DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

October 30, 2023

Jordan Yamashita
AVP, Compliance, California Compliance Officer
Molina Healthcare of California, Inc.
200 Oceangate, Long Beach, CA 90802

RE: Department of Health Care Services Medical Audit

Dear Mr. Yamashita:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Molina Healthcare of California Partner Plan, Inc, a Managed Care Plan (MCP), from May 23, 2022 through June 3, 2022. The audit covered the period of August 1, 2019 through April 30, 2022.

The items were evaluated and DHCS accepts the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final audit report and final CAP remediation document (final Attachment A) will be made available on the DHCS website and to the public upon request.

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Lyubov Poonka, Chief
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Stacy Nguyen, Chief
Managed Care Monitoring Branch
Managed Care Quality and Monitoring Division
Department of Health Care Services

Diana O'Neal, Lead Analyst
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Faazreen Mohammed, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Molina Healthcare of California Partner Plan, Inc.

Review Period: 08/01/2019 – 04/30/2022

Audit Type: Medical Audit and State Supported Services

On-site Review: 05/23/2022 – 06/03/2022

MCPs are required to provide a CAP and respond to all documented deficiencies included in the medical audit report within 30 calendar days, unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Finding Number and Summary, 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text, and include additional detail such as title of the document, page number, revision date, etc. in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.

Please note, DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP, therefore DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP, unless prior approval for an extended implementation effort is granted by DHCS.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3. Access and Availability of Care				
3.1.1 Corrective Actions for Non-Compliant Providers of Appointment Wait Times 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.	Revise an existing Policy & Procedure to include escalation path in instances where non-compliant providers fail to respond to Corrective Action Plans (CAPs) related to access standards.		Implementation ETA: 6/30/23	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised P&P, "NCP 04.01: Network Compliance Survey Corrective Action Plan Process" (05/24/23) which states that the Plan included escalation path Corrective Action Plans (CAPs) for non-compliant providers related to access standards. The Plan is responsible for timely CAP validation and the implementation of necessary corrective action for failed access standards. (NCP 04.01, II.A.c). **TRAINING** • At a minimum, the Plan conducts monthly Joint Operation Meetings (JOMs) with all major IPAs where the access standards are reviewed. The Plan provides current Access and Availability Standards and regulatory requirement reminders via various methods including but not limited to, Just the Fax (JTF), JOM meetings, and Provider Manuals. (NCP 04.01, II.E). **MONITORING AND OVERSIGHT** • The Network Compliance Department is responsible for obtaining a weekly report of the number of CAPs received and not received; reviewing the results and CAPs received; verifying the validity of the CAP responses by ensuring the inclusion of root cause, resolution/remediation, action that has been taken to prevent future occurrence(s), milestones, final expected date of compliance. A status report of CAPs received is

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				provided to the Provider Services Department on a weekly basis. (NCP 04.01, II.C) • The Plan will issue a Corrective Action Plan letter to those providers that are determined non-compliant. The provider will have 30 days to provide a response to the CAP. If no CAP response is received after 30 days have passed, a notice of non-compliance deficiency letter will be issued. All CAP results along with the status of CAPs are reviewed under the Access & Availability Committee and the Quality Improvement Committee (QIC). (NCP 04.01, II.D) • Escalation Procedure, in which the Plan will review, monitor, and make Recommendations to AVP Provider Network Mgmt. & Ops and VP, Network Mgmt. & Ops where applicable regarding performance in meeting applicable laws, DHCS, DMHC requirements, and performance standards. Findings will be shared with the QIC committee and sanctions may be imposed in a manner consistent with the impact of the deficiency on members. (NCP 04.01, II.F). • The Plan conducted a survey, and a total of 32 CAPs were issued to non-compliant providers. The Plan conducted 3 outreach calls to providers who did not provide a CAP response. Of those outreach attempts, nine (9) providers were identified as non-compliant in providing a CAP response. Those non-compliant providers will be presented to the Access & Availability Committee in November and the following QIC committee for further action, which may include administrative or financial sanctions, up to and including termination of the contract. (Att. B 2022 Molina Oct). • The Plan revised Policies and Procedures and demonstrated it has processes in place to prevent future non-compliance.

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				The corrective action plan for finding 3.1.1 is accepted.
3.1.2 Telephone Wait Times 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 question related to the wait times for providers to return calls to members was added to the 2022 Provider Access Survey. Everybody contacted in the survey passed this question.	See copy of the survey questions which demonstrate that question was added to survey.	Survey was conducted 9/7/22-10/9/22	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policies NSP 04 and NSP 04.01 describes the CAP process for providers that are non-compliant. Molina will issue a Corrective Action Plan letter to those providers that are determined non-compliant. The provider will have 30 days to provide a response to the CAP. If no CAP response is received after 30 days have passed, a notice of non-compliance deficiency letter will be issued. (NSP 04 Network Compliance Surveys & NSP 04.01 Network Compliance Surveys) **MONITORING AND OVERSIGHT** • Molina conducts an initial Provider Access Survey. When this survey identifies non-compliant providers, Molina conducts a subsequent re-survey, which occurs approximately 6 months from the original survey. The re-survey only surveys those providers that were previously identified as non-compliant in the original Provider Access Survey. If the re-survey shows that the previously non-compliant providers are still non-compliant

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				with any of the Provider Access Survey measures, corrective actions (CAPs) are issued. Along CAPs, training and education is provided to non-compliant providers. The forthcoming Policy and Procedure (CA PAA Survey Questions) • 2022 Provider Access Survey serves as evidence that the surveyed providers passed the wait time standard. Scores between 97%-100%. (MHCA Net 2-2022 Accessibility of Services Report) **The corrective action plan for finding 3.1.2 is accepted.**
3.1.3 Office Wait Time The Plan did not develop monitoring procedures that ensure provider compliance with requirements for network provider office waiting times.	Molina employs a monitoring process to ensure provider compliance with requirements for office waiting times that is consistent with DHCS Quarterly Monitoring Report Template (QMRT) and industry standards. Molina surveys its providers' offices via the Provider Access and Availability Survey (PAA). Molina selects a sample of providers of initially surveyed providers to validate their original survey response.	1. Enclosed is a copy of the survey with "in office wait time" questions. 2. Enclosed is a copy of an example of a re-survey.	-Survey was conducted 9/7/22-10/9/22. - Resurvey of non-compliant providers conducted in February 2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policies NSP 04 and NSP 04.01 describes the CAP process for providers that are non-compliant. Molina will issue a Corrective Action Plan letter to those providers that are determined non-compliant. The provider will have 30 days to provide a response to the CAP. If no CAP response is received after 30 days have passed, a notice of non-compliance deficiency letter will be issued. (NSP 04 Network Compliance Surveys & NSP 04.01 Network Compliance Surveys) **MONITORING AND OVERSIGHT** • Molina conducts an initial Provider Access Survey. When this survey identifies non-compliant providers, Molina conducts a subsequent re-

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				survey, which occurs approximately 6 months from the original survey. The re-survey only surveys those providers that were previously identified as non-compliant in the original Provider Access Survey. If the re-survey shows that the previously non-compliant providers are still non-compliant with any of the Provider Access Survey measures, corrective actions (CAPs) are issued. Along CAPs, training and education is provided to non-compliant providers. The forthcoming Policy and Procedure (CA PAA Survey Questions) • 2022 MHCA PAA Re-Survey Results Analysis demonstrates the MCP re-surveys providers that are non-compliant with timely access. (2022 MHCA PAA Re-Survey Results Analysis_LV) • The MCP selects a sample of providers of initially surveyed providers to validate their original survey response. **The corrective action plan for finding 3.1.3 is accepted.**
4. Member Rights				
4.1.1 Grievance Acknowledgement Letter The Plan did not send a QOS grievance acknowledgment letter within five	The Grievance and Appeals team collaborated with the Contact Center to develop a report to track open calls that are required to be sent to the Grievance Team for review. The Grievance and Appeals	Sample emails sent to Contact Center leadership & coordinators.	Currently Implemented & Operational as of 10/31/22.	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • P&P, A&G-CA-02, "Quality Review Program" (07/06/21) demonstrates the Plan has a process to audit daily if a grievance or an appeal is a standard grievance/appeal, was the grievance or appeal acknowledgement letter sent within 5 calendar days.

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calendar days from receipt of the grievance.	team re-educated the Operational leaders of the importance of timely routes and submission to the Grievance Team. This was completed during the Appeals & Grievances Committee, which includes leadership from all internal operational leaders.			If an employee fails to maintain the required score in their initial audit, the employee will be provided formal training for up to thirty (30) days, followed by a validation audit. The validation audit will be generated via QRP for a period of thirty (30) days. - MCP emails, “Action Required by Case Owners to Complete Case/Cases Failed to go to QNXT” (11/22, 12/22, 01/23, and 02/23) (Currently Implemented & Operational as of 10/31/22) demonstrates the Plan collaborated with the Contact Center to develop a report to track open calls that are required to be sent to the Grievance Team for review. These emails are sent to the Contact Center leadership & coordinator. • Workflow, “Process to Oversee Open Calls Related to Grievances” (10/31/22) demonstrates the Plan has a process to verify if open calls related to grievances are appropriately sent to the Complaint Tracking System (QNXT) for A&G processing. **TRAINING** • Committee Meeting, “A&G Committee” the A&G Committee, that includes leadership and/or appointees from all impacted operational areas, the A&G team routinely reminds them of the importance of compliance and the role they plan in ensuring compliance. During the A&G Committee a review of specific examples, including any cases that were routed untimely, misdirected, etc. that resulted in a complaint not being resolved in required timeframes.

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				• Reminder, “Contact Center Reminder”, (09/22 and 05/23) demonstrates the Plan has reminded the contact center the importance of saving complaint cases to QXNT. **MONITORING AND OVERSIGHT** • Audit Tool, “Member Intake and Grievance Resolution” (10/22) demonstrates the Plan utilizes a comprehensive audit tool to confirm internal and external regulatory requirements are met. • Reports, “Cases failed to go to QNXT” (01/23 and 02/23) 21 calls failed in January 2023 and 24 calls in February 2023. Cases are selected using a random sampling methodology. Within the random sampling, cases will be selected from each case type (i.e.: Appeals, Grievances, etc.) and assigned to an auditor by the audit manager. • Report, “Final Audit Report” (June 2023) demonstrates the Plan audits on a daily and monthly basis, the QA Team reviews an average of 350 cases in regard to acknowledgement letters being sent within five calendar days from the receipt of the grievance. Both audits are scored, and reported to the Team on a daily basis, with a comprehensive team report provided on a monthly basis. Grievance Acknowledgement overall score for the month of June 2023 remained the same at 100% compliant. **The corrective action plan for finding 4.1.1 is accepted.**

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4.1.2 Grievance Resolution Letters The Plan did not send QOS grievance resolution letters within 30 calendar days after receipt of grievances.	The Grievance and Appeals team collaborated with the internal Provider Relations Team to develop communication related to the importance of timely & accurate responses to the Grievance team. A Just the Fax was created and sent to all contracted Providers. The Grievance and Appeals team operationalized an internal requirement for Grievance Coordinators to review each of their open & assigned cases every 5 days, to ensure that appropriate actions related to investigation and/or resolution have been completed. In addition, a report was implemented to provide oversight. This report is shared with the Grievance Coordinators on a routine basis.	1. Just the Fax dated 01/06/2022 that was sent to all Contracted Providers. 2. Sample Reports: "5 Day no Touch" that is sent to Appeals & Grievances Coordinators.	1. Currently Implemented & Operational as of 01/06/22. 2. Currently implemented & operational as of 10/31/22.	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • P&P, A&G-CA-02, "Quality Review Program" (07/06/21) demonstrates the Plan has a process to audit daily if a grievance or an appeal is a standard grievance/appeal, was the grievance resolution letter sent within 30 calendar days after receipt of the grievance. If an employee fails to maintain the required score in their initial audit, the employee will be provided formal training for up to thirty (30) days, followed by a validation audit. The validation audit will be generated via QRP for a period of thirty (30) days. • Communication, "Just the Fax" notification was created and sent to all contracted Providers and Provider Relation Team members on the importance of timely & accurate responses to the Grievance team. • Workflow, "Process to Oversee Open Calls Related to Grievances" (10/31/22) demonstrates the Plan has a process to verify if open calls related to grievances are appropriately sent to the Complaint Tracking System (QNXT) for A&G processing. **TRAINING** • Committee Meeting, "A&G Committee" the A&G Committee, that includes leadership and/or appointees from all impacted operational areas, the A&G team routinely reminds them of the importance of compliance and the role they plan in ensuring compliance. During the A&G Committee a

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				review of specific examples, including any cases that were routed untimely, misdirected, etc. that resulted in a complaint not being resolved in required timeframes. • Reminder Notice, “Contact Center Reminder”, (09/22 and 05/23) demonstrates the Plan has reminded the contact center the importance of saving complaint cases to QXNT. In addition, operationalized an internal requirement for Grievance Coordinators to review each of their open & assigned cases every 5 days, to ensure that appropriate actions related to investigation and/or resolution have been completed. **MONITORING AND OVERSIGHT** • Audit Tool, “Member Intake and Grievance Resolution” (10/22) demonstrates the Plan utilizes a comprehensive audit tool to confirm internal and external regulatory requirements are met. • Reports, “Cases failed to go to QNXT” (01/23 and 02/23) 21 calls failed in January 2023 and 24 calls in February 2023. Cases are selected using a random sampling methodology. Within the random sampling, cases will be selected from each case type (i.e.: Appeals, Grievances, etc.) and assigned to an auditor by the audit manager. • Report, “Final Audit Report” (June 2023) demonstrates the Plan audits on a daily and monthly basis, the QA Team reviews an average of 350 cases in regard to resolution letters being sent within 30 calendar days from the receipt of the grievance. Both audits are scored, and reported to the Team

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				on a daily basis, with a comprehensive team report provided on a monthly basis. Grievance resolution overall score for the month of June 2023 remained the same at 99% compliant. **The corrective action plan for finding 4.1.2 is accepted.**
5. Quality Management				

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5.1.1 Reporting of Provider Preventable Conditions The Plan did not ensure that PPCs were reported to DHCS. The Plan policies did not include a process to report Provider Preventable Conditions.	Remediation includes: 1. Review and finalize draft P&P (completed) 2. Assigned staff member to log and submit PPCs (May 2023) 3. Explore opportunities to automate reporting process (continuous until implemented; ideally by Q4 2023)	1. Copy of the finalized P&P 2. Reporting confirmation Codes: **2023.05.17.1857-655** **2023.05.17.1923-867** 3. Explore opportunities to automate reporting	1. 5/21/22 2. 5/17/23 3. Anticipated by Q4 2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy HPO PD-02 PPC Reporting has been finalized to include process for reporting PPCs to DHCS. The MHC PIRR Clerk faxes PPCs daily through the DHCS 7107 form. (HPO PD-02 PPC Reporting) • Examples of PPC Reports submitted to DHCS by the MCP demonstrates the MCP manual process for submitting PPCs to DHCS is outlined in Policy HPO PD-02 PPC is operational. (PPC Reporting - 2023.06.20.0050-816 and five other examples) **MONITORING AND OVERSIGHT** • Policy HPO PD-02 states the MPC will screen the encounter data, including data received from network providers, for the presence of the PPCs included on Form DHCS 7107 on a monthly basis. The MCP will report any identified PPCs pursuant to the instruction provided on Form DHCS 7107 and as instructed by APL 16-011. The MCP will issue a special notice informing all network providers of PPC reporting requirements, including the reporting of PPCs to DHCS using the secure online reporting portal. The information will also be published annually through the Molina Medi-Cal Provider Manual. (HPO PD-02 PPC Reporting). **The corrective action plan for finding 5.1.1 is accepted.**

Submitted by Plan: Jordan Yamashita
Title: AVP, Compliance, California Compliance Officer

Date: 06/05/2023