4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	Supporting Documentation: 6.1.1 QM 50	medical care.	The MCP submitted 2014 Inter-Rater Reliability Analysis. This document does not appear to address any of the previously stated DHCS requirements to achieve compliance for this deficiency. **Update 6/19/14:** The MCP submitted a draft of P&P 53, titled Quality Improvement Internal Monitoring, and a copy of the memo "Rational for Revision to QM 53. The Plan also submitted "May 2014 QI Monitoring Audit." To close this finding the Plan must submit: • Information that P&P 53 is replacing P&P 50, and a signed approved copy of the P&P. • An explanation of the QI Monitoring Audit and how it is used in regards to the deficiency. • Results of the medical record review tool. **Update 6/24/14:** The MCP submitted "Memo DHCS 2014 Renumbering of P and P QM 50 to QM 53 and Memo – DHCS QI Monitoring Audit

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Description SA." **Update 7/17/14:** Language modifications were made to P&P QM 53 as well as scoring scales for the focused medical record reviews. The revised P&P is being presented at the next QIC meeting in August for approval. Per the conference call with the MCP, this item is now closed. **This deficiency is closed.**
6.1.2 The grievance system does not identify all inquiries that are complaints or expressions of dissatisfaction regarding quality of care as grievances. Among grievances that were actually identified, clinical personnel do not ensure that all quality of care grievances were identified. Files on quality of care grievances often contained little or no information about the medical director's review. Trends were not identified among quality of care issues identified as being tracked and trended.	Actions taken to ensure correction of the deficiency include: - The Quality Improvement (QI) Department has undergone a complete redesign to standardize best practice tools, and build the quality function into the organizational structure across various departments. - The development of a new QI Policy – QM-50 Quality Improvement Monitoring defines semiannual interdepartmental monitoring of compliance with MHC policies that will ensure adherence to quality of medical care, standards and guidelines, including, but not limited to, the appropriate handling of the following: UM Denials, UM Appeals, Accepted PQOC's and Grievances, and Focused Medical Record Review (MRR) Audits. - The audit will review a sample based on the 8/30 NCQA Sampling Methodology rule. - Quality Improvement Department revision of QM 01 PQOC policy and processes that include the following: o Restructured severity level system to provide category guidelines for each severity level that will effectively track and trend all cases o Established a two-tiered review process to ensure that all PQOC issues and grievances are appropriately identified and investigated. o The 1st level LVN reviews 100% of grievances o The 2nd level RN review validates all grievances reviewed at 1st level o QI RN review the case with the Medical Director on a regular basis to ensure that review findings and Medical Directors final assessment are appropriately dated and documented. - Implement a quarterly random review of 3% of the total volume of grievances and inquiries per county with a maximum of 50.	Initiated remedial action: - New CMO hired1/24/14. - QI Department redesign completed 12/31/13. - Developed P&P 2/10/14. - Develop Audit Tool 2/14/14. Long Term ongoing monitoring of corrective action includes: - Ongoing CMO training - Approval of audit tool 3/24/14 at Professional Review Committee - Acceptable level process implementation 4/1/14. Full compliance will be achieved by ongoing monitoring to ensure correction of the deficiency and ensure acceptable medical care.	To achieve compliance, the MCP must submit the following: • An approved, signed copy of P&P QM-01A Potential Quality of Care. • Evidence that QI RNs are reviewing cases with the Medical Director to ensure review findings and final assessments are appropriately dated and documented. • Results of grievance audit reported to the CQIC, if applicable. **Update 6/18/14:** The MCP submitted an approved, signed copy of P&P QM-01A, dated 4/9/14.

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	- Report grievance audit result to Clinical Quality Improvement Committee (CQIC) bi-annually. Supporting Documentation: 6.1.2: QM 01 - Potential Quality of Care (PQOC) 6.1.2: QI 50 - Quality Improvement Internal Monitoring	Medical Officer	To achieve compliance the Plan must submit the additional DHCS requirements previously noted. **Update 6/20/14**: The MCP submitted Potential Quality of Care data that shows Medical Directors are reviewing cases. **This deficiency is closed.**
6.1.3 Although the Plan stated that all delegated denials were reviewed, this review was by UM nursing staff. Medical Directors reviewed only about 1% of denials for appropriateness of the denial. A review of 1% of delegated denials does not ensure that care provided met standards for acceptable medical care. The requirements for meeting the responsibilities of the medical director were not met.	Molina will use the following review process to monitor delegated denials for appropriateness of the denial. - The monthly Denial Report submitted by the delegated medical group will be modified to expand review of denial by category. The two categories will be Administrative Denials and Medical Necessity Denials. Medical necessity denials will be reviewed and analyzed quarterly for appropriateness by a Molina Medical Director using a 10 or 10% sampling methodology. Administrative denials will be reviewed in the same fashion for appropriateness. - Review of Medical Group data and data available from high performing groups will be used to establish benchmarks for rate of denial over turn and unused authorizations. The recommended benchmarks will be submitted for approval at the UM or QI Committee. Supporting Documentation: 6.1.3 Final 2014 UM Audit Tool 1214 6.1.3 Final 2014 Monthly Tracking Log (format revised 01.17.14 ND) 6.1.3 Report Submission Matrix 2013	Benchmark for rate of overturn will be established by 4/15/14. Identified Reporting logs and the reporting format of data will be developed and submitted to the MALT and UM/QI committee for approval by 4/15/14. Medical group data and high performing groups will be established by 5/1/14.	This deficiency remains open. To achieve compliance, the MCP must submit the following: • UM/QI Committee approved reporting logs, data format and established benchmarks for rate of denial, over-turn and used authorizations. • An example of a medical necessity denial quarterly report depicting appropriateness by the Medical Director. **Update 6/20/14:** The MCP submitted "Medical Director Quarterly Audit - December 2013

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			(4Qtr)". This report does not speak to all outstanding deficiencies. SeespeakSee 1.1.3 Over Utilization and Under Utilization of UM Services and See 1.1.3 Memo DHCS 1.1.13, 6.1.3, DMHC 1, 9". In order to close this deficiency, the MCP must submit: • UM/QI Committee approved reporting logs, data format and established benchmarks for rate of denial, over-turn and used authorizations. • An example of a medical necessity denial reporting referenced in bullet point 2 above quarterly report depicting appropriateness by the Medical Director. **Update 6/24/14:** The MCP submitted 2014 underover and open auth report issues, Copy of MD Quarterly denial review form, MD Quarterly Review 2014 and Molina Delegate Open Auth Log 2014." **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments

6.4 PROVIDER TRAINING

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status (as required by GMC/2-Plan Contract A.7.5).

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
6.4.1 The requirements to ensure that a newly contracted provider receive training within 10 days from its effective date were not met.	Actions taken by the Provider Services (PS) Department to ensure correction of the deficiency include: - The Plan's PS-02 is being updated to incorporate other provider training avenues/options (including mailings of new Provider orientation training/education information, online training and participating provider group responsibility) to ensure required timelines are met. The Provider orientation sessions and on-site visits will also be a participating Provider group responsibility to provide an in-service training on Plan's provider manual and to conduct additional training, as needed, for newly contracted Providers and programs within ten (10) business days of the contract effective date. - Provider Operations Manual is being updated to include Provider Training and Education information/in-servicing requirements, including participating Provider group responsibility. The Provider Manual is currently under revision and scheduled to post on the website by the end of March 2014 or sooner. - A new standard operating procedure and self-service report are in development to assist PS in identifying all Providers joining Molina's Provider network, including effective date data elements. Over the next several weeks, the report will be built and tested for the quality and accuracy of the output. We anticipate completion by 4/30/14. - The Plan will update Provider communication tools/newsletters to better explain the scope and requirements of the new Provider orientation. Fall 2014 Provider Newsletter content will be completed by 6/20/2014 and a fax will go out to all Providers notifying them when the newsletter has been posted on the Provider communication section of the Molina website. The newsletter will post by 10/7/14.	-PS 02 to be completed 2/28/14. -Manual to be updated 3/31/14. -Standard operating procedures to be completed 4/30/14. -Newsletter 10/7/14	To achieve compliance, the MCP must submit the following: • Submit a copy of the revised and approved P&P PS-02. • Submit revised Provider Operations Manual that includes provider training and education information and in-service agreements. • Submit example of the new standard operating procedure and self-service report. **Update 6/20/14:** Plan submitted copy of revised P&P PS-02, revised Provider Manual, and flow charts of new operating procedures. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
6.5 FRAUD AND ABUSE			
Fraud and Abuse Reporting Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse…. 1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract. 2) Contractor shall provide effective training and education for the compliance officer and all employees. 3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines. 4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, Members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity…. 5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs (as required by GMC/2-Plan Contract E.2.26.B).			
6.5.1 The contract requires that the Plan "report to DHCS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity."	The Plan's Anti-Fraud Plan has been updated to include the requirement to report to DHCS all cases of suspected fraud and/or abuse within 10 working days. Pending DHCS approval of the revised Anti-Fraud Plan, the plan will be reviewed and approved at the Plan's 1Q14 Board meeting. Supporting Documentation: 6.5.1: See Redline Anti-Fraud Plan IV.B	Fraud Plan revised on 2/1/2014, to be approved by Plan Board on 3/27/2014.	To achieve compliance, the MCP must submit: • A copy of the approved Anti-Fraud Plan. • Evidence demonstrating how the MCP is complying with the requirement to report suspected fraud cases to DHCS within 10 working days. **Update 6/20/14:**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			The MCP submitted "Fraud Waste and Abuse Plan and FWA Tracking Log and Memo – 6.5.1 Fraud Plan". In order to close this deficiency, the MCP must submit: An approved P&P (signed & dated) for Anti-Fraud Plan. **Update 6/24/14:** The MCP submitted "CC 2." **This deficiency is closed.**
6.5.2 The Plan is required to ensure that ineligible and suspended providers from the Medi-Cal program are not employed or contracted. This requirement was not reflected in the Plan's subcontract with its PBM.	The Plan is working with the Pharmacy Benefits Manager (PBM) to have a "Sanctioned and Excluded Prescriber List" sent to us monthly. Once received, we will run a report in RxNavigator on the adjudication system, Rx Claim, to ensure that medications that are billed with these sanctioned/excluded provider's NPI or DEA numbers have been rejecting appropriately. Supporting Documentation: 6.5.2: PBM FWA Services	PBM report expected on 03/03/14.	The MCP is working with their PBM to have a sanctioned and excluded prescriber list submitted monthly. This deficiency remains open. To achieve compliance, the MCP must submit: • A copy of the latest PBM report utilized to ensure medications billed to sanctioned or excluded providers are rejected appropriately. **Update 6/20/14:** The MCP submitted "Sanctioned Provider Claims Report." **This deficiency is closed.**

8. Submitted By: _____ **Date:** _____

Title: **President, Molina Healthcare of California**