

MEDICAL REVIEW – SAN FRANCISCO SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

**Molina Healthcare
of
California Partner Plan, Inc.**

Contract Number: 06-55498 A13; 07-65851 A09;
and 09-86161 A05

Audit Period: June 1, 2012
Through
May 31, 2013

Report Issued: January 10, 2014

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I. INTRODUCTION

Molina Healthcare of California Partner Plan, Inc. (MHC or the Plan) has been contracted by the State of California Department of Health Care Services since April 1996 under the provisions of Section 14087.3, Welfare and Institutions (W&I) Code. As of July 1, 2006, Molina Healthcare of California Partner Plan, Inc. is the Medi-Cal contracted Commercial Plan for Riverside and San Bernardino Counties, and a Geographic Managed Care plan for Sacramento and San Diego Counties.

MHC is a Long Beach based health maintenance organization that was founded in 1980 and is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act. MHC is a National Committee on Quality Assurance (NCQA) accredited health plan.

The Plan provides healthcare services to Members through arrangements with 45 Independent Physician Associations (IPAs), 2,883 Primary Care Physicians (PCPs), 60 hospitals, 8,044 Specialists, and 17 Molina Medical Group (MMG) clinics.

As of May 17, 2013, MHC serves Members in three different programs. These programs include Medi-Cal, Medicare, Healthy Families, and Low Income Health Program (LIHP). Enrollment in these programs is as follows;

- Medi-Cal: 234,514
- Medicare: 8,500 (2012 figure)
- Healthy Families: 667
- Low Income Health Program (LIHP): 10,852

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of June 1, 2012 thru May 31, 2013. The on-site review was conducted from September 16, 2013 through September 27, 2013. The audit consisted of document review, verification studies, and interviews with Plan personnel.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability to Care, Member's Rights, Quality Management (QM), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan's mechanisms to detect underutilization are minimal and inadequate. The Plan's usage of metrics of low bed day utilization and ER usage are not valid mechanisms for detecting underutilization. The Plan's Health Care Services Program Description contained goals and metrics that Plan staff could not explain.

The Plan frequently exceeded the required time frames for processing prior authorization requests and did not ensure consistent application of appropriate UM guidelines. Inappropriate denials were issued with indication of facts that were not supported by an examination of the medical record or Medi-Cal guidelines.

The Plan did not have a specialty referral system to track and monitor referrals, authorizations, and denials. It does not integrate reports on the number, and types of appeals, denials, deferrals and modifications into the Quality Improvement System.

The Plan's Prior Authorization appeal process has significant and material deficiencies. The Plan stated that board certified specialists review appeals, but provided no evidence that this review occurs. There is no evidence that appeals are reviewed by licensed physicians, or that determinations are made by individuals not involved in the initial denial. The Plan upheld denials that did not adhere to presented criteria.

The requirements for the Delegation of Utilization Management were not applicable for Advanced Imaging, as it is a wholly owned subsidiary not a subcontractor subject to delegation provisions.

Category 2 – Case Management and Coordination of Care

The Plan's Case Management Policies *CM-02* and *CM-04* do not define Basic and Complex Case Management as they are defined by the Contract. The Plan submitted a "List of Members Receiving Basic Case Management and Complex Case Management" and it did not identify all Members as eligible for Basic Case Management. The list showed only 1,842 Members received Basic Case Management. During the audit, a review of 25 medical records showed that none of the 25 Members' records evidenced adequate Basic Case Management and none were on the aforementioned list.

The Plan was not in compliance with the requirements for California Children's Services (CCS). It was verified in medical record reviews and in interviews with Providers that the Plan did not maintain current rosters for Members receiving services from CCS. Without accurate identification of Members needing or receiving CCS services, the Plan was unable to demonstrate its ability to coordinate services.

The Plan was not in compliance with requirements for Early Intervention/Developmental Disabilities (EI/DD). It was verified in medical record reviews that the Plan did not maintain current rosters for Members receiving services from the Regional Center. Without accurate identification of Members requiring services from the Regional Center, the Plan was unable to demonstrate that it effectively coordinated care for Members receiving EI/ DD services and Services for Persons with Developmental Disabilities.

The Plan was not in compliance with the requirements for Initial Health Assessment. A Medical Record Review established that in a sample of 25 Members, 21 IHAs were missing, incomplete, or not accomplished within the required time frame of 120 days of enrollment for Members age 18 months and older or within 60 days of enrollment for Members who are less than 18 months old.

Category 3 – Availability and Accessibility

The Plan did not monitor waiting times in the provider's offices. The Plan's annual appointment availability and accessibility standards survey is based on self-reported data and the results had not been validated.

The Plan relies on grievance reports to validate that no access problems exist, however deficiencies in the grievance system render it an unreliable method for detecting access problems.

Emergency and Family Planning services claims were denied due to prior authorization in violation of the Contract. The Plan did not ensure that clean claims (Emergency services) were paid timely, or misdirected claims (both Emergency and Family Planning services) forwarded to appropriate capitated providers, within the required time frames.

The Plan does not have monitoring procedures to ensure the provision of all drugs prescribed in emergency circumstances.

Category 4 – Member’s Rights

The Plan’s Grievance system has significant and material deficiencies. The Plan’s grievance system does not capture all complaints, categorize inquiries that should be grievances, ensure that grievances are reported to an appropriate level, or capture complete grievance data for systematic aggregation and analysis. The Plan has acknowledged that it under-reported grievances, and that there were coding and referring problems in need of correction.

The Plan does not capture all complaints and expressions of dissatisfaction regarding the Plan and providers. The Plan received 461,500 inquiries and classified 219 as grievances. Criteria, tools, training and oversight to ensure appropriate classification of inquiries as grievances are lacking. Identified grievances are classified as Quality of Care or administrative by non-clinical personnel. No oversight is conducted by clinical personnel to ensure proper identification of all clinical Quality of care issues. Identified Quality of Care issues are not thoroughly addressed by the CMO/Medical Director. Trends are not identified among Quality of Care issues flagged as to be tracked and trended.

For two grievance cases related to requests for interpreting services, one of which involved a threshold language, the Plan did not translate and send the grievance acknowledgement and resolution letters in the Member’s designated languages.

The Plan did not submit the HIPAA breach notices and investigations to the required DHCS personnel within the required time frames.

Category 5 – Quality Management

The Plan’s QI Department was not directly involved in training call center employees and did not provide them with tools to ensure reliable identification and classification of inquiries, grievances, and Potential Quality of Care (PQOC) issues.

The Quality Improvement Committee (QIC) is an integral part of the Plan’s Quality Improvement System (QIS). The committee’s membership does not reflect significant involvement of contracted physicians from the community. The Plan’s Medical Director was absent at all QIC meetings during the audit period.

Medical records were not always maintained in a legible, detailed, and comprehensive manner as required by the Contract. The records reviewed did not consistently contain the minimum content required by the Contract. Many records lacked evidence of preventive health screenings. Procedures were not consistent with guidelines set forth in periodicity schedules as required by the Contract.

The Plan was not in compliance with Informed Consent for sterilization procedure per regulatory and contractual requirements. Informed consent was not always completed within the required time frame and with the rendering Provider's signature on the sterilization consent form on the day of the procedure.

Category 6 – Administrative and Organizational Capacity

The medical director's methods of ensuring standards for acceptable medical care are inadequate.

The Plan did not ensure that all newly contracted providers receive training within ten (10) working days after being placed on active status.

The Plan failed to notify DHCS of potential fraud cases within the required time frame.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that the medical services provided to Plan Members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The on-site review was conducted from September 16, 2013 through September 27, 2013. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Utilization Management – Category 1

Prior Authorization Requests: 95 medical and 27 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Notification of Prior Authorization Denial, Deferral, or Modification: 122 denial and modification letters were reviewed for written notification requirements.

Appeal Procedures: 19 prior authorization appeals were reviewed for appropriate and timely adjudication.

Case Management and Coordination of Care – Category 2

CCS: 8 medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

EI/DD: 5 medical records were reviewed for evidence of coordination of care between the Plan and Regional Centers.

Non-EI/DD, Non-CCS: 12 medical records were reviewed for evidence that baseline examination was sufficiently comprehensive to establish possible CCS and/or Regional Center eligibility.

Availability and Accessibility – Category 3

Emergency Service Claims: 17 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 15 family planning claims were reviewed for appropriate and timely adjudication.

Member's Rights – Category 4

Grievance Procedures: 65 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. In addition, 19 inquiries were reviewed.

Quality Management – Category 5

Medical Records:

61 records were requested, 9 were missing.

25 medical records were comprehensively reviewed for compliance with requirements.

11 medical records were reviewed for compliance with informed consent requirements.

Administrative and Organizational Capacity – Category 6

New Provider Training: 27 new provider training records were reviewed for timely Medical Managed Care program training.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

DATE OF AUDIT: September 16-27, 2013

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1

UTILIZATION MANAGEMENT PROGRAM

Utilization Management (UM) Program Requirements:

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. ...(as required by Contract)

GMC/2-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

GMC/2-Plan Contract A.5.2.C

Under- and Over-Utilization:

Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.

GMC/2-Plan Contract A.5.4

SUMMARY OF FINDINGS:

The Plan is required to include mechanisms in its UM Program to detect under-and over-utilization of services. An examination of the Plan's UM Program processes showed the detection of under-utilization was insufficient as the UM Committee's central emphasis was over-utilization and its metrics for under-utilization lacked validity.

The UM Committee met quarterly and presented measures for bedday utilization, ER visits, readmission rates, specialty pharmaceutical usage, and generic prescribing. While thresholds were presented for both over- and -underutilization in these areas, the emphasis was over-utilization without discussion of possible under-utilization. Metrics that may indicate under-utilization (high ER rates, readmission rates) were discussed in a context of over-utilization and budgetary impact. Discussion of possible access problems or under-utilization as causing high bed days, ER visits or readmissions was omitted. There were no examples of thresholds for low utilization for inpatient and ER being reached. Staff could not explain how low inpatient usage or ER usage would be valid indicators of under-utilization. The only demonstration of mechanisms to detect under-utilization was the measure of generic drug usage for hypertension and diabetes.

The Plan did not ensure that denials were appropriate or represented consistently applied criteria. Denial rates were not examined to detect unwarranted variation or possible under-utilization. Denials were not reported by medical necessity vs. not a covered benefit.

The Plan's 2013 Health Care Services (HCS) Program Description contained goals for admissions and readmissions that UM Staff, CMO and Medical Directors were unfamiliar with, and could not explain. The goals were considerably higher than historic performance, and the goal for readmissions was expressed as a percentage per annualized thousand, a metric that Plan staff could not explain.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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The Plan's written guidelines were not based on sound medical evidence. There was no evidence that they were regularly reviewed or updated. Guidelines were presented for GLP-1 Analogues, Xarelto and Baraclude that had no effective or approval date, and were neither indexed nor formatted as other guidelines reviewed. The Human Growth Hormone guideline placed a restriction on its usage in Turner Syndrome which was not supported by the references cited, or other scientific resources.

The requirements for the Utilization Management Program were not met, with respect to under-utilization and lack of valid measures and reasonable goals.

RECOMMENDATIONS:

- Develop and maintain a HCS Program Description which contains goals that are reasonable in light of past performance and expressed in valid units of measurement.
- Familiarize all involved personnel with HCS Program Description goals as strategic targets.
- Develop and implement mechanisms to systematically detect underutilization. Analyze existing metrics such as high ER usage rates in the context of ambulatory underutilization. Discontinue the use of measures that are not valid indicators of underutilization, such as low bedday utilization.
- Index with an approval and effective date all internally developed UM guidelines.
- Eliminate restrictions on therapy that are not supported by references.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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DATE OF AUDIT: September 16-27, 2013

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements...(as required by Contract)

GMC/2-Plan Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:

Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

GMC Contract A.5.2.G

Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2-Plan Contract A.5.2.G

Notification of Prior Authorization Denial, Deferral, or Modification:

Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

GMC Contract A.13.8.A

Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

2-Plan Contract A.13.8.A

SUMMARY OF FINDINGS:

The Plan stated that they used Medi-Cal Guidelines, InterQual, Apollo, and proprietary guidelines to process prior authorizations. Proprietary guidelines were developed by the corporate parent and approved and adopted by the regional Plan UM or P&T Committee. The Plan used criteria/guidelines for Baraclude, Xarelto and GLP-1 therapies that did not document an approval date or effective date. It did not index these guidelines, or record them in a standard format. There was no evidence that they were developed and adopted prior to denial of authorization requests for these therapies.

The Plan submitted a file containing the universe of prior authorizations. This file contained decision dates that were inaccurate and 82 of 95 files examined had incorrect dates. The Plan submitted information in this file indicating decisions were made earlier than supported by documentation.

The Plan frequently exceeded time frames for decision making:

- greater than 5 working days after all necessary information is received (11 of 95 files).
- greater than 14 days without notice to Member and Provider, or recording specific reason for delay and how it is in Member's interest (40 of 95 files).
- greater than 28 days (12 of 95 files).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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Pharmacy denials were in excess of required 24 hour turnaround time (15 of 27 reviewed).

The Plan issued inappropriate denials, stating facts that were not supported by an examination of the medical record or Medi-Cal guidelines. For example:

- Quoted a lack of labeled indication of pseudobulbar affect for a Nuodexta prescription, when the medical record contained description of symptoms of pseudobulbar affect – spontaneous outbursts of laughter.
- Quoted a Child Pugh Score of 7 as a reason for denial of Hepatitis C therapy. This score was not supported by medical record.
- Denied special formula for a premature infant because the Member did not have g-tube. This is not a limitation of the Medi-Cal benefit for premature infants.
- Denied operative treatment of fractures (non CCS diagnosis related conditions) when provided by a non CCS provider.

The Plan did not clearly document reasons for denial with Members/Providers in denial letters. For example:

- Zemaira was denied because the Member had not been abstinent from tobacco long enough, but there was no mention of the length of time a member needed to abstain from tobacco prior to Zemaira approval.
- The Plan included medical terminology incomprehensible to laypersons, such as Pugh Scores.

The Plan did not integrate UM and QI by referring inappropriate prescribing to the QI System. The Plan simply denies these requests, without further action. For example:

- Erythropoietin was requested in a member with uncontrolled hypertension.
- Humira was requested in patient undergoing treatment for tuberculosis.

The Plan denied Baraclude for noncompliance. It made no effort to offer case management services, or provide notice to the Provider or Member of possible denial of therapy based on noncompliance.

The requirements for Prior Authorizations were not met, due to the Plan exceeding decision timeframes, failing to adhere to Medi-Cal criteria and internal guidelines, and not clearly documenting reasons for denial.

RECOMMENDATIONS:

- Implement a system for all criteria/guidelines to clearly indicate an effective date (demonstrating consistent application), and the approval date (indicating they have been reviewed and updated as needed). An index and consistent format would help demonstrate the consistent application of guidelines.
- Review authorization logs and information presented in responses to audit requests for accuracy. Ensure dates of decisions accurately reflect the actual dates of decisions that are supported by documentation.
- Adhere to required timeframes for authorization decisions, for both medical and pharmacy prior authorizations.
- Adhere to Medi-Cal criteria and internal guidelines when issuing denials. Consult with qualified medical personnel familiar with diagnostic criteria before denying services based on lack of indication.
- Authorize covered services for non CCS diagnoses in CCS patients, and provide coordination of care between CCS and non CCS providers.
- Clearly communicate complete reasons for denial to Member and Provider, including what steps a Member may take to demonstrate medical need, and subsequently receive medically necessary care. Use clear language in terms comprehensible to laypersons.
- Integrate UM and QI by referring denials based on inappropriate prescribing to the QI system.
- Use noncompliance as a basis for denial of therapy only where reasonable efforts have been made to encourage compliance (case management, notice to provider and Member).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

DATE OF AUDIT: September 16-27, 2013

1.3

REFERRAL TRACKING SYSTEM

Referral Tracking System:

Contractor is responsible to ensure that the UM program includes: ... An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

GMC/2-Plan Contract A.5.1.F

SUMMARY OF FINDINGS:

The Plan did not have an established specialty referral system to track and monitor referrals requiring prior authorization. No process to integrate UM Activities into the Quality Improvement System using reports on the review of number and types of denials, deferrals and modifications was in place. The Plan stated that they have de-facto delegated referral tracking to PCPs. They did not identify this as a delegated UM activity to a subcontractor, nor did they have delegation agreements or oversight activities.

In response to questions about tracking of referrals requiring prior authorization, Plan personnel presented a report entitled "Referral Log Report". They represented this as evidence of tracking of Prior Authorizations. The report did not contain prior authorizations contained in the universe file shared pre Audit with the Department. It contained referrals for services that did not require a prior authorization.

Reviews of grievances, appeals, inquiries and a statement from a participating PCP in a delegated group disclosed that referrals were lost, delayed or otherwise unaccounted for.

The requirements for the Referral Tracking System were not met as the Plan did not have a specialty referral tracking system.

RECOMMENDATIONS:

- Develop and implement a system to track and monitor referrals, authorizations, and denials.
- Include the types of appeals, denials and deferrals and modifications:
 - The specific services requested
 - Reasons for denial or modification
 - Personnel making decisions to deny or modify.
- Integrate reports on the number, and types of appeals, denials, deferrals and modifications into the Quality Improvement System
- Use information from grievances, appeals and inquiries to ensure systems are in place to prevent lost, delayed or missing referrals.
- Track services that are authorized, but not rendered.
- Conduct oversight to ensure that delegated entities are tracking referrals.
- Familiarize all personnel with referral tracking systems, reports and their content, so as to be able to represent all reports shared with the Department in a straightforward and accurate manner.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

DATE OF AUDIT: September 16-27, 2013

1.4

PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:

There shall be a well-publicized appeals procedure for both providers and Members.
GMC Contract A.5.2.E

There shall be a well-publicized appeals procedure for both providers and patients.
2-Plan Contract A.5.2.E

SUMMARY OF FINDINGS:

The Plan's Prior Authorization appeal process has significant and material deficiencies.

The Plan stated that board certified specialists review appeals, but provided no evidence that this review occurs. There is no evidence that appeals are reviewed by licensed physicians, or that determinations are made by individuals not involved in the initial denial. No record is kept of attempts to obtain relevant medical records. Lost requests are not addressed. Denials that do not adhere to the Plan's own UM guidelines are upheld.

Although the Plan stated that they do not enforce any time limit on materials submitted by members in support of an appeal, the Plan's Policy *PO-20 Member Appeals Process* improperly limits the time in which a Member can submit evidence to 5 days from receipt of acknowledgement of the appeal.

The Plan did not document the identity or review findings of the board certified specialist that it quoted as upholding the denials in the Member notification letters. The Plan did not document its attempts to obtain medical records, and subsequently upheld denials because of records not received. The Plan upheld denials that did not adhere to presented criteria (criteria allowed for referral of chronic hordeolum to ophthalmology, while the Plan upheld a denial and redirected Member to optometry; Plan denied an excision of a mass as cosmetic, when symptoms of pain were documented in the record). The Plan did not document reasons related to missing authorizations/denials from delegated entities. The Plan's tracking of appeals contained errors in resolution date and disposition.

A sample of 19 appeals was selected for review:

- 19 of 19 had no documentation of the review conducted by the specialist, or the identity of the specialist from the Specialty Advisory Panel. The identity of the professional making the appeal decision was not documented.
- 2 of 19 were upheld because of lack of records received from the attending physician, without any documentation of communication efforts or attempts to obtain the records.
- 2 of 19 were upheld although they met guidelines for authorization.
- 1 of 19 stated there was no record of a denial by a delegated entity. During the course of the Appeal being processed, an authorization was submitted and subsequently approved by the IPA. The missing denial and subsequent authorization were not explained by the notes in the Appeal file.
- 1 of 19 contained a resolution date in conflict with a subsequent note that stated the case had not yet been resolved.
- 1 of 19 listed the denial as upheld, when it was overturned.

The requirements for the Prior Authorization Appeal Process were not met due to the 5 day limit for Members to submit evidence, failure to document identity or review findings of specialist upholding denials, and upholding denials not adhering to criteria.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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RECOMMENDATIONS:

- Revise the Plan's Policy and Procedure for Appeals to allow the Member a reasonable opportunity to submit supporting evidence, and inform the Member of any time limitations in the acknowledgement letter.
- Document the identity of the board certified specialists reviewing the denial and their review notes in the Plan's internal Appeals files.
- Document that a licensed medical professional not involved in the initial denial makes appeal decisions.
- Document efforts made to secure medical records, if lack of records is used as a reason to uphold a denial.
- Follow utilization criteria when considering appeals, and overturn denials that do not adhere to criteria.
- Accurately track resolution dates and disposition of Appeals.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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1.5

DELEGATION OF UTILIZATION MANAGEMENT

Delegated Utilization Management (UM) Activities:

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.

GMC/2-Plan Contract A.5.5

SUMMARY OF FINDINGS:

Prior Authorizations processed by Advanced Imaging were not included in the universe of Prior Authorizations performed by the Plan. Advanced Imaging's Notice of Action letters and utilization criteria were not available, nor were their personnel present for the interview of the Plan's UM Department.

Advanced Imaging is a wholly owned subsidiary of the Plan's parent corporation and under the parent organization's control. It was not a subcontractor subject to contract provisions related to the delegation of UM activities. The Plan is wholly accountable for UM activities performed by other units of the same corporate entity.

The requirements for the Delegation of Utilization Management were not applicable for Advanced Imaging, as it is a wholly owned subsidiary not a subcontractor subject to delegation provisions.

RECOMMENDATIONS:

- Include all Prior Authorizations processed by Advanced Imaging in the universe of Prior Authorizations performed by the Plan.
- Make available to DHCS auditors all notice of action letters, utilization criteria and utilization reports from Advanced Imaging.
- Include licensed and administrative personnel from Advanced Imaging in interviews of UM Department personnel.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1

CASE MANAGEMENT AND COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN

Case Management and Coordination of Services:

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network.

GMC/2-Plan Contract A.11.1

Out-of-Plan Case Management and Coordination of Services:

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services...

GMC/2-Plan Contract A.11.5

SUMMARY OF FINDINGS:

The Plan is required to maintain procedures to monitor care coordination including all medically necessary services for each Member through Comprehensive Case Management. These services include health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

Comprehensive Case Management services, delivered by the Primary Care Provider (PCP) in collaboration with the Plan, are to be provided through either Basic or Complex Case Management. According to the Contract, each Member must receive Basic Case Management which includes the initial health assessment, identification of providers to meet Member care needs, and coordination of carved out and linked services and referrals. In addition, the Plan must ensure that Members who require more intensive services receive Complex Case Management which includes Basic Case Management and provides multidisciplinary management of acute or chronic disease, intense coordination of resources including emotional and social support by a multidisciplinary case management team. Complex Case Management also includes the development of an individualized care plan with Member and PCP participation.

The Plan's Case Management Policies *CM-02* and *CM-04* do not define Basic and Complex Case Management as they are defined by the Contract. The Plan submitted a "List of Members Receiving Basic Case Management and Complex Case Management" and it did not identify all Members as eligible for Basic Case Management. The list showed only 1,842 Members received Basic Case Management. During the audit, a review of 25 medical records showed that none of the 25 Members' records evidenced adequate Basic Case Management and none were on the aforementioned list.

Comprehensive Medical Case Management services means services provided by a PCP in collaboration with the Plan to ensure the coordination of medically necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and continuity of care for Members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs. A medical record review established that the requirement for preventive services and continuity of care was not met.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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Basic Case Management includes the Initial Health Assessment (IHA). A Medical Record Review established that in a sample of 25 Members, 21 IHAs were missing, incomplete, or not accomplished within the required time frame of 120 days of enrollment for Members age 18 months and older or within 60 days of enrollment for Members who are less than 18 months old. The requirement for IHA completion is based upon the enrollment date. There was no documentation to explain why the IHA was not completed within the required time frame.

Basic Case Management also includes coordination of carved out services such as California Children's Services (CCS). The Plan did not reliably identify CCS Members for Basic Case Management. When interviewed, the Plan's Director for CCS was unable to provide a reasonable estimate of the number of members eligible for CCS. The Director for CCS is responsible for tracking and coordinating care and services for CCS eligible members. The best estimate of approximately 40 Members who were CCS eligible differed significantly from the roster submitted by the Plan that showed 2,544 newly enrolled members eligible for CCS. This statement by the Plan's Director for CCS was inconsistent with tracking of CCS Members receiving case management.

Complex Case Management includes Basic Case Management and the development of an individualized care plan with the participation of the Member and the PCP. The Plan's Policy *CM-04 Complex Case Management* states that care plans specific to Member's needs will be developed by the Case Manager with participation from the Member and PCP. The Plan's Policy *CM-02* defines Case Manager as a registered nurse with education and experience in case management.

The Plan provided three Complex Case Management care plans for review and each lacked evidence of individualized care planning and participation from the Member or PCP. The Contract requires that the Plan ensure Complex Case Management is provided by a multidisciplinary team but the care plans reviewed did not evidence an interdisciplinary plan. One care plan, with interventions that included teaching regarding etiology, complications, and self-management of diabetes and chronic obstructive airway disease, was created by a licensed clinical social worker whose qualifications for performing these interventions were not evident from her signatory. The Plan's Policy *CM-04* outlines the structure of a care plan that includes assessment, goals, interventions, and outcomes. In general, the three care plans lacked assignment of interventions to appropriate disciplines. One care plan included a "barrier" of mental illness but did not provide a goal or interventions relevant to that problem. Without disciplines assigned to interventions or goals and interventions assigned to a problem, verification that the Plan uses care planning to coordinate services was not possible.

Providers were interviewed and several reported they were unfamiliar with the Plan's Complex Case Management program. Some Providers explained that if Complex Case Management services were necessary they would be accomplished within their own practices or assistance would be sought from the Independent Practice Association. The Plan did not meet the requirement for Coordination of Care because it did not accurately track members, identify eligibility for case management, and/or consistently coordinate care.

RECOMMENDATIONS:

- Develop and implement policies and procedures that accurately reflect the contractual requirements for coordination of care including clarification of Basic Case Management, Complex Case Management, and Initial Health Assessment.
- Ensure that Providers understand the Plan's role in case management and how these services are coordinated with primary care.
- Develop and implement a monitoring system to ensure that initial health assessments are completed within required time frames and meet criteria established by the Contract for a comprehensive health appraisal.

❖ **COMPLIANCE AUDIT FINDINGS (CAF)** ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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- Develop and implement a system for identification of Members whose eligibility for services such as CCS and the Regional Center can be accurately tracked.
- Develop and implement care planning policies and procedures to ensure that care plans for Members receiving services under Complex Care Management meet the contractual requirement and are developed and implemented by qualified personnel from appropriate disciplines.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

DATE OF AUDIT: September 16-27, 2013

2.2

CALIFORNIA CHILDREN’S SERVICES (CCS)

California Children's Services (CCS):

Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program....(as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program...for the coordination of CCS services to Members.

GMC/2-Plan Contract A.11.9.A, B

SUMMARY OF FINDINGS:

Per Plan’s Policy *CM-03 CCS Program*, the Plan shall ensure coordination of care between the Plan, PCP, and CCS to provide health care services to eligible Members.

The Plan’s Policy *CM-02 Basic Case Management Program* stated that Basic Case Management Services are provided by the PCP in collaboration with the Plan to provide Initial Health Assessment, direct communication between Providers and Members, coordination of medically necessary services, and coordination of carved-out services such as CCS.

The Plan is responsible for identifying Members who would benefit from or who receive services from CCS. When interviewed, the Plan’s Director for CCS was unable to provide within reason, an estimate of the number of members eligible for CCS. The Director of CCS is responsible for tracking and coordinating care and services for CCS eligible members. The best estimate of approximately 40 Members who were CCS eligible differed significantly from the roster submitted by the Plan that showed 2,544 newly enrolled members eligible for CCS. This statement by the Plan’s Director for CCS was inconsistent with tracking of CCS Members receiving case management.

Eight CCS members were selected for medical record review. Evidence that each of the 8 CCS Members received all necessary screening and preventive medical services from PCPs was not found in the records. The IHAs for CCS Members were found to be incomplete and missing essential elements of screening and preventive services such as nutritional, dental, psychosocial, and developmental assessments. In 1 record reviewed, a child was referred for specialty services and the Plan denied the request because the child was “active on CCS”. The Provider documented that CCS did not show the child as an active CCS client.

Medical records for 6 non-CCS enrolled Members were reviewed. Baseline health assessments and diagnostic evaluations were not found to be sufficiently comprehensive and complete for identification of children with special health care needs who may require services through the CCS program.

The Plan did not meet the requirement for CCS because it did not demonstrate that it accurately tracked member eligibility and did not demonstrate that it ensured all necessary screening and preventive services were provided.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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RECOMMENDATIONS:

- Develop and implement a system to accurately identify Members whose eligibility and participation in CCS can be tracked.
- Develop and implement a monitoring system for Members receiving CCS services to ensure coordination of care between the Plan, PCPs, and CCS.
- Develop and implement a monitoring system to ensure Members enrolled in CCS are receiving all medically necessary diagnostic, preventive and treatment services through their PCPs.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

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2.3

EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

Services for Persons with Developmental Disabilities:

Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers...for the coordination of services for Members with developmental disabilities.

GMC/2-Plan Contract A.11.10.A, E

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services with Regional Center staff, which includes identification of all appropriate services, which need to be provided to the Member.

GMC Contract A.11.10.C

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

2-Plan Contract A.11.10.C

Early Intervention Services:

Contractor shall develop and implement systems to identify children under 3 years of age who may be eligible to receive services from the Early Start program and refer them to the local Early Start program...Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program.

Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

GMC Contract A.11.11

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program...Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

2-Plan Contract A.11.11

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

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SUMMARY OF FINDINGS:

According to the Contract, the Plan shall develop and implement procedures for the identification and referral of Members with developmental disabilities. The Plan provided a new Member spreadsheet that identified 84 Members were eligible for Regional Center services while the DHCS data sources showed that Regional Centers reported 86 Plan Members were receiving services. One Member who was identified by the Plan as receiving Regional Center services was an adult who did not have a qualifying condition and was not a Regional Center client.

A review of non-EI/DD Members' records showed the Plan was unable to identify and refer Members who are at risk or suspected of having a developmental delay. One Member was diagnosed with a speech delay but was not identified by either the Plan or the data available to DHCS as receiving services from the Regional Center(s).

It was verified in medical record reviews that the Plan did not maintain current rosters for Members receiving services from the Regional Center. Without accurate identification of Members requiring services from the Regional Center, the Plan was unable to demonstrate that it effectively coordinated care for Members receiving EI/ DD services and Services for Persons with Developmental Disabilities. **This is a repeat finding from 2005 medical audit.**

The requirement for Early Intervention/Developmental Disabilities was not met.

RECOMMENDATIONS:

- Develop and implement a system to accurately identify Members whose conditions qualify them for Regional Center services.
- Develop and implement a monitoring system for Members receiving services through the Regional Center to ensure coordination of care between the Plan, PCP, and the Regional Center.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

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2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR 53910.5(a)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

GMC Contract A.10.3.A

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

GMC/2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes...(as required by Contract)

GMC Contract A.10.6

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes...(as required by Contract)

2-Plan Contract A.10.6

Contractor shall repeated attempts, if necessary, to contact a Member and schedule an IHA.

Contractor shall make at least three documented attempts...Contact methods must include at least one telephone and one mail notification....

GMC Contract A.10.3.E

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

2-Plan Contract A.10.3.D

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

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SUMMARY OF FINDINGS:

The Plan did not ensure that IHAs were completed for new Members per regulatory and contractual requirements as evidenced by medical record reviews. The Plan's Policy # QM 10, *Initial Health Assessment, Provider Manual, and Member Services Guide* inconsistently state required timeframes for IHA completion. According to an interview with the Plan's Case Management staff, the Plan uses a timeframe of 120 days from the date of Member's enrollment for all age groups. The contract requires IHA completion within 60 days of enrollment for Members under 18 months of age, and 120 days for Members 18 months of age and older.

A Medical Record Review established that in a sample of 25 Members, 21 IHAs were missing, incomplete, or not accomplished within the required time frame of 120 days of enrollment for Members age 18 months and older or within 60 days of enrollment for Members who are less than 18 months old. The requirement for IHA completion is based upon the enrollment date. There was no documentation by the provider to explain why IHAs were not completed within the required timeframe.

The requirement for initial health assessment was not met.

RECOMMENDATIONS:

- Develop and implement a monitoring system to ensure IHA completion for new Members within the required timeframes per regulatory and contractual requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

GMC/2-Plan Contract A.9.3.A

Prenatal Care:

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

GMC/2-Plan Contract A.9.3.B

Monitoring of Waiting Times:

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments...

GMC/2-Plan Contract A.9.3.C

SUMMARY OF FINDINGS:

The Plan's policies *QM-09* and *PR-14* describe the accessibility standards for routine, urgent, specialty, and emergency care appointments and services. These standards were communicated to the providers via the Provider Manual and to Members via the Member Services Guide. The Plan monitored access through the Plan's Access and Availability committee (A&A Committee), a Quality Improvement subcommittee.

The Plan did not have a valid method of determining compliance with access standards. The Plan's annual appointment access and availability survey reliably measures prompted self-reported responses to close-ended questions of provider offices. There is no evidence that the responses from provider offices actually reflect appointment availability. The high compliance rates reported, and the contrast with CAHPS survey and grievance data suggest that the method is invalid.

The Plan submitted a report entitled *MHC CAHPS Brochure Survey Report 2013* that contains the statement:

"...we were informed that it normally takes a month or more for a person to secure an adult preventive care visit."

This statement indicates that the Plan recognizes that the 90% compliance rate reported for adult preventive services is not a valid measurement of appointment availability.

The survey results conflicted with CAHPS survey data that indicated the Plan performed below the state mean on access questions.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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The Plan stated that grievance reports validated that no problems exist for appointment access. A review of inquiries and the grievance system disclosed that complaints about access were not routinely logged as grievances. Ten patient grievance files were reviewed and the results were, as follows;

- For 5 of the 10, the grievance resolution did not ensure that Members received an appointment according to Plan's access standards from the time that the grievance was filed.
 - 3 of the 5 failed to meet the contract standard of 15 days for routine specialist appointments.
 - 1 of the 5 did not meet the contract standard of 96 hours for an urgent specialist appointment.
 - 1 of the 5 had no resolution, it merely stated, "Issue forwarded to appropriate department for investigation."

For Providers who did not meet the access standards, the Plan sent a letter titled "Access Corrective Action Plan", that identified the access standard the Provider did not meet and the improvement needed to comply with the standard. The Providers were asked to review, sign, and date a verification to acknowledge and agree to the findings and improvements needed. No Corrective Action Plan (CAP) was generated by the non-compliant Provider who was then added to next year's access survey.

The Plan did not have a procedure to monitor waiting times in the Provider's offices. Plan personnel stated that during the audit period the Plan did not monitor the Provider's office wait times.

The requirements to ensure that access and availability standards are implemented and monitored were not met.

RECOMMENDATIONS:

- Implement a valid method for measuring all access and availability standards.
- Track and trend as grievances all complaints related to access standards issues.
- Ensure that Members filing a grievance related to appointment time standards receive timely appointment (based on access standards) from the date the grievance was filed.
- Implement a process for Providers to develop a CAP for identified noncompliance with access standards.
- Develop procedures to ensure monitoring of waiting times in the Providers' offices.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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3.5

EMERGENCY SERVICE PROVIDERS (CLAIMS)

Emergency Service Providers (Claims):

Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge....

GMC/2-Plan Contract A.8.13.B

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D), and California Welfare and Institutions code Section 14091.3 GMC Contract A.8.13.B(3)

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D).

2-Plan Contract A.8.13.E

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section...Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.

GMC Contract A.8.5

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section...Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.

2-Plan Contract A.8.5

Contractor shall cover emergency medical services without prior authorization pursuant to 28 CCR 1300.67(g)(1). GMC Contract A.9.7.A

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.

2-Plan Contract A.9.7.A

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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SUMMARY OF FINDINGS:

As indicated in its Policy *CP-03 Claims Processing*, the Plan is required to reimburse the Provider within 45 working days that the Plan receives clean or complete claims which are claims that can be processed without further documentation. Based on the verification study conducted on emergency room claims, the Plan failed to pay 6 clean claims within the required timeframe of 45 working days from the date of receipt, paying the claims 28 to 92 days after the required timeframe.

If emergency room claims are not within the Plan's fiscal responsibility, they must be forwarded to the appropriate capitated Provider within 10 working days of receipt as indicated in Policy *CP-03*. Based on the verification study conducted on emergency room claims, the Plan failed to forward 5 claims within the 10 working day requirement, forwarding the claims 12 to 20 days after the required timeframe.

Although according to the Plan's Policy *CP-03*, it does not require prior authorization for emergency room claims, the verification study showed that 3 emergency room claims were denied because prior authorization was not obtained. During the onsite interview, the Plan's representatives attributed the denied claims to "human error".

The requirements were not met.

RECOMMENDATIONS:

Implement Policy *CP-03* by ensuring that the QNXT processing system and examiners shall do the following:

- Pay all clean claims within 45 working days.
- Forward all misdirected claims to appropriate capitated Providers within 10 working days.
- Not deny emergency room claims due to prior authorization.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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3.6

FAMILY PLANNING (PAYMENTS)

Family Planning: (Payment):

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate....(as required by Contract)

GMC/2-Plan Contract A.8.9

Claims Processing—Contractor shall pay all claims submitted by contracting Providers in accordance with this section...Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.

GMC Contract A.8.5

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section...Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.

2-Plan Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

If claims are not within the Plan's fiscal responsibility, they must be forwarded to the appropriate capitated Provider within 10 working days of receipt as indicated in the Plan's Policy *CP-03 Claims Processing*.

Based on the verification study conducted on family planning claims, the Plan failed to forward 5 claims within the 10 working day requirement, forwarding the claims 9 to 12 days after the required timeframe.

The Plan does not require prior authorization for family planning claims billed as indicated in Policy *CP-03* but the verification study showed that 3 family planning claims were denied because prior authorization was not obtained. During the onsite interview, the Plan's representatives attributed the non-compliance to "human error".

The requirements were not met.

RECOMMENDATIONS:

Implement Policy *CP-03* by ensuring that the QNXT processing system and examiners shall do the following:

- Forward all claims to capitated Providers within 10 working days.
- Not deny family planning claims because of prior authorization.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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3.7

ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours.... Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation.

GMC Contract A.10.8.G.1

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.

2-Plan Contract A.10.8.G.1

SUMMARY OF FINDINGS:

Molina Healthcare, Inc. and CaremarkPCS Health, L.L.C., entered into Prescription Benefit Services Agreement effective January, 1, 2013. CVS/Caremark is contracted with the Plan to provide pharmaceutical services.

The Plan's pharmacy function is overseen by the Pharmacy and Therapeutics (P & T) Committee. The Director of Pharmacy reports to the Pharmacy and Therapeutics Committee at minimum on a quarterly basis. Any issues discussed at the P & T Committee are submitted to the Quality Improvement Committee.

The Plan's *Policy P21: Oversight of the Provision of Drugs in the Emergency Room Setting*, requires that contracting emergency Providers or hospitals provide a sufficient quantity of emergency drugs until the Member can reasonably be expected to have a prescription filled. The Plan has a policy *P-02: Drug Benefit*, for the provision of pharmaceutical drugs to Members in emergency circumstances by pharmacies. The Plan's *Policy P-02: Drug Benefit* grants authorization overrides for 72-hour supply to pharmacies requesting emergency medication for Members.

The Plan's *Policy P21: Oversight of the Provision of Drugs in the Emergency Room Setting* indicates that compliance with emergency drug dispensing requirement is to be monitored through grievance and appeal. Plan personnel confirmed that there were no grievance and appeal cases related to emergency drug dispensing reported for 1st quarter 2013. However, monitoring involving such grievance cases precludes unreported cases where emergency dispensing requirements may have not been met. During the audit, Plan personnel stated that the Plan does not have any other monitoring procedures to ensure the provision of drugs prescribed in emergency circumstances. **This is a repeat finding from prior audit.**

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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As part of the Plan's Corrective Action Plan (CAP) from the prior audit, they produced a "Quarterly ER Monitoring Report" from 2009-2010, which showed that less than 1% of Plan ER visits had documentation of dispensed meds. The Plan's P & T Committee stated that "We feel that the reason for the low percentage is because drugs are dispensed as part of the ER visit, and are not billed to us." The Plan had no evidence that the cause for the low rate was lack of billing, and not lack of dispensing. Nevertheless, they discontinued said reports, without any investigation as to whether meds were indeed being dispensed, but not billed.

The Plan's Policy *P-02: Drug Benefit* indicates the pharmacy director shall report "emergency services overrides" to the P & T committee quarterly. A review of the Plan's P & T Committee minutes revealed that this only took place one time during the audit period.

The requirements to ensure complete monitoring of drugs prescribed in emergency circumstances were not met.

RECOMMENDATIONS:

Develop and implement policies and monitoring mechanisms to ensure the provision of drugs prescribed in emergency circumstances.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1

GRIEVANCE SYSTEM

Member Grievance System and Oversight:

Contractor shall implement and maintain a Member Grievance System in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g)), and 1300.68.01, 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).
GMC Contract A.14.1

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract)
GMC/2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
GMC/2-Plan Contract A.14.3.A

SUMMARY OF FINDINGS:

The Plan’s Grievance system has significant and material deficiencies.

The Plan’s grievance system does not capture all complaints, categorize inquiries that should be grievances, ensure that grievances are reported to an appropriate level, or capture complete grievance data for systematic aggregation and analysis. The Plan has acknowledged that it under-reported grievances, and that there were coding and referring problems in need of correction.

The Plan does not capture all complaints and expressions of dissatisfaction regarding the Plan and Providers. The Plan received 461,500 inquiries and classified 219 as grievances. The Plan is lacking criteria, tools, training and oversight to ensure appropriate classification of inquiries as grievances. Identified grievances are classified as Quality of Care or administrative by non-clinical personnel. No oversight is conducted by clinical personnel to ensure accurate identification of all clinical Quality of care issues. Identified Quality of Care issues are not thoroughly addressed by the CMO/Medical Director. Trends are not identified among Quality of Care issues flagged as to be tracked and trended.

The Plan receives grievances from Members primarily via phone call to the customer support center. The Customer Service Representative (CSR) documents inquiries and grievances in the Plan’s QNXT system by grievance type. Once the grievance is coded, the appropriate level of review is identified by the Grievance & Appeals unit, or it is sent to the Plan’s Quality Improvement Department.

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The Plan's Call Center employees are trained by the Member Services Department personnel on grievance and inquiry intake but the Plan does not have a mechanism to review and determine if inquiries are potential or actual grievance cases. Other findings include:

- Written tools for identifying grievances are not in place.
- Medical Directors and/or QI staff did not train call center staff in grievance identification.
- Inquiry audits to detect missed grievances were not conducted.
- Inquiry analysis to identify access issues was not conducted.
- System to flag potential grievances is not in place.
- Inquiries not resolved within 24 hours are not logged as grievances.

The Plan stated that the Grievance Committee meets quarterly or as needed to review and analyze trends and take action to remedy problems. The Plan stated that all grievances are reviewed by the Grievances and Appeals Department for proper classification between clinical and non-clinical grievances. Plan personnel stated that the review procedures do not include monitoring by clinical staff to ensure inquires and Quality Service/Care grievances were accurately classified.

The Member Grievances and Appeals report for the fourth quarter of 2012 that was submitted to the QISC Committee on February 14, 2013 contained detailed category information on grievances. The findings included:

- Access and Availability accounted for the majority of grievances 54% in 2012 with transportation being the highest category with 105 grievances for the year. Transportation grievances increased in the 3rd Quarter due to vendor change, however in the 4th Quarter, transportation grievances were down 37%. Plan terminated contract with ALC Transportation on November 22, 2012. Effective September 14, 2012 all trip/referrals were re-directed to an alternate transportation vendor.
- Appeals and grievances reported a 2012 increase in grievances related to a changed intake process. In 2011 the Plan reported complaints, inquiries, and grievances and in 2012 complaints were either ascertained as inquiries or grievance.
- The grievance report did not include an explanation for each grievance that was not resolved within 30 calendar days of receipt of the grievance.
- The report failed to identify incorrectly coded grievances and trends of delegates who had multiple grievances.

File review of 65 Grievances

- 7 out of 65 records reviewed had potential Quality of Care issues that were either never sent to QI, or were referred to QI and reviewed by CMO and not addressed.
- 8 out of 65 records reviewed concerned a delegated IPA and lost or delayed referrals.
- 9 out of 65 records reviewed had issues with Provider behavior. 6 complaints were to the office of one particular PCP. Only 1 of these complaints was forwarded to QI. The 3 other records concerned Provider behavior, and were handled by the Plan asking if the Member wanted to change PCP.
- 8 out of 65 records reviewed had the Plan sending the grievance to IPA for review and recommendations with no subsequent follow up documented, and the grievance then recorded as closed.
- 1 of 65 grievances appears to be an appeal, but not treated as such. The reason for denial does not match reason communicated to Member.
- 9 of 65 grievances were not resolved within 30 calendar days of receipt by the Plan.

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Review of 19 Inquiries

- 2 of 19 had issues that represented referral problems that should have been identified as grievances.
- 1 of 19 contained an accusation of fraud that was not referred for to the fraud unit.
- 1 of 19 required more than 24 hours for resolution, and was not recorded as a grievance.
- 1 of 19 contained incorrect dates in the inquiry log.

The 2012 and 2013 Member Services Guide contained a typographical error in the third paragraph of page 44 that stated “grievance” instead of “appeal”.

The requirements were not met due to inadequate staff training and tools, lack of inquiry monitoring, lack of grievance monitoring to detect appeals, fraud, quality of care, access, compliance, systemic problems, and proper classification.

RECOMMENDATIONS:

- Train call center staff by QI and Medical Directors on identification of grievances.
- Provide tools to call center staff to quickly flag any and all possible grievances.
- Consider all inquiries as grievances where the Plan is unable to distinguish between an inquiry and a grievance.
- Audit inquiries for possible missed grievances.
- Grievances should be noted as pending if another Unit, Department or group has been given the complaint for further review.
- Perform audits of a sample of all grievances to detect Appeals, Fraud, and Compliance issues, with corrective action and training to address issues not correctly identified by Grievance Department.
- Review of a sample of grievances designated as non-clinical by health care professionals to ensure Quality of Care issues are not missed.
- Document how potential Quality of Care issues were considered by CMO.
- Track and analyze both inquiries and grievances for patterns or trends related to systemic, repeated, and multiple problems with access issues, a Provider, delegated entity, or any other potentially systematic problem. Document results of such tracking and trending analysis.
- Improve the inquiry system by providing an audit tool to improve monitoring to ensure intake of grievances and correct grievances call coding.
- Modify existing grievance policy to ensure implementation of a functioning grievance system

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4.2

CULTURAL AND LINGUISTIC SERVICES

Cultural and Linguistic Program:

Contractor shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the requirements... (as stated in the Contract)

GMC Contract A.9.13

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the group needs assessment requirements...

2-Plan Contract A.9.13

Contractor will assess, identify and track the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical).

GMC/2-Plan Contract A.9.13.B

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program.

GMC Contract A.9.13.E/ 2-Plan Contract A.9.13.F

Linguistic Services:

Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC 2000d, 45 CFR Part 80) that prohibit recipients of Federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

GMC/2-Plan Contract A.9.12

Contractor shall comply with 42 CFR 438.10(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact... either through interpreters, telephone language services, or any electronic communication options...

GMC Contract A.9.14.B

Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact... either through interpreters, telephone language services, or any electronic options...

2-Plan Contract A.9.14.A

Types of Linguistic Services:

Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential Members:

- 1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact.
- 2) Fully translated written informing materials...
- 3) Referrals to culturally and linguistically appropriate community service programs.
- 4) Telecommunications Device for the Deaf (TDD).
- 5) Telecommunications Relay Service (711)

GMC Contract A.9.14.C/2-Plan Contract A.9.14.B

Key Points of Contact Include:

- 1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.
- 2) Non-medical care setting: Member services, orientations, and appointment scheduling.

GMC Contract A.9.14.E/2-Plan Contract A.9.14.D

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SUMMARY OF FINDINGS:

The Plan is required to ensure that fully translated written informing materials, including notice of action letters and grievance acknowledgement and resolution letters are available to Members 24 hours a day at all key points of contact.

According to the Plan's Policy HE-09, all Members are informed of their right to interpreter services and the Plan's Providers are informed that they are required to "offer interpretive services to all limited-English proficient patients" and if a patient refuses interpretive services it must be documented in the medical record.

For two grievance cases related to requests for interpreting services, one of which involved a threshold language, the grievance acknowledgement and resolution letters sent to Members were not translated in Member's identified threshold languages. During the interview, Plan personnel stated that they only translate letters when a Member asks the Member Services Department to have the letters translated, otherwise, all the grievance acknowledgement and resolution letters will only be sent in English. According to the Contract, the Plan must provide translated materials to a population group who indicate their primary language is other than English, if that group meets a numeric threshold of 3,000.

The Plan's process of not sending Members fully translated grievance acknowledgement and resolution letters does not meet the requirements.

RECOMMENDATIONS:

Develop and implement a monitoring system to ensure that Members receive fully translated written informing materials in their identified threshold language.

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4.3

CONFIDENTIALITY RIGHTS

Members' Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

- 1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
- 2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

Contractor agrees:

B. Safeguards—To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract....

H. Notification of Breach—During the term of this Agreement:

- 1). Discovery of Breach. To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract...
- 2). Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer...

I. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit...

GMC/2-Plan Contract G.3.B, H, and I

SUMMARY OF FINDINGS:

Plan Policy *HP-03 Privacy and Confidentiality of PHI* describes the Plan's process for compliance with Member's privacy rights regarding PHI. This policy explains the Plan's guidelines regarding the use, creation, collection, storage, transmission, access to, and disclosure of protected health information.

Plan Policy *HP-37 Privacy Incident Identification and Reporting*, requires that "Until Privacy Officer is notified, no external agencies may be notified..." This policy allows the Compliance Manager 24 hours to report a privacy incident to Privacy Officer.

In a review of suspected HIPAA breach cases, the 24-hr. DHCS Initial Notification of Breach was not submitted to the required DHCS personnel in 3 of 5 cases. In one case requiring immediate notification to DHCS, proper notice to the DHCS was not documented. Three of the 5 cases involved mis-sent faxes to unintended recipients on six different occasions.

The requirements to notify the required DHCS personnel of any HIPAA breaches were not met.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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RECOMMENDATIONS:

- Ensure that proper notification of any suspected security incident is submitted to the required DHCS personnel within the required time frame and that such notifications are documented.
- Revise Policy *HP-37 Privacy Incident Identification and Reporting* to ensure that Plan can abide by immediate and 24 hr. notifications of HIPAA breach as required by Contract.
- Ensure Fax numbers are verified with the intended recipient before sending to prevent breaches.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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CATEGORY 5 – QUALITY MANAGEMENT

5.1

QUALITY IMPROVEMENT SYSTEM

General Requirements:

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

GMC/2-Plan Contract A.4.1

SUMMARY OF FINDINGS:

The QI Department sets its priorities based on several sources including Utilization Management priorities, Case Management, Preventative Care, HEDIS, Consumer Assessment Health Plan Survey (CAHPS), and NCQA standards.

The Plan cited examples of HEDIS measure improvements that are not statistically significant as improvements in care. The Manager of QI Compliance stated that 6 out of 7 HEDIS measures related to Diabetes showed significant improvement. When questioned on the lack of statistical significance on 5 out of these 6 measures in the 2013 DHCS HEDIS Report, the Plan CMO asked to retract the word “significant”. Post Exit, the Plan submitted a QI study entitled: “Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)” as evidence of improvements of care. However, the Plan failed to meet either its stated goal, or the Minimum Performance Level (MPL) for this measure.

The Plan cited educating Members to decrease service level expectations in order to increase CAHPS survey results as an example of improving service. As an example of service improvement, the Plan cited its response to 2012 CAHPS Survey. In response to overall below-average member satisfaction, the Plan implemented member education on expected turnaround time for appointments. Although the Plan’s own internal report contained the statement: “*we were informed that it normally takes a month or more for a person to secure an adult preventative care visit.*”, no action was taken by the Plan to improve access; the emphasis of the effort was on changing member expectations, not improving service.

The Plan used a Provider self-reported survey to assess Access and Availability. The script required the Providers to state that they are not in compliance with Plan standards in order to be deemed noncompliant. The Plan has not validated the results of this survey.

The Plan required Providers not in compliance with Appointment Availability standards to attest that they have implemented a Corrective Action Plan, but had no evidence of the existence of the CAP.

The QI Department was not directly involved in training call center employees. The Plan did not provide tools to call center employees to ensure reliable identification of grievances. It did not audit nor analyze inquiries. Inquiries that should have been logged as grievances related to access were not logged as grievances.

The QI Department did not have effective procedures in ensuring Potential Quality of Care (PQOC) issues were consistently and accurately identified by the grievance process. The QI Department could not track and trend PQOC issues due to lack of complete data, and did not effectively track and trend data it did have.

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The requirements were not met.

RECOMMENDATIONS:

- Implement validated and credible measures of appointment availability.
- Require actual Corrective Action Plan submission by Providers not complying with appointment availability standards.
- Involve the QI Department and Medical Director in training of Call Center Staff.
- Develop tools to help call center staff correctly identify grievances.
- Review inquiries to ensure grievances are properly identified.
- Analyze grievances and inquiries to discover patterns and trends related to quality of care and service.
- Take strong actions to demonstrate significant improvements in care and service as a result of the QI process.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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5.3

QUALITY IMPROVEMENT PROGRAM DESCRIPTION AND STRUCTURE

Written Description: Contractor shall implement and maintain a written description of its QIS [Quality Improvement System]...(as required by Contract)

GMC/2-Plan Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review....

GMC/2-Plan Contract A.4.2

Governing Body: Contractor shall implement and maintain policies that specify the responsibilities of the governing body...(as required by Contract)

GMC/2-Plan Contract A.4.3.A-D

Provider Participation: Contractor shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

GMC/2-Plan Contract A.4.5

SUMMARY OF FINDINGS:

The Plan's written Quality Improvement Program included Purpose and Program Philosophy, Goals and Objectives, Scope of Program, Priorities for Improvement, Quality Improvement Activities, Authority and Accountability, Delegated Activities, Role of Participating Providers, Confidentiality and Conflict of Interest, QI Committee Organization Chart, and Quality Program Committee Role, Functions and Membership.

The Plan's Board of Directors (BOD) was responsible for the direction and provides oversight of the QI Program.

The QI Program established a QI Committee (QIC) that was chaired by the CMO. The QIC met quarterly and oversaw the Plan's QI functions. It had nine subcommittees that report to it. Although a variety of Community Provider Representatives are present at the subcommittee level, the QIC itself only has Community Provider Representatives with the following credentials:

- One Optometrist
- One PhD in Cytogenetics
- One Physical Therapist
- One Neonatologist
- One non-board certified practitioner listed by the Medical Board as having "No Patient Care Activities"
- One Public Health Physician who has delegated attendance to a deputy director

The QIC is an integral part of the Plan's QIS. The committee's membership does not reflect significant involvement of contracted physicians from the community.

The Plan's Medical Director was absent at all QIC meetings during the audit period. The UM Committee had no representative from surgery or surgery subspecialties.

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RECOMMENDATIONS:

- Ensure the QIC's Community Providers are reasonably representative of the community that provides care to the Plan's membership
- Ensure the Plan's Medical Director is an active participant at the QIC.
- Include representation from the surgical community in the UM Committee

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5.5

MEDICAL RECORDS

Medical Records

A. General Requirement

Contractor shall ensure that appropriate Medical Records for Members, pursuant to 28 CCR 1300.80(b)(4) and 42 USC 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each Encounter in accordance with 28 CCR 1300.67.1(c).

B. Medical Records

Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records...

C. On-Site Medical Records

Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services...(as required by Contract)

GMC Contract A.4.13.A, B, C, D

A. General Requirement

Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861 and MMCD Policy Letter 02-02.

B. Medical Records

Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records...

C. On-Site Medical Records

Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services...(as required by Contract)

2-Plan Contract A.4.13.A, B, C, D

SUMMARY OF FINDINGS:

The Plan is required to develop, implement, and maintain procedures pertaining to medical records including: storage and filing, confidentiality, release of information, informed consent, and maintenance of medical records in a legible, current, detailed, organized, and comprehensive manner.

The Plan developed and maintained policies and procedures pertaining to medical records but did not ensure these policies and procedures were implemented. The medical records were not always maintained in a legible, detailed, and comprehensive manner as required by the Contract. A review of 25 medical records was conducted. Fourteen of 25 records lacked legibility and 21 of 25 records were not comprehensive. The records reviewed did not consistently contain the minimum content required by the Contract. Many records lacked evidence of preventive health screenings and procedures were not consistent with guidelines set forth in periodicity schedules as required by the Contract. Ongoing problems were not always documented and addressed on subsequent visits. Some pediatric Members' records did not contain screening for vision, hearing, nutrition, dental including fluoride varnish, psychosocial, developmental, and tuberculosis. Some adult Members' records had incomplete documentation of screening measures for tuberculosis, lipid disorder, breast cancer, cervical cancer, and chlamydia infection.

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The Plan did not ensure that medical records were available at each provider encounter. Sixty-one medical records were requested from the Providers and 52 were obtained. There were 9 records missing.

The requirement for Medical Records was not met.

RECOMMENDATIONS:

Develop and implement a monitoring system to ensure that medical records are consistently completed and maintained in accordance with the provisions of the Contract.

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5.6

INFORMED CONSENT

Informed Consent

Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services, and at a minimum includes: ...All informed consent documentation, including the human sterilization consent procedures required by 22 CCR Sections 51305.1 through 51305.6, if applicable.

GMC Contract A.4.13.D.7

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes: ...All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.

2-Plan Contract A.4.13.D.6

Contractor shall ensure that Members are informed of the full array of covered contraceptive methods and that informed consent is obtained Members for sterilization, consistent with requirements of 22 CCR 51305.1 and 51305.3.

GMC Contract A.9.9.A.1

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.

2-Plan Contract A.9.9.A.1

SUMMARY OF FINDINGS:

California Code of Regulations (Title 22, Section 51305.1 and 51305.3) outlines the requirements for informed consent. Informed consent for sterilization must be signed by the Member at least 30 days before the procedure is performed. The Provider performing the sterilization must sign the consent form on the day of the procedure to certify that the Member voluntarily requested to be sterilized and fully understood the nature and consequences of the procedure.

The Plan's Policy *UM-90 Informed Consent* states that "physicians are required to obtain an informed consent from the patient prior to performing an invasive procedure" and that the informed consent process must be "conducted by a physician, mid-level practitioner (NP/PA), or RN designee". Policy UM-90 also states that "copies of the consent are retained in the member's medical record maintained by the physician performing the procedure".

The Plan was unable to identify all Members undergoing sterilization procedures. The Plan furnished a spreadsheet entitled "CA DHCS Out of Plan Sterilization.xlsx" and stated that it was a comprehensive list of Members undergoing sterilization procedures in the Plan. DHCS data contained numerous additional members who had undergone sterilization procedures. Chart review confirmed that these were Members not contained in Plan's spreadsheet.

The Plan is not in compliance with Informed Consent for sterilization procedure per regulatory and contractual requirements. Medical records were obtained during onsite visits to OB/GYN clinics. A review of these records showed that informed consent was not done within the required time frame for two of 11 Members. In two of 11 records the rendering Provider's signature was not recorded on the sterilization consent form on the day of the procedure as outlined in the Plan's Policy *UM-90 Informed Consent*. In one of 11 records the Consent Form PM330 was not present. In 11 of 11 records the person securing the consent did not indicate his or her credentials when signing the form as outlined by the Plan's Policy *UM-90 Informed Consent*.

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Without reliable identification of members undergoing sterilization procedures, the Plan was unable to demonstrate it effectively monitored compliance with the requirements for informed consent.

The requirement for informed consent was not met.

RECOMMENDATIONS:

Develop and implement a system to ensure that all Informed Consents are obtained and documented according to *CCR, Title 22, Sections 51305.1, 51305.3*, and the Plan's Policy *UM-90 for Informed Consent*.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1

MEDICAL DIRECTOR

Medical Director:

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53913.5 whose responsibilities shall include, but not be limited to...

GMC Contract A.1.6

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to...

2-Plan Contract A.1.6

- A. Ensuring that medical decisions are:
 - 1) Rendered by qualified medical personnel.
 - 2) Are not influenced by fiscal or administrative management considerations.
- B. Ensuring that the medical care provided meets the standards for acceptable medical care.
- C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- D. Developing and implementing medical policy.
- E. Resolving grievances related to medical quality of care.
- F. Direct involvement in the implementation of Quality Improvement activities.
- G. Actively participating in the functioning of the plan grievance procedures.

GMC/2-Plan Contract A.1.6

SUMMARY OF FINDINGS:

The Plan employed a full time Chief Medical Officer (CMO), and full time Medical Directors for each region. The CMO Chaired the QI Committee, developed the strategic plan and budgets, and was engaged with external regulatory relationships, the Pharmacy program, and Health Education.

The CMO/Medical Director does not ensure standards for acceptable medical care. He stated that he relied upon the grievance system and a review of delegated entity denials to ensure acceptable quality of medical care. Neither of these systems functions adequately to ensure acceptable medical care.

The grievance system does not identify all inquiries that are complaints or expressions of dissatisfaction regarding quality of care as grievances. Among grievances that were actually identified, clinical personnel do not ensure that all quality of care grievances were identified. Files on quality of care grievances often contained little or no information about the medical director's review. Trends were not identified among quality of care issues identified as being tracked and trended.

Although the Plan stated that all delegated denials were reviewed, this review was by UM nursing staff. Medical Directors reviewed only about 1% of denials for appropriateness of the denial. A review of 1% of delegated denials does not ensure that care provided met standards for acceptable medical care.

The requirements for meeting the responsibilities of the medical director were not met.

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RECOMMENDATIONS:

- Implement internal controls to proactively ensure standards for acceptable medical care are met.
- Ensure a comprehensive approach to medical care quality assurance through the active role of the Medical Director in the Grievance/Inquiry program, delegated denial reviews, and quality improvement activities.
- Ensure the CMO/Medical Director's delegated denial review includes the review of a significant and targeted sample to examine the appropriateness of the denial.
- Document the review of all clinical issues referred from the grievance system.
- Ensure the QI Committee tracks and trends quality concerns involving systems, providers, or IPAs.

6.4

PROVIDER TRAINING

Medi-Cal Managed Care Provider Training:

Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status....

GMC/2-Plan Contract A.7.5

SUMMARY OF FINDINGS:

Plan Policy *PR-02 Provider and Practitioner Education and Training*, requires that "mandatory education and training with the PCP will be scheduled within ten (10) days of a PCP being placed on "active status." The Plan defines "active" status as the point at which the PCP is allowed to have Membership assigned. Plan personnel stated that the PCP is not able to accept new Members until they receive the New Provider Orientation (NPO) training.

Although the Plan's definition of "active status" is that point at which Members are allowed to be assigned to a provider and no assignment takes place before completion of the NPO training, records show that 27 new primary care physicians received their New Provider Orientation more than 10 days after their contracts' effective dates. In addition, the Plan's process can result in timelines substantially longer than the 10 working days intended.

The requirements to ensure that a newly contracted provider receive training within 10 days from its effective date were not met.

RECOMMENDATIONS:

Develop and implement a system to ensure New Provider Orientation (NPO) training for all providers occurs within 10 working days after placing the newly contracted provider on active status.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

DATE OF AUDIT: September 16-27, 2013

6.5

FRAUD AND ABUSE

Fraud and Abuse Reporting

Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse....

- 1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
- 2) Contractor shall provide effective training and education for the compliance officer and all employees.
- 3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
- 4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, Members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity....
- 5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs....

GMC/2-Plan Contract E.2.26.B

SUMMARY OF FINDINGS:

The Plan maintains an Anti-Fraud Program. The program provides details regarding the Plan's policies and procedures for detecting, preventing, investigating, reporting, and responding in cases of fraud and/or abuse in the provision of health care services under the Medi-Cal Program. The program also provides information regarding the oversight roles of the Compliance Committee and Compliance Officer. The Plan's Provider Manual notifies and provides details to Providers about the Anti-Fraud Plan.

The contract requires that the Plan "report to DHCS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity." Based on the findings of fraud cases reviewed, the Plan failed to make proper notification to MMCD MR/PIU and/or complete the preliminary investigation within 10 working days of notice in two of seven cases.

The Plan is required to ensure that ineligible and suspended providers from the Medi-Cal program are not employed or contracted. This requirement was not reflected in the Plan's subcontract with its PBM.

The requirements for investigating and reporting of suspected fraud and abuse cases as well as tracking of suspended providers were not met.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: June 1, 2012 – May 31, 2013

DATE OF AUDIT: September 16-27, 2013

RECOMMENDATIONS:

- Ensure that the results of the preliminary investigation of a suspected fraud or abuse case be reported to DHCS within the required time frame of 10 working days.
- Ensure that the PBM contract includes the requirement to check the Medi-Cal Suspended & Ineligible list for suspended, excluded, or terminated providers.

MEDICAL REVIEW - NORTHERN SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

**Molina Healthcare
of
California Partner Plan, Inc.**

Contract Number: 06-55503 A04; 07-65852 A05
and 09-86162
State Supported Services

Audit Period: June 1, 2012
Through
May 31, 2013

Report Issued: January 10, 2014

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INTRODUCTION

This report presents the audit findings of Molina Healthcare of California Partner Plan, Inc.'s (MHC or the Plan) State Supported Services contract Nos. 06-55503 A04; 07-65852 A05; 09-86162. The State Supported Services contract covers contracted abortion services with MHC.

The onsite audit was conducted from September 16, 2013 through September 20, 2013. The audit period is from June 1, 2012 through May 31, 2013 and consisted of document review of materials supplied by the Plan and interview conducted onsite.

COMPLIANCE AUDIT FINDINGS

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion

*Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes: 59840 through 59857
HCFA Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336
State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDINGS:

The Plan informed both Members and Providers about the Plan's policy for pregnancy terminations through the *Member Service Guide and Provider Manual*.

Policy *UM-05, Abortion Services and Approval Process for the Use of Mifepristone*, states that "Elective abortions, regardless of gestational age, are covered for Molina Healthcare's members. Elective abortions do not require prior authorization by MHC Utilization Management Department. Members may seek abortions from any qualified provider or practitioner in network or out of network.

RECOMMENDATIONS:

None