CONTRACT AND ENROLLMENT REVIEW DIVISION
SANTA ANA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Molina Healthcare Of California Partner Plan, Inc.

2022

Contract Number:	06-55498, 07-65851, 09-86161 and 13-90285
Audit Period:	August 1, 2019 Through April 30, 2022
Dates of Audit:	May 23, 2022 Through June 3, 2022
Report Issued:	April 19, 2023

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PLAN: Molina Healthcare of California Partner Plan, Inc.
AUDIT PERIOD August 1, 2019 through April 30, 2022 **DATE OF AUDIT: May 23, 2022 through June 3, 2022**

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 that 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 April 30, 2022, the Plan provides services to approximately 509,901 members across five counties. The Plan's enrollment totals for its Medi-Cal line of business by county are Riverside (102,875 members), San Bernardino (98,761 members), Sacramento (56,235 members), San Diego (235,129 members), and Imperial (16,901 members).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of August 1, 2019 through April 30, 2022. The review was conducted from May 23, 2022 through June 3, 2022. The audit consisted of documents review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on March 3, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the audit report findings. On March 17, 2023, the Plan submitted a response. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance; Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit, for the audit period of August 1, 2018 through July 31, 2019 was issued on January 7, 2020. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized its Corrective Action Plan (CAP).

The summary of the findings by category is as follows:

Category 1 – Utilization Management

No findings were noted for the audit period.

Category 2 – Case Management and Coordination of Care

No findings were noted for the audit period.

Category 3 – Access and Availability of Care

The Plan must implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access. The Plan did not take effective action to enforce providers' compliance with access standards. The Plan did not communicate, monitor, and enforce provider compliance with access standards.

The Plan must have a documented system for monitoring and evaluating the

accessibility of care, including a system for addressing problems that develop, including but not limited to waiting time and appointments. The Plan did not implement a system to monitor, evaluate, and address accessibility problems related to the wait times for provider return calls to members.

The Plan must have a documented system for monitoring and evaluating the accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. The Plan did not develop monitoring procedures that ensure provider compliance with requirements for network provider office waiting times.

Category 4 – Member's Rights

The Plan must provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the grievance. The Plan did not send a Quality of Service (QOS) grievance acknowledgment letter within five calendar days of receipt of the grievance.

The Plan must send the grievance resolution letter within 30 calendar days of receiving the grievance. The Plan did not send the resolution letter for the QOS grievance within 30 calendar days after the grievance was received.

Category 5 – Quality Management

The Plan must use the DHCS secure online reporting portal to report Provider Preventable Conditions (PPCs) to DHCS. The Plan did not ensure that PPCs were reported to the DHCS. The Plan's policies did not have a process to report PPCs.

Category 6 – Administrative and Organizational Capacity

No findings were noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The review was conducted from May 23, 2022, through June 3, 2022. The audit included a review of the Plan's Contracts with DHCS, its policies for providing services, the procedures used to implement these policies, and verification studies of the implementation and effectiveness of such policies. Documents were reviewed, and interviews were conducted with the Plan's administrators, staff, and the delegated entities.

The following verification studies were conducted:

Category 1 – Utilization Management

Delegation of UM function: 14 delegated UM samples were reviewed for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Prior Authorization Requests: 16 urgent and 13 standard prior authorization samples for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Prior Authorization Appeals: 11 urgent and eight standard prior authorization appeal samples were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Blood Lead Anticipatory Guidance: 12 blood lead anticipatory guidance samples were reviewed to verify if the guidance on blood lead was provided at each periodic health assessment starting at six months of age.

Blood Level Screening Test: 12 blood level screening test samples were reviewed to verify if the guidance on blood lead was provided at each periodic health assessment starting at six months of age.

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation (NEMT) Services and Physician Certification Statement (PCS) Forms**:** 24 NEMT service samples were reviewed for completion.

Category 4 – Member's Rights

Call-Inquiry: 11 call-inquiry cases were reviewed to verify the grievance classification and investigation process.

Exempt Grievances: 15 exempt grievance cases were reviewed to verify the classification, reporting timeframes, and investigation process.

QOS Grievances: 14 QOS grievance cases were reviewed for timeliness, investigation process, and appropriate resolution.

Quality of Care (QOC) Grievances: 19 QOC standard and four QOC expedited grievances were reviewed for processing, clear and timely response, and appropriate level of review.

Category 5 – Quality Management

Potential Quality of Care (PQOC): Eight PQOC samples were reviewed for appropriate evaluation and effective action taken to address needed improvements.

Category 6 – Administrative and Organizational Capacity

Overpayment Reporting: Ten overpayment recovery cases were reviewed for timely reporting to DHCS and annual reporting of total overpayment recoveries to DHCS.

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

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CATEGORY 3 – ACCESS AND AVAILIBILTY OF CARE	
3.1	**APPOINTMENT PROCEDURES AND MONITORING OF WAIT TIMES**

3.1.1 Corrective Actions for Non-Compliant Providers of Appointment Wait Times

The Plan shall establish acceptable accessibility standards in accordance with California Code of Regulation (CCR) Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. *(Exhibit A, Attachment 9 (3)(C))*

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))*

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

Plan Policy QM–09 *Access to Health Care* (revised date 3/1/2022) stated that Plan conducted 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 a timely manner based on the established standards. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends.

Finding: The Plan did not take effective action to enforce providers' compliance with access standards. The Plan did not communicate, monitor, and enforce provider compliance with access standards.

In a verification study of samples from the 2019 and 2020 Provider Appointment Availability Survey, seven of 12 non-compliant providers indicated the following:

- In the case of four of seven non-compliant providers, the Plan indicated in the corrective action documentation that the actions included education, monitoring,

and outreach to all non-compliant providers; however, the Plan could not provide documentation to substantiate how the Plan conducted and communicated these actions to the non-compliant providers.

- For two of seven non-compliant providers, the Plan communicated the corrective actions to the non-compliant providers, but there was no documentation of provider response.

- For one of seven non-compliant providers, the Plan did not communicate the corrective actions to the non-compliant providers or provide any documentation of either provider response or Plan follow-ups.

In interviews, the Plan stated that CAPs were issued to non-compliant providers with follow-ups. However, the Plan could not provide documentation to substantiate how the Plan monitored and followed up on the corrective action requests.

Without ensuring non-compliant providers respond to corrective action requests, the Plan will continue to have non-compliant providers, resulting in members not having timely access.

Recommendation: Ensure implementation of effective corrective action completed by non-compliant providers to comply with appointment wait time standards.

3.1.2 Telephone Wait Times

The Plan shall establish acceptable accessibility standards in accordance with 28 CCR, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times for telephone calls (to answer and return). *(Contract, Exhibit A, Attachment 9(3)(C))*

Each health care service plan shall have a documented system for monitoring and evaluating the accessibility of care, including a system for addressing problems that develop, including but not limited to waiting time and appointments. *28 CCR § § 1300.67.2, (f) Accessibility of Services.*

The Plan Policy QM-09 *Access to Health Care* (revised date 3/1/2022) stated that the answer time for a live person in the physician's office to converse with a member caller is within ≤ 45 seconds of the call during office hours. The response time for returning member calls during office hours is within the same business day of the call.

Finding: The Plan did not implement a system to monitor, evaluate, and address accessibility problems related to the wait times for provider return calls to members.

A verification study of ten samples from the 2019 Provider Access and Availability Survey (PA&A) indicated that the Plan did not monitor the wait times for provider return calls to members.

In interviews, the Plan stated that it conducted a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to monitor the wait times for providers to return calls to members. However, this is not an effective monitoring procedure because the CAHPS survey does not identify non-compliant providers to issue corrective actions.

Not monitoring the wait times for provider return calls to members may result in members not having timely access to needed treatment.

Recommendation: Develop and implement a procedure to effectively monitor and evaluate the wait times for providers to return calls to members.

3.1.3 Office Wait Time

The Plan shall establish acceptable accessibility standards in accordance with 28 CCR, section 1300.67.2.1. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times in network providers' offices. *(Contract, Exhibit A, Attachment 9(3)(C))*

The Plan is required to have a documented system for monitoring and evaluating the accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. *(CCR, Title 28, 1300.67.2 (f))*

The Plan Policy QM-09 Access *to Health Care* (revised date 3/1/2022) stated that the wait time in offices (for scheduled appointments) should not exceed 30 minutes from the appointment time. All Primary Care Physicians were required to monitor waiting times and adhere to this standard.

Finding: The Plan did not develop monitoring procedures that ensure provider compliance with requirements for network provider office waiting times.

A verification study of all ten samples from the 2019 PA&A Survey indicated that the providers self-reported the office wait times data, and the Plan did not validate the data to determine actual compliance. The Plan did not have documentation to substantiate

how the Plan determined or computed the self-reported office wait times from the providers.

In interviews, the Plan stated it monitored office wait times through a PA&A survey. Plan personnel contacted the provider's office and asked for members' average office wait time. However, self-reported data from the PA&A survey is not separately validated by the Plan to ensure accuracy of network provider office wait times.

Without validating accurate provider compliance data for in-office wait times, the Plan cannot identify any provider non-compliance with office wait time standards, resulting in members not having timely access.

Recommendation: Develop and implement a procedure to effectively monitor and evaluate providers' compliance with office wait times.

CATEGORY 4 – MEMBER'S RIGHTS	
4.1	**GRIEVANCE SYSTEM**

4.1.1 Grievance Acknowledgement Letter

The Plan shall have in place a system in accordance with Title 28, CCR, section 1300.68 and 1300.68.01, Title 22 CCR section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph F.13), and Title 42, Code of Federal Regulations (CFR), section 438.402-424. *(Contract, Exhibit A, Attachment 14.1.)*

A grievance system shall provide for a written acknowledgment within five calendar days of receipt. *(CCR, Title 28, section 1300.68 (d)(1))*

In accordance with state law, Managed Care Plans (MCPs) must provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the grievance. *(APL 21-011, Grievance Acknowledgement Letter)*

The Plan Policy and Procedure AG-19A: *Member Grievance process (Medi-Cal)* (revised date 1/18/2022) stated that Medi-Cal members could file complaints anytime. According to Title 28 CCR section 1300.68 (d) (1), the member is sent a written acknowledgment within five calendar days of receipt of a grievance.

Finding: The Plan did not send a QOS grievance acknowledgment letter within five calendar days from receipt of the grievance.

In the verification study of QOS grievances, five out of 14 cases did not meet five days acknowledgment letter timeframe.

For example:

- A member filed a grievance on 9/2/2020, and the Plan sent the grievance acknowledgment letter on 11/2/2022. The Plan took 51 calendar days to send the acknowledgment letter.
- A member filed a grievance on 5/7/2021, and the Plan sent the grievance acknowledgment letter on 7/7/2021. The Plan took 60 calendar days to send the acknowledgment letter.

In both examples, the Plan did not send the grievance acknowledgment letters within five calendar days.

In interviews, the Plan stated that for these misdirected grievances the members initially contacted the other departments for their concerns. Then the other departments took some time to send them to the grievance department which caused the delay.

When Members are not informed of the grievance status can potentially lead to delays in resolving the grievance and create additional dissatisfaction.

Recommendation: Implement policies and procedures to ensure all grievance acknowledgment letters are sent to members within five calendar days.

4.1.2 Grievance Resolution Letters

The Plan must have a system in place in accordance with Title 28, CCR, section 1300.68 and 1300.68.01, Title 22 CCR section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph F.13), and Title 42, CFR, section 438. 402-424. *(Contract, Exhibit A, Attachment 14.1.)*

The Plan's resolution, containing a written response to the grievance, shall be sent to the complainant within 30 calendar days of receipt. *(CCR, Title 28, section 1300.68 (d)(3))*

Timeframes for resolving grievances and sending written resolutions to the member are delineated in federal and state law. The state's established timeframe is 30 calendar days. MCPs must comply with the state's established timeframe of 30 calendar days for grievance resolution. *(APL 21-001)*

Plan Policy AG-19A: Member Grievance process (Medi-Cal) (revised date 1/18/2022) stated that Standard Grievance Resolution Letter: Appeals & Grievances staff sends a written resolution of the grievance to the member within 30 calendar days.

Finding: The Plan did not send QOS grievance resolution letters within 30 calendar days after receipt of grievances.

In the verification study, 12 of 14 grievance cases, the Plan sent grievance resolution letters past the required 30-calendar day timeframe.

For example:

- A member filed a grievance on 10/25/2019, and the Plan sent the grievance

resolution letter on 1/8/2020. The Plan took 75 calendar days to send the resolution letter.

- A member filed a grievance on 7/21/2021, and the Plan sent the grievance resolution letter on 9/9/2021. The Plan took 50 calendar days to send the resolution letter.

In interviews, the Plan stated that for these misdirected grievances the members initially contacted the other departments for their concerns. Then the other departments took some time to send them to the grievance department which caused the delay. Non-timely grievance resolution letters can cause delays in resolving member complaints and can result in member harm.

Recommendation: Implement policies and procedures to ensure all written resolutions are sent to members within 30 calendar days from receipt of the grievance.

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CATEGORY 5 – QUALITY MANAGEMENT	
5.1	**QUALITY IMPROVEMENT SYSTEM**

5.1.1 Reporting of Provider Preventable Conditions

The Plan is required per Title 42, CFR, section 438.3(g) to report PPCs related encounters "in a form and frequency as specified by the State." Accordingly, Plans must screen the encounter data, including data received from their network providers, for the presence of PPCs on a monthly basis. Plans must use DHCS' secure online reporting portal to report PPCs to DHCS. *(APL 17-009, Quality Improvement System)*

The Plan is required to submit policies and procedures for reporting PPCs *(Contract, Exhibit A, Attachment 18.8(J))*

Plan Policy and Procedure *QM 21*: PQOC Concerns, Adverse Events and Never Events (revised 3/1/2022) The PQOC, Adverse Events and Never Events policy provides a structure for identification; documentation and tracking; reviewing, reporting and resolution; and recognition and prevention of PQOC issues including Serious Reportable Adverse Events identified by members, internal or external sources.

Plan Policy and Procedure *QM-01A*: PQOC, Serious Reportable Adverse Events, and Critical Incidents (revised date 2/5/2019) stated that the Plan will monitor and evaluate Critical Incidents, Serious Reportable Adverse Events/Never Events, Mortality and Morbidity identified by members or external sources to continuously improve the quality and effectiveness of care provided to Plan members.

Finding: The Plan did not ensure that PPCs were reported to DHCS. The Plan policies did not include a process to report Provider Preventable Conditions.

In a verification study of eight PQOC samples, four samples did not indicate that preventable conditions were reported to DHCS. The other four PQOC samples did not involve PPCs.

For example:

- A member had a retained laparotomy sponge after a surgical procedure. The member required another surgical procedure for removal. The Plan either did not report or ensure the provider reported the PPCs to DHCS.

- A member had an unwitnessed fall at a skilled nursing facility that resulted in a left trochanter fracture, which required hospitalization and repair. The Plan professional review committee reviewed the case. The Plan either did not report or ensure the provider reported the PPCs to DHCS.

In interviews, the Plan stated due to data formatting issues, the PPCs were not reported to DHCS. The Plan's policies and procedures QM-01A, QM-21 and QM-46 required continuous monitoring of clinical care safety. However, these three policies and procedures did not have the process for the Plan to report or ensure that a provider reported PPCs to DHCS as required by the Contract and APL 17-009.

Without taking appropriate actions to report PPCs to DHCS, members may receive poor quality of care.

Recommendation: Develop and implement policies and procedures to ensure PPCs are reported to DHCS in the form and frequency specified by the State of California.

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Molina Healthcare Of California Partner Plan, Inc. 2022

Contract Number:	06-55498, 07-65851 09-86161 and 13-90285 State Supported Services
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I. INTRODUCTION

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

The audit was conducted from May 23, 2022 through June 3, 2022 and covered the review period from August 1, 2019 through April 30, 2022. The audit consisted of a document review of materials provided by the Plan and interviews with Plan staff.

An Exit Conference with the Plan was held on March 3, 2023. There were no deficiencies found.

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State Supported Services

The Plan's policies and procedures, provider manual, and member handbook indicate that timely abortions and related services are covered for Plan members. Members do not need pre-approval for abortion services.

In the verification study, the claim samples billed under the procedural billing codes 59840 and S0199 were properly processed and paid. There were no material findings noted during the audit period.

RECOMMENDATION:

None