DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

RANCHO CUCAMONGA SECTION

REPORT ON THE MEDICAL AUDIT OF MOLINA HEALTHCARE OF CALIFORNIA, INC. FISCAL YEAR 2024-25

Contract Numbers: 23-30233, 23-30234, and 23-30342

Audit Period: March 1, 2024 — February 28, 2025

Dates of Audit: March 3, 2025 — March 14, 2025

Report Issued: August 13, 2025

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I. INTRODUCTION

Molina Healthcare of California, Inc. (Plan) has contracted with the State of California Department of Health Care Services (DHCS) since April 1996 under the provisions of the California Welfare and Institutions Code section 14087.3. The Plan provides medical managed care services to Medi-Cal members and is licensed under the Knox-Keene Health Care Service Plan Act.

The Plan is a full-risk managed care plan that serves government-sponsored programs such as Medi-Cal, Medicare, Integrated Medicaid-Medicare (Duals), and Marketplace (Covered California) population.

The Plan delivers care to members under the Two-Plan model in Riverside and San Bernardino Counties. The Plan provides services in Sacramento and San Diego Counties under the Geographic Managed Care model.

As of February 28, 2025, the Plan provided services to approximately 590,071 members across the four counties. The Plan's enrollment totals for the Medi-Cal line of business by county are Riverside and San Bernardino (212,330 members), Sacramento (79,785 members), and San Diego (297,956 members).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2024, through February 28, 2025. The audit was conducted from March 3, 2025, through March 14, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on June 26, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On July 11, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Population Health Management and Coordination of Care, Network and Access to Care, Member Rights, Quality Improvement and Health Equity Transformation, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of March 1, 2023, through February 29, 2024, was issued on July 31, 2024. This audit examined the Plan's compliance with the DHCS Contracts and assessed the implementation and effectiveness of the Plan's prior year, 2024 Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

There were no findings noted for this category during the audit period.

Category 2 – Population Health Management and Coordination of Care

The Plan must ensure all members receive the seven Enhanced Care Management (ECM) core service components: Outreach and Engagement, Comprehensive Assessment and Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, and Coordination of and Referral to Community and Social Support Services. The Plan did not ensure all members received the seven ECM core service components.

Category 3 – Network and Access to Care

There were no findings noted for this category during the audit period.

Category 4 – Member Rights

There were no findings noted for this category during the audit period.

Category 5 – Quality Improvement and Health Equity Transformation

There were no findings noted for this category during the audit period.

Category 6 – Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contracts.

PROCEDURE

DHCS conducted an audit of the Plan from March 3, 2025, through March 14, 2025, for the audit period of March 1, 2024, through February 28, 2025. The audit included a review of the Plan's Contracts with DHCS, policies and procedures for providing services, 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 the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization (PA) Requests: Twenty-three standard and one expedited PA requests were reviewed. Of the 24 authorizations, 13 denied and 11 approved PA requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to providers and members.

Appeal Procedures: Twenty PA appeals were reviewed for appropriate and timely adjudication.

Delegation of Utilization Management: Twenty-five PA requests from LaSalle Medical Associates Independent Physician Associates were reviewed for appropriate and timely adjudication.

Post Stabilization Authorization: Twenty-five post stabilization authorization requests were reviewed for appropriate and timely adjudication.

Category 2 – Population Health Management and Coordination of Care

California Children's Services: Ten medical records were reviewed for evidence of coordination of care between the Plan and California Children's Services providers.

Behavioral Health Treatment: Ten medical files were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

ECM: Ten medical records were reviewed to confirm coordination of care and fulfillment of ECM requirements.

Category 3 – Network and Access to Care

Emergency Service and Family Planning Claims: Fifteen emergency service claims and 15 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation: Fifteen records were reviewed to confirm compliance with Non-Emergency Medical Transportation requirements.

Non-Medical Transportation: Fifteen records were reviewed to confirm compliance with Non-Medical Transportation requirements.

Category 4 – Member Rights

Grievance Procedures: Twenty-two quality of care, 20 quality of service, and 18 expedited (3 quality of care and 15 quality of service) grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. Fourteen exempt grievances and 15 inquiry calls were reviewed for proper classification and routing to the appropriate level for review.

Category 5 – Quality Improvement and Health Equity Transformation

Quality Improvement System: Fifteen potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Twenty fraud and abuse cases were reviewed for proper reporting of suspected fraud, waste, and abuse to DHCS within the required timeframe.

Proposition 56 Directed Payments: Five claims were reviewed to verify if the Plan reported complete, accurate, reasonable, and timely payments.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.6 ENHANCED CARE MANAGEMENT

2.6.1 Enhanced Care Management Core Service Components

The Plan must ensure all members receive the following seven ECM core service components, as defined in All Plan Letters (APLs): Outreach and Engagement, Comprehensive Assessment and Care Management Plan (CMP), Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, and Coordination of and Referral to Community and Social Support Services. (*2024 Contract, Exhibit A, Attachment III, Section 4.4.11*)

The Plan must comply with all DHCS guidance, including but not limited to APLs. (*2024 Contract, Exhibit E, Section 1.1.2*)

The Plan must administer ECM that includes a Comprehensive Assessment and CMP, which must include, but is not limited to, identifying necessary clinical resources that may be needed to appropriately assess members health status and gaps in care and to inform the development of an individualized CMP. *(APL 23-032, Enhanced Care Management Requirements)*

The Plan must ensure ECM providers use a care management system that collects information from different sources to identify member needs and help the care team coordinate and communicate. *(2024 Contract, Exhibit A, Attachment III, Section 4.4.3, (E) and (F))*

The Plan is required to perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contracts, the DHCS' policies and guidance, APLs, and the Plan's Model of Care. (*2024 Contract, Exhibit A, Attachment III, Section 4.4.13*)

Plan policy, *ECM-CM-02 ECM Care Management Process* (revised 05/23/2024), stated that ECM providers will ensure members receive the following seven core ECM services to eligible members: Outreach and Engagement, Comprehensive Assessment and CMP, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports; and Coordination of and Referral to Community and

Social Support Services. Additionally, as part of the Plan's Comprehensive Assessment, it utilizes the Health Risk Assessment (HRA) to understand the member's needs and develop an individualized CMP.

Plan policy, *ECM-CM-05 ECM Monitoring and Oversight* (revised 11/18/2024), stated that the Plan will review and evaluate ECM provider performance and adherence to program requirements. The policy described a process to develop and implement corrective actions for deficiencies in adhering to ECM requirements.

Finding: The Plan did not ensure all members received the seven ECM core service components.

Although the Plan's policy, *ECM-CM-02,* stated that ECM providers would ensure that members received the seven core ECM services, the Plan did not ensure ECM providers followed this policy.

A verification study revealed the Plan did not ensure all ECM core service components were completed for two of the ten members enrolled in the ECM program. A review of medical records showed:

Core Service 1 – Comprehensive Assessment and CMP

- In two cases, there were no HRA records to document that ECM providers assessed the members' clinical needs. The Plan did not identify necessary clinical resources that may be needed to appropriately assess members' health status and gaps in care and to inform the development of an individualized CMP. The Plan cannot identify clinical needs requiring care coordination if it does not complete a clinical needs survey as part of its comprehensive assessment. A comprehensive assessment is required to develop an individualized CMP that addresses clinical and non-clinical care coordination needs.

A review of the Plan's ECM monitoring report found that 989 HRAs were not completed. Of these 989, 691 individualized CMPs were also not completed. Additionally, the Plan conducted an internal audit review through an ECM Audit Tool, which showed a 67 percent noncompliance rate for both HRA and individualized CMP of an ECM provider during the review period. Despite the ECM audit deficiencies, the Plan did not take corrective action to address the deficiencies. Therefore, the Plan did not fully implement its policy for effective ECM oversight.

In an interview, when asked if the Plan developed or implemented corrective actions to address deficiencies noted, it was stated that they only tracked HRA and CMP

completion but did not develop any corrective actions. The Plan did not hold its ECM providers accountable for all ECM requirements by not following its policy to correct deficiencies.

When the Plan fails to correct deficiencies identified during ECM oversight, it cannot ensure that all ECM core service components are completed. This can result in adverse health outcomes due to a lack of coordination of services and comprehensive care management.

Recommendation: Implement policies and procedures to ensure all members receive the seven ECM core service components.

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REPORT ON THE MEDICAL AUDIT OF MOLINA HEALTHCARE OF CALIFORNIA, INC. FISCAL YEAR 2024-25

Contract Numbers: 23-30265, 23-30266, and 23-30343

Contract Type: State Supported Services

Audit Period: March 1, 2024 — February 28, 2025

Dates of Audit: March 3, 2025 — March 14, 2025

Report Issued: August 13, 2025

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I. INTRODUCTION

This report presents the results of the audit of Molina Healthcare of California, Inc.'s (Plan) compliance and implementation of the State Supported Services contract numbers 23-30265, 23-30266, and 23-30343 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of March 1, 2024, through February 28, 2025. The audit was conducted from March 3, 2025, through March 14, 2025, which consisted of a document review, verification study, and interview with the Plan's administration and staff.

An Exit Conference with the Plan was held on June 26, 2025. No deficiencies were noted during the review of the State Supported Services Contracts.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Contracts require the Plan to provide eligible members the following State Supported Services: Current Procedural Terminology Codes 59840 through 59857 and the Centers for Medicare and Medicaid Services Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. *(State Supported Services Contract, Exhibit A)*

The Plan's policy, *HPO-CP-03 Processing of Claims* (revised 08/30/2023), stated that prior authorization is not required for providers of sensitive services. However, they must include documentation that the services were provided by a qualified provider.

The Provider Manual informs providers that abortion services are sensitive services that require timely access to care.

The Member Handbook informs members that they may choose any provider for outpatient abortion services. Members can go to any Medi-Cal provider without a referral or prior authorization from the Plan. Members under the age of 18 can receive abortion services without a parent or guardian's permission.

A review of 15 claims demonstrated that the Plan appropriately processed, paid, or denied abortion service claims within the required time frames.

Based on the review of the Plan's documents, no deficiencies were noted for the audit period.

Recommendation: None.