

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

REPORT ON THE MEDICAL AUDIT OF

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

Contract Number: 06-55498, 07-65851,
09-86161 and 13-90285

Audit Period: August 1, 2018
Through
July 31, 2019

Report Issued: January 7, 2020

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I. INTRODUCTION

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

The Plan is a full-risk managed care plan, which serves government sponsored programs such as Medi-Cal, Medicare, Cal MediConnect (Medicare-Medicaid Plan Dual options) 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. The Plan also delivers care to members in Imperial County under the Imperial Model Expansion.

As of July 1, 2019, the Plan provides services to 413,113 members across five counties. The Plan's enrollment totals for its Medi-Cal line of business by county is: Riverside (76,455 members), San Bernardino (53,128 members), Sacramento (50,781 members), San Diego (218,473 members) and Imperial (14,276 members).

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS medical audit for the period of August 1, 2018 through July 31, 2019. The on-site review was conducted from August 12, 2019 through August 23, 2019. The audit consisted of a review of documents, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on December 9, 2019. 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 findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

The audit evaluated five categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management (QM).

The prior DHCS medical audit (for the audit period of July 1, 2017 through June 30, 2018) was issued May 15, 2019. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their Corrective Action Plan (CAP).

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan's policies and procedures are not in place to implement effective corrective actions to bring non-compliant delegated entities into compliance. The Plan waited over a year to issue any corrective actions from 2018 to a delegated entity. A CAP was not issued to the delegate until June 25, 2019.

The Plan did not ensure that its members were notified of their denied prior authorization requests. Denials were automatically closed without review.

Category 2 – Case Management and Coordination of Care

The Plan did not take effective action to ensure that each new member completed the Staying Healthy Assessment (SHA) within 120 days of enrollment as part of the Initial Health Assessment (IHA). The Plan did not review and discuss the IHA completion reports regularly and failed to update the interventions to improve completion results.

Category 3 – Access and Availability of Care

The prior year audit found that the Plan did not have a process to implement any further investigation or corrective measure against providers who were identified with non-compliance to timely appointments or after-hour access and availability standards who did not respond to the corrective action request. During subsequent audit review period, the Plan was unable to demonstrate that changes had been made and were operationalized.

Category 4 – Member's Rights

There were no findings in this category.

Category 5 – Quality Management

There were no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS, Medical Review Branch to ascertain medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's contracts.

The audit evaluated five categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

PROCEDURE

The onsite review of the Plan was conducted from August 12, 2019 through August 23, 2019. The audit included 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 those 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: 31 medical and 29 pharmacy prior authorization requests were reviewed for compliance with contractual requirements, including medical necessity, consistent application of criteria, and timeliness.

Appeal Procedures: 11 medical and 10 pharmacy prior authorization appeals were reviewed to ensure that required timeframes were met and appeals are appropriately routed and adjudicated by appropriately qualified personnel.

Category 2 – Case Management and Coordination of Care

Individual Health Assessment (IHA): 27 records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Appointment wait times: 15 providers from the Plan's directory were surveyed. The survey consisted of five new patient specialty, five established patient routine specialty, five first prenatal, five established patient routine prenatal, five routine primary care provider, and five urgent care primary care providers. The "third-next available" appointments were used to measure access to care.

Category 4 – Member's Rights

Quality of Care Grievances: 19 Medi-Cal quality of care grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Quality of Service Grievances: 61 Medi-Cal quality of service grievances which included 36 standard, 6 expedited, and 19 exempt grievance cases were reviewed to verify the reporting timeframes and investigation process.

Category 5 – Quality Management

New Provider Training: 22 new provider training files 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 (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: August 1, 2018 through July 31, 2019

DATE OF AUDIT: August 12, 2019 through August 23, 2019

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1

DELEGATION OF UTILIZATION MANAGEMENT

1.1.1 Corrective Action Process for Delegated Entities

The Plan may delegate UM activities. If the Plan delegates UM activities, the Plan shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. (*Contract, Exhibit A, Attachment 5 (5)*)

The Plan is accountable for all UM functions and responsibilities that are delegated to subcontractors, including the oversight, monitoring, and evaluation of the delegated functions and actions/remedies if subcontractor's obligations are not met. (*Contract, Exhibit A, Attachment 4 (6)*)

The Plan is ultimately responsible for ensuring their subcontractors and delegated entities comply with all applicable state and federal laws and regulations, contract requirements, reporting requirements, and other DHCS guidance. The Plan must also have in place policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of noncompliance. (*All Plan Letter 17-004 Subcontractual Relationships and Delegation*)

Finding: The Plan's policies and procedures are not in place to implement effective corrective actions to bring non-compliant delegated entities into compliance.

Plan Policy No. DO-03: Delegate Sanctions and Escalation, stated the Plan may require a delegated entity to develop an Immediate Corrective Action Plan (ICAP) or CAP response based on deficiencies identified through Plan monitoring and audit activities to bring the delegated entity into compliance with applicable laws, regulatory, contractual or accreditation requirements. ICAPs and CAPs shall be designed so that they are feasible and calculated to bring the delegated entity into compliance within a reasonable period, which except in extraordinary circumstances shall be no longer than six months.

In 2018, the Plan conducted quarterly delegated oversight reviews of UM denials. The reviews identified a CAP was needed for a delegated entity in all four quarters of 2018. However, the Plan waited over a year to issue any corrective actions to the delegate (results from the 1st quarter review of 2018). An ICAP was not issued to the delegate until June 25, 2019.

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Plan Policy No. DO-03, stated ICAPs were required for systemic deficiencies so severe they require immediate correction to prevent further harm to members or risk to the Plan. At the end of the audit period, eight of the nine CAP elements remained open with no final expected date of compliance delineated on the CAP timeline.

Without an effective CAP process, the Plan cannot ensure their delegated entities comply with all applicable state and federal laws and regulations and contract requirements. The risk of prolonged non-compliance can lead to poor quality of care and potential Medi-Cal member harm.

Recommendation: Implement policy and procedures for CAPs to address identified deficiencies.

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PLAN: Molina Healthcare of California Partner Plan, Inc.

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1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Denied Pharmacy Prior Authorization Requests

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 5, Provision 3, the decision is considered denied and notice of the denial must be sent to the member on the date the time frame expires. *(Contracts, Exhibit A, Attachment 13 (C))*

The Plan shall notify members of a decision to deny, defer, or modify requests for prior authorizations by providing written notification to members and/or their authorized representative, regarding any denial, deferral, or modification of a request for approval to provide a health care service. *(Contracts, Exhibit A, Attachment 13 (8)(A))*

Finding: The Plan did not ensure that its members were notified of their denied prior authorization requests.

Plan Policy No. P-07: Prior Authorization Request Procedures, stated Medi-Cal prior authorizations not completed in the allotted time will be considered denied and notice of the denial is sent to the member on the date the time frame expires.

A verification study of pharmacy prior authorization requests revealed two members had denials without pharmacist review or notification to the member or provider. The denials were automatically closed without review.

The Plan did not aggregate or track auto-closed requests, which lead to an automatic prior authorization denial for the member. The Plan was not always able to confirm or verify whether the members with auto-closed pharmacy denials obtained needed medications.

The Plan is required to ensure members are able to obtain prescribed medication in a timely manner. Having a category of denied prior authorization requests, which are not monitored and clinically evaluated, leads to confusion and delay or denial of needed medication.

Recommendation: Consistently comply with contractual and regulatory requirements and implement policies and procedures for timeframes and review of prior authorizations.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1

INITIAL HEALTH ASSESSMENT

2.1.1 Completion of the Staying Healthy Assessment (SHA)

The Plan is required to ensure that the IHA includes an Individual Health Education Behavioral Assessment (IHEBA) and ensure that members' completed IHA and IHEBA tool are contained in the members' medical record and available during subsequent preventive health visits. (*Contract, Exhibit A, Attachment 10 (3)(B)*)

Medi-Cal Managed Care Division (MMCD) Policy Letter 08-003 requires the Plan to administer an age-specific IHEBA as part of the IHA. The Plan may use the MMCD SHA tool to complete IHEBA.

MMCD Policy Letter 13-001 requires the Plan to ensure that each new member complete the SHA within 120 days of the effective date of enrollment. A member's refusal to complete the SHA must be documented on the age-appropriate SHA questionnaire and kept in the members' medical record.

Finding: The Plan did not take effective action to ensure that each new member completes the SHA within 120 days of enrollment as part of the IHA.

Plan Policy No. QM 10: Initial Health Assessment, described that an IHA consisted of a history, physical examination, and an IHEBA. The IHEBA portion of the IHA must be documented on an age appropriate SHA questionnaire/form.

The Plan's *Quarterly IHA Completion Reports*, showed 2018 - Quarter 3 had 70 percent missing SHA records and 2018 - Quarter 4 had 72 percent missing SHA records. The 2019 - Quarter 1 report had only 55 IHA records received and 11 records had missing SHA. All three quarterly completion reports had identical barriers, interventions, and conclusions. The Plan did not update the barriers, interventions, and actions to be taken to help improve the missing SHA results.

The 2018 - Quarter 3, *Quality Improvement Committee (QIC) Meeting Minutes*, described the Plan's review of the 2018 - Quarter 2 IHA completion report. The action taken was the same action taken in the prior IHA completion reports. The 2018 - Quarter 4 and 2019 - Quarter 1 QIC Meeting minutes did not contain a Plan review of IHA completion reports. The Plan did not review and discuss the IHA completion reports regularly and failed to update the interventions to improve the missing SHAs.

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PLAN: Molina Healthcare of California Partner Plan, Inc.

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A verification study of 27 IHA samples revealed none of the samples had the required SHA. In addition, there were no documentation of member's refusal to complete the SHA. During the interview, Plan confirmed there were no SHA for the IHA samples.

The SHA assists primary care physicians in identifying and tracking members' high-risk behaviors and their needs for health education related to lifestyle, behavior, environment, culture, and language. If a SHA is not completed for each new member within 120 days of enrollment, the member's provider will not be able to identify health-risk behaviors and implement evidence-based clinical prevention interventions, and consequently, the quality of care may be compromised.

Recommendation: Take follow-up action to ensure the IHA includes an IHEBA using the age-appropriate DHCS approved SHA tool.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Appointment Wait Times Monitoring

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments, as indicated in Sub-provision A, Appointments." *(Contracts, Exhibit A, Attachment 9 (3)(C))*

The Plan shall establish acceptable accessibility standards in accordance with California Code of Regulations (CCR), Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. *(Contract, Exhibit A, Attachment 11 (B))*

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access, which includes but is not limited to taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies and to bring its network into compliance. *(CCR, Title 28, Section 1300.67.2.2 (d)(3))*

Finding: The Plan did not implement prompt investigations to ensure that CAPs issued to non-complying providers with timely appointments or after-hour access and availability standards were completed.

Plan Policy No. QM-09: Access to Health Care, stated the Plan conducts an annual appointment and after-hour availability audits on statistically valid samples of contracted primary care physicians, high volume specialists, high impact specialists, and behavioral healthcare practitioners, for the provision of access in timely manner based on the established standards. Providers who were identified with non-compliance of timely appointments or after-hour availability standards would be immediately investigated and corrective action would be implemented as appropriate.

The Plan did not have a process to address non-compliant providers who did not respond to the corrective action request. The Plan provided the corrective action documentation for 12 non-compliant providers. A review of this documentation indicated the Plan had scheduled to re-issue the CAP on nine non-compliant providers in 2019 - Quarter 3. The re-issue CAPs documentation was not provided.

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The Plan did not implement any further investigation or corrective measures against the non-complying providers who did not respond. In addition, a review of the *Access and Availability Committee Minutes*, did not indicate any further investigations or actions on non-complying providers who failed to respond to the corrective active requests.

The *Access and Availability Committee Minutes* for 2018 - Quarter 4, stated that the CAP letters for 2017 were sent to the delegated providers without prompt investigation. Almost a year later, on December 4, 2018, 542 CAP letters were sent to primary care providers, specialists, ancillary, non-physician mental health providers, and FQHC's who failed measurement. As of March 11, 2019, only 172 CAP responses have been received by the Plan.

The Plan is required to ensure that providers comply with the appointment timeliness and access and availability standard requirements. Without having a reliable process to ensure that non-complying providers are following the requirements, the Plan cannot accurately monitor and evaluate that members have timely access to health care.

This is a repeat finding. In the prior year audit, the Plan did not take any further action to ensure that non-complying providers respond to corrective active requests. The Plan was unable to demonstrate corrective actions were implemented and operationalized.

Recommendation: Develop policies and procedures to ensure that corrective actions are completed by providers who did not comply with appointment wait time standards.

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

REPORT ON THE MEDICAL AUDIT OF

**MOLINA HEALTHCARE OF
CALIFORNIA PARTNER PLAN, INC.**

Contract Number: 06-55503, 07-65852
09-86162 and 13-90286
State Supported Services

Audit Period: August 1, 2018
Through
July 31, 2019

Report Issued: January 7, 2020

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II. COMPLIANCE AUDIT FINDINGS2

I. INTRODUCTION

The audit report presents the findings of Molina Healthcare of California Partner Plan Inc. (Plan) and its implementation of the State Supported Services Contract Nos. 06-55503, 07-65852, 09-86162 and 13-90286 with the State of California. The State Supported Services Contract covers abortion services for the Plan.

The on-site audit of the Plan was conducted from August 12, 2019 through August 23, 2019 and the audit covered the review period from August 1, 2018 through July 31, 2019. The audit consisted of a document review of materials provided by the Plan and interviews with Plan staff.

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State Supported Services

The Plan outlines their processes and procedures for the consistent and accurate processing of sensitive service claims through the Provider Manual, Member Handbook and their California Processing Guidelines. Abortion services are covered for Plan members and do not require prior authorization. However, if there is a hospital overnight stay required for the service performed, it is considered separate and the member will need to have prior authorization.

No errors were noted in the verification study conducted to determine appropriate and timely adjudication of State Supported Services claims. The Plan is in compliance with the current Contract.

RECOMMENDATION:

None