



JENNIFER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

Richard Chambers, President  
Molina Healthcare of California Partner Plan, Inc  
200 Oceangate, Suite 100  
Long Beach, CA 90802

June 3, 2016

RE: Department of Health Care Services Medical Audit

Dear Mr. Chambers:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Molina Healthcare of California Partner Plan, Inc, a Managed Care Plan (MCP), from August 24, 2015 through September 4, 2015. The survey covered the period of August 1, 2014 through July 31, 2015.

On January 8, 2016, the MCP provided DHCS with a Corrective Action Plan (CAP) in response to the report originally issued on January 7, 2016.

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

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

If you have any questions, feel free to contact Jeanette Fong, Chief, Compliance Unit, at (916) 449-5096 or [CAPMonitoring@dhcs.ca.gov](mailto:CAPMonitoring@dhcs.ca.gov).

Sincerely,

Dana Durham, Chief  
Contract Compliance Section

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Enclosures: Attachment A CAP Response Form

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

**ATTACHMENT A  
Corrective Action Plan Response Form**



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

**Review/Audit Type:** DHCS A&I Medical Review Audit

**Review Period:** 08/01/2014 - 07/31/2015

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<b>2. Case Management and Coordination of Care</b>				
<p><b>2.1 Basic Case Management</b></p> <p>1) Ensure that the contractual requirements for Coordination of Care including Basic Case Management specifically completion of Initial Health Assessments that meet the criteria for a comprehensive health</p>	<p>The Quality Improvement (QI) Department Outreach team will request a copy of the Initial Health Assessment (IHA) from the Primary Care Provider (PCP) of members they have scheduled for an IHA.</p>	<p>2.1b- a Notification to Provider (Sample)</p> <p>2.1b- b 2016 RC Audit Results</p> <p>2.1b- c Response Memo Audits</p>	<p>02/19/2016</p>	<p>02/09/2016: The plan initially submitted the following documentation:</p> <p>-A copy of its "California Children's Services and Regional Center Implementation Program Description" (01/19/2016) which describes robust activities designed to improve coordination between the plan and CCS and</p>

<p>appraisal are met in a timely manner.</p>			<p>the RC.</p> <p>-A sample master report template for both CCS and RC to identify and track members eligible for each program.</p> <p>-The following 3 template letters as evidence that the Plan is communicating with providers to monitor the provision of Basic Case Management:</p> <ol style="list-style-type: none"> <li>1) Notification letter informing providers of members eligible for participating in CCS and RCs</li> <li>2) Attestation request letter to provider</li> <li>3) Attestation response form from provider where provider must attest to providing Basic CM services for CCS/RC eligible members</li> </ol> <p>The plan has additionally committed towards:</p> <p>-Performing monthly audits by reviewing a random sample of member medical records for CCS and RC to ensure that the PCP is providing Basic Case Management. This process is expected to be implemented on 04/29/2016.</p> <p>-CCS Program Management will be responsible for trending PCP compliance and reporting results to the QIC. Implementation will begin 07/29/2016.</p> <p><u>03/29/2016</u>: The plan submitted both a sample of the CCS and RC templates in use as evidence that</p>
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			<p>eligible members are being tracked.</p> <p><u>04/04/2016</u>: The plan submitted a tracking list of 25 members along with enrollment dates and IHA completion dates to demonstrating timely completion of IHAs. Corresponding redacted IHAs were also provided in each case to demonstrate that these are being collected from PCPs as indicated.</p> <p><u>05/06/2016</u>: Per DHCS' follow-up request, the plan additionally submitted:</p> <ul style="list-style-type: none"> <li>-A sample of a letter sent by the plan's CCS/RC Audit Team to a provider ("Provider Audit Results and CAP Request") as evidence that the plan is now performing audits to ensure the provision of Basic Case Management and that CAPs are being requested when indicated.</li> <li>-A memo from the plan's Director of UM to DHCS (04/27/2016) which summarizes progress regarding implementation of the plan's new monitoring process. Highlights include: <ul style="list-style-type: none"> <li>-Since 09/01/2015, the plan has hired 2 supervisors and 20 staff (clinical and non-clinical) to support coordination of care for RC and CCS members.</li> <li>-The first audit for RC monitoring began on 03/29/2016 with results received on 04/25/2016. The plan submitted audit results</li> </ul> </li> </ul>
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				<p>that show 71%-94% compliance for various components measured (e.g., Basic Case Management, IHA, diagnostic services, preventive care, specialty referrals, EPSDT screening, etc.).</p> <p>-The first audit for CCS monitoring began in April 2014 and is currently underway.</p> <p><b>This finding is closed.</b></p>
<p>2) Implement an effective monitoring system for accurate identification and tracking of Members whose services are carved out to ensure that the Basic Case Management Services are provided by the Primary Care Providers.</p>	<p>a) A California Children's Services (CCS) and Regional Center (RC) Implementation Program Description has been developed to track program requirements, current process and planned process improvements.</p>	<p>2.1b - Attachment 1 - CCS_RC Program Description</p>	<p>02/19/2016</p>	<p>The documentation submitted under Deficiency 2.1(1) above satisfies this item.</p> <p><b>This finding is closed.</b></p>
	<p>b) Two (2) master reports have been developed and implemented for accurate monitoring, identification and tracking of Molina members whose services are carved out to CCS and RC.</p> <p>The reports reconcile:</p> <ul style="list-style-type: none"> <li>• CCS Master Eligibility Report: Bi-monthly Centers for Medicare and Medicaid Services (CMS) website state feed of Molina members, with Molina eligibility systems, currently receiving CCS services</li> <li>• RC Master Eligibility Report: The RC county logs produced monthly, with Molina eligibility systems, currently receiving RC services</li> </ul>	<p>2.1b - Attachment 2 - Master CCS Eligibility Report</p> <p>2.1b - Attachment 3 - Master RC Eligibility Report</p>	<p>09/02/2015</p>	
	<p>c) Molina has revised the existing CCS and RC template letters to providers notifying them of members participating in CCS and R C s . The revisions include informing the PCP of responsibilities for Basic Case Management.</p> <p>An attestation has been developed and will be included in the letter for the PCP to return to the plan</p>	<p>2.1b - Attachment 4 - Primary Care Phys CCS Notification</p> <p>2.1b - Attachment 5 - PCP RC Notification</p> <p>2.1b - Attachment 6 - PCP</p>	<p>04/29/2016</p>	

	<p>within 14 calendar days attesting that Basic Case Management Services, IHA, medically necessary diagnostic, preventive and specialty referrals for treatment have been rendered to the member.</p>	<p>Attestation Request</p> <p>2.1b - Attachment 7 - RC-PCP Attestation Request</p> <p>2.1b - Attachment 8 - PCP Attestation Form</p> <p>2.1b - Attachment 9 – RC - PCP Attestation Form</p>		
	<p>d) On a monthly basis, Molina Health Care Services (HCS) Department will request PCP medical records and perform a random sample audit of member medical records for CCS and RC participating Molina members, to ensure that the PCP is providing Basic Case Management:</p> <ul style="list-style-type: none"> <li>• 10% of PCPs listed in the monthly eligibility reports will be random sampled for auditing</li> <li>• 30 medical records will be requested from the sampled PCPs NCQA 8/30 method will be used to audit (if the first eight (8) records do not pass at 100%, the remaining 22 will be audited)</li> <li>• A corrective action plan (CAP) will be required from non-compliant PCPs</li> <li>• Additional training will be conducted with non-compliant PCPs by Provider Services Department</li> <li>• Non-Compliant PCPs will be re-audited to ensure performance improvement</li> </ul>		04/29/2016	
	<p>e) CCS Program Management will be responsible for the trending and analysis of PCP compliance. Results will be reported quarterly to the Quality Improvement Committee (QIC).</p>		07/29/2016	
<p><b>2.2 California Children's Services</b></p> <p>1) Implement a system to accurately identify Members whose eligibility and participation in the</p>	<p>a) A CCS and RC Implementation Program Description have been developed to track program requirements, current process and planned process improvements.</p>	<p>2.2a - Attachment 1 – CCS_RC Program Description</p>	01/17/2016	<p>The documentation submitted under Deficiency 2.1 above satisfies this item.</p> <p><b>This finding is closed.</b></p>

<p>CCS program can be tracked and monitored and ensure that Members enrolled in CCS receive medically necessary diagnostic, preventive and treatment services through their Primary Care Providers.</p>	<p>b) A master report has been developed and implemented, for accurate monitoring, identification and tracking of Molina members whose services are carved out to CCS.</p> <p>The report reconciles:</p> <ul style="list-style-type: none"> <li>• CCS Master Eligibility Report: Bi-monthly CMS website state feed of Molina members, with Molina eligibility systems, currently receiving CCS services</li> </ul>	<p>2.2a - Attachment 2 - Master CCS Eligibility Report</p>	<p>09/02/2015</p>		
	<p>c) Molina has revised the existing CCS template letter to providers notifying them of members participating in CCS. The revisions include informing the PCP of responsibilities to provide medically necessary diagnostic, preventive and treatment services. An attestation has been developed and will be included in the letter for the PCP to return to the plan within 14 calendar days attesting that Basic Case Management Services, IHA, medically necessary diagnostic, preventive and specialty referrals for treatment have been rendered to the member.</p>	<p>2.2a - Attachment 3 - PCP CCS Notification</p> <p>2.2a - Attachment 4 - PCP Attestation Request</p> <p>2.2a - Attachment 5 - PCP Attestation Form</p>	<p>04/29/2016</p>		
	<p>d) On a monthly basis, Molina Health Care Services (HCS) Department will request PCP medical records and perform a random sample audit of member medical records for CCS and RC participating Molina members, to ensure the PCP is providing Basic Case Management:</p> <ul style="list-style-type: none"> <li>• 10% of PCPs listed in the monthly eligibility reports will be random sampled for auditing</li> <li>• 30 medical records will be requested from the sampled PCPs NCQA 8/30 method will be used to audit. If the first eight (8) records do not pass at 100%, the remaining 22 will be audited</li> <li>• A corrective action plan (CAP) will be required from non-compliant PCPs</li> <li>• Additional training will be conducted with non-compliant PCPs by Provider Services Department</li> <li>• Non-Compliant PCPs will be re-audited to ensure performance improvement</li> <li>• Reporting and analysis will be made to the UMC</li> </ul>		<p>04/29/2016</p>		

	on a quarterly basis			
	e) CCS Program Management will be responsible for the trending and analysis of PCP compliance. Results will be reported quarterly to the QIC.		07/29/2016	
2) Update Member Handbook 2015-2016 to include that the CCS program is for children from birth to age 21 years old only.	a) The Member Handbook 2016-2017 was submitted to the State for review and approval and includes language that the CCS program is for children from birth to age 21 years old only.		01/01/2016	<u>03/29/2016</u> : The plan submitted the draft version “2016/2017 Evidence of Coverage/Disclosure Form” (Member Services Guide). Page 51 includes language that is now consistent with the contractual requirement.  <b>This finding is closed.</b>
	b) The update regarding CCS program eligibility will be included in the Plan’s 2016-2017 Medi-Cal Evidence of Coverage (EOC) document which will be distributed via the annual member mailing, included in the new member welcome kits, and posted on the website.		04/29/2016	
3) Ensure the coordination of care between the Plan, Primary Care Providers and the specialty providers occurs.	a) A CCS and RC Implementation Program Description have been developed to track program requirements, current process and planned process improvements.	2.2c - Attachment 1 – CCS_RC Program Description	01/17/2016	<u>02/09/2016</u> : The plan submitted the following documentation:  -A copy of its “California Children’s Services and Regional Center Implementation Program Description” (01/19/2016) which describes robust activities designed to improve coordination between the plan and CCS and the RC.  -A sample master report template for both CCS and RC to identify and track members eligible for each program.
	b) A master report has been developed and implemented, for accurate monitoring, identification and tracking of Molina members whose services are carved out to CCS.  The report reconciles: <ul style="list-style-type: none"> <li>• CCS Master Eligibility Report: Bi-monthly CMS website state feed of Molina members, with Molina eligibility systems, currently receiving CCS services</li> </ul>	2.2c - Attachment 2 - Master CCS Eligibility Report	09/02/2015	
	c) Molina is assembling a dedicated team of Case Managers - Registered Nurses,(RN), Master of Social Work (MSW), and/or Licensed Clinical Social Worker (LSW) who will be responsible for reaching out to all members identified in the CCS Master Eligibility	2.2c - a RPT_CCA117_Individualize d_Care_PlanAL_redacted  2.2c - b	04/29/2016	

	report. The Case Managers will coordinate care and services between the Plan, CCS, PCPs and Specialty Providers. A personalized Care Plan will be developed for each member.	RPT_CCA117_Individualized_Care_Planjja(1)_redacted  2.2c - c RPT_CCA117_Individualized_Care_Planjl_redacted  2.2c - d RPT_CCA117_Individualized_Care_PlanKS_redacted  2.2c - e RPT_CCA117_Individualized_Care_PlanMC_redacted		<u>05/06/2016</u> : The plan submitted five sample individualized care plans which include interventions to coordinate care between all disciplines.  <b>This finding is closed.</b>
<b>2.3 Early Intervention Services / Developmental Disabilities</b>  1) Implement an effective monitoring system to accurately identify Members and refer them to the RC for Coordination of Care.	a) A CCS and RC Implementation Program Description have been developed to track program requirements, current process and planned process improvements.	2.3a - Attachment 1 – CCS_RC Program Description	01/17/2016	<u>02/09/2016</u> : The plan submitted a copy of its “California Children’s Services and Regional Center Implementation Program Description” (01/19/2016) which describes robust activities to accurately identify Members and refer them to the RC for Coordination of Care.
	b) A master report has been developed and implemented, for accurate monitoring, identification and tracking of Molina members whose services are carved out to RCs.  The reports reconcile: <ul style="list-style-type: none"> <li>RC Master Eligibility Report: The RC county logs produced monthly, with Molina eligibility systems to identify members currently receiving RC services.</li> </ul>	2.3a - Attachment 2 - Master RC Eligibility Report	09/02/2015	<u>02/11/2016</u> : The plan submitted the following documentation:  -A sample master report template for RC to identify and track members eligible for the program.
	c) Training will be conducted for staff that may identify and refer members eligible for RC services, by diagnosis codes, to the Molina RC staff. Departments identified are Case Management, Prior Authorization (PA) and Concurrent Review:		04/29/2016	-A sample template letter for both the member and PCP informing both parties that the plan has identified a RC eligible condition.  <u>03/29/2016</u> : The plan submitted

	<ul style="list-style-type: none"> <li>• Training will take place in Q1 2016, then bi-annually thereafter</li> <li>• Training will be implemented into HCS New Employee Orientation Training (NEO)</li> </ul>			<p>both a RC template in use as evidence that eligible members are being tracked.</p>
	<p>d) Molina has developed notification letters for members and PCPs that Molina has identified a condition that may be covered by RC services.</p> <p>This process will:</p> <ol style="list-style-type: none"> <li>1. Notify the member that Molina has identified a condition that may be covered by RC services and instruct them to follow up with their PCP for a screening. Case Management will follow-up with the member to verify that the screening appointment is made.</li> <li>2. Notify the PCP that Molina has identified a condition that may be covered by RC services. The letter will notify the PCP to screen the member for RC eligibility, and refer to RC if indicated.</li> </ol> <p>Reconciliation of identified members to those approved for services will be made by utilization of the monthly master RC report described above.</p>	<p>2.3a - Attachment 3 - Member Eligibility</p> <p>2.3a - Attachment 4 - PCP RC Referral</p>	<p>04/29/2016</p>	<p>04/18/2016: The plan submitted evidence of sign-in sheets and materials as evidence that a CCS/RC refresher training for was held in Q1 of 2016. The training schedule for 2016 was also attached as evidence of ongoing training scheduled for August 2016.</p> <p><b>This finding is closed.</b></p>
<p>2) Ensure that providers receive the Monthly RC Report that identifies the Members who have been assessed by the RC.</p>	<p>a) A CCS and RC Implementation Program Description have been developed to track program requirements, current process and planned process improvements.</p>	<p>2.3b - Attachment 1 – CCS_RC Program Description</p>	<p>01/17/2016</p>	<p>The documentation submitted under Deficiency 2.3(1) above satisfies this item.</p> <p><b>This finding is closed.</b></p>
	<p>b) A master report has been developed and implemented, for accurate monitoring, identification and tracking of Molina members whose services are carved out to RCs.</p> <p>The reports reconcile:</p> <ul style="list-style-type: none"> <li>• RC Master Eligibility Report: The RC county logs produced monthly, with Molina eligibility systems to identify members currently receiving RC services</li> </ul>	<p>2.3b - Attachment 2 - Master RC Eligibility Report</p>	<p>09/02/2015</p>	

	c) The report described above will be used to identify members assigned to each PCP and notify the PCP of the member's participation with the RC. The notification will include the RC client ID number and demographics for the assigned RC.	2.3b - Attachment 3 - Provider Notification for RC Members	04/29/2016	
<b>2.4 Initial Health Assessments</b>  1) Develop and implement an effective system to validate the performance of a complete Initial Health Assessment including Individual Health Education Behavioral Assessment and other required elements within the required timeframe.	a) The QI Department implemented a Member Outreach unit to assist members with scheduling their PCP appointments for their IHA and Individual Health Education Behavioral Assessment (IHEBA). The outreach staff will contact the PCP office after the scheduled appointment date to verify that the appointment for the IHA was kept, and will review the IHA and IHEBA medical record documentation to validate the performance of a complete IHA, IHEBA, and other required elements within the required timeframe.	2.4a - Attachment 1 - IHA Member Outreach SOP  2.4a - Attachment 2 - Outreach Flowchart  2.4a - Attachment 3 - Appointment Reminder	11/04/2015	<u>02/11/2016</u> : The plan submitted the following documentation to support that new processes have been created to ensure timely completion of IHAs:  -Standard Operating Procedure QM-SP-028 titled, "Initial Health Assessment Member Outreach Process" (01/22/2016)  -Outreach Flow Chart
	b) For medical record documentation that does not meet the IHA, IHEBA, and/or other required elements, Provider Services Department will conduct provider education about accurate assessment and documentation of the IHA/IHEBA and other required elements.	2.4a - Attachment 4 - Medical Record Request SOP	03/25/2016	-Appointment outreach template form to remind members of their scheduled appointment.  -A medical record request template form that will be sent to providers beginning 03/25/2016 to validate performance of the IHA/IHEBA.
	c) An IHA completion report based on claims/encounters will be developed to represent all IHA codes and covering all age ranges and will be presented to the QI Strategy Committee (QISC) on a quarterly basis. Barriers to meeting goals, opportunities and interventions to improve outcomes will be discussed and approved at these committee meetings.		04/29/2016	-A blank "MediCal – New enrollee list" template that will be generated on a monthly basis and submitted to the QI Member Outreach unit.  -The "Palantir IHA Outreach Report – Quarter 4 2015) to demonstrate that the Plan is tracking on a quarterly basis the number of call attempts made to conduct IHAs.

				<p>In addition, the Plan has committed to running an IHA completion report based on claims/encounters and will report this to the QISC on a quarterly basis beginning 04/29/2016.</p> <p>04/18/2016: The plan submitted the following additional information:</p> <p>-“IHA Completion Report – 2015 Annual Report” as documented evidence that the plan is tracking IHA completion rates by utilizing claims data. The QI Strategy Committee reviewed and conducted a barrier analysis of the data.</p> <p>-A validation audit of 52 files demonstrating that the Plan monitored for both timely completion of the IHA as well as a comprehensive physical exam including the SHA/IHEBA.</p> <p><b>This finding is closed.</b></p>
2) Ensure an efficient system of monitoring and tracking access of newly enrolled Members with their Primary Care Providers.	a) QI Member Outreach unit will receive a new member data report within 30 days of enrollment from the Finance Department.	<p>2.4b - Attachment 1 - Sample of MediCal - New Enrollee list</p> <p>2.4b - Attachment 2 - IHA Member Outreach SOP</p>	09/25/2015	<p>The documentation submitted under Deficiency 2.4(1) above satisfies this item.</p> <p><b>This finding is closed.</b></p>
	<p>b) The newly developed QI Member Outreach unit will attempt to contact each new Medi-Cal member three (3) times:</p> <ul style="list-style-type: none"> <li>• Phone: Two (2) attempts</li> <li>• Mail: One (1) attempt</li> </ul>	<p>2.4b - Attachment 3 - SOP Outreach Flowchart</p> <p>2.4b - Attachment 4 - SOP Medical Record Request</p>	10/06/2015	

	The team will follow up with members who failed to complete their IHA appointment, and attempt to reschedule this appointment. All outbound calls will be tracked and documented in the Palantir system.	2.4b - Attachment 5 - SOP Appointment Reminder		
	c) Palantir reporting will be utilized to track IHA completion status among new Medi-Cal members.	2.4b - Attachment 6 - Palantir Outreach Report	10/06/2015	
	d) An IHA completion report based on claims/encounters will be developed to represent all IHA codes and covering all age ranges and will be presented to the QISC on a quarterly basis. Barriers to meeting goals, opportunities and interventions to improve outcomes will be discussed and approved at these committee meetings.			
<b>2.5 Complex Case Management</b>  1) Implement policies and procedures regarding care planning to ensure that individual care plans for Members receiving Complex Case Management services meet the requirements per Contract.	a) The HCS Department will create a refresher training course for Case Management staff on follow-up and outcomes of Individualized Care Plan (ICP) goals and problems. HCS will also develop an audit tool for internal monitoring and oversight.		03/04/2016	<u>04/04/2016</u> : The plan submitted the following documentation as evidence that ICPs for members receiving CCM meet the requirements of the Contract :  -A PowerPoint training titled, "Care Plan Refresher & Use of Audit Tool Training (February 2016) which includes guidelines for creating individualized ICPs with measurable goals.  -Multiple sign-in sheets as evidence that case management staff from the plan's various service areas have been trained.  -A blank "Care Plan Audit Tool" template that demonstrates that ICPs are monitored for goals that address HRA issues identified.  -A blank "Manager Case Review Tool" that demonstrates ICPs are
	b) HCS will deliver ICP refresher training to management and staff.		04/29/2016	
	c) HCS Department will update Policy and Procedure (P&P) CM-04 to include audit/monitoring protocol.	2.5a – Care Plan Audit Tool and Manager Case Review Tool samples	04/29/2016	

				<p>reviewed to ensure that goals reflect the needs identified by the assessment and the member's main health concerns are addressed.</p> <p><u>06/03/2016</u>: Per DHCS' request, the plan submitted a sample "Care Plan Audit Tool" (04/21/16) as evidence that three ICPs were being reviewed. The tool measured several components including whether goals and interventions matched identified issues and whether follow-up tasks were in place to ensure goals were being addressed.</p> <p><b>This finding is closed.</b></p>
<p>2) Educate network Providers to understand the Plan's role in Case Management, Basic or Complex, and how these services are coordinated with the Primary Care Providers.</p>	<p>a) The Provider Services Department will deliver bi-annual communication to PCPs regarding the Plan's Basic/Complex Case Management via a Just the Fax communication.</p>		<p>04/29/2016 10/28/2016</p>	<p><u>02/11/2016</u>: The plan submitted evidence of SBIRT, EPSDT, and Case Management Training conducted by its Provider Services Department in January and February 2016 to various counties. Risk level criteria and the Case Management Referral handouts were attached.</p>
	<p>b) The Provider Services Department will conduct a Provider Operation Management Meeting (POMM) with providers in all counties to focus on the Plan's Basic/Complex Case Management requirements.</p>	<p>2.5b - Attachment 1 - POMM IE</p> <p>2.5b - Attachment 2 - POMM IM</p> <p>2.5b - Attachment 3 - POMM LA</p> <p>2.5b – Attachment 4 - POMM SAC</p> <p>2.5b - Attachment 5 - POMM SD</p> <p>2.5b – JTF bi-annual communication provided on 4.26.16.</p>	<p>Ongoing</p>	<p><u>05/06/2016</u>: The plan submitted its "Just the Fax" communication that was sent to providers on 02/05/2016. The fax demonstrates that PCPs are being reminded of the State requirement to provide Basic and Complex Case Management services to member in collaboration with the health plan.</p> <p><b>This finding is closed.</b></p>

	c) The Provider Services representatives will educate providers during quarterly provider on-site visits. The Complex Case Management job aid will be utilized to educate providers regarding identifying members that meet specific Case Management criteria.	2.5b - Attachment 6 - Complex Case Mgmt Criteria  2.5b - Attachment 7 - MHC Case Mgmt Referral  2.5b – JTF bi-annual communication provided on 4.26.16.	Ongoing	
	d) Provider Services Department will educate new providers regarding Case Management and how services are coordinated via the New Provider Orientation (NPO) training conducted during the onboarding process.		Ongoing	
<b>4. Members' Rights</b>				
<b>4.3 Confidentiality Rights</b>  1) Ensure that the 24 hour DHCS Initial Notification of Breach is submitted to the DHCS Medi-Cal Managed Care Division Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security	a) The Compliance Department will meet with the HIPAA Program Office on a monthly basis to monitor and discuss any incidents that did not meet the initial 24 hour turnaround time reporting requirement for reporting Privacy Incident Reports (PIR) to the State. A Root Cause Analysis will be conducted on incidents that were not reporting within the required timeframe to ensure appropriate corrective action is implemented to mitigate the issue.		12/14/2015	<u>02/11/2016</u> : The plan submitted evidence of a PowerPoint training titled, "MHC HIPPA Program" (01/02/2016) which contains slides that are reinforce the 24hr reporting requirement and the three DHCS entities that breaches must be reported to.
	b) Additional training was provided to Compliance Department staff to communicate the process for reporting incident reports to the appropriate State contacts within the required timeframes.	4.3a - Attachment 1 - HIPAA staff training slides  4.3a - Attachment 2 - MHC HIPAA training sign in sheet  4.3a - a Timely Reported Breach	01/26/2016	<u>05/06/2016</u> : The plan submitted a sample email (02/26/2016) that demonstrates a potential privacy incident was correctly sent to all three entities as required.  <b>This finding is closed.</b>
<b>5. Quality Management</b>				
<b>5.4 Member Records</b>				

Implement monitoring procedures to verify that a complete and comprehensive medical record is kept for each Member in order to improve compliance to the requirements.	a) The updated P&P Quality Management (QM) 101 will be approved at the next QIC meeting.	5.4a - Attachment 2 - QM 101 Final Policy	03/25/2016	<p><u>04/04/2016</u>: The Plan submitted P&amp;P QM 101, "Medi-Cal Primary Care Physician Full Scope Medical Record Review" (approved 02/23/2016) which describes the medical record review process which will be performed as part of the FSR every three years.</p> <p>-A blank "FSR MMR Tracking Log" which will allow the plan to record files reviewed along with the MRR score.</p> <p><u>05/06/2016</u>: Per DHCS' follow-up request, the plan additionally submitted:</p> <p>-A redacted "FSR MRR Tracking Log" in use for Jan, Feb, and Mar 2016 as evidence that the Plan is conducting MRR reviews.</p> <p>-A blank template titled, "Full Scope Medical Review Survey," that is used for the MRR audits. The template includes a comprehensive review of the medical record.</p> <p>-A sample MRR audit conducted on 03/04/06 which demonstrates use of the tool. Sample audit demonstrated 91.96 compliance.</p> <p><b>This finding is closed.</b></p>
	b) The QI Facility Site Review (FSR) staff will implement a tracking log for Molina members' medical record reviews for future audit record review.	<p>5.4a - Attachment 3 - FSR Tracking Log</p> <p>5.4a - a FSR MRR Tracking Log</p> <p>5.4a - b MRR tool</p> <p>5.4a - c Sample Audit</p>	01/04/2016	