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.

2023

Contract Number:	06-55498, 07-65851, 09-86161 and 13-90285
Audit Period:	May 1, 2022 Through April 30, 2023
Dates of Audit:	May 1, 2023 Through May 12, 2023
Report Issued:	June 27, 2023

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PLAN: Molina Healthcare of California Partner Plan, Inc.
AUDIT PERIOD: May 1, 2022, through April 30, 2023 **DATE OF AUDIT: May 1, 2023, through May 12, 2023**

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 580,983 members across five counties. The Plan's enrollment totals for its Medi-Cal line of business by county are Riverside (118,712 members), San Bernardino (114,277 members), Sacramento (63,292 members), San Diego (263,262 members), and Imperial (21,440 members).

II. 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 1, 2023, through May 12, 2023. 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 delegated entities.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: One expedited and 20 standard prior authorization samples for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Delegated Prior Authorization Requests: One expedited and 22 standard delegated prior authorization samples for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Prior Authorization Appeals: Three expedited and 13 standard prior authorization appeal samples were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment: Ten medical records were reviewed for completeness and timely completion.

Behavioral Health Treatment: Ten medical records were reviewed for evidence of care coordination and collaboration between the provider of care and individual member. The

records were also reviewed to ensure treatment plans were completed with the required elements and crisis plans.

Category 3 – Access and Availability of Care

Transportation: 13 Non-Emergency Medical Transportation and 13 Non-Medical Transportation services files were reviewed for Physician Certification Statement forms, Medi-Cal enrollment, and completion of the trip.

Category 4 – Member's Rights

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

Exempt Grievances: 17 exempt grievance cases were reviewed to verify the classification, reporting timeframes, and investigation process.

Quality of Service (QOS) Grievances: 14 QOS grievance cases were reviewed for timeliness, investigation process, and appropriate resolution.

Withdraw Grievances: Seven withdrawn grievance cases were reviewed for classification and usage for track and trend.

Quality of Care (QOC) Grievances: 23 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.

III. MEDICAL AUDIT FINDINGS

This report presents the findings of the DHCS medical audit for the period of May 1, 2022, through April 30, 2023. The review was conducted from May 1, 2023, through May 12, 2023. The audit consisted of a document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was offered on June 15, 2023. The Plan declined to hold an Exit Conference, as there were no findings in this review.

The audit evaluated six performance categories: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management, and Administrative and Organizational Capacity. This report is a summary without findings.

Implementation of Prior Year Audit Recommendations
The prior DHCS medical audit identified deficiencies for the period of August 1, 2019 through
April 30, 2022. The audit report was issued on April 19, 2023. The Plan's Corrective Action Plan (CAP) was not open when this onsite review was initiated. Therefore, the Plan did not have enough time to address the deficiencies in the CAP.

The following sections below present the prior audit findings and the Plan's corrective actions to resolve those deficiencies so far.

Category 3 – Access and Availability of Care

Corrective Actions for Non-Compliant Providers of Appointment Wait Times

The prior year's audit found that 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 this audit, the Plan did not have enough time to implement a CAP for the prior year's audit findings.

Telephone Wait Times

The prior year's audit found that the Plan did not implement a system to monitor, evaluate, and address accessibility problems related to waiting times for provider return calls to members.
In this audit, the Plan did not have enough time to implement a CAP for the prior year's audit findings.

Office Wait Time

The prior year's audit found that the Plan did not develop monitoring procedures that ensure provider compliance with network provider office waiting times requirements.

In this audit, the Plan does not have enough time to implement a CAP for the prior year's audit findings.

Category 4 – Member's Rights

Grievance Acknowledgement Letter

The prior year's audit found that the Plan did not send a QOS grievance acknowledgment letter within five calendar days from receipt of the grievance.

In this audit, the Plan does not have enough time to implement a CAP for the prior year's audit findings.

Grievance Resolution Letters

The prior year's audit found that the Plan did not send QOS grievance resolution letters within 30 calendar days after receipt of grievances.

In this audit, the Plan did not have enough time to implement a CAP for the prior year's audit findings.

Category 5 – Quality Management

Reporting of Provider Preventable Conditions

The prior year's audit found that the Plan did not ensure that Provider Preventable Conditions were reported to DHCS. The Plan policies did not include a process to report Provider Preventable Conditions.

In this audit, the Plan did not have enough time to implement a CAP for the prior year's audit findings.

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REPORT ON THE MEDICAL AUDIT OF

Molina Healthcare Of California Partner Plan, Inc. 2023

Contract Number:	06-55498, 07-65851 09-86161 and 13-90285 State Supported Services
Audit Period:	May 1, 2022 Through April 30, 2023
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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 1, 2023 through May 12, 2023 and covered the review period from May 1, 2022 through April 30, 2023. The audit consisted of a document review of materials provided by the Plan.

An Exit Conference with the Plan was offered on June 15, 2023. The Plan declined to hold an Exit Conference, as there were no findings in this review.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Molina Healthcare of California Partner Plan, Inc.

AUDIT PERIOD: May 1, 2022 through April 30, 2023
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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 proper billing codes. There were no material findings noted during the audit period.

RECOMMENDATION: None.