DEPARTMENT OF Managed Health Care Help Center

DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

RURAL EXPANSION

MEDICAL SURVEY REPORT OF

MOLINA HEALTHCARE OF CALIFORNIA

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: MARCH 9, 2016

Rural Expansion
Medical Survey Report
Molina Healthcare of California
A Full Service Health Plan
March 9, 2016

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EXECUTIVE SUMMARY

Pursuant to Welfare and Institutions Code section 14005.27 and authorized under AB 1467, Medi-Cal managed care expanded to Medi-Cal beneficiaries residing in 28 rural California counties. The DHCS entered into an Inter-Agency Agreement with the Department[1] to perform medical surveys of each health plan participating in the Rural Expansion. Mandatory enrollment of Medi-Cal beneficiaries from Fee-For-Service into Medi-Cal managed care began in September 2013.

On June 5, 2015, the Department notified Molina Healthcare of California (or the "Plan") that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department's medical survey team conducted the onsite portion of the medical survey from August 24, 2015 through August 28, 2015.

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the Rural Expansion Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the Rural Expansion populations. This medical survey evaluated the following elements specifically related to the Plan's delivery of care to the Rural Expansion populations as delineated by the DHCS-Molina Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations: [2]

I. **Utilization Management**
The Department evaluated Plan operations related to utilization management, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting under- and over-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

II. **Continuity of Care**
The Department evaluated Plan operations to determine whether medically necessary services are effectively coordinated both inside and outside the network, to ensure the coordination of special arrangement services, and to verify that the Plan provides for completion of covered services by a non-participating provider when required.

III. **Availability and Accessibility**
The Department evaluated Plan operations to ensure that its services are accessible and available to members throughout its service areas within reasonable timeframes, and are addressing reasonable patient requests for disability accommodations.

[1] The Inter-Agency Agreement (Agreement Number 13-90168) was approved on June 11, 2014.
[2] All references to "Contract" are to the DHCS-Molina Health Care Contract and Two-Plan contracts issued by the DHCS. All references to "Section" are to the Knox-Keene Act of the Health and Safety Code. All references to "Rule" are to Title 28 of the California Code of Regulations.

IV. Member Rights

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

V. Quality Management

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care.

The scope of the medical survey incorporated review of health plan documentation and files from the period of August 1, 2014 through July 31, 2015.

SUMMARY OF FINDINGS

The Department identified seven potential deficiencies during the current medical survey.

2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

AVAILABILITY & ACCESSIBILITY	
1	**The Plan does not consistently meet contractual timely access standards as set forth in its own policies and procedures.** DHCS-Molina Health Care Contract, Exhibit A, Attachment 9 - Access and Availability, Provision 3 – Access requirements; DHCS-Molina Health Care Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 – Access Standards; Rule 1300.67.2.2.(c)(1)(5).
MEMBER RIGHTS	
2	**The Plan does not have an established and effective mechanism for identifying and addressing exempt grievances.** DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(1); Rule 1300.68(a); Rule 1300.68(d)(8).
3	**The Plan does not consistently identify, resolve, and track all issues contained in members' grievances.** DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68(a); Rule 1300.68(d)(8); Rule 1300.68(e)(2).
4	**The Plan's grievance acknowledgment and resolution letters do not consistently display the Department's toll-free telephone number, the Department's TDD line, the Plan's telephone number, and the Department's Internet website address in 12-point boldface type.** DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2 – Grievance System Oversight; Section 1368.02(b); Rule 1300.68(d)(7).
5	**The Plan's responses to enrollee grievances do not clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination for the delay, modification, or denial of services based on medical necessity.** DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2 – Grievance System Oversight; Rule 1300.68(d)(4).
6	**The Plan does not have policies and procedures that enable members to make a standing request to receive all informing material in a specified alternative format.** DHCS-Molina Contract, Exhibit A, Attachment 13 – Member Services, Provision 4 – Written Member Information.

QUALITY MANAGEMENT	
7	**The Plan's Quality Improvement Program does not take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf.** DHCS-Molina Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; Rule 1300.70(a).

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT RURAL EXPANSION MEMBERS

On November 1, 2013, as part of the Medi-Cal managed care rural expansion, the Plan expanded services to beneficiaries in Imperial County. The Plan maintained 15,685 members as of March 31, 2015.

DISCUSSION OF POTENTIAL DEFICIENCIES

AVAILABILITY AND ACCESSIBILITY

Potential Deficiency # 1: The Plan does not consistently meet contractual timely access standards as set forth in its own policies and procedures.

Contractual/Statutory/Regulatory Reference(s): DHCS-Molina Health Care Contract, Exhibit A, Attachment 9 - Access and Availability, Provision 3 – Access requirements; DHCS-Molina Health Care Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 – Access Standards; Rule 1300.67.2.2.(c)(1)(5).

<u>DHCS-Molina Health Care Contract, Exhibit A, Attachment 9 - Access and Availability</u>
3. Access Requirements
Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

<u>DHCS-Molina Health Care Contract, Exhibit A, Attachment 9 - Access and Availability</u>
4. Access Standards
Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.
B. Standards for Timely Appointments
Members must be offered appointments within the following timeframes:
1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
2. Urgent appointment for services that do require prior authorization – within 96 hours of a request;
3. Non-urgent primary care appointments – within ten (10) business days of request;
4. Appointment with a specialist – within 15 business days of request;
5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

<u>Rule 1300.67.2.2.(c)(1)(5)</u>
(c) Standards for Timely Access to Care.
(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.
(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer members appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);
(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);
(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (G) and (H);
(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);
(E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H);
(F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (G) and (H);
(G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;

Documents Reviewed:
- Plan Policy QM 09: Access to Health Care (12/02/14)
- 2014 TAR CAPs Folder 2014 TAR Submission

Assessment: The DHCS-Molina Health Care Contract, Exhibit A, Attachment 9 - Access and Availability, Provision 3 and Provision 4 set forth acceptable accessibility requirements for appointments.

Plan Policy QM 09, Access to Health Care, sets forth the Plan's compliance goals as follows:

TABLE 1
Compliance with Appointment Standards

APPOINTMENT TYPE	CONTRACTUAL REQUIREMENT	PLAN STANDARD AND GOAL	COMPLIANT[3]	DEFICIENT
PCP urgent care appointments without prior authorization	Within 48 hours of request	Within 24 hours of request (goal: 90% compliance)	78.7%	21.3%
Specialist urgent care appointments without prior	Within 48 hours of request	Within 24 hours of request (goal: 85% compliance)	74.8%	25.2%

[3] The Plan's actual compliance rates are based on the requirements set forth in the DHCS-Molina Health Care Contract, Exhibit A, Attachment 9 - Access and Availability, Provisions 3 and 4.

authorization				
Non-urgent appointments with specialist physicians	Within 15 business days of request	Within 10 business days of request (goal: 85% compliance)	75.2%	24.8%
Non-urgent appointments with a non-physician mental health care provider	Within 10 business days of request	Within 10 business days of request (goal: 80% compliance)	60.9%	39.1%
Behavioral health urgent care appointments with prior authorization	Within 96 hours of request	Within 48 hours of request (goal: 80% compliance)	40.9%	59.1%
Behavioral health urgent care appointments without prior authorization	Within 48 hours of request	Within 48 hours of request (goal 80% compliance)	59.3%	41.7%

To monitor providers' compliance with the appointment wait time requirements, the Plan conducts an annual Appointment Access Survey via its vendor. As seen in the table above, the 2014 survey reveals compliance rates that do not reach the Plan's goals. Plan staff confirmed these access issues in onsite interviews. The Plan's Director of Quality Improvement stated that the Plan had updated the survey tool, which resulted in a shortened survey period and may have contributed to low compliance rates due to lower provider response rates. Plan staff stated that corrective action plans were issued to non-compliant providers, which they provided to the Department post-onsite. Any resulting changes in compliance rates would not be seen until subsequent annual measurement periods.

Conclusion: The DHCS-Molina Health Care Contract, Exhibit A, Attachment 9 - Provisions 3 and 4 establish maximum allowed wait times for various types of health care appointments. The Plan's rates of compliance with wait time standards for urgent PCP appointments, urgent and non-urgent specialist appointments, and urgent and non-urgent non-physician mental health providers appointments show that the Plan does not consistently meet the timely access standards set forth in the DHCS-Molina Health Care Contract or the Plan's own goals. Therefore, the Department finds the Plan in violation of these contractual, requirements.

MEMBER RIGHTS

Potential Deficiency #2: The Plan does not have an established and effective mechanism for identifying and addressing exempt grievances.

Contractual/Statutory/Regulatory Reference(s): DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(1); Rule 1300.68(a); Rule 1300.68(d)(8).

DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System
1. Member Grievance System
Contractor shall implement and maintain a Member Grievance 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 D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

Section 1368(a)(1)
(a) Every plan shall do all of the following:
(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Rule 1300.68(a)
Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.
(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:
(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
(2) "Complaint" is the same as "grievance."

Rule 1300.68(d)(8)
Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in subsection (b).

Documents Reviewed:

- Plan Policy PO-19: Member Grievance Process (revised 04/18/14)
- DHCS Pre-Onsite Document Request: Rural Expansion 1.Call Inquiry Log
- DHCS Onsite Document Request: Memo to DMHC – DMHC Rural Expansion Medical Exempt Survey Log (Item 2c) (06/24/15)
- 300 Inquiry Log Entries (08/01/14 – 7/31/15)

Assessment: The DHCS-Molina Contract, Section 1368(a)(1), and the Rules require the Plan to have an established and effective mechanism for identifying and addressing exempt grievances. The DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System requires the Plan to "implement and maintain a Member Grievance System" in accordance with regulatory requirements, and "resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance."

Section 1368(a)(1) requires the Plan to maintain a grievance system under which members may submit their grievances and to "provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of member grievances and rectification when appropriate." Rule 1300.68(a) defines the term *grievance* as "a written or oral expression of dissatisfaction regarding the plan and/or provider" and asserts that "'Complaint' is the same as 'grievance.'"

Rule 1300.68(d)(8) enables plans to manage "Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day [as] exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance."

Plan Policy PO-19, Member Grievance Process, the Plan implements the requirements, stating:

> Grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and all include a complaint, dispute, and a request for reconsideration or appeal made by an enrollee of the enrollee's representative and remains unresolved to the member's satisfaction. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance … a grievance may be presented in person, telephone, fax, e-mail, or in writing to MHC or at any office of a MHC provider and can require an expedited or standard resolution.

In response to the Department's pre-onsite request for an Exempt Grievance Log, the Plan provided a Memo to DMHC – DMHC Rural Expansion Medical Exempt Survey Log (Item 2c) (06/24/15), which states:

> Molina Healthcare of California currently submits all Appeals and Grievances under a C Code category in the call tracking notes at which point Appeals and Grievance works the case. The Contact Center will work with the Appeals and Grievance Department to develop a process to ensure all complaints resolved within 24 hours are tracked and reported.

The Plan's inability to produce the requested Exempt Grievance Log demonstrates that it does not have an effective system for identifying, documenting, and tracking exempt grievances. When asked during interviews if there was a process in place to categorize and track exempt grievances, Plan staff responded, "Not yet." They further acknowledged that they have been experiencing challenges with coding exempt grievances, stating that they are currently "building a process to get inquiries over to Grievances and Appeals so grievances can kick in if it will go over 24 hours." This suggests that some inquiries could be exempt grievances.

The Department reviewed 300 inquiry log entries randomly selected from the universe of 13,488 for the period of August 1, 2014 to June 30, 2015. It was determined that 11 (4%) of the entries reviewed were not appropriately classified as grievances. Furthermore, because the Plan miscategorized these grievances, they were not included in the Plan's data gathering, analysis, and reporting activities.

The following are examples of inquiry log entries that should have been classified as grievances:

- *File ID # ():* The member complained that she was unable to pick up her prescription medication at the pharmacy. Plan staff contacted the pharmacy and verified that the enrolled could pick up the medication that day.

- *File ID # ():* The member complained about his inability to access care. He went first to a hospital emergency room, where he was advised to see his primary care provider. (There was no documentation in the file to determine whether the member actually received services in the emergency room.) The member then then went to an urgent care clinic but was denied services because it did not accept his health insurance coverage. Plan staff first informed the member that only certain locations are contracted to provide health care for Plan members and subsequently transferred the member to another Plan staff member who could assist him if he wished to change health insurance plans.

- *File ID # ():* The member requested a change in her primary care provider, as the current physician "keeps changing her scheduled appointments further and further out." The member requested a provider close to home. Although the primary care provider change was made, the access issue was not appropriately followed up because it was not classified as a grievance.

- *File ID # ():* The member complained about paying for medication despite having Medi-Cal benefits. Plan staff confirmed the member's membership in the Plan and that the pharmacy chosen by the member was an active account. The log included the statement, "CALL CLOSING - SATISFACTION: Thank you." No resolution was provided to the member.

- *File ID # ():* The member stated that she received a bill for $190.00. Plan staff informed her that there was no claim on file. There was no further investigation or resolution as to why the member was billed for services.

- *File ID # ():* The member's mother complained about the late arrival of transportation, which caused the member to be 50 minutes late for a scheduled appointment. The member's mother stated that she no longer wanted to use that transportation company. Despite a number of notations in the file about the member's dissatisfaction ("CALL REASON/COMPLAINT: Member is upset;" "EXPRESSING DISSATISFACTION DUE TO: members mom is upset …"), this inquiry was not elevated to a grievance. There is no documentation in the file that action was taken to address the member's dissatisfaction or provide a resolution to the member's complaint.

The Plan did not categorize all statements of dissatisfaction from enrollees as grievances nor did it maintain a log of exempt grievances as required. The Department found that some grievances were misclassified as inquiries, and therefore, did not undergo review, acknowledgement, and resolution as required by the Plan's contract and regulatory requirements. During interviews, Plan staff acknowledged that they have been experiencing challenges with coding exempt grievances. Staff explained that they are currently "building a process to get inquiries over to grievances and appeals so grievances can kick in if it will go over 24 hours," although they do not yet have any aspect of this process in place. Based on the examples cited above from the results of the Department's review of the Plan's Inquiry Log, this process has yet to be successfully implemented. No comments were made regarding review of inquiries that may be miscategorized standard or expedited grievances.

Conclusion: The DHCS-Molina Contract, Attachment 14, Provision 1, requires the Plan implement and maintain a grievance system in which the Plan shall resolve each grievance and provide written notice of the resolution to the enrollee as quickly as the enrollee's health condition requires, within 30 calendar days from receipt. Section 1368(a)(1) and Rules 1300.68(a)(1) and (2), require the Plan to implement and maintain a grievance system whereby members may submit their grievances to the Plan. Rule 1300.68(d)(8) outlines the process for the Plan to process and log exempt grievances, The Department's review of the Plan's Inquiry Log shows that the Plan misclassifies grievances as inquiries, thereby forgoing required investigation and resolution of members' dissatisfactions with both the Plan and providers. Further, the Plan confirmed it does not maintain a log of exempt grievances. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

TABLE 2
Grievances Misclassified as "Inquiries"

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Call Inquiry Log	300	Inquiries that should have been classified as grievances	289 (96%)	11 (4%)

Potential Deficiency # 3: The Plan does not consistently identify, resolve, and track all issues contained in members' grievances.

Contractual/Statutory/Regulatory Reference(s): DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68(a); Rule 1300.68(d)(8); Rule 1300.68(e)(2).

DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System
1. Member Grievance System
Contractor shall implement and maintain a Member Grievance 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 D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

Rule 1300.68(a)
(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system...

Rule 1300.68(e)(2)
(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:
(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the member at all levels of grievance review and to describe the issue or issues raised in grievances as 1) coverage disputes, 2) disputes involving medical necessity, 3) complaints about the quality of care and 4) complaints about access to care (including complaints about the waiting time for appointments), and 5) complaints about the quality of service, and 6) other issues.

Documents Reviewed:

- Plan Policy PO-19: Member Grievance Process (revised 04/18/14)
- Rural Expansion 1.Call Inquiry Log
- 31 Standard Grievance and Appeals Files (08/01/14 – 07/31/15)

Assessment: The Plan does not consistently document and address all of the issues raised in member grievances that contain multiple components. The DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System requires the Plan to "implement and maintain a Member Grievance System" in accordance with regulatory requirements, "resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance." Similarly, Rule 1300.68(a) requires the Plan to "provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt ..." Rule 1300.68(e)(2) requires the Plan to "track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances."

Plan Policy PO-19, Member Grievance Process, confirms the regulatory requirements, stating:

> Grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and all include a complaint, dispute, and a request for reconsideration or appeal made by an member of the member's representative and remains unresolved to the member's satisfaction. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance … a grievance may be presented in person, telephone, fax, e-mail, or in writing to MHC or at any office of a MHC provider and can require an expedited or standard resolution.

The Plan did not consistently address and resolve all issues included in members' grievances. The Department's review of grievance files found that when members submitted complaints with multiple issues, including quality of care and quality of service, the Plan did not address, track, and trend all components. Additionally, the Plan did not address issues that were misclassified as inquiries. (See Deficiency #2.)

The Department reviewed 27 standard grievance and four (4) standard appeal files randomly selected from the universe of 54 files. The file review revealed that all grievance issues were not being identified—and as a result were also not being categorized for tracking and trending. In seven (7) (23%) of the files reviewed, when the complaint contained multiple issues not all issues were identified, categorized and addressed. The following are examples of these omissions:

- *File ID # ():* The member complained about waiting one hour and 40 minutes to see his provider, with whom he had an appointment. The member also stated that the provider staff are uncaring, and he does not feel comfortable with the provider. Plan staff classified this complaint as an "access" issue. The quality of service aspect of the grievance was not addressed in the file or the resolution letter (e.g., by an offer to change the provider).

- *File ID # ():* The member submitted a lengthy written complaint regarding office visits with two different providers in which she detailed the negative effects of taking her prescribed medication. The member complained of (1) lengthy wait times for multiple appointments; (2) inappropriate provider behavior (e.g., the provider was unsanitary, wiped the nose and then shaking the member's hand); and (3) significant symptoms after taking prescribed medications, stating, "I feel poisoned." The Plan classified the grievance as "Specific Medical Care Incident (provider related – C)." The resolution letter addressed the member's appointment, prescriptions, and lengthy wait time issues for one of the providers and encouraged her to advise her provider should she experience side effects from medications. However, the resolution letter did not address the quality of service issue with the second provider in which her complaint cited unsanitary practices during the appointment.

- *File ID # ():* The member's complaint included multiple issues with her provider: She waited an hour for a follow-up appointment; the medical assistant and provider were confused as to why she was there, lost her chart, and never came back to the exam room; the office staff were rude and eating while assisting her. The Plan classified the grievance as "administrative," and the resolution letter mentioned each of the member's complaints. However, there was no documentation in the file evidencing that the quality of service complaints were appropriately identified and classified as such for follow-up.

Conclusion: The DHCS-Molina Contract, Attachment 14, Provision 1, requires the Plan implement and maintain a grievance system in which the Plan shall resolve each grievance and provide written notice of the resolution to the Member as quickly as the Member's health condition requires, within 30 calendar days from receipt. Section 1300.68(e)(2) requires that the Plan shall track and monitor grievances received, including a description of the issue or issues raised in grievances. The Plan's contract requires the Plan to resolve each grievance in accordance with current regulations. When a grievance has multiple issues, the Plan does not consistently detect and resolve all underlying issues, which may prevent the Plan from identifying and addressing opportunities for improvement. Therefore, the Department finds the Plan in violation of contractual and regulatory requirements.

TABLE 3
All Grievance Issues were Not Categorized and Addressed

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances and Appeals	31	All grievance issues categorized for tracking and trending	24 (77%)	7 (23%)

Potential Deficiency #4: The Plan's grievance acknowledgment and resolution letters do not consistently display the Department's toll-free telephone number, the Department's TDD line, the Plan's telephone number, and the Department's Internet website address in 12-point boldface type.

Contractual/Statutory/Regulatory Reference(s): DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2 – Grievance System Oversight; Section 1368.02(b); Rule 1300.68(d)(7).

DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System
2. Grievance System Oversight
Contractor shall implement and maintain procedures as described below to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

Section 1368.02(b)
Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

> The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Rule 1300.68(d)(7)
The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act.

Documents Reviewed:

- Plan Policy PO-19: Member Grievance Process (revised 04/18/14)
- 31 Standard Grievance and Appeals Files (08/01/14 – 07/31/15)

Assessment: The DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2 – Grievance System Oversight, requires the Plan to implement and maintain procedures … to monitor the Member's grievance system and the expedited review of grievances required under Sections 1300.68 and 1300.68.01. Section 1368.02(b) and Rule 1300.68(d)(7) require the Plan's grievance and appeal acknowledgment and resolution letters to include a quoted statement with the DMHC's toll-free telephone number, the DMHC's TDD line, the Plan's telephone number, and the DMHC's website address. Furthermore, the four items in the statement must be in 12-point boldface type while the rest of the statement is in regular type.

Plan Policy PO-19, Member Grievance Process refers to, but does not properly outline, all of the statutory requirements. Specifically, it does not indicate that certain information must be displayed in 12-point boldface type:

> Written notification to the member of MHC's proposed resolution of the grievance, including: The right to contact the Department of Managed Health Care (DMHC), with appropriate language and toll-free telephone number (1-888-HMO-2219) and TDD line (1-877-688-9891), as provided in Health and Safety Code Section 1368.02, subparagraph (b).

The Department reviewed 27 standard grievance files and four (4) standard appeal files randomly selected from the universe of 54 files. The Department determined that the required statement laid out in Section 1368.02(b) was either in bold type in its entirety, or only the Department's web address and telephone number were in bold type and not the Department's telephone number and TDD line, as required. Therefore, the Plan did not appropriately format the statement in 31 (100%) of the acknowledgment letters and did not appropriately format the statement as required in 30 (97%) of the resolution letters.

Conclusion: The DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2 – Grievance System Oversight, Section 1368.02(b), and Rule 1300.68(d)(7) require the Plan's grievance and appeal acknowledgment and resolution letters to include a quoted statement with the DMHC's toll-free telephone number, the DMHC's TDD line, the Plan's telephone number, and the DMHC's website address. Furthermore, the four items in the statement must be in 12-point boldface type while the rest of the statement is in regular type. As the Plan did not consistently include the required language in the specified format in its acknowledgment and resolution letters to enrollees, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

TABLE 4
Acknowledgment and Resolution Letters Include Language in Format Required by Section 1368.02(b) and Rule 1300.68(d)(7)

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances and Appeals	31	Acknowledgment letter includes language as required in boldface type	0 (0%)	31 (100%)
Standard Grievances and Appeals	31	Resolution letter includes language as required in boldface type	1 (3%)	30 (97%)

Potential Deficiency #5: **The Plan's responses to member grievances do not clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination for the delay, modification, or denial of services based on medical necessity.**

Contractual/Statutory/Regulatory Reference(s): DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2 – Grievance System Oversight; Rule 1300.68(d)(4).

DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System
2. Grievance System Oversight
Contractor shall implement and maintain procedures as described below to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

Rule 1300.68(d)(4)
(d) The plan shall respond to grievances as follows:
(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

Documents Reviewed:

- Plan Policy UM-67: Member Appeal of Medical Necessity Denial or Modification Determination (revised 02/02/15)
- Medi-Cal Program 2013/2014 Member Services Guide
- 4 Standard Appeals Files (08/01/14 – 07/31/15)

Assessment: The DHCS-Molina Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2 – Grievance System Oversight requires the Plan to implement and maintain procedures to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858. Rule 1300.68(d)(4) requires that "for grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination."

The Plan does not consistently include a clear explanation of the criteria, clinical guidelines, or medical policies used to delay, modify, or deny services based on medical necessity. The Department reviewed 27 standard grievance and four (4) standard appeal files randomly selected from the universe of 54 files. Of these 31 files, four (4) contained appeals for services that were based on medical necessity. In three (3) of these files, the Plan's written responses were not clear; the Plan cited, but did not describe, the criteria used in making its denial decisions; and the Plan gave no clinical reasons why the enrollees' medical conditions did not meet the criteria

The criteria and/or clinical guidelines used by the Plan's reviewing physician in reaching the decision did not match or was not consistent with the criteria and/or guidelines cited in the resolution letter. In addition, the resolution letters did not appropriately cite and delineate guidelines to justify the decision to uphold the denial in the following three (75%) of the four (4) appeal files reviewed:

- *File #2:* The case was an appeal for an outpatient surgical procedure involving the excision of a facial tumor for the member's 7-month-old child. The appeal was upheld due to lack of medical necessity. The clinical information and the guidelines cited in the resolution letter do not match the clinical information and guidelines cited by the physician reviewer in the internal documentation. Specifically, the physician reviewer's account contains more clinical information and rationale for the decision, while the resolution letter is significantly abbreviated. Additionally, the cited criteria in the letter are not the same as that which was cited by the physician reviewer.
    - The physician reviewer's note in the internal documentation states: "The asked for surgery is not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request. You do have a growth on your nose. To have this covered you must meet the rules in the guideline. The information sent in shows that this lesion is not causing any problem with your functional activities. Therefore, this procedure would be considered for cosmetic purposes only. This is not a covered benefit. Please talk with your provider about your

health care options. (CRITERIA USED FOR DECISION: Medi-Cal Program Member Services Guide, pages 33-34).

- The resolution letter states: "Thank you for your patience while we reviewed your first level appeal request concerning the denial of: Excision of Mass that was requested by the following physician: [physician name]. As stated in our acknowledgment letter, a formal first level appeal was filed on your behalf. The records provided have been reviewed by a member of Molina Healthcare's specialty physician advisor panel, who is board certified [name of physician reviewer] Pediatrics & Pediatric Hematology/Oncology. The physician agrees with the original decision and has upheld the denial for: Excision of Mass. Based on the following guidelines: Molina Medi-Cal Program 2013/2014 Member Service Guide, Page 15[4]. The clinical guideline criteria for the following would be indicated if: the mass is not causing any problems with the things you do."

- *File #4:* The case was an appeal for the medication Victoza, which was requested by the member's physician in order to treat a diagnosis of diabetes mellitus (uncontrolled). The appeal was upheld due to lack of medical necessity. The clinical information and the guidelines cited in the resolution letter do not match those documented by the physician reviewer elsewhere in the file. Specifically, the physician reviewer's rationale contained clinical information and recommendations that the letter did not. Additionally, the criteria cited in the letter were not the same criteria that were used by the physician reviewer.

  - The physician reviewer's rationale states: "The asked for medication (Victoza) is not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request. You do have diabetes. To have this covered you must meet the rules in the guideline. The information sent in does not show that you have tried and failed formulary alternatives. You would have to meet all of the rules before this could be approved. Please talk to your provider about your health care options. (CRITERIA USED FOR DECISION: Medi-Cal Program 2013/2014 Member Services Guide; page 6).
    The Medi-Cal Program 2013/2014 Member Services Guide, page 6, lists the following under "Prescription drug coverage:"
    - FDA approved drugs prescribed by a doctor that are listed in our approved drug list or "Drug Formulary."
    - Drugs approved by Molina Healthcare's committee of pharmacists & doctors.
    - Drugs and devices for birth control.
    - For brand name or generic drugs:
    - Up to a 30 day supply for brand name drugs and up to a 60 day supply for generic drugs through pharmacies with Molina Healthcare."

[4] The Molina Medi-Cal Program 2013/2014 Member Services Guide, Page 15, defines a prior authorization as "a request for service from your doctor. Molina Healthcare's Medical Doctors and your doctor review the medical necessity of your care before the care or service is given to ensure it is appropriate for your specific condition." The document then states, "Approvals are given based on medical need." However, the document does not cite medical necessity criteria for the infant's condition.

  - o The resolution letter states, in part, "The physician agrees with the original decision and has upheld the denial for Victoza. Based on the following guidelines: California Code of Regulations; Title 22, Section 51303(a)[5]. The clinical guideline criteria for the following would be indicated if you had doctor notes that showed you have tried and failed other medicines.

The resolution letter cites the California Code of Regulations, Title 22, Section 51303(a), and not medical necessity guidelines. The letter also notes the requirement that the member must have tried and failed other medications in order to be approved for the requested medication; however, it does not clarify which medications must be tried and failed in order for the requested medication to be approved, and it is not known from which medical necessity guideline the criterion is taken.

- *File #17:* The case was an appeal that involved a denial for magnetic resonance imaging (MRI) of the lumbar spine due to the member's diagnosis of lumbar radiculopathy. The denial was upheld due to lack of medical necessity. The physician reviewer's documented rationale contains adequate clinical information, supporting argument for the decision, and a recommendation, while the resolution letter is significantly abbreviated. Although InterQual medical necessity guidelines were cited in the resolution letter (CP Imaging Subset Imaging, Spine, Lumbar), the description of the guidelines was not comprehensive, as it only noted one criterion.

  - o The physician reviewer's rationale states, "The asked for MRI of your spine is not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request. You do have pain and numbness in your arms and legs. To have this covered you must meet the rules in the guidelines. The information sent in does not show that you have had at least 6 weeks of physical therapy or a home exercises. You would have to meet all of the rules before this could be approved. Please talk to your provider about your health care options (CRITERIA USED FOR DECISION: IQ Product CP Imaging Subset Imaging, Spine, Lumbar.)
  - o The resolution letter states: "The records provided have been reviewed by a member of Molina Healthcare's specialty physician advisor panel, who is board certified: [physician reviewer's name], Family Medicine. The physician agrees with the original decision and has upheld the denial for MRI of the Back Spine without Dye. Based on the following guidelines: InterQual: CP Imaging Subset

[5] California Code of Regulations, Title 22, Section 51303(a) states "Health care services set forth in this article and in Chapter 5, Article 4 (commencing with Section 54301 of this title), which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury are covered by the Medi-Cal program, subject to utilization controls, to the extent specified in this Chapter, Chapter 5, and Chapter 11. Such utilization controls shall take into account those diseases, illnesses, or injuries which require preventive health services or treatment to prevent serious deterioration of health. Nothing in this section shall preclude payment for family planning services, or for early, periodic screening, diagnosis and treatment services (EPSDT), provided under the Child Health and Disability Prevention (CHDP) Program. Authorization may only be granted when fully documented medical justification is provided that the services are medically necessary. Services not requiring prior authorization are subject to other utilization controls, as specified in this chapter."

> Imaging, Spine, Lumbar. The clinical criteria for the following would be indicated if you had at least 6 weeks of special exercises that will help make the muscles strong."

During interviews, Plan staff noted that the Medical Directors rendering clinical decisions utilize guidelines based on a hierarchical system: Medi-Cal criteria, then Molina clinical guideline, followed by InterQual guidelines, and finally other resources. The Chief Medical Officer explained that the Plan cites only the superseding guideline. Staff also noted that the resolution letter includes the language utilized by the Medical Director who rendered the decision to uphold, deny, or modify the appeal. However, as the file review outcome indicates, this practice is not consistent.

Conclusion: DHCS-Molina Contract, Exhibit A, Attachment 14, and Section 1300.68(d)(4) require that the Plan's response to grievances shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. Review of the Plan's resolution letters in standard and expedited denial files revealed that the letters did not consistently include clear and concise explanations, criteria or guidelines, and clinical reasons for its decisions. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

TABLE 5
Use of Criteria and Guidelines in Medical Necessity Denials

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Appeals	4	Criteria and/or guidelines used for the decision match criteria and/or guidelines in resolution letter	1 (25%)	3 (75%)
		Resolution letter cites guidelines used	1 (25%)	3 (75%)

Potential Deficiency #6: The Plan does not have policies and procedures that enable members to make a standing request to receive all informing material in a specified alternative format.

Contractual/Statutory/Regulatory Reference(s): DHCS-Molina Contract, Exhibit A, Attachment 13 – Member Services, Provision 4 – Written Member Information.

DHCS-Molina Contract, Exhibit A, Attachment 13 – Member Services,
4. Written Member Information
C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members'

understanding of the health plan processes and ensure the Member's ability to make informed health decisions.
1) Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.
2) Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.
3) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

Documents Reviewed:

- Plan Policy HE-03: Communications to Members (revised 06/01/15)

Assessment: The DHCS-Molina Contract, Exhibit A, Attachment 13 – Member Services, Provision 4 – Written Member Information, requires the Plan to publish written Member informing materials in alternative formats upon request and in a timely fashion. The Plan must also establish policies and procedures to enable members to make a standing request to receive all informing material in a specified alternative format.

Plan Policy HE-03, Communications to Members, confirms members' right to receive materials in alternative formats but does not address the requirement for a standing request. The policy states:

> Upon enrollee request, the Plan will translate existing member health education and health informing materials into the enrollees preferred language and/or into an alternate/accessible format (refer to MS-43 on requesting existing member material in an alternate format). A request for materials in the enrollee's preferred language is made via the Member Services Department who then forward the document(s) to R&I to fulfill the request. Materials requested in an alternative/accessible format are also initiated via Member Services who then forward the request to the Disability and Senior Access Services Department to fulfill the request (refer to Disability and Senior Services Department P&P DS-01).

During onsite interviews, Plan staff stated that their system does not allow enrollees to make a standing request to receive materials in alternative formats. Staff further stated that members must make a request each time they wish to have information in alternative formats.

Conclusion: The DHCS-Molina Contract, Exhibit A, Attachment 13 – Member Services, Provision 4 – Written Member Information, requires the Plan to establish policies and procedures to enable members to make a standing request to receive all informing material in a specified alternative format. The Plan's policies to not address this issue, and Plan staff confirmed that the Plan does not offer this option to members. Therefore, the Department finds the Plan in violation of this contractual requirement.

QUALITY MANAGEMENT

Potential Deficiency #7: The Plan's Quality Improvement Program does not take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf.

Contractual/Statutory/Regulatory Reference(s): DHCS-Molina Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; Rule 1300.70(a).

The DHCS-Molina Contract, Exhibit A, Attachment 4 – Quality Improvement System
1. General Requirement
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

Rule 1300.70(a)
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Documents Reviewed:
- Plan Policy QM 01A: Potential Quality of Care – PQOC
- Molina leveling tool – Potential Quality of Care – Issue Codes – Severity Codes
- PQI Case reviews- 3 Rural Expansion

Assessment: The DHCS-Molina Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, requires the Plan to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf. Rule 1300.70(a)(1) requires the Plan to document that quality of care problems are identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.
The Plan's Quality Improvement Program (Plan Policy QM01A, Potential Quality of Care) has developed the following severity level system to rate quality of care issues that come to its attention through the grievance process and other activities:

- Level 0: No Quality of Care Issue
- Level 1: Potential Quality Issue
- Level 2: Quality of Care Issue without negative outcome
- Level 3: Quality of Care Issue with negative outcome
- Level 4: Gross and flagrant violation of acceptable medical practice or service Standard

The Department reviewed three (3) PQI files submitted by the Plan, which comprise the universe of PQI files, and determined that that one (33%) of these three cases was leveled incorrectly.

File #1: This case involved a member seen in the emergency room who was misdiagnosed. The member was later seen at a facility out of the country and was told she had gallstones, which required surgery. Medical records received by the Plan indicated the member had cholecystitis (inflammation of the gallbladder). The Plan leveled the case at a 1; however, the Department determined that the case should have been leveled at a 2. As a result of the incorrect leveling, no corrective actions were implemented.

The Department determined that the Plan does not assign appropriate severity levels to potential quality issues (PQIs) in order to ensure that quality of care cases undergo appropriate review and advance through the Plan's quality review process as outlined in Plan policy QM01A, Potential Quality of Care. When cases are determined to be Level 1 severity, i.e., a potential quality issue (PQI), the Plan does not conduct further review or investigation, refer the case to the Peer Review Committee, or develop a Corrective Action Plan (CAP). As a result of misclassification of severity levels, the Plan failed to effectively monitor quality of care and ensure that all quality issues are documented, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated for all of its providers.

Conclusion: The Plan is required by The DHCS-Molina Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Rule 1300.70 to document that problems related to quality are being identified and that effective action is taken to improve care when deficiencies are identified. As a result of misclassification of severity levels, the Department determined that the Plan failed to effectively monitor quality of care and ensure that all quality issues are documented, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated for all of its providers. Therefore, the Department finds the Plan in violation of these requirements.

TABLE 6
Consideration of Potential Quality Issues

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
PQI Files	3	Plan identified and took appropriate action on quality issues	2 (66%)	1 (33%)

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Jennifer Friedrich	Medical Survey Team Lead
Cindy Liu	Attorney
MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS	
Elizabeth Fuhrmann, PhD., RN and Cliff Ridenour, LCSW	Utilization Management Surveyors
Madeline Hommel	Availability & Accessibility Surveyor
Annalisa Almendras, PhD.	Member Rights Surveyor
Dawn Wood, MD	Quality Management Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED	
Richard Chambers	Plan President
James Novello	Chief Operating Officer
James Cruz, MD	Chief Medical Officer
Michael Siegel, MD	Medical Director
Michael Brodsky, MD	Medical Director
Carol Pranis, RN	Director, Quality
Yasamin Hafid	Director, Compliance
Shirley Kim	Director, Health Plan Operations
Jody Mcleish	Director, Healthcare Services
Marianne Maciel	Director, Healthcare Services
Rikki Haffner	Director, Operational Oversight
Richard Golfin	Director, Delegation Oversight
Sharon Fetterman	Director, Utilization Management
Mary Curry	Director, Utilization Management
Sal Laique	Director, Provider Services
Andy Nguyen, Pharm.D	Director, Pharmacy
Blanca Martinez	Director, Case Management
Donna Davis	Director, Case Management
Tammy Jurkatis	Director, Member Services
Stephanie Williams	Director, Member Services
Victoria Luong, Ph.D	Director, Health Education
Lisa Hayes	Director, Disability and Senior Access
Megan Dankmyer	Director, Long Term Care
Teresa Morgan	Director, Claims
John Robertson	Director, Claims
Deborah Miller	Vice President, Healthcare Services
Rajeev Narula,	Vice President, Finance
Yunkyung Kim	Vice President, Government Contracts
Michelle Espinoza	Vice President, Provider Network
Suma Verghese	Assistant Vice President, Health Plan Operations
Jennifer Rasmussen	Assistant Vice President, Case Management
Leslie Fonseca	Assistant Vice President, Utilization Management

Ellen Rudy, Ph.D	Assistant Vice President, Quality
Timothy Zevnik	Assistant Vice President, Compliance
Milaine Isaac	Assistant Vice President, Provider Network
Khaled Ghaly	Assistant Vice President, Claims
Elizabeth Igwe	Manager, Healthcare Services
Lisha Robinson	Manager, Delegation Oversight
Maria Ochoa	Manager, Claims
Ann Valentin	Supervisor, Utilization Management
Linda Bomersback, RN	Delegation Oversight Nurse
Amritha Roser	Health Educator Ill
Matilde Gonzalez	Cultural & Linguistic Specialist

APPENDIX C. LIST OF FILES REVIEWED

Note: The statistical methodology utilized by the Department is based on an 80% confidence level with a 7% margin of error. Each file review criterion is assessed at a 90% compliance rate.

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	File Number
Standard Grievances	31	UMXGR17865302 1502104120 UMXGR19050543 14-016201140 UMXGR18159862 UMXGR19919867 UMXGR19554550 UMXGR17104015 UMXGR20972390 UMXGR21264508 UMXGR17837264 UMXGR18037155 UMXGR19471825 1508904305 UMXGR21430438 UMXGR17655537 1430902162 UMXGR17981723 UMXGR20579600 UMXGR17585069 UMXGR19252983 UMXGR20739986 UMXGR17644898 UMXGR20006259 UMXGR20462189 UMXGR19324446 UMXGR17285685 UMXGR18305687 UMXGR1829966 UMXGR19824874 UMXGR20310031
Potential Quality Issues	3	2111 1940 1610

UM Medical Necessity Denials	30	1515090020 1423803856 1511404059 1506804152 1511700157 1433503772 1504900874 1504801507 1513203878 1421703766 1422090114 1512504103 1432590125 1506890206 1501200899 1427690182 1512101803 1514000886 1429790080 1512090400 1513403861 1427602567 1434490244 1511803084 1511803084 1511990368 1502190233 1423490318 1500703210 1436100207