

MEDICAL REVIEW – SOUTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

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

Contract Numbers: 06-55498, 07-65851
and 09-86161

Audit Period: August 1, 2014
Through
July 31, 2015

Report Issued: January 7, 2016

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES	4
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 2 – Case Management and Coordination of Care	6
	Category 4 – Member’s Rights	16
	Category 5 – Quality Management	18

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, MHC 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. In 2013, MHC acquired the Medicaid Expansion and the dual eligibility program.

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 the Quality Assurance (NCQA) accredited health plan.

MHC has been serving Medi-Cal Members since January 1980. The Plan's focus is on government-sponsored programs such as: Medi-Cal, Medicare, Cal MediConnect (duals demo), and Marketplace (Covered California). As of June 30, 2015, there are 593,000 Members across 6 counties.

The Plan's enrollment totals for its Medi-Cal line of business in Riverside, San Bernardino, Sacramento, and San Diego Counties as of October 2015 are as follows:

- San Diego: 202,481
- San Bernardino: 86,780
- Riverside: 81,878
- Sacramento: 58,893

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of August 1, 2014 through July 31, 2015. The on-site review was conducted from August 24, 2015 through September 4, 2015. The audit consisted of a review of documents, verification studies, and interviews with Plan personnel.

An Exit Conference was held on October 27, 2015 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan did not submit any additional documentation after the Exit Conference.

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

The summary of the findings by category follows:

Category 2 – Case Management and Coordination of Care

The Plan did not completely meet the contractual requirements for Coordination of Care including Basic Case Management services specifically the completion of Initial Health Assessments in a timely manner. In addition, the Plan lacked an effective monitoring system to ensure that Members who are eligible for Basic Case Management receive these services from the Primary Care Providers.

The Plan does not have an accurate system to identify Members' eligibility and participation in the CCS program and to ensure that they receive medically necessary diagnostic, preventive and treatment services through their PCPs. In addition, the Plan's Member Handbook did not indicate the correct age range to be in the CCS program as stated in the Contract. Furthermore, the Plan lacked an effective monitoring system to ensure that Coordination of Care occurs between the Primary Care Providers and the specialty providers.

The Plan did not implement an effective monitoring and tracking system for accurate identification and referral of eligible Members to the Regional Center for Coordination of Care.

The Member's medical records lacked the elements for the completion of the Initial Health Assessments, including Individual Health Education Behavioral Assessment elements within the required timeframe. In addition, the Plan does not have an efficient system of monitoring and tracking access of newly enrolled Members with their Primary Care Providers.

The Plan did not implement policies and procedures regarding care planning to ensure that individual care plans for Members receiving Complex Case Management services effectively meet all the requirements according to the contract. Also, the providers lacked a clear understanding about the Plan's role in Basic and Complex Case Management and how the services are coordinated with the Primary Care Providers.

Category 4 – Member's Rights

The Plan does not follow its' policies and the Contract requirements which require the Plan to notify the DHCS Medi-Cal Managed Care Division Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer of the discovery of a security incident or breach within the required timeframe.

Category 5 – Quality Management

The Plan did not implement effective monitoring procedures to verify that a complete and comprehensive medical record is kept for each Member in order to improve compliance to the requirements.

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 August 24, 2015 through September 4, 2015. 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:

Category 1 – Utilization Management

Prior Authorization Requests: 30 medical and 31 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review by the Plan.

Appeal Procedures: 45 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 10 medical records were reviewed for evidence of Coordination of Care between the Plan and CCS Providers.

Individual Health Assessment (IHA): 24 medical records were reviewed for completeness and timely completion.

Complex Case Management (CCM): 5 medical records listed as CCM were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Emergency Service Claims: 30 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 30 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance Procedures: 48 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Medical Records: 16 providers were interviewed to ensure that the providers are delegated the responsibility of securing and maintaining medical records at each site. Also the Plan’s policies and procedures were reviewed for completeness.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 11 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1

BASIC CASE MANAGEMENT

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. These services are provided through either basic or complex case management activities based on the medical needs of the member.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the Contractor, and shall include:

- 1) Initial Health Assessment (IHA);
- 2) Individual Health Education Behavioral Assessment (IHEBA);
- 3) Identification of appropriate providers and facilities (such as medical, rehabilitation, and support
- 4) Direct communication between the provider and Member/family;
- 5) Member and family education, including healthy lifestyle changes when warranted; and
- 6) Coordination of carved-out and linked services, and referral to appropriate community resources and

GMC/2-Plan Contract A.11.1

SUMMARY OF FINDINGS:

The Plan's Policy # CM-04, Case Management, states that Case Management involves assessment of the Member's condition; determination of available benefits and resources; collaboration between the Plan and providers and the development and implementation of an individualized, multidisciplinary case management plan with performance goals, monitoring and follow-up. These services are provided by the Primary Care Provider (PCP) in collaboration with Molina to ensure the coordination of medically necessary health care services including waiver program or carved out services, the provision of preventive services in accordance with established standards and periodicity schedules and continuity of care for Members.

The Plan's Policy # CM-04, further defines the process of coordination of carved out services such as California Children's Services (CCS) and Early Intervention and Developmental Disability (EI/DD). The Policy further states that the Plan is responsible for the identification of Members who would benefit from or who receive services from the CCS program and the Regional Center.

Twenty-four (24) Members' medical records for IHA completion were reviewed to ensure that Basic Case Management services are provided to the Members by the Primary Care Providers. Based on the review, the following were disclosed:

- Sixteen (16) medical records were incomplete (missing required components such as IHEBA/SHA, complete history & physical exam and/or other elements of IHA).
- 2 medical records were unavailable for review.

Based on the interview with the Plan's Director for CCS, there was a significant inconsistency with tracking and monitoring of CCS Members receiving Case Management. [Please see Section 2.2 CCS].

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

Interview with providers disclosed the Plan did not accurately follow their monitoring system with some of their Primary Care Providers for Coordination of Care and provision of medically necessary covered diagnostic, preventive and treatment services identified for its Members with EI/DD conditions.

The Plan did not completely follow their Policy and did not fully meet the contractual requirements. [Policy CM-04 and Contract Reference: 2 Plan and GMC: A11.1]

RECOMMENDATIONS:

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 appraisal are completely met in a timely manner.
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.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

2.2

CALIFORNIA CHILDREN'S SERVICES (CCS)

California Children's Services (CCS):

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:

The Plan's Policy # CM-03, CCS Program, outlines the process of identification and referral of Members who are potentially eligible for California Children's Services (CCS) benefits to the appropriate county CCS program for eligibility consideration. Also, the Plan Policy CM-04, Case Management, states that Basic Case Management Services are provided by the PCP in collaboration with the Plan to provide Initial Health Assessments, direct communication between Provider and Members, coordination of medically necessary services and coordination of carved-out services such as CCS.

The Plan is responsible for the identification of Members who would benefit from or who receive services from the CCS program as required by the contract. A list of CCS-eligible Members requested from the Plan for the review period showed 1,116 newly enrolled Members eligible for CCS while the DHCS Universe list supplied by the Plan listed only 40 Members who were CCS eligible. Based on the interview, the Plan's Director for CCS stated that they have an estimate of approximately more than 7,000 CCS eligible Members. This statement by the Plan's Director for CCS was inconsistent with tracking and monitoring of CCS Members receiving Case Management.

Member Handbook 2015-2016 states that CCS is a state program for children up to the age of 21 years and 11 months with special needs. However, according to the contract requirements, CCS program is for children with CCS eligible conditions from birth to age 21 years old only.

Ten (10) medical records for CCS Members were reviewed for the verification study. Based on the review, following were disclosed:

- Ten (10) records did not include any documentation from Primary Care Providers and no documentation that IHA was conducted, therefore evidence that CCS Members received all the necessary screening and preventive medical services from Primary Care Providers were not found.
- Ten (10) records had no documentation of Coordination of Services between the PCP, CCS specialty providers and the CCS local program.
- Five (5) CCS Members were actually the mothers of the Members.
- Six (6) records had no documentation of baseline health assessments and diagnostic evaluations to establish or raise reasonable suspicion of a CCS eligible condition
- Two (2) Members did not have CCS eligible conditions as verified by the Plan. However, they are still open in the CCS eligible Members list.
- Three (3) Members had CCS open dates listed more than a month before birth
- Six (6) records had no documentation of the Plan's involvement in the Coordination of Care

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

According to the contract requirements, the Plan has the responsibility to identify and track Member eligibility and to ensure that Members with CCS-eligible conditions are referred in a timely manner to the CCS program, continue to provide medically necessary covered services not authorized by CCS and document coordination of care and case management between the Member's Primary Care Providers, CCS specialty providers, and the local CCS program.

RECOMMENDATIONS:

1. Implement a system to accurately identify Members whose eligibility and participation in the 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.
2. Update Member Handbook 2015-2016 to include that the CCS program is for children from birth to age 21 years old only.
3. Implement an effective monitoring system to ensure the coordination of care between the Plan, Primary Care Providers and the specialty providers occurs.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

2.3

EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

actor shall develop and implement procedures for the identification of Members with developmental ilities.

- C. Contractor shall provide all screening, preventive, Medically Necessary, and therapeutic Covered Services to Members with developmental disabilities. 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 the Regional Center staff, which includes identification of all appropriate services, including Medically Necessary Outpatient Mental Health Services which need to be provided to the Member.
- E. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2 for the coordination of services for Members with developmental disabilities.

GMC Contract A.11.10.A, C, E

- A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.
- 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.
- E. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers...for the coordination of services for Members with developmental disabilities.

2-Plan Contract A.11.10.A, C, E

Early Intervention Services:

Contractor shall develop and implement systems to identify children under 3 years of age who may be eligible to

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 ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

SUMMARY OF FINDINGS:

The Plan's Policy # UM-55, Early Start Eligible Member Referral, states that the purpose of this policy is to identify Members who are at risk or suspected of having a developmental disability or delay through appropriate screening or assessment measures and to establish a coordinated and integrated system for Molina Members between the age of 0 to 36 months with disabilities or at high risk to receive screening, preventive and medically necessary and therapeutic services covered by the State contract.

The Plan's Policy # UM-53, Developmental Disabilities Services, states that DDS services are for eligible members from 36 months to adults. DDS includes Members with a disability that originates before the member attains 18 years of age, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. The Members are identified as having an eligible or potentially eligible condition either through referral for CCS triage; diagnostic codes report tracking or Regional Center monthly report.

Interviews with several providers disclosed that the Members were not evaluated for eligibility and were not referred to the Regional Center. In addition, the providers did not receive notification or report that identifies Molina Members who have been assessed by the Regional Center. The Plan did not completely follow their Policy and the Contract requirements which states, the Plan shall develop and implement procedures for the identification and referral of Members with developmental disabilities. **This is a repeat finding.** [Reference: Policy # UM-53, 2 Plan and GMC Contracts: A.11.10]

The Policies state that the Plan shall provide Case Management, coordinating services with Primary Care Physicians, specialists and allied health professions. However, according to the interviews with several providers, the Plan did not follow the monitoring system with their Primary Care Providers for Coordination of Care and provision of medically necessary covered diagnostic, preventive and treatment services identified for its Members with EI/DD conditions.

RECOMMENDATIONS:

1. Implement an effective monitoring system to accurately identify Members and refer them to the Regional Center for Coordination of Care.
2. Ensure that providers receive the Monthly Regional Center Report that identifies the Members who have been assessed by the Regional Center.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

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 shall ensure the provision of an IHA within 120 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.

GMC Contract A.10.5

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 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.

2-Plan Contract A.10.5

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 make repeated attempts, if necessary, to contact a Member and schedule an IHA. Contractor shall make at least three documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA. Contact methods must include at least one telephone and one mail notification. Contractor must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed.

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...

2-Plan Contract A.10.3.D

Individual Health Education Behavioral Assessment:

Contractor shall ensure that the IHA includes the IHEBA as described in Exhibit A, Attachment 10, Provision 8, Subprovision A.

2-Plan and GMC Contract A.10.3.B

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

SUMMARY OF FINDINGS:

The Contract requires the provision of a complete Initial Health Assessment (IHA) that includes an Individual Health Education Behavioral Assessment (IHEBA) to all new Members within stipulated timelines and that reasonable attempts to contact each Member are documented in the medical record.

The Plan's Policy # QM 10, Initial Health Assessment (IHA), ensures that all Members receive an Initial Health Assessment (IHA) and an Individual Health Education Behavioral Assessment (IHEBA) for each Member within 120 calendar days of the effective date of notice of enrollment in MHC. Individual Members may be excluded from the IHA requirement if they meet certain conditions or circumstances.

The Plan's Policy # QM 10, further states that IHA shall consist of a comprehensive history, physical and mental status examination and IHEBA to enable a provider of primary care services to assess and manage the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

According to the review of IHA Completion Report of third and fourth quarter 2014, Medical Record Review audits were performed to ensure that IHA is being conducted within the 120 day time period as required by Department of Health Care Services.

The Plan monitored compliance for the timely provision of the IHA through the Facility Site Review (FSR). However, other than FSR, no other efforts were made to monitor IHA completion or evaluate completion rates.

For the Verification Study, twenty four (24) medical records were reviewed for compliance with the IHA requirements. Based on the review, sixteen (16) medical records were incomplete. The records were missing the required components such as IHEBA/SHA, complete history & physical exam and/or other elements of IHA.

The Plan did not have proper methodology to confirm the performance of a complete IHA with all the required elements including IHEBA for its Members. In addition, the Plan lacked an effective system of monitoring and tracking the assignment of newly enrolled and/or paneled Member with its Primary Care Provider. There was no record of information the Plan is actively engaged in encouraging its Members to obtain initial assessments with their assigned Providers.

RECOMMENDATIONS:

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.
2. Ensure an efficient system of monitoring and tracking access of newly enrolled Members with their Primary Care Providers.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

2.5

COMPLEX CASE MANAGEMENT

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. These services are provided through either basic or complex case management activities based on the medical needs of the member.

Complex Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include, at a minimum:

- 1) Basic Case Management Services
- 2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
- 3) Intense coordination of resources to ensure member regains optimal health or improved functionality
- 4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually

Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals.

GMC/2-Plan Contract A.11.1

SUMMARY OF FINDINGS:

According to the Contracts, the Plan shall ensure the provision of Comprehensive Medical Case Management to each Member. In addition, the Plan 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 Plan's provider network. These services are provided through either Basic or Complex Case Management activities based on the medical needs of the Member.

The Plan's Policy # CM-04, Case Management, describes the procedures and processes used to coordinate care and services to Members. Comprehensive Medical Case Management Services are provided by the Primary Care Providers in collaboration with the Plan. 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 the development of an individualized care plan with Primary Care Providers and Member participation. Individualized Care Plan includes assessments, goals, interventions and outcomes.

Several of the providers interviewed were unfamiliar with the Plan's Complex Case Management program. If a Member needs Complex Case Management, it would be accomplished within their own practice or seek assistance from the IPA they belong.

Medical records of five (5) Complex Case Managed Members were reviewed for the verification study. Review of the medical records disclosed the following:

- All five (5) medical records had Individual Care Plans (ICPs); however, four (4) records had no documented follow up or outcome if the goals or problems have been resolved or ongoing.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

- One (1) ICP had documentation of several co-morbidities of the Member pertaining to cardiac problems. However, no goals or interventions were provided relevant to the specific problem. Without goals and interventions assigned to a problem, there is a lack of care planning to coordinate all services needed.
- Two (2) medical records were missing the documentation of IHA.

RECOMMENDATIONS:

1. Implement policies and procedures regarding care planning to ensure that individual care plans for Members receiving Complex Case Management services effectively meet the requirements per Contract.
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.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

CATEGORY 4 – MEMBER’S RIGHTS

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....

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

Business Associate agrees:

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, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164,

GMC/2-Plan Contract G.III.C.2.

Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. Notice to DHCS. (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement....

2. Investigation and Investigation Report . To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

-Plan Contract G.III.J

SUMMARY OF FINDINGS:

The Plan’s Policy # HP-38, Privacy Incident Management, Investigation and Response, describes the effective and efficient management, investigation and response to suspected and known privacy incidents. In addition, Attachment A of the Policy describes the notification of the breaches will be sent to the following: the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer within 24 hours. Furthermore, the Policy states the requirements for investigations of the incidents that within seventy-two (72) hours of the discovery of the incident, notification will be sent to the following: the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer.

A total of eleven (11) HIPAA breach cases for the audit period were reviewed for the verification study. Based on the review, all 11 HIPAA breach cases were notified only to the DHCS Privacy Officer. Also, out of 11 cases, six (6) were not submitted within 24 hours as required by the Contracts. [Contract Reference: 2 Plan and GMC Contract Reference: Exhibit G].

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

The Plan does not follow their policies and the contract requirements which require the Plan to notify the DHCS Medi-Cal Managed Care Division Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer of the discovery of a security incident or breach within the required timeframe.

RECOMMENDATION:

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 Officer within the required timeframe.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

CATEGORY 5 – QUALITY MANAGEMENT

5.4

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

Medical Records

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 ..:

- 1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
- 2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.
- 3) For the release of information and obtaining consent for treatment.
- 4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Records

Contractor shall ensure that an individual is delegated the responsibility of securing...

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,..:

- 1) Member identification on each page; personal/biographical data in the record.
- 2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
- 3) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
- 4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered...etc.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

SUMMARY OF FINDINGS:

The Plan's Policy # CD-17, Practitioner/Provider Credentialing and Recredentialing-Medical Record Content, Documentation and Review, states the procedures and established standards for documentation of care in Medical Record Maintenance for each Member. In addition, the Plan has developed procedures to maintain patient medical records and to safeguard the confidentiality of information and established standards for the administration and maintenance of medical records by individual Providers to facilitate communication, coordination, and continuity of care. Furthermore, the Plan is utilizing an updated Focused Medical Record Review (MRR) tool to address the issue of missing/ incomplete IHA according to the amended contract.

Based on the review of thirty nine (39) Member's medical records, the Plan lacked proper implementation of its policies and procedures in keeping and maintaining a complete and comprehensive medical record that reflects accurate patient information with all aspects of care including coordination of care for each Member in accordance with the Contract requirements.

RECOMMENDATION:

Implement effective monitoring procedures to verify that a complete and comprehensive medical record is kept for each Member in order to improve compliance to the requirements.

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

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

Contract Numbers: 06-55503, 07-65852
and 09-86162
State Supported Services

Audit Period: August 1, 2014
Through
July 31, 2015

Report Issued: January 7, 2016

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

INTRODUCTION

The audit report presents the findings of the contract compliance audit of Molina Healthcare of California Partner Plan and its implementation of the State Supported Services contract Nos. 06-55503, 07-65852 and 09-86162 with the State of California. The State Supported Services contract covers abortion services for Molina Healthcare Plan.

The onsite audit of the Plan was conducted from August 24, 2015 through September 4, 2015. The audit covered the review period from August 1, 2014 through July 31, 2015 and consisted of a document review of materials provided by the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Health Plan

AUDIT PERIOD: August 1, 2014 – July 31, 2015

DATE OF AUDIT: August 24 - September 4, 2015

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*

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.
State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDINGS:

The Plan Policy UM-05, *Abortion Services and Approval Process for the Use of Mifepristone*, states that abortion services are covered for MHC Members. Abortion services include the use of Mifepristone (Mifiprex). These abortion services do not require Prior Authorization.

The Plan Policy UM-62, *Family Planning Services*, states that the Plan shall reimburse all abortion services, pregnancy testing, and counseling performed by out-of-plan family planning Providers at the applicable Medi-Cal rate.

The Plan has guidelines to provide instructions for the billing of abortion services for participating Providers and for claims processors when paying or denying a claim with updated billing codes.

The Plan's Member Handbook states that pregnancy termination (abortion) services are covered for Members. These services do not require prior authorization.

The Provider Manual informs providers of the rights of Members to receive timely access to care for abortion services.

Although the billing procedure codes are not included in the Plan's Policies, the Plan personnel indicated that the Plan's billing codes are included in the Claims Processing Guide and in their billing code system. Molina has guidelines to provide instructions for the billing of abortion services for participating Providers and for claims processors when paying or denying a claim with updated billing codes. The Plan is in compliance with the contractual requirements.