of Care Surveyor
Madeline Hommel	Availability & Accessibility Surveyor
Annalisa Almendras, PhD.	Member Rights Surveyor
Betty Fuhrmann, PhD., RN	Quality Management Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED	
Richard Chambers	Plan President
James Novello	Chief Operating Officer
James Cruz, MD	Chief Medical Officer
Michael Siegel, MD	Medical Director
Michael Brodsky, MD	Medical Director
Carol Pranis, RN	Director, Quality
Yasamin Hafid	Director, Compliance
Shirley Kim	Director, Health Plan Operations
Jody Mcleish	Director, Healthcare Services
Marianne Maciel	Director, Healthcare Services
Rikki Haffner	Director, Operational Oversight
Richard Golfin	Director, Delegation Oversight
Sharon Fetterman	Director, Utilization Management
Mary Curry	Director, Utilization Management
Sal Laique	Director, Provider Services
Andy Nguyen, Pharm.D	Director, Pharmacy
Blanca Martinez	Director, Case Management
Donna Davis	Director, Case Management
Tammy Jurkatis	Director, Member Services
Stephanie Williams	Director, Member Services
Victoria Luong, Ph.D	Director, Health Education
Lisa Hayes	Director, Disability and Senior Access
Megan Dankmyer	Director, Long Term Care
Teresa Morgan	Director, Claims
John Robertson	Director, Claims
Deborah Miller	Vice President, Healthcare Services
Rajeev Narula,	Vice President, Finance
Yunkyung Kim	Vice President, Government Contracts
Michelle Espinoza	Vice President, Provider Network
Suma Verghese	Assistant Vice President, Health Plan Operations
Jennifer Rasmussen	Assistant Vice President, Case Management
Leslie Fonseca	Assistant Vice President, Utilization Management
Ellen Rudy, Ph.D	Assistant Vice President, Quality

Timothy Zevnik	Assistant Vice President, Compliance
Milaine Isaac	Assistant Vice President, Provider Network
Khaled Ghaly	Assistant Vice President, Claims
Elizabeth Igwe	Manager, Healthcare Services
Lisha Robinson	Manager, Delegation Oversight
Maria Ochoa	Manager, Claims
Ann Valentin	Supervisor, Utilization Management
Linda Bomersback, RN	Delegation Oversight Nurse
Amritha Roser	Health Educator III
Matilde Gonzalez	Cultural & Linguistic Specialist

APPENDIX C. LIST OF FILES REVIEWED

Note: The statistical methodology utilized by the Department is based on an 80% confidence level with a 7% margin of error. Each file review criterion is assessed at a 90% compliance rate.

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	File Number	Explanation
Standard Grievances and Appeals	3	UMXGR18373885 UMXGR18427159 UMXGR18456727	The Department reviewed the three grievances and appeals cases reported by the Plan.
Potential Quality Issues	5	1594 1937 2125 2260 2073	The Department reviewed the five potential quality issues reported by the Plan.
UM Medical Necessity Denials	3	1423000869 1423702879 1516104138	The Department reviewed the three UM medical necessity denials reported by the Plan.