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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

November 8, 2016

Deborah Miller, President
Molina Healthcare of California Partner Plan, Inc
200 Oceangate, suite 100
Long Beach, CA 90802

RE: Department of Managed Health Care Rural Expansion Survey

Dear Ms. Miller:

The Department of Managed Health Care conducted an on-site Rural Expansion Survey of Molina Healthcare of California Partner Plan, Inc, a Managed Care Plan (MCP), from August 24, 2015 through August 28, 2015. The survey covered the period of August 1, 2014 through July 31, 2015.

On November 4, 2016, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on March 9, 2016.

All items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS' 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, feel free to contact me at (916) 552-8946 or Joshua Hunter at (916) 440-7587.

Sincerely,

Jeanette Fong, Chief

Managed Care Quality and Monitoring Division
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Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Michel Huizar, Contract Manager
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Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan Name: Molina Healthcare of California

Review/Audit Type: DMHC Rural Expansion Medical Survey Report **Review Period: 08/01/2014-07/31/2015**

Deficiency Number and Finding	Action Taken	Implementation Documentation	Expected Completion Date	DHCS Comments
2. Availability and Accessibility				
1. The plan does not consistently meet contractual timely access standards as set forth in its own policies and procedures.	As an immediate corrective action, the Plan updated the standards in the Access to Health Care Policy and Procedure (QM-09) in August 2015 to align with the state's regulatory standards for timely access to care. The Plan is currently in the process of analyzing its 2015 Timely Access survey results with the updated access to care standards to determine rate of compliance. As part of this analysis, The Plan will evaluate results to determine if further updates should be made to QM-09. In an effort to provide additional training and education to the Provider community, the Plan has developed a multi prong communication approach to disseminate information including: • The Plan will develop a Timely Access job aid for Timely Access to Healthcare Standards and will include the document in The Plan's quarterly communication (Cleo Column) to providers as well as in any materials generated for routine provider visits. • The Plan will also ensure Access to Health Care Standards is a standing agenda item topic at the Provider Joint Operations Meetings. • The Plan will share survey data with IPAs/MSOs to identify each IPAs/MSOs specific providers who needed further education in regards to the Access Health	1a QM-09 Policy	Beginning 7/01/16 and On-going	**09/28/16** - The following documentation submitted supports the MCP's subsequent efforts to correct this finding: - Timely Access Job Aid for Timely Access Standards as evidence that providers are informed of the various timely access requirements. - Agendas and sign-in sheet for Provider Joint Operations meetings have access & availability as a recurring item. - JOM 2015 Results for LA County shows the percentage of compliance for adhering to timely access standards by PCPs, Specialists, Behavioral Health and Ancillary. **11/4/16** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - The MCP submitted examples of

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	Care. • The Plan will identify any providers that did not meet the Access to Health Care standards and issue a corrective action plan. These providers are also automatically resurveyed for the following year's annual survey. In addition, the Plan would like to respond to the Department's statement that "The Plan's Director of Quality Improvement stated that the Plan had updated the survey tool, which resulted in a shortened survey period and may have contributed to low compliance rates due to lower provider response rates." The Plan would like to clarify that, the Plan's Director of Quality Improvement stated that the Plan's Quarter 2 2014 Provider Access and Availability survey was conducted using a modified survey tool. In July 2014, the Plan was informed by DMHC that this tool was not compliant with the DMHC Provider Access and Availability methodology. In order to comply with DMHC regulations, the Plan conducted a second Provider Access and Availability survey in Quarter 4 2014 using the DMHC Model Provider Appointment Availability Survey Methodology and survey tool. This resulted in a shortened survey period and may have contributed to low compliance rates due to lower provider response rates.			corrective action plans submitted to providers that were not compliant with timely access standards. The memo included with the corrective action plans states that the MCP is currently tracking receipt of all completed corrective action plans and continues to communicate with providers that still have outstanding corrective action plans. **This finding is closed.**

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3. Members' Rights				
2. The Plan does not have an established and effective mechanism for identifying and addressing exempt grievances.	The Plan immediately implemented a process to establish an effective mechanism for identifying and addressing exempt grievances to include: • The Grievance Department and Member Services Contact Support Center (CSC) developed a unique call code to accurately identify exempt grievances which enabled the plan to generate an exempt grievance report for tracking purposes (see attachment which displays a screen shot of the call code). As a result, the Plan is now able to effectively identify and distinguish between inquiries, complaints and true grievances. • All exempt grievances identified through the newly created call code is tracked on a daily basis by the CSC leadership and routed to the Appeals and Grievance (A&G) team via the A&G application. • On a daily basis, upon receipt of an exempt grievance the A&G intake unit reviews each exempt case to validate that the disposition of the case is accurately identified and the call is coded correctly. After the case is reviewed and validated, it is resolved and closed in the A&G application and saved for tracking purposes. • On a quarterly basis beginning March 2016, an exempt grievance report will be reviewed through A&G Committee. Additionally, any issues or trends identified through the exempt grievance report will be escalated through A&G Committee to other high level oversight committees within the Plan to ensure immediate follow up and corrective	2a AG SOP 12 2b AG-19 Grievance Process 2c Call Center Training Sign in 2d Grievance Training Materials 2e Grievance Training Sign in 2f call code screen shot	4/30/16	**05/13/16-** The following documentation submitted supports the MCP's subsequent efforts to correct this finding: -P&P: A&G -19 "Member Grievance Process" which includes requirements for exempt grievance handling and maintenance of the exempt grievance log (page 3). -"Exempt Grievance Training" PowerPoint (March 2, 2016) and corresponding sign-in sheets as evidence that the plan has conducted training for all staff members to ensure they accurately identify, categorize and document the disposition of exempt grievances. -Screenshot of the plan's "Call Tracking Wizard" as evidence that the member service reps have a designated code to input for exempt grievances. **11/4/16** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - The MCP submitted a blank Exempt Grievance Report

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	action is taken by the appropriate leadership. • A training module was developed specifically for CSC staff and conducted in March 2016 to ensure accurate identification and coding of exempt grievances during the intake process. • Training was also provided to A&G staff in March 2016 as a refresher to assist staff in accurately identifying, categorizing and documenting the disposition of grievances. A&G staff were also introduced to the new exempt grievance monitoring and tracking process. • Additionally, policy Appeals and Grievance AG-19 specifically outlines the documentation process and was re-issued to staff for education and training purposes.			template that is used to track exempt grievances. The report contains all of the requirements set forth in Title 28 1300.68. - The MCP submitted the A&G Committee Meeting agenda and meeting materials from the August 23, 2016 meeting. Exempt grievances are a topic on the agenda and an exempt grievances presentation is located on page 32 of the meeting packet. - Memo from the MCP regarding exempt grievances states that the exempt grievance reports are reviewed quarterly by the A&G Committee. **This finding is closed**.
3. The Plan does not consistently identify, resolve, and track all issues contained in members' grievances.	The Plan immediately implemented remediation efforts to ensure the Plan is able to consistently identify, resolve, and track all issues contained in members' grievances to include: • The A&G Department developed an internal quality monitoring and review process to conduct an independent, secondary review of all acknowledgement and resolution letters. The quality team's review tool assesses whether all of the issues were accurately identified, documented and resolved. The review team confirms that all issues were routed to the appropriate	3a AG-19 GA Process 3b Grievance SOP 3c MHC SOP GA Quality Team 3d Staff Meeting Sign in	3/31/16	**05/13/16-** The following documentation submitted supports the MCP's subsequent efforts to correct this finding: -"SOP: QTP2 Quality Review Process" (11/01/15) as evidence of the plan's internal quality monitoring and review process to ensure all member concerns have been investigated and a clear resolution is provided.

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	department for corrective action and that resolution actions are documented in the grievance database and enrollee resolution letter. The quality monitoring tool is reviewed by A&G leadership on a bi-weekly basis to address any potential staff performance issues and to ensure continued improvement. • An A&G team meeting was held in January 2016 to provide refresher training to ensure that all staff are aware of this requirement and are providing consistent and adequate consideration to the enrollee's grievance. • Additional refresher training will be held on 5/16/16 for all A&G staff to review the Plan's policies and procedures for identification, documentation and rectification of the enrollee's grievance. • On a quarterly basis, the grievance trend report is reviewed through A&G Committee for follow up and corrective action. Additionally, any issues or trends identified through the exempt grievance report will be escalated through A&G Committee to other high level oversight committees within the Plan to ensure immediate follow up and corrective action is taken by the appropriate leadership in those functional areas.			-"Appeals & Greivances Department Agenda" (03/01/16) as evidence that the plan conducted training on the audit findings including the need to address all member concerns. **11/4/16** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - The MCP submitted a screen shot from of the audit tool used during the grievance internal QA process. The tool contains a field to confirm whether all issues from the grievance have been addressed. **This finding is closed.**
4. The Plan's grievance acknowledgment and resolution letters do not consistently display the Department's toll-free telephone number, the Department's TDD line,	In response to the Department's finding related to acknowledgement and resolution letter consistency and accuracy, the Plan immediately implemented the following corrective actions: • All acknowledgement and resolution letter templates were updated to reflect Department's toll-free telephone number,	4a Staff Meeting Sign in 4b MHC SOP Quality Team 4c Medi-Cal Template	1/30/16	**05/13/16-** The following documentation submitted supports the MCP's subsequent efforts to correct this finding: -"SOP: QTP2 Quality Review Process" (11/01/15) as evidence

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the Plan's telephone number, and the Department's Internet website address in 12-point boldface type.	the Department's TDD line, the Plan's telephone number, and the Department's Internet website address in 12-point boldface type. • An A&G team meeting was held in January specifically to review the letters and to ensure that all staff are aware of this requirement and are consistently and accurately using the recently updated letter templates. • Additional refresher training will be held on 5/16/16 for all A&G staff to confirm they are using the accurate letter templates centrally located on the department's internal SharePoint site.	Letters		of the plan's internal quality monitoring and review process to ensure that the correct template is used. -"Appeals & Grievances Department Agenda" (03/01/16) as evidence that the plan conducted training on the audit findings including the requirement to use the correct template. -Acknowledgement and Resolution template letters as evidence that the required language is displayed in the correct format. **This finding is closed.**
5. The Plan's responses to member grievances do not clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination for the delay, modification, or denial of services based on medical necessity.	To ensure the Plan's responses to member grievances clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination for the delay, modification or denial of services based on medical necessity, the Plan has implemented several key process improvements. The Plan has revised and updated relevant policies as noted below to ensure compliance with the requirement. The Plan has provided the following documentation: • Policy CA-HCS-CAM-351, Notification of Denial, Deferral or Modification Request for Plan Authorization of Services, revised to reflect the relevant standards. • A summary of the templates to be used for	5a Denial Language Training 5b HCS-CAM-351 Policy 5c Denial Language Templates 5d1 Denial Templates Training Agenda 5d2 Denial Templates Training Sign-In Sheets	5/31/16	**05/13/16-** The following documentation submitted supports the MCP's subsequent efforts to correct this finding: -PowerPoint "Denial Language Training" (01/22/16) as evidence that were trained on how to compose clear denial language. -Denial language template language that has been created for specific scenarios. The user can customize the language and is required to input the criteria used as the basis for the denial.

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	Plan reasons for decisions to deny, delay, or modify provider requests. In addition, the Plan created a 'Denial Language Seminar' to ensure staff is aware of the regulatory requirements. The Seminar included a post seminar examination for participants at the conclusion of the event. The Plan held the first such Seminar on January 25, 2016. Training materials for the Seminar are attached as supporting documentation. The Plan will also institute regular, ongoing training sessions on the use of the new template so that Medical Directors are consistently updated with regard to new additions to the templates and lessons learned from applicability of the templates. Attached to this response is a draft schedule of training sessions on the new template, which will include sign-in sheets, evaluations, and break out practice sessions for participants. The plan will also ensure the application of the templates and evaluate the quality and consistency of clinical decision-making of Medical Directors by conducting an annual quality review Inter-rater Reliability as is described in Policy UM-38, Application of Review Criteria/Guidelines; Physician Inter-rater Reliability as provided in the attached documentation. The Plan will require use of the new template language starting no later than May 1, 2016. Training will be conducted on the use of the new templates in April 2016.	5d3 Denial Templates Training Materials 5e UM-38 Policy		-PowerPoint "Medical Director Denial Language Training – Best Practices and Resources for Effective Member Communication" (April 2016) as evidence that medical directors were trained on the audit findings and appropriate denial letter language. -P&P UM-38: "Application of Review Criteria/Guildelines; Physician Inter-rater Reliability" (05/15/15) as evidence that the plan has processes in place to ensure consistent application of criteria via IRR. **11/4/16** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - 2016 Inter-Rater Reliability analysis (05/18/16) which summarizes the results of the MCP's most recent IRR. The MCP met its goal of 90%. - Medical Director Quarterly Audit Q2 2016. The MCP audits Medical Director determination files are audited on a quarterly basis to ensure the Plan provides clear and concise explanations,

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				descriptions of the criteria or guidelines used, and the clinical reasons for the Plan's decisions to deny, delay, or modify services based on medical necessity. 6 out of 9 directors received a pass score. Training will be implemented for Medical Directors that received a "no pass" score. **This finding is closed**
6. The Plan does not have policies and procedures that enable members to make a standing request to receive all informing material in a specified alternative format.	In response to this finding, the Plan revised policy Disability Services DS-01 "Seniors and Persons with Disabilities: Accessible Healthcare" to reflect a procedure that enables members to make a standing request to receive all member informing material in a specified alternative format. The redlined version of the policy is attached with an expected final approval date of June 30, 2016. The Disability Services (DS) Department is engaged with IT to determine whether any system enhancements are needed to place identifiers in member QNXT profiles to ensure the Plan will be able to identify members who have made standing alternative format requests and fulfill those requests in a timely manner. Member Services and other relevant staff such as Member Appeals and Grievances, Healthcare Services, Pharmacy, Government Contracts and Quality staff will be trained to intake and record standing member requests for alternative formats	6a DS-01 Policy	7/15/16	**05/13/16-** The following documentation submitted supports the MCP's subsequent efforts to correct this finding: -DS-01: "Seniors and Persons with Disabilities: Accessible Healthcare" policy which includes processes to ensure members can make a standing request to receive all informing material in a specified alternative format. **This finding is closed**

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	according to the revised policy. In addition, a communication regarding the revise policy outlining the process will be sent to all Plan staff to ensure awareness of the process on June 11, 2016. All recipients will be required to attest that they have read and understood the policy and procedures related to standing requests by July 15, 2016.			
5. Quality Management				
7. The Plan's Quality Improvement Program does not take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf.	The Plan instituted several significant internal improvements to take effective action to address any needed improvements on potential quality of care (PQOC) issues related to Providers. As an immediate remediation effort, the staffing model for Medical Director participation in the PQOC process was redesigned to increase the number of Medical Directors assigned to the review of PQOCs. The redesign includes the assignment of a Lead Medical Director who will oversee the review and reporting process and provide guidance to the team. In addition, 5 Regional Medical Directors have been assigned to the review of cases for Providers in their regions. A third RN was also added to the PQOC team to increase timeliness of case processing. Assignments of PQOC cases have been re-routed to reflect consistency in line of business and county. Cases will be reviewed by Medical Directors familiar with the County or line of business so that patterns of member grievances and concerns about deviation from the expected standard of care can be	7a PQOC Workflow 7b Average TAT Report 7c Cases Pending Template 7d MD Reviewer CHAMP tool 7e Memo – PQOC Workflow 7f PQOC Medical Director Workflow 7g Outstanding Cases Template 7h PQOC CAP Policy draft 7i PQOC Tracking Log	10/01/15 3/31/16	**05/13/16-** The following documentation submitted supports the MCP's subsequent efforts to correct this finding: -"CHAMP Application Overview for Medical Director PQOC Review" job aid and "PQOC Database" desktop reference manual as evidence that medical directors were trained on the plan's migration to the new electronic database. -"MHC PQOC Medical Director Workflow" (04/04/16) as evidence that designated medical directors are assigned to each region. **09/28/16** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding:

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	more readily identified. The Medicare and SNF/LTC PQOC cases will also have dedicated Medical Directors assigned to identify and review cases. To date, the newly assigned Medical Directors have reviewed all current cases and worked as a team to ensure consistency in assignment of severity level. The Lead PQOC Medical Director's key responsibilities include: • To provide oversight of the Medical Director Review process; train new Medical Directors and maintain ongoing process integrity for all Medical Directors participating in the PQOC reviews. • Meet regularly and as needed with review Nurses to address both routine and urgent concerns. • Report to the CMO on a regular basis as well as to escalate issues impacting the PQOC process. • Ensure the Medical Director Review process is performed in a manner in which it's intended and provide coverage for reviews when the primary assigned Medical Director is not available. Additionally, the staffing model redesign ensures consistent and regular involvement of the CMO through scheduled and ad hoc meetings with the PQOC Lead Medical Director. CMO participation in the Medical Director review process and in the training of new Medical Directors in the PQOC process will ensure the appropriate level of attention from senior leadership. To ensure consistency in the Medical Director	Template 7j PQOC Database Reference	8/31/16 1/04/16	- QM 110 Potential Quality of Care (PQOC) Corrective Action Plan Monitoring and Tracking (06/02/16) was revised and approved. The severity levels have been modified to better identify quality of care issues. **This finding is closed.**

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	Review Process, the PQOC case review training will be added to Medical Director Meetings (twice a year-scheduled for Q3 and Q4 2016). The training material will include cases reflective of actual cases and will be distributed to all PQOC Medical Directors for their review and assignment of severity level prior to the meeting. Cases will then be reviewed as a group at the Medical Director meeting. Alignment of the severity level assignment will be reported and variations from the appropriate level will be reviewed as a team. Through this process, the PQOC Lead Medical Director can identify whether further training is required. The Chief Medical Officer (CMO) participates in this process by independently reviewing the training cases and participating in the Medical Director meeting to discuss cases as a team. To further improve the PQOC review process, the Plan has transitioned from a paper based review process to an electronic based process with the implementation of a centralized PQOC database effective Jan 4, 2016. This database is built upon the Compliance HIPAA Management Program (CHAMP) to provide consistent, effective review of PQOC cases and ensure cases advance through the plan review process. The CHAMP platform allows for: • Clearly defined severity levels. • Electronic file uploading, file review, and Medical Director Case review notation and severity leveling. • A PQOC Database Desktop Reference Guide for consistent staff and Medical Director training and reference.		12/01/15	

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	• Electronic reporting of open cases, review and corrective action plan status. • PQOC reporting that identify trends in line of business and county. Reports identify outstanding cases, turnaround times and cases pending provider follow-up. These reports will be pulled monthly and presented to the PQOC Lead Medical Director. • PQOC Lead Medical Director visibility on tracking and trending, status of outstanding cases and turnaround times. In preparation for the conversion to electronic based reviews using the CHAMP database, several policies and procedures were revised to reflect the updated process. Policy & Procedure (P&P) Quality Management QM 01A Potential Quality of Care-PQOC and QM 01B Potential Quality of Care - PQOC for CBAS SNF and MSSP were reviewed and revised. Severity Level revisions were approved at the 12/1/15 Quality Improvement Committee (QIC) meeting. The revised 2016 CHAMP Severity levels more precisely identify quality of care issues: • Level 1: No quality of care issue identified • Level 2: Adverse occurrence, handled appropriately by provider • Level 3: Moderate deviation from the standard of care • Level 4: Significant deviation from the standard of care <u>In addition, a PQOC Corrective Action Plan (CAP) P&P is in development to clearly define the processing and follow-up of CAPs. The policy will be</u>			

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	presented at the 5/24/16 QIC meeting for review and approval. The draft policy is attached and addresses: • Development of tracking log for CAPs issued to ensure timely completion and documentation of outcomes. • Review of open Tracking Log issues as a standing agenda item for each Peer Review meeting. Any PQOC cases which are pending due to non-responsive providers or IPAs, non-closed incomplete CAPs, or incomplete peer reviews will be escalated first to PQOC Lead Medical Director then to CMO as outlined in the CAP policy.			