State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Richard Chambers, President
Molina Healthcare of California Partner Plan, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

RE: Department of Health Care Services Medical Audit

Dear Mr. Chambers:

The Department of Health Care Services (DHCS) Audits and Investigations Division conducted an on-site medical audit of Molina Healthcare of California, a Managed Care Plan (MCP), from September 16, 2013 through September 27, 2013. The audit covered the review period of June 1, 2012, through May 31, 2013.

On March 11, 2014, the MCP provided DHCS with a response to its Corrective Action Plan (CAP) originally issued on January 24, 2014.

All remaining open items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS's final response to the MCP's CAP.

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

If you have any questions, contact Mr. Edgar Monroy, Chief, Compliance Unit, at (916) 449-5233 or CAPMonitoring@dhcs.ca.gov.

Sincerely,

Original signed by Nathan Nau, Chief
Contract Compliance Section

Encl.

cc: Emily Cresenciana Bautista, Contract Manager
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CORRECTIVE ACTION PLAN

1. **Plan Name: Molina Healthcare of California**
2. **Review Type: Medical Audit**
3. **Review Period: 6/1/12 – 5/31/13**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
1.1 UTILIZATION MANAGEMENT PROGRAM			
Utilization Management (UM) Program Requirements: Contractor shall develop, implement, and continuously update and improve a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services (as required by GMC/2-Plan Contract A.5.1). There is a set of written criteria or guidelines for utilization review based on sound medical evidence that is consistently applied and regularly reviewed and updated (as required by GMC/2-Plan Contract A.5.2.C). **Under- and Over-Utilization:** Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor shall report to DHCS the internal reporting mechanisms it uses to detect Member Utilization Patterns to DHCS upon request (as required by GMC/2-Plan Contract A.5.4).			
1.1.1 The Plan is required to include mechanisms in its UM Program to detect under- and over-utilization of services.	On a quarterly basis, the Utilization Management Committee (UMC) reviews health plan utilization rates for a number of indicators on all lines of business, including: • Acute bed days per 1,000 members • Admissions per 1,000 members • Skilled Nursing Facility (SNF) bed days per 1,000 members • Average Length of Stay (ALOS) • 30 day Readmission rates to determine whether rates are above benchmark goal indicating possible under-utilization of PCP or specialist post-hospital discharge • Emergency Department utilization rates to determine whether rates are above benchmark goals indicating possible under-utilization of PCP or specialist or urgent care facility due to accessibility issues • Pharmacy utilization rates overall and by targeted category The UMC reviews these indicators on a rolling 12-month basis to identify variances as well as trends that indicate under- and over-utilization. The UMC will establish benchmarks as best practice indicators and compare the plan performance to those best practice benchmarks. In addition, the UMC will look at the number and type of Appeals and Grievances related to access to		The MCP submitted a copy of its Health Care Services Program outlining mechanisms to detect under- and over-utilization of services. On a quarterly basis, the MCP reviews utilization rates for multiple indicators on all lines of business. The indicators will be reviewed on a rolling 12-month basis to allow for the identification of variances as well as trends that indicate under- and over-utilization. Emphasis on detecting under-utilization is being

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	acute care, outpatient specialty care and PCP access, other outpatient services and Behavioral Health services. In 2014, the UMC will also focus on: • Health plan coordination of California Children's Services (CCS) Services • Pre-service Denial rates for medical necessity • Administrative Denial Rates The UMC and the Quality Committees closely monitor Healthcare Effectiveness Data and Information Set® (HEDIS) measures to identify and improve under-utilization of these services through targeted intervention. The results in this area continue to be monitored to determine the effectiveness of the interventions and to recommend interventions as needed. HEDIS measures for 2014 include: • Prenatal visits in first trimester • Postpartum visit time frame • Childhood immunization rates • HbA1C for Diabetic control • Cervical Cancer Screening • Identification of need for alcohol and other drug dependency services Data is reported to the UMC for review and discussion on a quarterly basis. The UM/CMC recommends interventions when a trend is identified and monitors the efficacy of the intervention taken. The Quality Improvement (QI), UM, and Pharmacy Departments collaborate in monitoring of utilization patterns across practices and provider sites, including primary care practitioners and high volume specialists. These activities include monitoring all potential quality issues related to under- and over-utilization of services as well as results of annual delegation audits and facility site review audits. Per the recommendation of the CAP, an index has been developed that lists all treatment and medication therapy guidelines, including the date of the guideline review and approval. The index was reviewed and approved by the UMC. Medical Director training will include instructions to carefully review the treatment index and the treatment or therapy guidelines, including references in support of a decision to restrict therapy. The Plan will utilize a vendor to identify high-risk members with COPD and Asthma, where utilization data will be reviewed to detect under-utilization and/or adherence issues. The Plan will ensure appropriate use of controlled medications to decrease exacerbations and ER visits. Other conditions/disease states, such as Diabetes, HTN, and CHF, have been identified as potential target areas.		highlighted. This deficiency remains open. To achieve compliance, the MCP must submit: • A copy of the medical director training scheduled to be completed by 3/13/14. **Update 6/18/14:** The MCP submitted a PowerPoint copy of the medical director training. **This deficiency is closed.**

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	To address patient safety, the plan implemented a narcotics program to identify members who are receiving narcotics from 4 or more prescribers. Additional prescriptions will be rejected, and the Pharmacy Department will alert the prescriber. A report has been developed to monitor members' morphine equivalent dose for narcotics prescribed. MTMP (Medication Therapy Management Program) will be implemented with targeted Plan population to identify medication-related problems and work to resolve them. Pharmacists will evaluate members' medication therapy, generate the member's personal medication record and develop medication-related action plan and referrals when appropriate, document and follow-up. Supporting documentation: 1.1.1 HCS 2014 Program Description		
1.1.2 The Plan did not ensure that denials were appropriate or represented consistently applied criteria. Denial rates were not examined to detect unwarranted variation or possible under-utilization. Denials were not reported by medical necessity vs. not a covered benefit.	To ensure that denials are appropriate or represent consistently applied criteria, denial language retraining was completed in August 2013 for the Medical Directors. The training covered National Committee Quality Assurance (NCQA) criteria for denial language to include simplifying denial language, citing the correct decision criteria, providing detail around why criteria were not met, and reminding patients about consulting with their Physicians about other healthcare options. Quarterly audits were completed. These included 10 approved and denied cases per Medical Director to ensure appropriate selection and application of criteria. This audit will be repeated quarterly. An authorization report was developed to track and trend authorizations. This report also is used to report denials by medical necessity vs. not a covered benefit. The data will be reviewed monthly at the Medical Affairs Leadership Team workgroup to analyze for possible under-utilization and reported to the Quality Improvement Strategic Committee (QISC) quarterly meetings. Supporting Documentation: 1.1.2 Authorization Report sample 1.1.2 MD Denial Training 1.1.2 MD audit tool 1.1.2 2014 IRR training		The MCP conducted training to ensure denials were appropriate and represented consistently applied criteria. In addition, quarterly audits of approved and denied cases are being conducted; however, this deficiency remains open. To achieve compliance, the MCP must submit: • Results of the quarterly audits completed in December 2013 and March 2014. • Copy of the latest authorization report used to report denials by medical necessity vs. not a covered benefit. • Provide copies of the UM Committee and QI Committee meeting minutes. DHCS acknowledges the

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			MCP submission for this audit finding. A portion of this finding was identified in the DMHC non-routine survey completed on June 4, 2014. Ongoing monitoring and corrective action for this finding will be achieved through the DMHC CAP. **Update 6/18/14:** The MCP submitted the results of the Medical Director Quarterly Audit-December (Q4) 2013. All other deficiencies referenced in DHCS requirements to achieve compliance remain outstanding. **Update 6/20/14:** The MCP submitted "Appendix III, 2014 Inter-Rater Reliability Analysis and Memo – Denials – Consistently Applied Criteria and Minutes from 04-17-14 QIC FINAL and QIP Q3-Q4 Semi Annual and Annual Report and QIC 2-27 and UMC Minutes 2.19.2014 and UMC Minutes 4.16.2014." **This deficiency is closed.**
1.1.3 The Plan's 2013 Health Care Services (HCS) Program Description contained goals for admissions and readmissions that UM Staff, CMO, and	Molina establishes goals for admission/readmission as well as other indicators. These goals are established and reported to monitor financial performance. As stated in the Health Care Services (HCS) Program Description, we will go beyond these established financial goals by establishing under- and over-utilization targets.		Established goals should be reasonable based on past performance and expressed in valid units of

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Medical Directors were unfamiliar with and could not explain. The goals were considerably higher than historic performance, and the goal for readmissions was expressed as a percentage per annualized thousand, a metric that Plan staff could not explain.	Per the recommendation of the CAP, the 2014 HCS Program Description will be reviewed with staff and posted on the HCS SharePoint site. Supporting Documentation: 1.1.3 HCS_CA_Program Description 2014 final		measurement. This deficiency remains open. To achieve compliance, the MCP must submit: • Documentation of established goals relating to admissions and readmissions. **Update 6/20/14:** The MCP submitted "Over Utilization and Under Utilization of UM Services and Memo DHCS 1.1.13, 6.1.3, DMHC 1, 9." **This deficiency is closed.**
1.1.4 The Plan's written guidelines were not based on sound medical evidence. There was no evidence that the guidelines were regularly reviewed or updated. Guidelines were presented for GLP-1 Analogues, Xarelto and Baraclude that had no effective or approval date and were neither indexed nor formatted as other guidelines reviewed. The Human Growth Hormone guideline placed a restriction on its usage in Turner Syndrome, which was not supported by the references cited, or other scientific resources.	For non-specialty medications, the Plan is in the process of updating the formulary to be consistent with a Molina National Formulary. Criteria will have an effective date, approval date, the formatting will be consistent and the criteria will be indexed. For CA guidelines developed and approved from the March 2013 Pharmacy & Therapeutics (P&T) Committee until the national guidelines are in place, they will be indexed with effective dates and approval dates. The Human Growth Hormone (HGH) criteria for Turner Syndrome, similar to other FDA approved indications in our guidelines, is in place to ensure that HGH is prescribed for the appropriate patient and only when medically necessary. The criteria specifically address verification of TS diagnosis, age, contraindications, and documentation/labs that are standard with usage of GH (growth chart, epiphyseal closure, TSH levels, etc.). American Association of Clinical Endocrinologists (AACE) and American Medical Association (AMA) were cited and discussed the safety and efficacy of this indication. Additionally, the guideline was externally peer-reviewed by two specialists with both references cited in the document. Both specialists did not have an issue with the criteria of Turner Syndrome. a. April 2010: Board certified in Internal Medicine, Endocrinology. AMR Tracking Num: 181848. Date completed: 4/19/2010		The MCP is in the process of updating their drug formulary to be consistent with their national formulary. Criteria will include an effective date, approval date and the formatting will be consistent and indexed. This deficiency is provisionally approved pending receipt of new formulary guidelines to be implemented in August 2014. MCP to provide DHCS supporting documentation of new formulary guidelines. **Update 6/20/14:**

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	b. April 2010: Board certified in Pediatrics, Pediatric Endocrinology. AMR Tracking Num: 181858. Date Completed: 4/19/2010 Medical Coverage Guidelines are reviewed and approved for utilization by Molina Healthcare's Medical Coverage Guidance Committee. These guidelines are then forwarded to Molina Healthcare of California for review and approval by the Utilization Management Committee. The Medical Coverage Guideline documents can be found on the following internal sites: Medical Coverage Guidance Documents Supporting documentation: 1.1.4 UM Review Criteria Annual Approval and Table of Contents MCG_2_19_14 1.1.4 Example MCG- 026 Chronic Plaque Psoriasis Biologic Therapies		The MCP submitted "Sample Guideline GLP-1 Antagonists Molina." **This deficiency is closed.**
1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS			
Prior Authorization and Review Procedures: Contractor shall ensure that its pre-authorization, concurrent review, and retrospective review procedures meet the following minimum requirements (as required by GMC/2-Plan Contract A. 5.2.A, B, D, F, H, and I). **Exceptions to Prior Authorization:** Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing (as required by GMC Contract A.5.2.G). Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing (as required by 2-Plan Contract A.5.2.G). **Notification of Prior Authorization Denial, Deferral, or Modification:** Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative. This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01 (as required by GMC Contract A.13.8.A). Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative. This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01 (as required by 2-Plan Contract A.13.8.A).			
1.2.1 The Plan stated that it used Medi-Cal Guidelines, InterQual, Apollo, and	For non-specialty medications, plan is in the process of updating the formulary to be consistent with a Molina National Formulary. Criteria will have a clear effective date, approval date, the formatting will		The MCP is in the process of updating their drug

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proprietary guidelines to process prior authorizations. Proprietary guidelines were developed by the corporate parent and approved and adopted by the regional Plan UM or P&T Committee. The Plan used criteria/guidelines for Baraclude, Xarelto and GLP-1 therapies that did not document an approval date or effective date. It did not index these guidelines, or record them in a standard format. There was no evidence that they were developed and adopted prior to denial of authorization requests for these therapies.	be consistent and the criteria will be indexed. For CA guidelines developed and approved from the March Pharmacy & Therapeutics (P&T) Committee until the national guidelines are in place, they will be indexed with clear effective and approval dates. Supporting Documentation: 1.2.1 PA Guideline Vyvanse Example Update : 8/29/14 Please find the attached universal guidelines and Pharmacy Formula		formulary to be consistent with their national formulary. Criteria will include an effective date, approval date and the formatting will be consistent and indexed. This deficiency is provisionally approved pending receipt of new formulary guidelines to be implemented in August 2014. MCP to provide DHCS supporting documentation of new formulary guidelines. **Update 6/24/14:** The MCP submitted a memo "Prior Authorization Review Requirements." **Update 7/17/14:** The MCP has stated they will submit new formulary guidelines by 8/29/14. **This deficiency is closed.**
1.2.2 The Plan submitted a file containing the universe of prior authorizations. This file contained decision dates that were inaccurate, and 82 of 95 files examined had incorrect dates. The Plan submitted information in this file indicating decisions were made earlier than supported by documentation.	Plan is actively working to include the decision date to the newly developed authorization report. This report will be used for future audit requests.	3/31/2014	The MCP is developing an updated authorization report to be used for future audit requests. The report will include a decision date. To achieve compliance, the MCP must submit: • Evidence the newly

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			developed authorization report includes accurate decision dates. **Update 6/18/14:** The MCP submitted a screenshot of "Authorizations Report". The report includes values for "Decision Date" that occurs after, or on the same date, as the value contained in the "Referral Create Date". To close this finding the Plan must submit samples of supporting documentation that correspond to the authorizations referenced in the report. **Update 6/24/14:** The MCP submitted "Pages from 1.2.2 DHCS CAP –1- 30, 30-60, and 61-95; memorandum response, a complete case file sample – pages 1-30." **This deficiency is closed.**
1.2.3 The Plan frequently exceeded time frames for decision making: • greater than 5 working days after all necessary information is received • greater than 14 days without notice to Member and Provider, or recording specific reason for delay and how it is in Member's interest • greater than 28 days	Additional supervisory and staff positions were added. Job fairs were held to fill open positions; overtime was approved for staff to work on resolving the prior authorization backlog and until all open positions were filled and open Medical Director positions was also filled. Staggered shifts were implemented to include weekday, weekend and holiday coverage of Utilization Management (UM) staff. This change was to ensure our Turn Around Time (TAT) is within compliance. UM staff was retrained on standardized processes to improve workflow timeliness. Staff was educated on new daily productivity standards. Monthly audits are performed by supervisory staff. Results are reviewed with the staff and additional training/coaching is performed as needed.	Identified and began to fill open positions in June 2013. As of January 2014, 90% of all open positions are filled. Staggered shifts were implemented on September 1, 2013.	To address decision timeframe issues, the MCP added additional supervisory and staff positions. Technical support has standardized processes to improve workflow timeliness. Turnaround time is monitoring daily and

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	Technical support services made it a priority to improve UM systems. Automated email updates are sent to supervisors and managers when cases are approaching turnaround time deadlines. Turnaround times have improved and maintained with a small variance in the month of November due to 7 day enterprise wide system failure of the fax system in which the plan had to revert to a manual process. See attached Prior Authorization (PA) Report for monthly turnaround time report. Turnaround is monitored daily. Supporting Documentation: 1.2.3 PA report 1.2.3 CAM training 1.2.3 Staff audit tools 1.2.3 Molina CAM Philosophy	August 2013 UM staff was retrained on standardized processes. As of January 2014, technical support services made a priority to improve UM systems.	reported monthly. This deficiency remains open. To achieve compliance, the MCP must submit: • Sign in sheets for UM training on standardized processes. • Sample report of monthly audit performed by supervisory staff. DHCS acknowledges the MCP submission for this audit finding. A portion of this finding was identified in the DMHC non-routine survey completed on June 4, 2014. Ongoing monitoring and corrective action for this finding will be achieved through the DMHC CAP. **Update 6/18/14:** The MCP submitted two documents "UM Standardized Processes Training Sign-in Sheets". Each sheet contains multiple tabs, labeled with different trainings, containing lists of staff names." The MCP must still submit a sample report of the monthly audit performed by supervisory staff.

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			Update 6/20/14: The MCP submitted "Q 2 Team Audit Analysis." **This deficiency is closed.**
1.2.4 Pharmacy denials were in excess of required 24 hour turnaround time.	Since the audit period, the department has hired three technicians who have been fully trained. To further assist with increased Prior Authorization and call volume, we are in the process of hiring five more technician positions. Once filled, they will assist in prior authorizations and bringing our turnaround time into compliance.	By June 2014, the Plan will hire 5 more technicians. Compliance with turnaround time by 4Q 2014.	To address pharmacy denial turnaround time, the MCP has hired three technicians, with plans to hire additional staff by June 2014. To achieve compliance, the MCP must submit: • Evidence that additional technical staff has been hired and fully trained to assist with prior authorization and call volume, resulting in improved turnaround time. **Update 6/20/14:** The MCP submitted "Pharmacy New Tech Hired and Trained." **This deficiency is closed.**
1.2.5 The Plan issued inappropriate denials, stating facts that were not supported by an examination of the medical record or Medi-Cal guidelines.	See 1.1.2		The MCP conducted training to ensure denials were appropriate and represented consistently applied criteria. In addition, quarterly audits of approved and denied cases are being conducted; however, this

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			deficiency remains open. To achieve compliance, the MCP must submit: • Results of the quarterly audits completed in December 2013 and March 2014. • Copy of the latest authorization report used to report denials by medical necessity vs. not a covered benefit. DHCS acknowledges the MCP submission for this audit finding. A portion of this finding was identified in the DMHC non-routine survey completed on June 4, 2014. Ongoing monitoring and corrective action for this finding will be achieved through the DMHC CAP. **Update 6/18/14:** The MCP submitted the "Medical Director Quarterly Audit-December 2013 (Q4). This submission satisfies one component of DHCS requirements for the MCP to achieve compliance. To close this deficiency, the MCP must submit the quarterly audit completed March 2014 and a copy of the referenced authorization report." **Update 6/30/14**

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			The MCP submitted the March 2014 Quarterly Audit and authorization reports for January 2014, February 2014 and March 2014. **This deficiency is closed.**
1.2.6 The Plan did not clearly document reasons for denial with Members/Providers in denial letters.	The Plan will revise letters to state reasons for denial and take proactive steps to include clarifying verbiage to approval letters to providers, when appropriate. Per HRX 8, medical terms (Pugh score) were defined in language comprehensible to laypersons (at 6th grade reading level and based on SMOG readability formula index moving forward) with appropriate explanation. The Plan will continue to define medical terms in parenthesis so that language and reasons for approval/denial are clear to laypersons. The Plan will continue to urge medication compliance through prior authorization approval letters. In addition, the Plan will solicit the assistance of case management as appropriate.	Policy will be revised and presented to Pharmacy and Therapeutics P&T Committee in March 2014 for approval. Letter Template will be revised and implemented in April 2014.	The MCP is in the process of revising policy and template denial letters to clearly document reason(s) for denial. This deficiency remains open. To achieve compliance, the MCP must submit: • Revised policy and procedure approved by Pharmacy and Therapeutics P&T Committee. • Revised denial template letter and include three examples demonstrating operational use. DHCS acknowledges the MCP submission for this audit finding. A portion of this finding was identified in the DMHC non-routine survey completed on June 4, 2014. Ongoing monitoring

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			and corrective action for this finding will be achieved through the DMHC CAP. **Update 6/18/14:** The MCP submitted "P&P P07, revised, signed, and dated 3/11/14." To close this deficiency the MCP must submit a copy of the revised denial template and three examples demonstrating its operational use. **Update 6/20/14:** The MCP submitted "Non-Compliance Language Example 1 and Non-Compliance Language Example 2." These two submissions, Example 1 & Example 2, are the same document. The MCP also submitted "Memo – 1 2 6 and 1 2 8 Prior Authorization Review Requirements and Molina CA MD Approval fax draft 4 25 14." **Update 6/24/14:** The MCP submitted "Denial Template, Non-Compliance Language Example 1 & 2." In order to close this deficiency, the MCP must submit a copy of the revised denial template (refer to

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			DHCS's APL 05005) and three examples demonstrating its operational use. **Update 12/23/14:** This deficiency is being deferred to DMHC in their non-routine survey. **This deficiency is closed.**
1.2.7 The Plan did not integrate UM and QI by referring inappropriate prescribing to the QI System. The Plan simply denies these requests, without further action.	The Plan will establish and implement a process that identifies potential inappropriate prescribing and integrates Pharmacy and Case Management departments. High-risk disease states identified include COPD, CHF, Specific CV diseases, Asthma, Diabetes, and Cancer. Currently, the Clinical Pharmacist is assisting the Interdisciplinary Team in Sacramento by conducting Comprehensive Medication Reviews for members (adherence, appropriate indication and dose, potential optimization), followed by a Medication Action Plan. The clinical Pharmacist works directly with the case manager to present written recommendations with supporting evidence. Follow-up by the case manager with the prescriber for their assessment.	Process development: June 2014. Implementation: 3Q14	To address this deficiency, the MCP is developing a process that will identify potential inappropriate prescribing. This deficiency remains open. To achieve compliance, the MCP must submit: • Evidence that a process that identifies potential inappropriate prescribing has been established and has been implemented. **Update 6/20/14:** The MCP submitted "Case Management Referral Log and Recommendations to Case Management." **This deficiency is closed.**
1.2.8 The Plan denied Baraclude for noncompliance. It made no effort to	Plan will include verbiage regarding the need for compliance in approval letter to Provider for specialty drugs and specific non-specialty classes. If Member becomes non-compliant, Member and Provider will	Policy will be revised and presented to the Pharmacy and Therapeutics P&T	To address this deficiency, the MCP is revising its prior

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offer case management services, or provide notice to the Provider or Member of possible denial of therapy based on noncompliance.	receive written notification. In addition, Member will be referred to case management. Supporting Documentation: 1.2.8 P-07 Prior Authorization Request Procedures redline	Committee in March 2014. Implementation date: April/May 2014.	authorization procedure to address compliance and non-compliance for specialty drugs and specific non-specialty drugs. To achieve compliance, the MCP must submit: • A revised P&P P-07 that has been approved and signed. • An example of a non-compliant written notification to the member and provider demonstrating operational use. **Update 6/20/14:** The MCP submitted "See 1.2.6 Memo – 1 2 6 and 1 2 8 Prior Authorization Review Requirements and See 1.2.6 Molina CA MD Approval fax draft 4 25 14." In order to close this deficiency, the MCP must submit; a revised P&P P-07 that has been approved and signed. **Update 6/24/14:** The MCP submitted "P-07 Prior Authorization Request Procedures 3-11-2014." **This deficiency is closed.**

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1.3 REFERRAL TRACKING SYSTEM			
Referral Tracking System: Contractor is responsible to ensure that the UM program includes: … An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals (as required by GMC/2-Plan Contract A.5.1.F).			
1.3.1 The Plan did not have an established specialty referral system to track and monitor referrals requiring prior authorization. No process to integrate UM Activities into the Quality Improvement System using reports on the review of number and types of denials, deferrals and modifications was in place.	An authorization report was developed to track and monitor prior authorizations. This report is used to track the types of denials (medical necessity vs. administrative) and types of services denied (PA/Inpatient). This report will be used to identify the requested service beginning with the quarter 4 data and reported quarterly at Quality Improvement Strategic Committee QISC meeting. The data will also be reviewed monthly at the Medical Affairs Leadership Team workgroup. The Plan is also utilizing the newly developed authorization report to track and monitor unused authorizations. The unused authorization report was sent to the providers to notify them of authorizations that were requested and approved for their members, but not used according to claims data. The provider was instructed to contact the UM department for an extension if the requested service is still needed.	Authorization Report was developed on 3/31/13. Data will be reviewed at Medical Affairs Leadership Team workgroup by 3/31/14. 12/31/13 began sending unused authorization report to providers.	The MCP has developed an authorization report to track and monitor prior authorizations. The report will track types of denials and types of services denied. The report will also be utilized to track and monitor unused authorizations. This deficiency remains open. To achieve compliance, the MCP must submit: • Copy of the latest authorization report used to track the type of denials. • Copy of the latest unused authorization report that tracks and monitors unused authorizations. **Update 6/19/14:** The MCP submitted "Denial Report & Unused_AuthReport_month for Oct 2013 to May 2014

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			for total of 8 months." **This deficiency is closed.**
1.3.2 Reviews of grievances, appeals, inquiries and a statement from a participating PCP in a delegated group disclosed that referrals were lost, delayed or otherwise unaccounted for.	Healthcare Services will collaborate with Grievances and Appeals department to request the number of complaints and/or grievances in the past 12 months for any lost prior authorization referral resulting in a delayed service. An educational document will be created to teach prior authorization staff on searching the Utilization Management (UM) documentation systems to better search for prior authorization referrals that were sent in.	Will collaborate with Grievance and Appeals Department by 3/31/14. Educational document will be created for prior authorization staff by 4/15/14.	To address lost or delayed grievances and appeals, the MCP is creating a document to educate staff on searching UM systems for prior authorization referrals submitted to the MCP. To achieve compliance, the MCP must submit: • Copy of the education document created for prior authorization staff. • Evidence that oversight of delegated entities is being conducted on tracking referrals. **Update 6/18/14:** The MCP submitted a copy of the quick reference guide for Prior Authorization staff which contains instructions for searching the Plan's UM system for prior authorizations. This submission satisfies the

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			DHCS requirement for the education document. To close this deficiency the Plan must submit evidence that oversight of delegated entities is being conducted on tracking referrals. **Update 6/19/14:** The MCP submitted "April 2014 Unused Authorizations (Multicultural), Draft Molina Delegate Open Auth Log 2014, and Memo - 1 3 2 Oversight of Delegated Entities." **This deficiency is closed.**
1.4 PRIOR AUTHORIZATION APPEAL PROCESS			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
Appeal Procedures: There shall be a well-publicized appeals procedure for both providers and Members (as required by GMC Contract A.5.2.E). There shall be a well-publicized appeals procedure for both providers and patients (as required by 2-Plan Contract A.5.2.E).			
1.4.1 The Plan's Prior Authorization appeal process has significant and material deficiencies. The Plan stated that board certified specialists review appeals, but provided no evidence that this review occurs. There is no evidence that appeals are reviewed by licensed physicians, or that determinations are made by individuals not involved in the initial denial. No record is kept of attempts to obtain relevant medical records. Lost requests are not addressed. Denials that do not adhere to the Plan's own UM guidelines are upheld. The Plan did not document the identity or review findings of the board certified specialist that it quoted as upholding the denials in the Member notification letters. The Plan did not document its attempts to obtain medical records, and subsequently upheld denials because of records not received. The Plan did not document reasons related to missing authorizations/denials from delegated entities. The Plan's tracking of appeals contained errors in resolution date and disposition.	Per Health Plan policy Utilization Management UM 67, "The MHC Medical Director's designee, a board certified specialist of the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment that was denied and who was not involved in the original adverse decision and who is not a subordinate of the reviewer who made the original adverse decision reviews each member appeal of a Utilization Management (UM) decision and determines whether to uphold or overturn the initial denial or modification decision." The identity of the Physician reviewer is located in the member appeal file or in QNXT (electronic medical management system). The Physician reviewer employed by Molina has a unique identifier in the system. The Manager of Appeals process will conduct an audit for the month of January. All January appeals should be closed and ready for audit. The Physician reviewer's name will be quoted, as upholding the denials, in the Member notification letter. This practice will be referenced in the next revision of policy UM-67. The appeals Nurse searches the QNXT system for medical information obtained at the time of the original denial to support the appeals review. This expectation has been documented in the Appeals Work Flow and will be noted in the next revision of policy UM 67. The appeals Nurse will document attempts to obtain additional or new relevant medical records that may support the decision making process beyond the records already in the QNXT system. These attempts will be documented in the appeals nurse notes in the call tracking system in QNXT. This will be captured in a revision of the Appeals Work Flow. This expectation has been documented in the Appeals Work Flow and will be noted in the next revision of UM- 67. Tracking of lost record retrieval will be documented in the updated tracking log. Molina Health Plan has a contract with an outside vendor, Advanced Medical Reviews (AMR), which performs independent medical review using board certified Physicians. AMR will be used in situations where the plan is experiencing a high volume of appeals or the medical necessity decision is outside the specialty scope of experience of Molina Medical Directors. A "Member Appeal Work Flow" has been created as a training tool for all staff involved in the Appeals Process and is an attachment to policy UM 67. Please see supporting documentation.	UM 67, UM 41 and workflow were reviewed and approved by the UM Committee on February 19, 2014. All deficiencies listed will be completed by 3/1/2014 with the exception of the following; The IRR audit will be completed by March 31, 2014.	The MCP submitted revised P&Ps UM-41 and UM-67. Both were signed. However, the MCP makes several references to the next revision of policy UM-67. This deficiency remains open. To achieve compliance the MCP must submit: • A copy of the revised policy UM-67, or clarification the final policy has already been submitted. • A copy of the IRR Audit completed 3/31/14. DHCS acknowledges the MCP submission for this audit finding. This finding was identified in the DMHC non-routine survey completed on June 4, 2014. Ongoing monitoring and corrective action for this finding will be achieved through the DMHC CAP. **Update 6/18/14:**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	Molina's Chief Medical Officer (CMO) has reviewed policy UM 67 and UM 41 Expedited Appeals Process with the Medical Director staff individually. A new Manager was hired to oversee the Healthcare Services HCS business unit staff responsible for processing appeals, including medical necessity review. The Manager's responsibilities include improving the appeals process. The Manager has made two key improvements in the management of appeals. The first is the creation of an appeals checklist that lists all steps that must be completed to result in an appeal that meets regulatory requirements. The manager conducts 100% audit on appeals files using the checklist as a guide. The second improvement was the creation of an electronic appeals log to document the progression, aging and location of all open appeals in various stages of work-up and determination. The log is the key to maintaining compliance with regulatory standards for DHCS, DMHC and National Committee Quality Assurance NCQA. The Manager reviews the log several times a day to look for barriers to the process and location of the appeals file. The log and checklist are in use now. UM 67 will be revised further to include a procedure for use of the checklist and the log. The goal for policy revision is February 28, 2014 followed by UM Committee approval. The Manager will be responsible for training all appeals staff on the changes to the policies and workflows within one week of UM Committee approval. Responsible party: John Robertson III. Currently, two staff members have been trained to process appeals in the HCS unit. They are responsible for preparing the appeals case for review by the Medical Director and ensuring timely processing of the appeal in accordance with regulations regarding timeliness of appeal decision making. Three additional employees were hired and are currently in training. The Manager responsible for oversight of appeals processing is also responsible for reporting the status of timeliness of appeals processing, any actual or potential barriers to meeting timeliness standards, or delays in Medical Director review of appeals cases to the VP of Healthcare Services weekly. The appeals inventory and TAT for each file in process is reported. The Medical Directors are responsible for documentation of the rationale for the appeals determination decision. The Medical Director's decision is documented electronically in the QNXT (electronic medical management system) notes. The Medical Director handwrites in the appeal. The Medical Director's documentation in QNXT is used to formulate the Member resolution letter. The signature in the resolution letter is signed by the appeals nurse. Please see sample letter in the supporting documentation. This process will be added to the next revision of UM 67. With respect to the documentation of first level appeals for delegated providers, paper records are received from the delegated Providers. The HCS appeals staff manually extracts documents from the records for Medical Director review. The Medical Director hand writes the appeal determination in the appeal note section of the appeals file. All of the supporting documentation supporting the decision is kept in the appeals file as well.		The MCP submitted "the 2014 IRR Analysis, dated 3/31/14, approved 4/16/14." The Plan also submitted a copy of approved, signed P&P UM 67, dated 4/16/14, a revision of the P&P previously approved 2/19/14. **Update 12/23/14:** This deficiency is being deferred to DMHC in their non-routine survey. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	The Medical Director conducting the appeal review will evaluate whether the initial denial met the criteria for denial by reviewing the criteria/guidelines and the initial Medical Director's notes justifying the denial. Molina has developed an Inter-Rater-Reliability (IRR) audit process to assure quality and consistency in the application of criteria. The IRR audit will be used to evaluate Medical Director accuracy in application of guidelines used to make medical necessity decisions. Molina will perform this audit at least once per year to evaluate the consistency with which health care professionals involved in UM apply criteria in decision making. Molina will use the results to improve consistency. All UM staff participating in medical necessity determinations will be involved in the IRR Audit. Medical Directors conducting appeals reviews will report cases that did not meet the criteria at the time of the first denial to the CMO. At least quarterly, the CMO will review any reported cases that did not meet the guidelines and will conduct performance coaching with Medical Directors regarding use of guidelines as needed. If the denial determination was made by a network Provider the CMO will contact the provider to review the correct application of the guideline. The CMO will collect the information and review to identify trends, determine need for network provider education on guidelines and process gaps. The Compliance Department is conducting quarterly focused audits on appeals for oversight purposes. Supporting Documentation: 1.4.1 Appeal File Checklist 1-10-14 1.4.1 Member Appeal Workflow- 1st Level, 2nd Level, and Expedited 1.4.1 P & P UM 67 1.4.1 P & P UM 41 1.4.1 2014 Appeals- Member Log (sample) 1.4.1 Inter-Reliability (IRR) Training 1.4.1 MD Medicaid Audit Tool		
1.4.3 Although the Plan stated that it does not enforce any time limit on materials submitted by members in support of an appeal, the Plan's Policy *PO-20 Member Appeals Process* improperly limits the time in which a Member can submit evidence to 5 days from receipt of acknowledgement of the appeal.	Member appeals process policy Provider Operations PO 20 has been modified to 15 calendar days for submission of additional evidence, per DHCS' recommendation. Supporting Documentation: 1.4.3 PO 20 Member Appeal Process Redline	2/20/2014	The MCP submitted revised P&P PO 20 Member Appeals Process that allows members 15 days to submit evidence from the acknowledgement letter in support of their appeal. This deficiency remains

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
The requirements for the Prior Authorization Appeal Process were not met due to the 5 day limit for Members to submit evidence, failure to document identity or review findings of specialist upholding denials, and upholding denials not adhering to criteria.			open. To achieve compliance, the MCP must submit: • An approved, signed copy of P&P PO 20. **Update 6/18/14:** The MCP submitted an approved, signed copy of PO 20, dated 4/18/14. **This deficiency is closed.**
1.5 DELEGATION OF UTILIZATION MANAGEMENT			
Delegated Utilization Management (UM) Activities: Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities (as required by GMC/2-Plan Contract A.5.5).			
1.5.1 Prior Authorizations processed by Advanced Imaging were not included in the universe of Prior Authorizations performed by the Plan. Advanced Imaging's Notice of Action letters and utilization criteria were not available, nor were their personnel present for the interview of the Plan's UM Department. Advanced Imaging is a wholly owned subsidiary of the Plan's parent corporation and under the parent organization's control. It was not a subcontractor subject to contract provisions related to the delegation of UM activities. The Plan is wholly accountable for UM activities performed by other units of the same corporate entity.	The Plan has conflicting requirements from competing state agencies. DMHC (The Plans Licensing entity) identifies the responsibilities performed by Advanced Imaging as delegated, regardless of whether Advanced Imaging is part of the Corporate Parent. The Plan has significant restrictions and oversight responsibilities because of that requirement. DHCS states that because Advanced Imaging is part of the same Corporate Entity, it is not considered a delegated entity. The Plan will attempt to satisfy requirements from both agencies.		No actual deficiency was identified since no review was conducted of Advanced Imaging. **This deficiency is closed**.

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
The requirements for the Delegation of Utilization Management were not applicable for Advanced Imaging, as it is a wholly owned subsidiary not a subcontractor subject to delegation provisions.			
2.1 CASE MANAGEMENT AND COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN			
Case Management and Coordination of Services: Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member. Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network (as required by GMC/2-Plan Contract A.11.1). **Out-of-Plan Case Management and Coordination of Services:** Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs to ensure coordinated service delivery and efficient and effective joint case management for services (as required by GMC/2-Plan Contract A.11.5).			
2.1.1 The Plan's Case Management Policies *CM-02* and *CM-04* do not define Basic and Complex Case Management as they are defined by the Contract. The Plan submitted a "List of Members Receiving Basic Case Management and Complex Case Management" and it did not identify all Members as eligible for Basic Case Management.	Case Management policies CM-02 and CM-04 have been combined into a single policy. Basic and Complex Case Management are defined per the contract and additional revisions have been made to better describe how the Plan delivers these services. The policy was submitted to the Plan's Utilization Management (UM) Committee and was approved on 2/19/14. The Plan has designed a new report that will capture all members eligible for Basic Case Management. The new report specifications have been reviewed with the Information Technology (IT) liaison and have been submitted for development. Over the next several weeks, the report will be built and tested for the quality and accuracy of the output. We anticipate completion by 4/1/14. The Plan will update numerous provider communication tools to better explain the scope and responsibilities of Comprehensive Medical Case Management services. (See responses to 2.1.2 for details.) In addition, the Quality Improvement/Compliance team is designing a new Focused Medical Record Review tool and process that will be conducted by the Facility Site Review nurses. The tool will include criteria for: the Initial Health Assessment (IHA) and Initial Health Education Behavioral Assessment (IHEBA); Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs; direct communication between the Provider and Member/family; Member and family education, including healthy lifestyle changes when warranted;	3/1/14 4/1/14 4/1/14	The MCP submitted revised case management policies that have been combined into a single policy/procedure. The newly revised policy now defines basic and complex case management per the contract. To achieve compliance, the MCP must submit: A copy of the new report that captures all members eligible for basic case management. **Update 6/23/14:**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	and, coordination of carved out and linked services, and referral to appropriate community resources and other agencies. Provider offices who upon audit do not meet the requirements will be subject to re-education and will be put on a corrective action plan. Full details of this set of corrective actions can be found in sections 2.1.2, 2.1.3 and 2.4. Supporting Documentation: 2.1.1 Policy and Procedure CM-04 Case Management		The MCP submitted a spreadsheet that captures all members eligible for basic case management. **This deficiency is closed.**
2.1.2 Comprehensive Medical Case Management services means services provided by a PCP in collaboration with the Plan to ensure the coordination of medically necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and continuity of care for Members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs. A medical record review established that the requirement for preventive services and continuity of care was not met.	The Plan will update numerous provider communication tools to better explain the scope and responsibilities of Comprehensive Medical Case Management services. A. The Provider Operations Manual is currently under revision and is scheduled to be posted on the website by the end of March 2014 or sooner. B. Provider Orientation materials are currently under revision and are scheduled to be completed by 2/28/14. C. Provider Newsletter - All revisions related to case management content are complete and were submitted to the newsletter team 2/5/14. A fax will go out to all providers notifying them when the newsletter has been posted on the provider section of the Molina website. The newsletter will be posted to the website by 5/9/14. The Molina Medical Group (MMG) clinics provide a substantial proportion of primary care services for our Members. The MMGs are under new leadership and are significantly changing their approach to caring for the Medi-Cal population, including increased collaboration with the Plan. In the last six months, MMG has added a Director of Case Management and other multi-disciplinary staff within their clinics (such as Pharmacists, Social Workers and behavioral health practitioners) to address the comprehensive needs of the membership. Plan and MMG leadership are meeting regularly to collaborate around the delivery and coordination of member care. In addition, the MMGs in the Sacramento region are piloting a "complexist" program in one clinic (soon to be two) where the most complex, chronically ill members are identified and aggressively co-managed by an interdisciplinary team comprised of both MMG (complex Physician, Nurse Case Manager, Social Worker and the complex Physician's MA) and Plan staff (Medical Director, Case Manager, Pharmacist). This team meets weekly for 90 minutes to discuss treatment planning, referral, follow up and monitoring of member needs and services. Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - Implementation of a Focused Medical Record Review (MRR) Audit and Monitoring Process - Molina will conduct a random Focused Review Audit to monitor all medical record deficiencies identified by the state. The audit criteria will include but not limited to: • documentation • coordination and continuity of care	A. 4/1/14 B. 2/28/14 C. 5/9/2014 Initiated remedial action: • Developed policy 2/10/14 • Developed audit tool 2/14/14 Long Term ongoing monitoring of corrective action includes: • Approval of audit tool 3/24/14 at PRC • Acceptable level process implementation 4/1/14. • The Plan will achieve full compliance through ongoing provider monitoring and will ensure the deficiency is corrected using the 8/30 sampling methodology to measure the impacts of compliance on medical records.	The MCP has acknowledged to updating numerous provider communication tools to explain the scope and responsibilities of comprehensive medical case management. The MCP submitted revised editions of its provider manual, provider orientation materials and the spring edition of its provider newsletter. However, this deficiency remains open. To achieve compliance, the MCP must submit: • Sample of a recently completed focused medical record review audit. **Update 6/18/14:** The MCP submitted "Case Management and Coordination of Care: Within and out of plan and CM-03 CCS Program and Medi-Cal Managed Care Provider Manual and New Provider Orientation and Partners in Care Newsletter –CA and

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	• pediatric preventive care • adult preventive care • OB/CPSP preventive • Initial Health Assessment (IHA) includes history and physical, and Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA) • Subsequent assessment and annual SHA re-administration according to updated SHA policy - The MRR tool is inclusive of meeting the contractual requirements. - The MRR audit will be executed through a random medical record review process stratified by high volume providers based on enrollment of Molina Health Care members. - The audit will be tracked and reported by use of a newly developed electronic Medical Record Review tool that will score weighted elements. Weighted elements will ensure that all critical elements are in compliance. - The audit will review a sample based on the 8/30 National Committee Quality Assurance (NCQA) Sampling Methodology rule. - If a provider office is found to be out of compliance based on the 8/30 review a corrective action plan CAP will be given to the provider office. - The provider/provider office will have 30 business days to submit the CAP to the QI Department. - Upon acceptance of the CAP the provider will be entered back into the random sample pool for further review by the QI Department. - The audit will be conducted by Facility Site Review (FSR) Nurses who are trained and certified by DHCS. - An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported to Professional Review Committee PRC quarterly. - Ongoing provider education is conducted by FSR Nurses during focused reviews, periodic and initial scheduled audits. Supporting Documentation: 2.1.2: QM 50 2.1.2: Focused MRR Tool 2.1.2: 8/30 Methodology NCQA 2.1.2: IHA Timeline Clarification 2.1.2 Provider Newsletter Content		Focused Medical Record Review Report 2014- Pilot 5-30-1 and FMRR Education Kit.“ **This deficiency is closed.**
2.1.3 Basic Case Management includes the Initial Health Assessment (IHA). A Medical Record Review established that in a sample of 25 Members, 21 IHAs were missing, incomplete, or not accomplished within the required time	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - Molina ensures that the Plan’s policy QM 10, Provider Manual and Member Services Handbook consistently state the required timeframes of 120 days for Initial Health Assessment (IHA) completion for all ages. - Implementation of a Focused Medical Record Review (MRR) Audit and Monitoring Process.	Initiated remedial action: • Developed policy 2/10/14 • Developed audit tool 2/14/14 Long Term ongoing monitoring of corrective action includes:	Per amended contract language (1/1/14) the MCP shall ensure for the provision of an Initial Health Assessment (IHA) within 120 calendar days following the

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
frame of 120 days of enrollment for Members age 18 months and older or within 60 days of enrollment for Members who are less than 18 months old. The requirement for IHA completion is based upon the enrollment date. There was no documentation to explain why the IHA was not completed within the required time frame.	- Molina will conduct a random Focused Review Audit to monitor all medical record deficiencies identified by the state. The audit criteria will include but not limited to: • history and physical, • pediatric preventive care • adult preventive care • OB/CPSP preventive • Initial Health Assessment includes history and physical, and Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA) • Subsequent assessment and annual SHA re-administration according to updated SHA policy - The MRR tool is inclusive of meeting the contractual requirements. - The MRR audit will be executed through a random medical record review process stratified by high volume providers based on enrollment of Molina Health Care members. - The audit will be tracked and reported using a newly developed electronic MMR tool that will score weighted elements. Identifying and scoring weighted elements will ensure that all critical elements are in compliance. - The audit will review a sample based on the 8/30 National Committee Quality Assurance (NCQA) Sampling Methodology rule. - If a provider office is found to be out of compliance based on the 8/30 review a corrective action plan CAP will be given to the provider office. - The provider/provider office will have 30 business days to submit the CAP to the QI Department. - Upon acceptance of the CAP the provider will be entered back into the random sample pool for further review by the QI Department. - The audit will be conducted by Facility Site Review FSR Nurses who are trained and certified by DHCS. - An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported to Professional Review Committee (PRC) quarterly. - Ongoing provider education is conducted by Facility Site Review (FSR) Nurses during focused reviews, periodic and initial scheduled audits. Supporting Documentation: 2.1.3: QM 50 2.1.3: Focused MRR Tool 2.1.3: 8/30 Methodology NCQA 2.1.3: IHA Timeline Clarification	• Approval of audit tool 3/24/14 at PRC • Acceptable level process implementation 4/1/14. • The Plan will achieve full compliance through ongoing provider monitoring and will ensure the deficiency is corrected using the 8/30 sampling method to measure the impact of compliance on medical records.	date of enrollment for members under the age of 18 months. **This deficiency is closed.**
2.1.4 Basic Case Management also includes coordination of carved out services such as California Children's Services (CCS). The Plan did not reliably	The Healthcare Services (HCS) Department will develop a system to accurately identify members whose eligibility and participation in California Children's Services (CCS) can be tracked. That system will be described in the revised policy Case Management CMO3--California Children's Services Program. CCS Policy CM03 will identify the steps necessary to accurately identify members who may be eligible for	4/15/2014	To reliably identify CCS members, the MCP is developing a system to accurately identify members

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
identify CCS Members for Basic Case Management. The Director for CCS is responsible for tracking and coordinating care and services for CCS eligible members.	CCS services and the steps in coordinating and tracking the care and services provided to CCS members. Policy CM03 will be revised and then submitted to the Utilization Management UM Committee for review and approval. On a monthly basis, the CCS Manager will contact each County CCS unit to obtain a list of Molina Members who are recently enrolled or recently dis-enrolled from CCS. The lists will be compared to Molina's list of enrolled Members receiving CCS. Any discrepancy in the lists will be analyzed and reconciled. The reconciled list will be used to identify Members for coordination of services. The CCS Manager will request a monthly report of members by CCS diagnoses (ICD9-10) and Date of Birth (CCS age specific) from the Molina Claims, Pharmacy, in-patient and Prior Authorization Departments to capture the universe of Molina Members with potential CCS qualifying conditions. This report will be used to identify additional Members with CS eligible conditions and to coordinate CCS services. The Utilization Management (UM) CCS staff will contact the family to inform them about the CCS program. UM CCS staff will encourage the Member's family to schedule an office visit with the PCP for evaluation and further discussion of the CCS program. The UM CCS Staff will assist the Member in scheduling an appointment or in locating a CCS certified Physician as needed. Coordination of CCS Services will include: notifying the PCP via fax of the member and the potential CCS eligible condition and the need for an evaluation; PCP will discuss the CCS program with the family. If the family agrees to participate, the PCP will evaluate the Member's condition and complete and submit the referral to DHCS-CCs; UM CCS staff will follow up with the PCP to ensure that the referral has been submitted to CCS; UM CCS staff will follow-up with DHCS-CCS on the status of the referral. If CCS approves the referral, UM staff will send an e-mail notification to the PCP and a letter to the Member notifying the family of the approval. If denied, UM staff will investigate the reason for denial and follow-up with the family to assist in coordinating other available services and assistance with an appeal if requested. Staff that process authorizations and UM concurrent review staff will receive refresher training on the types of diagnoses and codes that may indicate CCS eligibility.		who are eligible or participate in CCS. The system will be described in revised P&P CM 03 – California Children's Services Program. This deficiency remains open. To achieve compliance, the MCP must submit: • A copy of revised P&P CM 03, which will identify the steps necessary to accurately identify members who may be eligible for CCS services and the steps in coordinating and tracking their care. **Update 6/18/14:** The MCP submitted P&P CM03, approved, signed, and dated 4/16/2014. The P&P contains detailed steps for accurately identifying members CCS eligibility, tracking, and care coordination. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
2.1.5 The Plan provided three Complex Case Management care plans for review and each lacked evidence of individualized care planning and participation from the Member or PCP. The Contract requires that the Plan ensure Complex Case Management is provided by a multidisciplinary team but the care plans reviewed did not evidence an interdisciplinary plan. The Plan's Policy *CM-04* outlines the structure of a care plan that includes assessment, goals, interventions, and outcomes. Without disciplines assigned to interventions or goals and interventions assigned to a problem, verification that the Plan uses care planning to coordinate services was not possible.	Care plans authored by Molina staff are documented in the Plan's case management software platform called Clinical Care Advance (CCA). Over the last several months, the design and functionality of the care plans in CCA have undergone significant enhancement and when fully implemented will address the identified deficiencies. The care plan enhancements allow for a more individualized, Member-centric care plan developed by the Case Manager, the Member and the Interdisciplinary Care Team. The care plan is specific to the member and is customizable to account for the Member's preference, readiness to engage and his/her agreement. This customization also makes it easier to document within the care plan itself which disciplines are involved and new sections call out the Member's participation in carved out or linked services. There is also a specific area where the Member involvement and consent is documented. The enhanced version is available in CCA today and will be fully implemented once staff are trained and begin using the new version. Staff will receive training on the use of the new care plan and the features described above in March of 2013. In addition, the training will emphasize the need to document the specifics of the interdisciplinary aspects of the care plan and the need to have goals and interventions that address both the assessed needs and the identified barriers. If the Member's assessed needs require case management at a higher or lower level than the staff assigned can provide or the Member's needs require assignment to a staff person with particular subject matter expertise, the staff will discuss the findings with his/her Supervisor so that the Member can be assigned accordingly. For example, if a Member is assessed by a Case Manager who is an RN with expertise in clinically complex conditions and the Member's needs are assessed to be primarily related to a Behavioral Health condition, the Supervisor would reassign the case to a Case Manager of an appropriate discipline with experience in behavioral health. Similarly, should a Case Manager with a Master's in Social Work assess a Member with severe heart disease who is a candidate for transplant, the Supervisor would identify a Case Manager with the appropriate discipline and experience. This practice is also described in the policy Case Management CM-04, which was revised and was approved by the Utilization Management Committee on 2/19/14. Supporting Documentation: 2.1.5 Policy and Procedure CM-04 Case Management 2.1.5 Sample Care Plan	4/1/2014	Per the MCP, care plans have undergone significant enhancement that will allow for more individualized, member centric care and better allows member participation. The program will be implemented once the staff has been fully trained, which occurred in March. Also, P&P CM-04 Case Management has been revised and approved to identify a case manager with the appropriate discipline and experience. This deficiency is provisionally approved pending receipt of an actual care plan depicting evidence of interdisciplinary plan. **Update 6/20/14:** The MCP submitted "Individualized Care Plan Report _1 and Individualized Care Plan Report _2." **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
2.1.6 Providers were interviewed and several reported they were unfamiliar with the Plan's Complex Case Management program. Some Providers explained that if Complex Case Management services were necessary they would be accomplished within their own practices or assistance would be sought from the Independent Practice Association. The Plan did not meet the requirement for Coordination of Care because it did not accurately track members, identify eligibility for case management, and/or consistently coordinate care.	The Plan will update numerous Provider communication tools to better explain the scope and responsibilities of Comprehensive Medical Case Management services. A. Provider Operations Manual - currently under revision and scheduled to post on the website by the end of March 2014 or sooner. B. Provider Orientation materials - currently under revision and scheduled for completion by 2/28/14 C. Provider Newsletter - all revisions related to case management content are complete and were submitted to the newsletter team 2/5/14. A fax will go out to all providers notifying them when the newsletter has been posted on the provider section of the Molina website. The newsletter will post by 5/9/14. The Molina Medical Group (MMG) clinics provide a substantial proportion of primary care services for our Members. The MMGs are under new leadership and are significantly changing their approach to caring for the Medi-Cal population, including increased collaboration with the Plan. In the last six months, MMG has added a Director of Case Management and other multi-disciplinary staff within their clinics (such as Pharmacists, Social Workers and Behavioral Health practitioners) to address the comprehensive needs of the membership. Plan and MMG leadership are meeting regularly to collaborate around the delivery and coordination of Member care. In addition, the MMGs in the Sacramento region are piloting a "complexist" program in one clinic (soon to be two) where the most complex, chronically ill Members are identified and aggressively co-managed by an interdisciplinary team comprised of both MMG (complex Physician, Nurse Case Manager, Social Worker and the complex Physician's MA) and Plan staff (Medical Director, Case Manager, Pharmacist). This team meets weekly for 90 minutes to discuss treatment planning, referral, follow up and monitoring of Member needs and services. In addition, as described in 2.1.1, the Facility Site Review team will be conducting focused audits of medical records to assess, and if needed, remediate Provider compliance with these requirements. Supporting Documentation: 2.1.6 Provider Newsletter Content	A. 4/1/14 B. 2/28/14 C. 5/9/2014	The MCP has updated numerous provider communication tools to address scope and responsibilities of comprehensive case management with provider network. The MCP submitted revised provider operations manual, orientation materials, and newsletter. **This deficiency is closed.**
2.2 CALIFORNIA CHILDREN'S SERVICES (CCS)			
California Children's Services (CCS): Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program (as required by Contract). Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program…for the coordination of CCS services to Members (as required by GMC/2-Plan Contract A.11.9.A, B).			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
2.2.1 The Plan is responsible for identifying Members who would benefit from or who receive services from CCS. The Director of CCS is responsible for tracking and coordinating care and services for CCS eligible members.	See 2.1.4		To reliably identify CCS members, the MCP is developing a system to accurately identify members who are eligible or participate in CCS. The system will be described in revised P&P CM 03 – California Children's Services Program. To achieve compliance, the MCP must submit: • A copy of revised P&P CM 03, which will identify the steps necessary to accurately identify members who may be eligible for CCS services and the steps in coordinating and tracking their care. **Update 6/24/14:** The MCP submitted "CM-03 CCS Program and 2.2.1 Memo – California Children's Services." **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
2.2.2 Eight CCS members were selected for medical record review. Evidence that each of the 8 CCS Members received all necessary screening and preventive medical services from PCPs was not found in the records. The IHAs for CCS Members were found to be incomplete and missing essential elements of screening and preventive services such as nutritional, dental, psychosocial, and developmental assessments.	**Update 7/31/14** To ensure that CCS members' medical record files are complete and include essential elements of screening and preventative services, the Molina Quality Improvement Department will conduct random Focused Medical Record Review (FMRR) Audits. The audit criteria will include but not limited to: • Documentation, • Coordination and continuity of care, • Pediatric preventive care, • Initial Health Assessment includes history and physical, nutritional, dental, psychosocial, and developmental assessments. • Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA), • Subsequent assessment and annual SHA re-administration according to updated SHA policy The Quality Improvement Department will receive the monthly CCS file to identify CCS members and their assigned PCPs. The audits will be executed through a random medical record review process stratified by high volume providers based on enrollment of Molina Health Care members, including CCS members. The FMRR tool is inclusive of meeting the CCS contractual requirements. Audits will be tracked and reported by use of an electronic MRR tool that will score weighted elements based on DHCS Medical Record Review Guidelines and scoring requirements. Weighted elements will ensure that all critical elements are in compliance. The audit will review a sample based on the 8/30 rule. If a provider office is found to be out of compliance based on the 8/30 review a corrective action plan (CAP) will be given to the provider office. The Provider/Provider office will have 30 business days to submit the CAP to the QI Department. Upon acceptance of the CAP the provider will be entered back into the random sample pool for further review by the QI Department. Ongoing provider education is conducted by FSR review nurses during Focused reviews, Periodic and Initial scheduled audits.		To achieve compliance, the MCP must submit: • Supporting documentation demonstrating medical record files are complete and include essential elements of screening and preventative services. **Update 6/25/14:** The MCP submitted "2.2.2 CCS Chart Review Memo." **Update 7/17/14:** Per last week's conference call, the MCP will submit a final response by 7/25/14. **Update 7/31/14** : The MCP submitted "2.2.2 response **Update 8/4/14** **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
2.2.3 Medical records for 6 non-CCS enrolled Members were reviewed. Baseline health assessments and diagnostic evaluations were not found to be sufficiently comprehensive and complete for identification of children with special health care needs who may require services through the CCS program.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - Implementation of a Focused Medical Record Review (MRR) Audit and Monitoring Process. - Molina will conduct a random Focused Review Audit to monitor all medical record deficiencies identified by the state. The audit criteria will include but not limited to: • Documentation, • Coordination and continuity of care, • Pediatric preventive care, • Adult preventive care, • OB/CPSP preventive, • Initial Health Assessment includes history and physical, and Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA), • Subsequent assessment and annual SHA re-administration according to updated SHA policy, • Access and appointment availability. - The MRR tool is inclusive of meeting the contractual requirements. - MRR documentation criteria include baseline health assessment and sufficient diagnostic evaluations in identifying members with special health care needs. - California Children's Services (CCS) eligible conditions will be available for Facility Site Review (FSR) as reference guide. An FSR Nurse will verify with provider when a potential CCS condition is identified during medical record review. - The MRR audit will be executed through a random medical record review process stratified by high volume providers based on enrollment of Molina Health Care members. - The audit will be tracked and reported by use of a newly developed electronic MRR tool that will score weighted elements based on DHCS Medical Record Review Guidelines and scoring requirements. - Weighted elements will ensure that all critical elements are in compliance. - The audit will review a sample based on the 8/30 rule. - A sample size of 30 is a valid sample size when trying to determine if the null hypothesis can or cannot be rejected. In this case, we are looking to determine if the physician is or is not in compliance. The null hypothesis is that they ARE in compliance. A sample size of 30 is sufficient to prove or disprove this hypothesis. When testing the null hypothesis, a sample of 8 is a valid sample size when the 8 pieces of sample are randomly selected and are the initial 8 surveys completed. The results for those 8 must be identical either proving or disproving the null hypothesis. - A sample size of 30 is valid using the appropriate formula and the critical value of K is 1.36/Ö30=.248. Because the calculated value of K is smaller than the critical value, the null hypothesis cannot be rejected. Alternatively, the probability of observing a K value of .222, as determined by the normalized z statistics, is .103. Because this is more than the significance level of .05, the null hypothesis cannot be rejected, leading to the same conclusion. (Source: Malhotra, Naresh K and David F. Birks, Third European Edition Marketing Research an Applied Approach. Pearson Education Company. Prentice Hall Inc. 2007.)	Initiated remedial action: • Developed policy 2/10/14 • Developed audit tool 2/14/14 Long Term ongoing monitoring of corrective action includes: • Approval of audit tool 3/24/14 at PRC • Acceptable level process implementation 4/1/14. • Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency utilizing the 8/30 sampling methodology impacts compliance of medical records.	The MCP will conduct random focused review audits to include baseline health assessments and sufficient diagnostic evaluations for identifying members with special health care needs. Full compliance will be achieved by ongoing provider monitoring. This deficiency is provisionally approved pending receipt of a focused review audit report. The MCP must provide the April 2014 focused review audit report. **Update 6/18/14:** The MCP submitted "FMRR PCP Report Card sample." **Update 6/24/14:** The MCP submitted "Focused Medical Record Review Report 2014 – Pilot 5-30-14, Focused Medical Record Review Report June 2014, and Memo Focused Medical Record Review Reporting _SA." **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	- NCQA provides the following explanation for the sampling methodology in its May 1, 2001 memo titled “Explanation of ‘8 and 30’ File Sampling Procedure” http://www.ncqa.org/tabid/125/Default.aspx - “The statistical test underlying the [“8/30”] classification decision is based on the binomial distribution, the characteristics of which are very well known. This fact allows the classification decision to be based on a very small sample of 30 files, regardless of the size of the population of eligible records. The use of the binomial distribution is possible because the decision based on the 8 and 30 file sampling methodology is BINARY. That is, the decision based on the file review falls into one of two possible categories ("in compliance"/"out of compliance").”As such, there is no statistical difference between an outcome using the 8/30 sample methodology vs. a 50 sample size. - If a provider office is found to be out of compliance based on the 8/30 review a corrective action plan (CAP) will be given to the provider office. - The Provider/Provider office will have 30 business days to submit the CAP to the QI Department. - Upon acceptance of the CAP the provider will be entered back into the random sample pool for further review by the QI Department. - The audit will be conducted by FSR Nurses who are trained and certified by DHCS. - MRR tool is inclusive of the elements to address the issue of missing/incomplete IHA as identified in according to our contractual agreement. - An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported quarterly to Professional Review Committee (PRC) quarterly. - Ongoing provider education is conducted by FSR review nurses during Focused reviews, Periodic and Initial scheduled audits. Supporting Documentation 2.2.3 QM 50 2.2.3 Focused MRR Tool 2.2.3 8/30 Methodology NCQA		

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
2.2.4 The Plan did not meet the requirement for CCS because it did not demonstrate that it accurately tracked member eligibility and did not demonstrate that it ensured all necessary screening and preventive services were provided.	The Healthcare Services (HCS) Department will monitor Members receiving California Children's Services (CCS) services to ensure coordination of care between the Plan, PCP, CCS and the Member. On a monthly basis, the CCS Manager will contact each County CCS unit to obtain a list of Molina Members who are recently enrolled or recently dis-enrolled from CCS. The lists will be compared to Molina's list of enrolled Members receiving CCS. Any discrepancy in the lists will be analyzed and reconciled. The reconciled list will be used to identify Members for coordination of services. The CCS Manager will request a monthly report of members by CCS diagnoses (ICD9-10) and Date of Birth (CCS age specific) from the Molina Claims, Pharmacy, in-patient and Prior Authorization Departments to capture the universe of Molina Members with potential CCS qualifying conditions. This report will be used to identify additional Members with CCS eligible conditions and to coordinate CCS services. The following steps will be added to the revision of the CCS policy Case Management CM03. All Members identified as potentially or actually eligible for CCS services will be assigned to a Utilization Management (UM) staff person for care coordination or case management services, including coordination with DHCS-CCS program and the PCP. The assigned UM staff member will monitor the Member's participation in CCS for the duration of the Member's enrollment with Molina or until the Member is no longer eligible for CCS Services. The UM staff assigned will assess the Member at least every 6 months to determine if the Member needs any assistance with coordination of CCS services, other Molina benefits or case management services not provided by CCS. The Molina electronic record will contain documentation of all outreach and CCS coordination activity. The CCS Manager will be responsible for assigning all existing members currently receiving CCS Members to a UM CCS staff for assessment of CCS status and need for coordination of services. When an authorization for a covered CCS service is denied because the Member is already receiving CCS services, Molina UM CCS staff will contact the provider. The provider will be requested to submit the CCS service request form directly to CCS with a copy to Molina. The case will then be assigned to a UM CCS staff Member for ongoing coordination of care services between the Member, DHCS-CCS, and the CCS Provider. Supporting Documentation: 2.2.4 Focused MRR Tool 2.2.4 NCQA 8-30 Sampling Methodology 2.2.4 QM 50	4/15/2014	The MCP will produce a monitoring report that identifies CCS eligible conditions and to ensure coordination of care between the Plan, PCP, CCS and the Member. The report will be used to identify additional members with CCS eligible conditions and coordinate services. MCP is submitting revised CCS P&P CM-03 under previous finding. This deficiency is provisionally approved pending the MCP's submission of the above documentation. **Update: 6/19/14:** The MCP submitted a copy of the monitoring report used to identify CCS eligible conditions. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
2.3 EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES			
Services for Persons with Developmental Disabilities: Contractor shall develop and implement procedures for the identification of Members with developmental disabilities. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers…for the coordination of services for Members with developmental disabilities (as required by GMC/2-Plan Contract A.11.10.A, E). Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services with Regional Center staff, which includes identification of all appropriate services, which need to be provided to the Member (as required by GMC Contract A.11.10.C). Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member (as required by 2-Plan Contract A.11.10.C). **Early Intervention Services:** Contractor shall develop and implement systems to identify children under 3 years of age who may be eligible to receive services from the Early Start program and refer them to the local Early Start program….Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation (as required by GMC Contract A.11.11). Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program….Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation (as required by 2-Plan Contract A.11.11).			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
2.3.1 According to the Contract, the Plan shall develop and implement procedures for the identification and referral of Members with developmental disabilities.	The Manager of the Molina California Children's Services (CCS) Department will revise the Molina policy and procedure for Early Intervention Services and Developmental Disabilities Program. The revised policy will be reviewed and approved by the Utilization Management (UM) Committee.	4/15/2014	This deficiency remains open. To achieve compliance, the MCP must submit: • A revised, approved P&P relating to Early Intervention Services and Developmental Disabilities Program **Update 6/18/14:** The MCP submitted revised P&P UM-63, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services. The P&P is signed, dated 4/16/14. **This deficiency is closed.**
2.3.2 A review of non-EI/DD Members' records showed the Plan was unable to identify and refer Members who are at risk or suspected of having a developmental delay.	The California Children's Services (CCS) Manager will request a monthly report of Members by IE/DD diagnosis (ICD9-10) and Date of Birth (CCS age specific) from the Molina claims, Pharmacy, in-patient and Prior Authorization Departments to create a list of Members with potential Regional Center qualifying conditions.	4/15/2014	To identify and refer members who are at risk or suspected of having a developmental delay, the MCP will run monthly report of members by IE/DD diagnosis codes and date of birth, which will be used to create a list of members with qualifying conditions. This deficiency is provisionally approved. The MCP must provide a copy of the most recent monthly report demonstrating this process has been operationalized.

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Update 6/20/14: The MCP submitted "Regional Center Report May 2014." **This deficiency is closed.**
2.3.3 It was verified in medical record reviews that the Plan did not maintain current rosters for Members receiving services from the Regional Center. Without accurate identification of Members requiring services from the Regional Center, the Plan was unable to demonstrate that it effectively coordinated care for Members receiving EI/ DD services and Services for Persons with Developmental Disabilities.	Currently, Healthcare Services (HCS) receives the County Regional Center's list of Molina Members who are enrolled in or recently dis-enrolled from the Regional Center on a monthly basis. The list is compared to Molina's list of enrolled Members receiving Regional Center Services. Any discrepancy in the list will be analyzed and reconciled. The Utilization Management (UM) Manager will identify a staff person to serve as a liaison for each Regional Center in each of the counties served by Molina. Each Regional Center liaison will be expected to develop regular communication with the assigned Regional Center for the purposes of improved coordination of services. The list of Members compiled by data mining will be used to identify members with DD-eligible conditions and to coordinate Regional Center Services. The UM staff will contact the family to determine whether the Member is currently receiving Regional Center Services. If the Member is not receiving services the HCS Staff person will determine why they are not receiving services and inform them about the Regional Center Services if appropriate. UM staff works to coordinate Regional Center Services initially by encouraging the Member's family to schedule a PCP visit for evaluation and further discussion of DD Regional Center Services. The UM staff will assist the Member in scheduling an appointment or in locating a Physician knowledgeable about IE/DD services as needed. UM staff will notify Member's PCP via fax of Member potential IE/DD Regional Center eligible conditions and follow-up to schedule an office visit as needed. PCP will discuss the IE/DD program with family. If the family agrees to participate, the PCP will complete and submit the referral to the Regional Center. The UM staff will follow up with the PCP to ensure the referral has been submitted to the Regional Center. UM staff will follow up with the Regional Center on the status of the referral. If the Regional Center approves the referral, UM staff will send an email notification to the PCP and send a letter to the Member notifying the family of the approval. If denied, UM staff will investigate the reason for denial and follow-up with the family to assist in coordinating other available services and assistance with an appeal if requested. Staff that process authorizations, UM concurrent review staff and case management staff will receive training on the revised IE/DD policy and training on the types of diagnoses and codes that may indicate Regional Center eligibility.	4/15/2014	The MCP receives the County Regional Center's list of plan members who are enrolled in or recently disenrolled from the Regional Center on a monthly basis. The MCP will compare this list with the MCP's list of enrolled members and review for discrepancies to be reconciled. The list of members will be used to coordinate Regional Center Services. **This deficiency is closed.**
2.4 INITIAL HEALTH ASSESSMENT			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
Provision of Initial Health Assessment: Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR 53910.5(a)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below (as required by GMC Contract A.10.3.A). Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below (as required by 2-Plan Contract A.10.3.A). <u>Provision of IHA for Members under Age 21</u> For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger, whichever is less. For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment. GMC/2-Plan Contract A.10.5 <u>IHAs for Adults, Age 21 and older</u> Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment. Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes… (as required by Contract) GMC Contract A.10.6 Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment. Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes (as required by 2-Plan Contract A.10.6). Contractor shall repeated attempts, if necessary, to contact a Member and schedule an IHA. Contractor shall make at least three documented attempts. Contact methods must include at least one telephone and one mail notification (as required by GMC Contract A.10.3.E). Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement (as required by 2-Plan Contract A.10.3.D).			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
2.4.1 The Plan did not ensure that IHAs were completed for new Members per regulatory and contractual requirements as evidenced by medical record reviews. The Plan's Policy *# QM 10, Initial Health Assessment*, *Provider Manual*, and *Member Services Guide* inconsistently state required timeframes for IHA completion. According to an interview with the Plan's Case Management staff, the Plan uses a timeframe of 120 days from the date of Member's enrollment for all age groups. The contract requires IHA completion within 60 days of enrollment for Members under 18 months of age, and 120 days for Members 18 months of age and older.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - Molina ensures that the Plan's policy QM 10, Provider Manual and Member Services Handbook consistently state the required timeframes of 120 days for Initial Health Assessment IHA completion for all ages. - Implementation of a Focused Medical Record Review (MRR) Audit and Monitoring Process. - Molina will conduct a random Focused Review Audit to monitor all medical record deficiencies identified by the state. The audit criteria will include but not limited to: • history and physical, • pediatric preventive care • adult preventive care • OB/CPSP preventive • Initial Health Assessment includes history and physical, and Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA) • Subsequent assessment and annual SHA re-administration according to updated SHA policy - The MRR tool is inclusive of meeting the contractual requirements. - The MRR audit will be executed through a random medical record review process stratified by high volume providers based on enrollment of Molina Health Care members. - The audit will be tracked and reported by use of a newly developed electronic Medical Record Review tool that will score weighted elements. Weighted elements will ensure that all critical elements are in compliance. - The audit will review a sample based on the 8/30 National Committee Quality Assurance (NCQA) Sampling Methodology rule. - A sample size of 30 is a valid sample size when trying to determine if the null hypothesis can or cannot be rejected. In this case, we are looking to determine if the Physician is or is not in compliance. The null hypothesis is that they ARE in compliance. A sample size of 30 is sufficient to prove or disprove this hypothesis. When testing the null hypothesis, a sample of 8 is a valid sample size when the 8 pieces of sample are randomly selected and are the initial 8 surveys completed. The results for those 8 must be identical either proving or disproving the null hypothesis. - A sample size of 30 is valid using the appropriate formula and the critical value of K is 1.36/Ö30=.248. Because the calculated value of K is smaller than the critical value, the null hypothesis cannot be rejected. Alternatively, the probability of observing a K value of .222, as determined by the normalized z statistics, is .103. Because this is more than the significance level of .05, the null hypothesis cannot be rejected, leading to the same conclusion. (Source: Malhotra, Naresh K and David F. Birks, Third European Edition Marketing Research an Applied Approach. Pearson Education Company. Prentice Hall Inc. 2007.) - NCQA provides the following explanation for the sampling methodology in its May 1, 2001 memo titled "Explanation of '8 and 30' File Sampling Procedure" http://www.ncqa.org/tabid/125/Default.aspx	Initiated remedial action: • Developed policy 2/10/14 • Developed audit tool 2/14/14 Long Term ongoing monitoring of corrective action includes: • Approval of audit tool 3/24/14 at PRC • Acceptable level process implementation 4/1/14. • Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency utilizing the 8/30 sampling methodology impacts compliance of medical records.	To achieve compliance, the MCP must submit: • A revised P&P QM 10 to reflect the contractual requirement of IHA completion within 60 days of enrollment for members under 18 months of age. • The MCP response must include examples of random focused review audits that monitor all medical record deficiencies. • The MCP must provide, if applicable, an example of a provider CAP based upon 8/30 review. **Update 6/19/14:** The MCP submitted a "Focused Medical Record Review Report Card" for a site (site name redacted), an example of a provider CAP based on 8/30 review. The Plan also submitted an excerpt of "DHCS Amended Contract Language" dated 1/1/14. The language for IHA requirements for members under the age of 18 months has been changed from a 60 day timeframe to 120 days. The submission contains the statement that the Plan is waiting for a fully executed

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	- "The statistical test underlying the ["8/30"] classification decision is based on the binomial distribution, the characteristics of which are very well known. This fact allows the classification decision to be based on a very small sample of 30 files, regardless of the size of the population of eligible records. The use of the binomial distribution is possible because the decision based on the 8 and 30 file sampling methodology is BINARY. That is, the decision based on the file review falls into one of two possible categories ("in compliance"/"out of compliance")." As such, there is no statistical difference between an outcome using the 8/30 sample methodology vs. a 50 sample size. - If a Provider office is found to be out of compliance based on the 8/30 review a corrective action plan (CAP) will be given to the Provider office. - The Provider/Provider Office will have 30 business days to submit the CAP to the QI Compliance Team. - Upon acceptance of the CAP the Provider will be entered back into the random sample pool for further review by the QI Department. The audit will be conducted by Facility Site Review (FSR) Nurses who are trained and certified by DHCS. - MRR tool is inclusive of the elements to address the issue of missing/incomplete IHA according to our contractual agreement. - An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported quarterly. - Ongoing Provider education and reinforcement of IHA and SHA completion by Provider Services during quarterly provider on site visit. - Ongoing Provider education is conducted by FSR Nurses during focused reviews, periodic and initial scheduled audits. Supporting Documentation: 2.4.1: Focused MRR Tool 2.4.1: NCQA 8/30 Sampling Methodology 2.4.1: IHA Timeline Clarification		contract. **This deficiency is closed.**
2.4.2 A Medical Record Review established that in a sample of 25 Members, 21 IHAs were missing, incomplete, or not accomplished within the required time frame of 120 days of enrollment for Members age 18 months and older or within 60 days of enrollment for Members who are less than 18 months old. The requirement for IHA completion is based upon the	See 2.4.1 Supporting Documentation: • 2.4.2: Focused MRR Tool • 2.4.2: NCQA 8/30 Sampling Methodology • 2.4.2: IHA Timeline Clarification • 2.4.2: QM 50		To achieve compliance, the MCP must submit: • A revised P&P QM 10 to reflect the contractual requirement of IHA completion within 60 days of enrollment for members under 18 months of age.

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
enrollment date. There was no documentation by the provider to explain why IHAs were not completed within the required timeframe. The requirement for initial health assessment was not met.			**Update 6/19/14:** The MCP submitted an excerpt of "DHCS Amended Contract Language" dated 1/1/14. The language for IHA requirements for members under the age of 18 months has been changed from a 60 day timeframe to 120 days. The submission contains the statement that the Plan is waiting for a fully executed contract. **This deficiency is closed.**
3.1 APPOINTMENT PROCEDURES AND MONITORING WAIT TIMES			
Appointment Procedures: Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments (as required by GMC/2-Plan Contract A.9.3.A). **Prenatal Care:** Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request (as required by GMC/2-Plan Contract A.9.3.B). **Monitoring of Waiting Times:** Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments (as required by GMC/2-Plan Contract A.9.3.C).			
3.1.2 The Plan did not have a valid method of determining compliance with access standards. The Plan's annual appointment access and availability	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include process and policy revisions include: - Revision to policy QM 09 Access to Health Care - Revision to policy QM 01 Potential Quality of Care (PQOC)	Initiated remedial actions, which include: - Implemented CAP to providers who did not meet contractual requirements Q4 2013. CAP full	To achieve compliance, the MCP must submit: • Provider Access & Availability/After Hours

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
survey reliably measures prompted self-reported responses to close-ended questions of provider offices. There is no evidence that the responses from provider offices actually reflect appointment availability. The high compliance rates reported, and the contrast with CAHPS survey and grievance data suggest that the method is invalid.	- Annual Provider Access and Availability Survey - The survey revisions include custom questions that will allow the QI team to accurately assess and validate the availability of appointments and after hours care. - Corrective action and ongoing monitoring of the deficiency will include the use of the annual Provider Access and Availability Survey (conducted by NCQA accredited vendor) results. - Results will be reviewed by QI Staff and presented to all functional health plan areas during the CQIC/QISC and reported to the QI Committee. - The review will analyze and compare the results of the annual Provider Access and Availability Survey with these additional monitors: • Annual CAHPs member survey, • Mid-year Mini-CAHPS results, • New Post-Appointment Survey (member experience with recent appointment), • Access related Grievances, and • Access related PQOC issues as noted in the revision of P&P: QM 01 A and B – PQOC - Ongoing monitoring will be through administering a Corrective Action Plan (CAP) process described in policy and procedure QM-09. This process has been implemented as of Q4 2013. - All providers out of compliance who failed the Access and Availability Survey were faxed detailed information about the elements failed, and information on how to make corrections. - CAPs must be completed and returned to the Plan within 30 business days. Ongoing monitoring will be conducted during Focused Medical Record Review MRR audit and the Quality Improvement Monitoring Audit Process. - Other functional areas are working with QI staff include Provider Services. - Provider Services is assisting in follow-up of providers who received CAPs. Supporting Documentation: 3.1.2: QM-09 3.1.2: QM 01 PQOC 3.1.2: QM 01 PQOC Redline 3.1.2: QM 50 **Update 8/29/14** Molina received noticed from vendor indicating the report will be finalized by Sept 10th 2014 **Update 9/10/14** Please see the 2014 MHC Provider Access Appointment Availability and After Hours Survey Report. The survey methodology was revised for 2014(multiple choice questions vs. yes/no questions) as per the DMHC/DHCS recommendations in the audit report. This means that for many questions, there is no comparison possible with 2013 results. 2014 will be the new baseline for comparison with future years'	implementation as of 12/15/13. - Revised P&Ps 2/10/14. Long Term ongoing monitoring of corrective actions includes: - Draft Provider Access survey tools due from NCQA Accredited vendor 2/19/14 - Approval of P&Ps 2/27/14 at the Quality Improvement Committee Meeting (QIC) - Acceptable level process implementation: • Provider Access & Availability/After Hours Survey administered 3/15--5/15/14. • Final Survey Report to plan 6/15/14. • Final Survey Report analysis and comparison with CAHPs and grievance data completion by 6/30/14. - Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency through analysis and CAP provider monitoring.	Survey administered 3/15-5/15/14. • Final Survey Report Results to the plan 6/15/14. **Update 6/19/14:** The MCP submitted script of r administered 3/15-5/15/14. This submission satisfies one component of DHCS requirements for the Plan to achieve compliance. To close this deficiency please submit the final Survey Report Results to the plan 6/15/14. Plan submitted memo that they have a new timeline to administer survey. Survey report to be sent to plan on 7/15/14. **Update 7/17/14:** Per last week's conference call with the MCP, it was agreed that the MCP would submit the survey results by 7/31/14. **Update 7/24/14:** MCP received notice from vendor about delay in finalization of report – report to be submitted by 8/31/14. **Update 12/23/14:** MCP submitted completed survey from subcontractor.

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	reports.		The 2014 report will serve as a baseline for future reports. **This deficiency is closed.**
3.1.5 The Plan stated that grievance reports validated that no problems exist for appointment access. A review of inquiries and the grievance system disclosed that complaints about access were not routinely logged as grievances.	The deficiency identified was due to lack of correct call coding and identification of grievances. The following Training Materials will ensure proper training of Contact Support Center (CSC) staff. CSC agents were retrained on the Appeals and Grievance (A&G) processes and procedures, which includes appropriate use of Call Types and Call Codes used for categorizing A&G to ensure appropriate tracking and trending of grievances. Supporting Documentation: 3.1.5: CSC Appeals & Grievance Training; Appeals & Grievance Training	Training 100% completed 2/14/14; Ongoing training for new hires.	The MCP has taken steps to correct this deficiency with the creation of the new training materials. This deficiency remains open. To achieve compliance, the MCP must submit: • Grievance logs that show that access grievances are being coded properly. **Update 6/18/14:** The MCP submitted two PowerPoint documents that present a rollup of the number of Access/Availability Grievance Codes. Each document contains a comparison of 2012 and 2013 results for a selected quarter (Q1 & Q4). The documents do not provide evidence of correct coding. To achieve compliance the MCP must submit samples of logs used by Call Center staff that contains a narrative description of the reason for the call, and the coding of the call. Please submit a legend for codes used in the log.

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Update 6/19/14: The MCP submitted Master Log Quarterly Report for 2014 Q1. The logs show that of 609 calls received 106 were coded as Access issues, and a grievance was processed for 73 of the 106. This submission satisfies the requirement for evidence that calls about access is being properly coded. **This deficiency is closed.**
3.1.6 For 5 of the 10, the grievance resolution did not ensure that Members received an appointment according to Plan's access standards from the time that the grievance was filed.	The Appeals and Grievance (A&G) training will be modified and implemented by 3/15/14 to include training to Contact Support Center (CSC) agents and A&G staff regarding appointment access standards. CSC agents were retrained on the A&G processes and procedures, which includes appropriate use of Call Types and Call Codes used for categorizing A&G to ensure appropriate tracking and trending of grievances. Supporting Documentation: 3.1.6: CSC Appeals & Grievance Training; Appeals & Grievance Training	Training 100% completed 2/14/14; Ongoing training for new hires. Re-training regarding access standards will be completed by 3/15/14.	Review of MCP supporting documentation does not address plan access standards. This deficiency remains open. To achieve compliance, the MCP must submit: • Evidence that the MCP is implementing established access standards. **Update 6/18/14:** The MCP submitted a PowerPoint training presentation for Call Center staff. The document contains a table for access standards that apply to various member situations. The training does not provide evidence of the operationalization of the

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			standards. To achieve compliance the Plan must submit evidence that members are receiving an appointment within the standards, after filing a grievance. **Update 6/25/17:** The MCP submitted "3.1.6 CAP Access Standards Report and Memo CSC Appeals and Grievance Training." **This deficiency is closed.**
3.1.7 For Providers who did not meet the access standards, the Plan sent a letter titled "Access Corrective Action Plan," that identified the access standard the Provider did not meet and the improvement needed to comply with the standard. The Providers were asked to review, sign, and date a verification to acknowledge and agree to the findings and improvements needed. No Corrective Action Plan (CAP) was generated by the non-compliant Provider who was then added to next year's access survey.	See response for 3.1.2.		To achieve compliance, the MCP must: • Develop and implement a CAP process for providers who fail to meet access standards. **Update 6/19/14:** The MCP submitted CAP process for providers who fail to meet access standards. **This deficiency is closed.**
3.1.8 The Plan did not have a procedure to monitor waiting times in the Provider's offices. Plan personnel stated that during the audit period the Plan did not monitor the Provider's office wait times.	Actions taken by the Quality Improvement QI Department to ensure correction of the deficiency include: - Implementation of a Focused Medical Record Review (MRR) Audit and Monitoring Process - Molina will conduct a random Focused Review Audit to monitor all medical record deficiencies identified by the state. The audit criteria will include but not limited to: • Documentation • Coordination and continuity of care • Pediatric preventive care	Initiated remedial action: • Developed policy 2/10/14 • Developed audit tool 2/14/14 Long Term ongoing monitoring of corrective action includes: • Approval of audit tool 3/24/14 at PRC • Acceptable level process	The MCP has taken steps for correcting this deficiency by including the monitoring of wait times in the Medical Record Focused Review Tool. This deficiency is provisionally approved pending the receipt of

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	• Adult preventive care • OB/CPSP preventive • Initial Health Assessment (IHA) includes history and physical, and Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA) • Subsequent assessment and annual SHA re-administration according to updated SHA policy - The MRR tool is inclusive of meeting the contractual requirements. - The MRR audit will be executed through a random medical record review process stratified by high volume providers based on enrollment of Molina Health Care members. - The audit will be tracked and reported by use of a newly developed electronic MRR tool that will score weighted elements. Weighted elements will ensure that all critical elements are in compliance. - The audit will review a sample based on the 8/30 National Committee Quality Assurance (NCQA) Sampling Methodology rule. - If a Provider office is found to be out of compliance based on the 8/30 review a corrective action plan (CAP) will be given to the provider office. - The Provider/Provider office will have 30 business days to submit the CAP to the QI Department. - Upon acceptance of the CAP the provider will be entered back into the random sample pool for further review by the QI Department. - The audit will be conducted by Facility Site Review (FSR) Nurses who are trained and certified by DHCS. - An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported to Professional Review Committee (PRC) quarterly. - Ongoing provider education is conducted by FSR Nurses during focused reviews, periodic and initial scheduled audits. Supporting Documentation: 3.1.8: QM 50 3.1.8: Focused MRR Tool 3.1.8: 8/30 Methodology NCQA	implementation 4/1/14. • Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency utilizing the 8/30 sampling methodology impacts compliance of medical records.	evidence that the Focused MRR Audit Tool has been operationalized. **Update 7/17/14;** Medical Record Focused Reviews are fully operational. Results have been submitted for April, May and June. Additional audits have been scheduled. Per last week's conference call, this deficiency is now closed. **This deficiency is closed.**
3.5 EMERGENCY SERVICE PROVIDERS (CLAIMS)			
Emergency Service Providers (Claims): Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge (as required by GMC/2-Plan Contract A.8.13.B). For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D), and California Welfare and Institutions code Section 14091.3 (see GMC Contract A.8.13.B(3)). For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D) (as required by 2-Plan Contract A.8.13.E). Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39 (as required by GMC Contract A.8.5). Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36 (as required by 2-Plan Contract A.8.5). Contractor shall cover emergency medical services without prior authorization pursuant to 28 CCR 1300.67(g)(1) (as required by GMC Contract A.9.7.A). Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216 (see 2-Plan Contract A.9.7.A). Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h) (Title 28 CCR Section 1300.71(g)).			
3.5.1 As indicated in its Policy *CP-03 Claims Processing*, the Plan is required to reimburse the Provider within 45 working days that the Plan receives clean or complete claims, which are claims that can be processed without further documentation.	Molina will implement a formalized written workflow process to ensure timeliness of claims processing with a focus on the aged claims no later than March 30, 2014. Molina is working with various cross functional departments to enhance the current training manual to focus on the accuracy of provider information loaded in the claims processing system QNXT by April 30, 2014. The current oversight process will be enhanced to include the monitoring and reporting to the functional business areas of concerns to be completed by the end 2nd Quarter 2014.	End of 2nd Quarter	To achieve compliance, the MCP must submit: • The formalized written workflow process to ensure timeliness of claims processing. • Submit evidence monitoring has begun. **Update 6/18/14:**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			The MCP provided "Escalation process for Aged Claims." In order to close this deficiency, the MCP must provide a finalized (singed & dated) version of its P&P. **Update 6/18/14:** The MCP provided evidence of monitoring activities and formalized written standard operating procedure of workflow process. **Update 6/20/14:** The MCP submitted "CAP DHCS Memo Claims Timeliness." In order to close this deficiency, The MCP must provide a finalized (singed & dated) version of its P&P. **This deficiency is closed.**
3.5.2 If emergency room claims are not within the Plan's fiscal responsibility, the claims must be forwarded to the appropriate capitated Provider within 10 working days of receipt as indicated in Policy *CP-03*.	Molina has implemented a front-end screen process, which includes applicable job aides and workflow processes. We developed this process collaboratively with our various cross-functional departments to determine claim type (appeals, corrected claim, PDR's etc.), within 2 days of receipt. This process was implemented on 12/02/2013, and was designed to assist with accurately identifying misdirected claims timely and allow for claims to be routed to the appropriate payer within 10 days of receipt. Molina hired a total of 4 additional staff in December 2013 and January 2014 to improve timeliness of screening and forwarding claims to the appropriate functional areas for processing. We will be working collaboratively with Provider Services in educating our Providers with the correct PO Box address for claims to be submitted within the next 30 days. A post-implementation focused audit will be conducted to ensure timeliness compliance at the end of the first quarter 2014.	End of 1st Quarter 2014	To achieve compliance, the MCP must submit: • Results of the post-implementation focused audit. **Update 6/20/14:** The MCP submitted "ER Family Planning Misdirected Focused Audit Mar 2014." **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
3.5.3 Although according to the Plan's Policy *CP-03,* it does not require prior authorization for emergency room claims; the verification study showed that 3 emergency room claims were denied because prior authorization was not obtained.	Molina has developed and implemented a focused audit process to ensure Emergency Room claims are processed timely and accurately. Additional training was conducted with the staff to ensure understanding of the applicable requirements pertaining to the processing of ER claims.	9/27/2013	To achieve compliance, the MCP must submit: • The results of the focused audit of Emergency Room claims. **Update 6/18/14:** The MCP submitted "ER & Family Planning Accuracy." **This deficiency is closed.**
3.6 FAMILY PLANNING (PAYMENTS)			
Family Planning: (Payment): Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate (as required by GMC/2-Plan Contract A.8.9). Claims Processing—Contractor shall pay all claims submitted by contracting Providers in accordance with this section. Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39 (as required by GMC Contract A.8.5). Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section. Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36 (as required by 2-Plan Contract A.8.5). Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h) (as required by CCR, Title 28, Section 1300.71(g)).			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
3.6.1 If claims are not within the Plan's fiscal responsibility, the claims must be forwarded to the appropriate capitated Provider within 10 working days of receipt as indicated in the Plan's Policy *CP-03 Claims Processing*. Based on the verification study conducted on family planning claims, the Plan failed to forward 5 claims within the 10 working day requirement, forwarding the claims 9 to 12 days after the required timeframe.	See response to 3.5.2		To achieve compliance, the MCP must submit: • Results of the post-implementation focused audit. **Update 6/20/14:** The MCP submitted "See 3.5.2 ER Family Planning Misdirected Focused Audit Mar 2014." **This deficiency is closed.**
3.6.2 The Plan does not require prior authorization for family planning claims billed as indicated in Policy *CP-03* but the verification study showed that 3 family planning claims were denied because prior authorization was not obtained.	See response to 3.5.3		To achieve compliance, the MCP must submit: • The results of the focused audit of Family Planning claims. **Update 6/24/14:** The MCP submitted "CA ER and Family Planning Accuracy revised, CAP DHCS Memo Family Planning Denied for No Authorization Focus Audit, and CA Exception Claim ER Family Planning Denied with No Auth Report." **This deficiency is closed.**
3.7 ACCESS TO PHARMACEUTICAL SERVICES			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
Pharmaceutical Services and Prescribed Drugs: Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations... Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours…. Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation (as required by GMC Contract A.10.8.G.1). Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations... At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled (as required by 2-Plan Contract A.10.8.G.1).			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
3.7.1 The Plan's Policy P21: Oversight of the Provision of Drugs in the Emergency Room Setting indicates that compliance with emergency drug dispensing requirement is to be monitored through grievance and appeal. Plan personnel confirmed that there were no grievance and appeal cases related to emergency drug dispensing reported for 1st quarter 2013. However, monitoring involving such grievance cases precludes unreported cases where emergency dispensing requirements may have not been met.	Molina will revise the following policies and establish monitoring mechanisms to ensure provision of drugs prescribed in emergency circumstances. Policy P21 Oversight of the Provision of Drugs in the Emergency Room Setting will be revised and will cross-reference PR 36 – Hospital Dispensing of Emergency Medications Education. An annual letter will survey all contracted hospitals of the requirement to provide patients receiving services in the hospital's emergency room access to a 72-hour supply of medication to last until the patient can reasonably be expected to fill their prescription. The annual letter will also request the hospital include a copy of their current process for dispensing medication in the emergency department. The survey will be issued, collected and analyzed along with additional data collected by the Plan's Provider Services Department and Pharmacy Department. The findings will be presented quarterly to the Utilization Management (UM) Committee. Based on review of the findings, a corrective action plan will be developed by the UM Committee and Provider Services, and communicated to the hospital by the Director of Provider Services in collaboration with the Chief Medical Officer. Progress on the corrective action plan will be monitored by the Pharmacy Department and reported at the UM Committee and QI Committee. If the hospital is unable to meet the requirement, the issue will be escalated to Plan leadership. PR 21 and PR 36 will be revised and approved by the UM Committee, QI Committee and Provider Services by 4/1/14. The annual survey letter will be revised by Provider Services and approved by the UM Committee and QI Committee by 5/1/14. All contracted hospitals will be sent a survey letter by 5/15/14. Data evaluation, corrective action plan development, and communication with deficient hospitals by 8/1/14. Supporting Documentation: 3.7.1 Hospital Survey Letter	5/1/14: Organize the committee, conduct the review of running reports, modify reports, develop telephone survey process/tool, and design data evaluation methodology. 6/1/14: Conduct telephone survey 8/1/14: Complete results and analyze data. 8/30/14: Submit findings and proposed corrective actions to UM Committee, QI Committee and Provider Services.	To achieve compliance, the MCP must submit: • Submit revised P&P P21 and PR 36 when completed. • Submit analysis of the data collected from the annual survey. The MCP submitted copies of P&P P21, revised, signed, and dated 4/1/14, and P&P PS 36(note: this P&P was previously identified as P**R** 36.That appears to be a typo as the title of the policy PS36 is the same as referred to as PR36), revised, signed, and dated 3/28/14. The Plan must submit the analysis of the data collected from the annual survey to close this deficiency. The Plan submitted a memo stating that the data analysis will be available in August 2014. Hospitals found not to be compliant will be referred to the Quality Improvement Committee for review and required CAP. **Update 6/24/14:** The MCP submitted "DHCS CAP_ Pharmacy." **Update 7/17/14:** It was agreed during the conference call that this

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			deficiency would remain open pending the receipt of hospital survey results by 8/15/14. **Update 8/26/14** Attached please find the hospital survey results required to close this deficiency. The Plan is waiting for a response from DHCS. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
3.7.2 As part of the Plan's Corrective Action Plan (CAP) from the prior audit, the Plan produced a "Quarterly ER Monitoring Report" from 2009-2010, which showed that less than 1% of Plan ER visits had documentation of dispensed meds. The Plan's P& T Committee stated that "We feel that the reason for the low percentage is because drugs are dispensed as part of the ER visit, and are not billed to us." The Plan had no evidence that the cause for the low rate was lack of billing, and not lack of dispensing. Nevertheless, the Plan discontinued said reports, without any investigation as to whether meds were indeed being dispensed, but not billed.	A policy and process to monitor the dispensing of drugs by contracted hospital's emergency department will be developed. An initial review of all previous reports identifying Members who had received drugs from an emergency visit, going back one year will be conducted. As part of the review, the composition and validity of the reports will be determined, and modifications of the report structure will be made. These reports will also help identify members who may not have received drugs upon emergency department discharge. As a mechanism to evaluate each hospital's compliance with the requirement, a telephone survey process and telephone survey tool will be developed to randomly sample members who had an emergency department visit at our contracted hospitals. A special committee composed of Plan representatives from Provider Services, Pharmacy, Medical Directors, Case Management and Utilization Management (UM) will be organized to develop a plan to evaluate the running reports, design the telephone survey process, telephone survey tool, and develop a data evaluation methodology. The telephone survey findings and proposed corrective actions will be reported to the UM Committee, Quality Improvement Committee, and Provider Services for final approval. **Update Plan Response 9/18/14** A special committee has been organized and is composed of Plan representation from Provider Services, Pharmacy, Medical Affairs (medical directors and the CMO), and Health Care Services (UM and case management). A methodology has been developed to randomly sample members who had an emergency department visit at a contracted hospital, to analyze if emergency room physicians were compliant with providing the member a 72 hour supply or adequate supply of medication in an emergency situation. This methodology was dependent upon first completing audit deliverable 3.7.3. This has been completed and closed by DHCS/DMHC as of July 2014. The telephone survey process and telephone survey tool to randomly sample members who had an emergency department visit will be completed and submitted to the MHC UM committee for approval by November 19, 2014. Anticipating approval, the telephone survey will be submitted to DHCS/DMHC for approval on or before November 21, 2014. **Update Plan Response 11/21/14** The Quarterly Post Emergency Room Prescription Drug Survey was developed to provide outreach to all targeted members to determine if members who received a prescription during an emergency room visit had appropriate access to a 72 hour/3 day supply of necessary prescription drugs. The Myers Group (TMG) has been selected to conduct the survey.	8/30/2014	To achieve compliance, the MCP must submit: • The development of the policy and process to monitor the dispensing of drugs by contracted hospital's emergency department. • The development of the telephone process and survey tool. • The development of a data evaluation methodology. **Update 6/19/14:** The MCP submitted "ER Meds Hospital Survey" which satisfies a portion of the requirement to develop a policy and process to monitor the dispensing of drugs by contracted hospitals' ER. All other requirements remain open. The Plan submitted a memo stating that the data analysis will be available in August 2014. Hospitals found not to be compliant will be referred to the Quality Improvement Committee for review and required CAP. **Update 6/24/14:** The MCP submitted "DHCS CAP_ Pharmacy."

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Update 7/17/14: It was agreed that this deficiency would remain open pending the receipt of the audit results by 8/15/14. **Update 8/26/25:** Per DHCS Deficiency remains open **Update 12/23/14:** The quarterly post emergency room prescription drug survey is complete. A subcontractor has been selected to conduct the survey. Follow up and verification of MCP action will be conducted through the annual audit process. **This deficiency is closed.**
3.7.3 The Plan's Policy *P-02: Drug Benefit* indicates the pharmacy director shall report "emergency services overrides" to the P & T committee quarterly. A review of the Plan's P & T Committee minutes revealed that this only took place one time during the audit period. The requirements to ensure complete monitoring of drugs prescribed in emergency circumstances were not met.	Plan will present report of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled (i.e., 72 hours) on a quarterly basis to the Pharmacy and Therapeutics (P&T) committee. The report will list Members who were seen by an Emergency Room provider AND received one or more prescriptions at the retail Pharmacy. The report will be generated on a quarterly basis initially, where the Days Supply will be monitored to determine if the Member received an adequate supply (i.e., 72 hour supply). Plan will develop a report to monitor drugs prescribed to Members by Emergency Room Physicians to ensure the Member received an adequate supply (i.e., 72 hours) of a covered outpatient drug in an emergency situation. **Update : 7/31/14** The two reports were condensed into one full report which contains first and last name member information. Please see attached report 3.7.3 ER Provider Retail Rx report 2Q2014	Develop and Implement: July 2014 Present to P&T beginning: 3Q14 Meeting on a quarterly basis.	To achieve compliance, the MCP must submit: • Report developed that lists members who were seen by an ER provider and received one or more prescriptions at a retail pharmacy. • Report developed to monitor drugs prescribed to members by ER provider to ensure adequate supply received. **Update 6/20/14:** The MCP submitted "Memo

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			– 3 7 3 Access to Pharmaceutical Services." In order to close this deficiency, the MCP must submit; • Report developed that lists members who were seen by an ER provider and received one or more prescriptions at a retail pharmacy. • Report developed to monitor drugs prescribed to members by ER provider to ensure adequate supply received. **Update 6/24/14:** The MCP submitted "Memo – 373 Access to Pharmaceutical Services." **Update 7/17/14:** During the conference call, it was agree that the MCP would submit the ER prescription drug report by 7/31/14 in order to close this deficiency. **Update 7/31/14** The MCP submitted two reports. **Update 8/4/14** **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
4.1 GRIEVANCE SYSTEM			
Member Grievance System and Oversight: Contractor shall implement and maintain a Member Grievance System in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c) (as required by GMC Contract A.14.1). 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) (as required by 2-Plan Contract A.14.1). Contractor shall 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 (as required by GMC/2-Plan Contract A.14.2). Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e) (as required by GMC/2-Plan Contract A.14.3).			
4.1.1 The Plan's grievance system does not capture all complaints, categorize inquiries that should be grievances, ensure that grievances are reported to an appropriate level, or capture complete grievance data for systematic aggregation and analysis.	See response for 3.1.6		Grievance and Appeals Training has been modified to include all expressions of dissatisfaction be logged as grievances, all quality of care issues are referred to quality improvement. Training addresses capturing grievances, categorizing grievances and capturing complete data. This deficiency remains open. To achieve compliance, the MCP must submit: • Documentation showing that the MCP is tracking and analyzing inquires and grievances appropriately.

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Update 6/20/14: The MCP submitted "May 2014 Member Services Issue Log." **This deficiency is closed.**
4.1.2 The Plan does not capture all complaints and expressions of dissatisfaction regarding the Plan and Providers. The Plan is lacking criteria, tools, training, and oversight to ensure appropriate classification of inquiries as grievances. The Plan uses non-clinical personnel to classify identified grievances as Quality of Care or administrative. The Plan does not use clinical personnel to provide oversight to ensure accurate identification of all clinical Quality of care issues. Identified Quality of Care issues are not thoroughly addressed by the CMO/Medical Director. Trends are not identified among Quality of Care issues flagged as to be tracked and trended.	The Plan retrained Contact Support Center (CSC) Agents on the Appeals and Grievance (A&G) processes and procedures, which included appropriate use of Call Types and Call Codes used for categorizing appeals and grievances to ensure appropriate tracking and trending of grievances. The following actions have been taken by the Quality Improvement (QI) Department to ensure correction of the deficiency: - Potential Quality of Care (PQOC) tools and resources to be used for training Call Center staff, Healthcare Services, Grievance and Appeals Unit and other departments is currently in development process. - QI Department will collaborate and work with Directors in every department to provide a PQOC presentation and ongoing training. - Revised policy and procedure QM 01- Potential Quality of Care to improve process and ensure that grievances are accurately and consistently identified. - Restructured severity level system to provide category guidelines for each severity level that will effectively track and trend all individual cases and systemic trends, including severity levels, case categories and review timeframes are reported to Clinical Quality Improvement Committee CQIC. - QI established a two-tiered review process to ensure that all PQOC issues and grievances are appropriately identified and investigated. • The LVN reviews 100% of grievances at the 1st level. • The 2nd level RN reviews and validates all grievances reviewed at the 1st level. - QI RN reviews the case with the Medical Director to ensure that review findings are appropriately documented. Supporting Documentation : 4.1.2: QM 01A Potential Quality of Care (PQOC) 4.1.2: QM 50: Quality Improvement Internal Monitoring 4.1.2: Quality Improvement New Employee Orientation Training Presentation 4.1.2: PQOC iLearn Training	Develop PQOC tools and resources 2/25/14, policy revision 2/10/14 Long Term ongoing monitoring of corrective action includes: Approval of PQOC tools and resources 4/17/14 at the QI Committee. Print and Fulfillment 4/23/14. Acceptable level process implementation 04/17/14.	The MCP submitted a revised P&P QM 01A, which has been approved and signed. Potential Quality of Care (PQOC) tools and resources are being developed. A two-tier review process has been implemented to ensure all PQOC issues and grievances are appropriately identified and investigated. This deficiency is provisionally approved pending receipt of the developed PQOC tools and resources. **Update 6/19/14:** The MCP submitted Potential Q1 reports on Quality of Care (PQOC) Report and a Grievance and Inquiry Audit Report. These reports audited member grievances to see if there were PQOC issues in the complaint.

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Update 6/24/14: The MCP submitted "QM 53 Draft QI Monitoring Redlined-revised 6-17-14 and PQOC iLearn." **This deficiency is closed.**
4.1.3 The Plan's Call Center employees are trained by the Member Services Department personnel on grievance and inquiry intake but the Plan does not have a mechanism to review and determine if inquiries are potential or actual grievance cases.	The Contact Support Center (CSC) is developing a SSRS Report that will search all Call Tracking Notes completed by an agent and search for key words that demonstrate dissatisfaction from the member. This report will be audited daily and reviewed by CSC Supervisors. If it is determined a grievance should have been submitted, a grievance will be created and submitted. Follow up coaching will also be conducted with the agent who handled the initial call. The results will be shared with the Appeals and Grievance Committee on a quarterly basis.	4/15/2014	To achieve compliance, the MCP must submit: • A sample of most recent SSRS Report that searches all call tracking notes for key words demonstrating member dissatisfaction. **Update 6/20/14:**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			The MCP submitted "SSRS DMHC." **This deficiency is closed.**
4.1.4 Written tools for identifying grievances are not in place.	The Plan retrained Contact Support Center (CSC) agents on the Appeals and Grievances (A&G) processes and procedures, which included appropriate use of Call Types and Call Codes used for categorizing appeals and grievances to ensure appropriate tracking and trending of grievances. Supporting Documentation: 4.1.4: CSC Appeals & Grievance Training 4.1.4: Appeals & Grievance Training	Training 100% completed 2/14/14; Ongoing training for new hires.	The MCP submitted two separate training presentations for appeals and grievances, which also includes categorizing appeals and grievances by call types and codes. Update 7/17/14: During the conference call, reviewing the June submission was satisfactory to close this deficiency. **This deficiency is closed.**
4.1.5 Medical Directors and/or QI staff did not train call center staff in grievance identification.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency includes: - Potential Quality of Care (PQOC) tools and resources to be used for training Contact Support Center (CSC) staff, Healthcare Services, Grievance and Appeals Unit and other departments is in development. - -PQOC PowerPoint training will be made mandatory for those staff handling appeals and grievances and newly hired employees. Supporting Documentation: 4.1.5: QM 01A Potential Quality of Care (PQOC) 4.1.5: Quality Improvement New Employee Orientation Training Presentation 4.1.5: PQOC iLearn Training	Develop PQOC tools and resources 2/25/14, policy revision 2/10/14. Long Term ongoing monitoring of corrective action includes: Approval of PQOC tools and resources 4/17/14 at the QI Committee. Print and Fulfillment 4/23/14. Acceptable level process implementation 04/17/14.	The MCP is developing PQOC tools and resources used for grievance identification training. This deficiency is provisionally approved pending receipt of the developed PQOC tools and resources. **Update 6/18/14:** The MCP submitted "Potential Quality of Care and Critical Incidents - Overview and Reporting".

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Update 6/19/14: The MCP also submitted QI Dept. document "Grievance and Appeals Training." **This deficiency is closed.**
4.1.6 Inquiry audits to detect missed grievances were not conducted. Inquiry analysis to identify access issues was not conducted. System to flag potential grievances is not in place.	See response to 4.1.3		To achieve compliance, the MCP must submit: • A copy of most recent SSRS Report that searches all call tracking notes for key words demonstrating member dissatisfaction. **Update 6/20/14:** The MCP submitted "See 4.1.3 SSRS DMHC." **This deficiency is closed.**
4.1.7 Inquiries not resolved within 24 hours are not logged as grievances.	Exempt grievances are defined as those handled and resolved within the next business day following receipt of the grievance. These are "exempt" from the formal grievance process with respect to the acknowledgment and resolution timeframes/correspondence. The Appeals and Grievance (A&G) Department is currently in development of a new call code within the call tracking system to ensure that these issues are captured for reporting purposes, and further investigation will be conducted for root cause analysis. Those cases not resolved in 24 hours will be forwarded to A&G for review. All cases not resolved within 24 hours will follow the regular grievance process.	2/14/14 initial training, although this will be an ongoing effort	The deficiency is provisionally approved pending the receipt of evidence that the new call code has been implemented. The submission must include the code definition. **Update 6/25/14:** The MCP submitted "4.1.7 Grievance Table and Memo Grievance System." **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
4.1.8 The Plan stated that the Grievance Committee meets quarterly or as needed to review and analyze trends and take action to remedy problems. The Plan stated that the Grievances and Appeals Department reviews all grievances are for proper classification between clinical and non-clinical grievances. Plan personnel stated that the review procedures do not include monitoring by clinical staff to ensure inquires and Quality Service/Care grievances were accurately classified.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency includes: - QI Department will conduct a random review of the total volume per county quarterly with the following criteria; 3% of total grievances; 3% of total inquiries Maximum of 50 - The result will be reported to Clinical Quality Improvement Committee (CQIC) bi-annually. Supporting Documentation: 4.1.8: QM 01A Potential Quality of Care (PQOC) 4.1.8: QM 50 Quality Improvement Internal Monitoring	P & P QM 01A Revision 2/10/14 Long Term ongoing monitoring of corrective action includes: Approval of P & P QM 50 4/17/14 at the QI Committee. Acceptable level process implementation 4/17/14.	To achieve compliance, the MCP must submit: • A copy of the revised, approved P&P QM 01A. • A copy of the most recent quarterly random review. **Update 6/18/14:** The MCP submitted "QM 01A PQOC and QI PQOC Report 2014." **This deficiency is closed.**
4.1.9 The grievance report did not include an explanation for each grievance that was not resolved within 30 calendar days of receipt of the grievance.	The final report did not contain the sample numbers that were found to be out of compliance for the resolution timeframe. The Appeals and Grievance (A&G) Department believes these cases are those the departments stated were not resolved due to being forwarded to another area. The A&G Department has revised internal policies PO-19 and PO-20 to clearly define the Potential Quality of Care (PQOC) process and ensure the Member's concerns are clearly addressed. Supporting Documentation: 4.1.9: Member Grievance policy PO19 4.1.9: Member Appeal policy PO20	2/20/2014 - Pending policy revision approval from DHCS.	To achieve compliance, the MCP must submit: • Copies of approved, signed P&P PO-19 and PO-20 Additionally, a portion of this finding was identified in the DMHC non-routine survey completed on June 4, 2014. Ongoing monitoring and corrective action for this finding will be achieved through the DMHC CAP. **Update 6/18/14:** The MCP submitted "PO 19 Member Grievance Process and PO 20 Member Appeal Process." **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
4.1.10 The report failed to identify incorrectly coded grievances and trends of delegates who had multiple grievances.	The Appeals and Grievance (A&G) database, deployed January 2, 2014, will allow the A&G Department to correct any miscoded grievances. In addition to the quarterly reports, A&G will develop and implement monthly trend reports for providers with 3 or more grievances reported per month, a new policy will be developed by 03/15/14 to address the trend and analysis deficiency.	Database deployed 1/2/2014, policy in development, will be implemented by 3/15/2014.	To achieve compliance, the MCP must submit: • The newly developed policy and procedure that addresses the trend and analysis deficiency. • Copy of most recent monthly trend report for providers with 3 or more grievances reported per month. **Update 6/18/14:** The MCP submitted PO 30 Member Grievance Root Cause Analysis." **Update 6/20/14:** The MCP submitted "Grievance May 2014 Trend Report Final." **This deficiency is closed.**
4.2 CULTURAL AND LINGUISTIC SERVICES			
Cultural and Linguistic Program: Contractor shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services Contractor shall review and update their cultural and linguistic services consistent with the requirements (as stated in the GMC Contract A.9.13). Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the group needs assessment requirements (as required by 2-Plan Contract A.9.13).			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
Contractor will assess, identify, and track the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical) (as required by GMC/2-Plan Contract A.9.13.B). Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program (as required by GMC Contract A.9.13.E/ 2-Plan Contract A.9.13.F). **Linguistic Services:** Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC 2000d, 45 CFR Part 80) that prohibit recipients of Federal financial assistance from discriminating against persons based on race, color, religion, or national origin (as required by GMC/2-Plan Contract A.9.12). Contractor shall comply with 42 CFR 438.10(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact…either through interpreters, telephone language services, or any electronic communication options (as required by GMC Contract A.9.14.B). Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact…either through interpreters, telephone language services, or any electronic options (as required by 2-Plan Contract A.9.14.A). **Types of Linguistic Services:** Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential Members: 1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact 2) Fully translated written informing materials 3) Referrals to culturally and linguistically appropriate community service programs 4) Telecommunications Device for the Deaf (TDD) 5) Telecommunications Relay Service (711) (as required by GMC Contract A.9.14.C/2-Plan Contract A.9.14.B). **Key Points of Contact Include:** 1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers, including pharmacists 2) Non-medical care setting: Member services, orientations, and appointment scheduling (as required by GMC Contract A.9.14.E/2-Plan Contract A.9.14.D).			

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
4.2.1 For two grievance cases related to requests for interpreting services, one of which involved a threshold language, the grievance acknowledgement and resolution letters sent to Members were not translated in Member's identified threshold languages. According to the Contract, the Plan must provide translated materials to a population group who indicate their primary language is other than English, if that group meets a numeric threshold of 3,000.	The Plan offers telephonic interpreter services at any time; during a Member service inquiry call, while Member is receiving care, and throughout the grievance intake process to ensure that there are no language barriers. If the Member's profile indicates a language of preference (threshold or other), correspondences will be sent in the appropriate language. Members may also verbally request that correspondence be translated in their written language of preference at any time. If the Member's profile does not indicate a language of preference or indicates "English," the translation insert will be provided with all correspondence. The Appeals and Grievance (A&G) unit has developed and implemented policy PO-17 to address the deficiency noted. Additionally, policy Utilization Management UM-67 has been revised to reflect the above processes. All grievances and appeals, including language of preference, are tracked, monitored, and reported to several committees (QISC, QIC, UMC etc.) on a quarterly basis. Supporting Documentation: 4.2.1: PO17 Appeals and Grievance Cultural Linguistic Services 4.2.1: UM67 Member Appeal of Medical Necessity, Denial or Modification determination	Pending policy approval from the appropriate committees and DHCS, 100% of the letters are translated in our threshold and other languages, or if primary language is unknown translation insert is included starting 02/03/2014.	The MCP has implemented PO-17 to address a member's language preference when sending correspondence. UM-67 has also been revised to reflect the same process. To achieve compliance, the MCP must submit: • Copies of policies PO-17 and UM-67 that ensure there will be no language barriers. **Update 6/18/14:** The MCP submitted PO 17 Cultural and Linguistic Services and UM-67 Member Appeal of Medical Necessity Denial." **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
4.3 CONFIDENTIALITY RIGHTS			
Members' Right to Confidentiality Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information. 1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network. 2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009 (also see 2-Plan Contract A.13.1.B). **Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:** Contractor agrees: B. Safeguards—To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract. H. Notification of Breach—During the term of this Agreement: 1). Discovery of Breach. To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract… 2). Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer… I. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit (as required by GMC/2-Plan Contract G.3.B, H, and I).			
4.3.1 In a review of suspected HIPAA breach cases, the 24-hr. DHCS Initial Notification of Breach was not submitted to the required DHCS personnel in 3 of 5 cases.	Privacy Office policy HP-37 has been modified to ensure that the plan is able to meet the 24-hour reporting requirement. Rather than allowing 24 hours to report to the Privacy Official, the Compliance Manager must now report to the Privacy Official on the same day of the incident. This ensures that the Plan's reporting requirement to the Plan's Privacy Official does not impede their ability to meet the 24-hour reporting requirement to the agency. Supporting Documentation: 4.3.1: HP-37 III.H.2	12/18/2013	The MCP submitted an approved, modified HP-37 that will ensure the plan meets the 24-hour reporting requirement. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
5.1 QUALITY IMPROVEMENT SYSTEM			
General Requirements: 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 (as required by GMC/2-Plan Contract A.4.1).			
5.1.1 The Plan cited examples of HEDIS measure improvements that are not statistically significant as improvements in care. However, the Plan failed to meet either its stated goal, or the Minimum Performance Level (MPL) for this measure.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - The 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 redesign includes the implementation and expansion of the HEDIS Interventions Team. Efforts of this team represent a more dynamic approach to improving HEDIS performance. - The QI Compliance team is implementing strong interventions to improve HEDIS measures as defined in the 2013 HEDIS Improvement Plans (IPs) submitted to the state in December 2013 and January 2014: • Continue Low Back Pain and Avoidance of Antibiotics for Acute Bronchitis interventions with monthly monitoring • Implementation of newly redesigned Motherhood Matters Baby and Me Program with monthly tracking and interventions to improve PNC and PPC rates • Coordination of efforts with HEDIS Interventions Team to improve Sacramento County CDC LDL control and improvement of Medication Management. • HEDIS Interventions include focused outreach efforts and active monthly monitoring of rates. HEDIS/Intervention work plan identifies monthly monitoring of preventive services to ensure that members receive the care needed for management of conditions. Supporting Documentation: 5.1.1: 2014 HEDIS Work plan and Attachments	Initiated remedial actions, which include: • QI Department redesign completed 12/31/13. • DHCS HEDIS IPs submitted 12/9/13 and 1/30/14. • Implement Motherhood Matters program pending DHCS approval 3/15/14 . • 2014 HEDIS intervention work plan 1/1/14 Long Term ongoing monitoring of corrective actions includes: • Implementation of HEDIS IP interventions 12/9/13 and 1/30/14 • Development and submission of the Motherhood Matters program for approval by DHCS. The expected date when full compliance will be achieved will be ongoing with 2-5% incremental improvements on achieving stated goal, or minimum Performance level (MPL).	While the MCP has taken necessary steps to address this deficiency and has submitted their 2014 HEDIS work plan. To achieve compliance, the MCP must submit: • The results of the HEDIS Improvement Plan interventions - 12/9/13 & 1/30/14. • Submission of newly redesigned Motherhood Matters and monthly tracking activity. **Update 6/19/14:** The MCP submitted redesigned Motherhood Matters documents and the following HEDIS Improvement Plans for 2013: • CDC: LDL-Cholesterol Screening 12/9/13 • Use of Imaging Studies for Low Back Pain (LBP) 12/9/13 • Monitoring of

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Persistent Medications: ACE Inhibitors & ARBs 12/9/13 • Monitoring of Persistent Medications: Diuretics 12/9/13 • Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) 1/30/14 • Childhood Immunizations, Combination 3 (not dated) • PPC-Postpartum 1/30/14 • PPC-Prenatal 1/30/14 **This deficiency is closed.**
5.1.2 The Plan cited educating Members to decrease service level expectations to increase CAHPS survey results as an example of improving service. As an example of service improvement, the Plan cited its response to 2012 CAHPS Survey. In response to overall below-average member satisfaction, the Plan implemented member education on expected turnaround time for appointments.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include process and policy revisions include: - Policy revisions to QM 09 Access to Health Care - Police revisions to QM 01 Potential Quality of Care (PQOC) - Annual Provider Access and Availability Survey o The survey revisions include custom questions that will allow the QI team to accurately assess the availability of appointments and after hours care. - Corrective action and ongoing monitoring of the deficiency will include the use of the annual Provider Access and Availability Survey (conducted by NCQA accredited vendor) results. o Results will be reviewed by QI Staff and presented to all functional health plan areas during the Clinical Quality Improvement Council (CQIC), Quality Improvement Strategic Council (QISC) and reported to QI Committee. o The review will analyze and compare the results of the annual Provider Access and Availability Survey with these additional monitors: • Annual CAHPs member survey,	Initiated remedial actions, which include: • Developed policies 2/10/14 Long Term ongoing monitoring of corrective actions includes: • Draft from NCQA Accredited vendor Provider Access survey tools 2/19/14. Approval of policies in 2/27/14 QI Committee. • Health Education Member intervention completion by 5/31/14. • Provider engagement visits will be ongoing throughout 2014. • Acceptable level process implementation:	While the MCP has taken the necessary steps to address this deficiency, to achieve compliance, the MCP must submit: • Provider monitoring results relating to access and availability/after-hours survey. **Update 6/19/14:** Monitoring results provided and a CAP to a provider. Also see 3.1.7 Follow up

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
	• Mid-year Mini-CAHPS results, • New Post-Appointment Survey (member experience with recent appointment), • Access related Grievances, and • Access related Potential Quality of Care PQOC issues as noted in the revision of P&P: QM 01 Potential Quality of Care. - Ongoing monitoring will be through administering a Corrective Action Plan (CAP) process described in policy and procedure QM-09. The Plan implemented this process as of Q4 2013. - All providers out of compliance who failed the Access and Availability Survey were faxed detailed information about the elements failed, and information on how to make corrections. - CAPs must be completed and returned to the Plan within 30 business days. - Other functional areas are working with QI staff include Provider Services. - Provider Services is assisting in follow-up of providers who received CAPs. - QI department has included other functional areas to coordinate correction of the deficiency. QI is working with the Health Education Department with strategies for the 2014 approach to access standards. Some strategies include but not limited to member education on alerting the health plan when there are issues with timely access - Ongoing education will occur by the Provider Engagement team who will re-educate Providers on access and availability standards, and follow up on any CAPs that were implemented as a result of the Provider Access and Availability Survey. - Provider engagement visits will include education regarding strategies to improve patient flow thus reducing wait times. Supporting Documentation: 5.1.2: QM-09 5.1.2: QM 01 PQOC 5.1.2: QM 01 PQOC Redline 5.1.2: QM 50	o Provider Access & Availability/After Hours Survey administered 3/15--5/15/14 o Final Survey Report to plan 6/15/14 o Final Survey Report analysis and comparison with CAHPs and grievance data completion by 6/30/14. The Plan will achieve full compliance through ongoing provider monitoring and will ensure the deficiency is corrected through analysis and CAP Provider monitoring.	CAPS. **This deficiency is closed.**
5.1.3 The Plan used a Provider self-reported survey to assess Access and Availability. The script required the Providers to state that they are not in compliance with Plan standards to be deemed noncompliant. The Plan has not validated the results of this survey.	See response to 5.1.2		To achieve compliance, the MCP must submit: • Provider monitoring results. **Update 6/19/14:** Monitoring results provided. Also see 3.1.7 Follow up CAPS. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
5.1.4 The Plan required Providers not in compliance with Appointment Availability standards to attest that they had implemented a CAP even though the providers had no evidence of the existence of the CAP.	See response to 5.1.2		To achieve compliance, the MCP must submit: • Evidence of a CAP by providers found to be out of compliance with the access and availability survey. **Update 6/19/14:** The MCP submitted example of CAP sent to provider. **This deficiency is closed.**
5.1.5 The QI Department was not directly involved in training call center employees. The Plan did not provide tools to call center employees to ensure reliable identification of grievances. It did not audit nor analyze inquiries. Inquiries that should have been logged as grievances related to access were not logged as grievances.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - Potential Quality of Care (PQOC) tools and resources to be used for training Center staff, Healthcare Services, Grievance and Appeals Unit and other departments is in development process. - PQOC Issues training is available via iLearn, Molina's training web portal. Molina will make the training mandatory for MHC staff and newly hired employees. - QI Department will collaborate and work with Directors in every department to provide PQOC presentation and ongoing training specific to California health plan. Supporting Documentation: 5.1.5: P&P QM 01 Potential Quality of Care (PQOC) 5.1.5: P&P QM 01 Potential Quality of Care (PQOC) Redline Revision 5.1.5: QI 50: Quality Improvement Internal Monitoring 5.1.5: Quality Improvement New Employee Orientation Training Presentation 5.1.5: PQOC Issues Training iLearn Slides	Initiated remedial action: • Approval of PQOC tools and resources 4/17/14 at the QI Committee. Long Term ongoing monitoring of corrective action includes: • Print and Fulfillment 4/23/14. • Acceptable level process implementation 6/2/14. • Full compliance will be achieved by ongoing monitoring of call center staff to ensure correction of the deficiency.	The MCP has taken action to correct this deficiency by developing training tools and resources. PQOC training is being made mandatory for all staff. Monitoring of call center staff to ensure reliable identification of grievances will be ongoing. This deficiency remains open. To achieve compliance, the MCP must submit: • Results of monitoring call center staff to ensure correction of this deficiency. **Update 6/20/14:** The MCP submitted "See 4.1.1 May 2014 Member

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Services Issue Log." In order to closed this deficiency, the MCP must submit; • Results of monitoring call center staff to ensure correction of this deficiency. Update 6/25/14: The MCP submitted "5.1.5 May 2014 Member Services Issue Log, SSRS Report PHI, and Memo Quality Improvement System." **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
5.1.6 The QI Department did not have effective procedures for ensuring that it could consistently and accurately identify Potential Quality of Care (PQOC) issues using the grievance process. The QI Department could not track and trend PQOC issues because it lacked complete data and did not effectively track and trend the data it did have.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - Revised policy and procedure QM 01 - Potential Quality of Care (PQOC) to improve process and ensures that grievances are accurately and consistently identified. - Restructured severity level system to provide category guidelines for each severity level that will effectively track and trend all cases - 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 - QI RN reviews the case with the Medical Director and ensure that review findings are appropriately documented. - Implement a random review of the total volume of grievances and inquiries per county quarterly according to the following: o 3% of total grievances o 3% of total inquiries o Maximum of 50 - The result will be reported to Clinical Quality Improvement Committee (CQIC) bi-annually. Supporting Documentation: 5.1.6: QM 01 PQOC 5.1.6: QM 01 PQOC Redline 5.1.6: QI 50	Initiated remedial action: • Policy Revision 2/10/14. Long Term ongoing monitoring of corrective action includes: • Approval of policies 4/17/14 at the QI Committee. • Acceptable level process implementation 4/1/14. • The Plan will achieve full compliance through ongoing monitoring of grievances and inquiries and will ensure the deficiency is corrected through quarterly audits.	The MCP has taken steps to remedy this deficiency. It has submitted P&P QM 01 PQOC and QI 50. This deficiency remains open. To achieve compliance, the MCP must submit: • The most recent results of the random review of total volume of grievances and inquires per county. **Update 6/18/14:** The MCP submitted Q1 2014 GRIEVANCE AND APPEALS MONITORING AUDIT REPORT. The report satisfies the requirement need to close this deficiency. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
5.3 QUALITY IMPROVEMENT PROGRAM DESCRIPTION AND STRUCTURE			
Written Description: Contractor shall implement and maintain a written description of its QIS [Quality Improvement System] (as required by GMC/2-Plan Contract A.4.7.A-I). **Accountability:** Contractor shall maintain a system of accountability, which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review (as required by GMC/2-Plan Contract A.4.2). **Governing Body:** Contractor shall implement and maintain policies that specify the responsibilities of the governing body (as required by GMC/2-Plan Contract A.4.3.A-D). **Provider Participation:** Contractor shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes. (as required by GMC/2-Plan Contract A.4.5).			
5.3.1 The QIC is an integral part of the Plan's QIS. The committee's membership does not reflect significant involvement of contracted physicians from the community.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - QI Department, Provider Services and the Network team are working to increase the number of contracted Physicians participating in the QI Committee focusing on cardiologist, endocrinologists, primary care providers, surgeons and behavior health providers.	Initiated remedial actions, which include: • Recruitment initiated 2/10/14. • Initial increase in participation at 4/17/14 QIC. • Full implementation at 8/28/14 QI	The MCP is working to increase the number of contracted providers participating in the QI Committee. Full recruitment implementation expected by 4th quarter. This deficiency is provisionally approved pending receipt of updated committee list or documentation of MCP effort to increase number of contracted provider participation.

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
			Update 6/19/14: The MCP provided updated roster of QUALITY IMPROVEMENT COMMITTEE (QIC). **This deficiency is closed.**
5.3.2 The Plan's Medical Director was absent at all QIC meetings during the audit period. The UM Committee had no representative from surgery or surgery subspecialties.	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - Action by QI Department and Chief Medical Officer to ensure Medical Director attendance at all QI Committee meetings. Provider Services and the Network team are recruiting surgeons for the UM Committee.	Initiated remedial actions, which include: • Full implementation at 4/17/14 QI Committee.	The MCP has initiated remedial action to include the Chief Medical Officer and Medical Director attends all QI Committee meetings. The MCP is also recruiting surgeons to attend the UM Committee meetings. Full compliance is expected by April QI Committee meeting. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
5.5 MEDICAL RECORDS			
Medical Records A. General Requirement Contractor shall ensure that appropriate Medical Records for Members, pursuant to 28 CCR 1300.80(b)(4) and 42 USC 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each Encounter in accordance with 28 CCR 1300.67.1(c). B. Medical Records Contractor shall develop, implement, and maintain written procedures pertaining to any form of medical records… C. On-Site Medical Records Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site. D. Member Medical Record Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services (as required by GMC Contract A.4.13.A, B, C, D). A. General Requirement Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861 and MMCD Policy Letter 02-02. B. Medical Records Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records… C. On-Site Medical Records Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site. D. Member Medical Record Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services…(as required by 2-Plan Contract A.4.13.A, B, C, D).			
5.5.1 The Plan developed and maintained policies and procedures pertaining to medical records but did not ensure these policies and procedures were implemented. The medical records were not always maintained in a legible, detailed, and comprehensive manner as	Actions taken by the Quality Improvement (QI) Department to ensure correction of the deficiency include: - Implementation of a Focused Medical Record Review (MRR) Audit and Monitoring Process. - Molina will conduct a random focused MRR Audit to monitor all medical record deficiencies identified by the state. The audit criteria will include but not limited to: • medical record management, • documentation,	Initiated remedial action: • Developed P&P 2/10/14 • Develop Audit Tool 2/14/14 Long Term ongoing monitoring of corrective action includes: • Approval of audit tool 4/9/14 at the	The MCP has taken steps to address this deficiency. It has submitted P&P QM 50, its Focused MRR Tool and NCQA 8/30 audit sampling methodology. However, this deficiency remains open. To

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
required by the Contract. The records reviewed did not consistently contain the minimum content required by the Contract. Many records lacked evidence of preventive health screenings and procedures were not consistent with guidelines set forth in periodicity schedules as required by the Contract. Ongoing problems were not always documented and addressed on subsequent visits. Some pediatric Members' records did not contain screening for vision, hearing, nutrition, dental (including fluoride varnish) psychosocial, developmental, and tuberculosis. Some adult Members' records had incomplete documentation of screening measures for tuberculosis, lipid disorder, breast cancer, cervical cancer, and chlamydia infection. The Plan did not ensure that medical records were available at each provider encounter.	• coordination and continuity of care, • pediatric preventive care, • adult preventive care, • OB/CPSP preventive, • access and appointment availability • informed and sterilization consents - Section II of the tool (Medical Record Documentation) addresses baseline health assessment and sufficient diagnostic evaluations to identify members with special health care need. - The MRR tool is inclusive of meeting the contractual requirements. - The MRR audit will be executed through a random medical record review process stratified by high volume providers based on enrollment of Molina Health Care members. - The audit will be tracked and reported by use of a newly developed electronic Medical Record Review tool that will score weighted elements. Weighted elements will ensure that all critical elements are in compliance. - The audit will review a sample based on the 8/30 National Committee Quality Assurance (NCQA) Sampling Methodology rule. - If a Provider office is found to be out of compliance based on the 8/30 review a corrective action plan (CAP) will be given to the Provider office. - The Provider/Provider Office will have 30 business days to submit the CAP to the Quality Improvement Compliance Team. - Upon acceptance of the CAP the Provider will be entered back into the random sample pool for further review by the Quality Improvement Department. The audit will be conducted by Facility Site Review (FSR) Nurses who are trained and certified by DHCS. - MRR tool is inclusive of the elements to address the issue of missing/incomplete IHA according to our contractual agreement. - An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported quarterly. - Ongoing Provider education and reinforcement of IHA and SHA completion by Provider Services during quarterly provider on site visit. - An analysis of data finding, barrier, interventions, and follow-up will be conducted and reported quarterly to Professional Review Committee (PRC). - Ongoing Provider education is conducted by FSR Nurses during focused reviews, periodic and initial scheduled audits. Supporting Documentation: 5.5.1: QM 50 5.5.1: Focused MRR Tool 5.5.1: 8/30 Methodology NCQA	Clinical Quality Management Committee. • Acceptable level process implementation 4/1/14. • Full compliance will be achieved by ongoing provider monitoring to ensure correction of the deficiency utilizing the 8/30 sampling methodology.	address this deficiency, the MCP must submit: • Copy of approved, signed P&P QM 50. • Results of most recent Focused Medical Record Review (MRR). **Update 6/18/14:** The MCP submitted a copy of Policy No. 53. The policy is signed and dated 4/17/14. The document contains no information regarding this policy as a revision or replacement of previous policy. The policy contains information on the process for MRR. In order to address this deficiency the MCP must submit information about Policy No.53's relation to P&P QM50, and the results of the most recent Focused MRR. **Update 6/19/14:** The MCP submitted additional revision to No 53 to address Master trainer concerns. To close this deficiency the Plan must submit the results of the most recent Focused MRR. **Update 6/24/14:** The MCP submitted "Memo DHCS 2014 Renumbering of P and P QM 50 to QM 53."

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			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.**
5.6 INFORMED CONSENT			
Informed Consent Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services, and at a minimum includes: …All informed consent documentation, including the human sterilization consent procedures required by 22 CCR Sections 51305.1 through 51305.6, if applicable (as required by GMC Contract A.4.13.D.7). Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes: …All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable (as required by 2-Plan Contract A.4.13.D.6). Contractor shall ensure that Members are informed of the full array of covered contraceptive methods and that informed consent is obtained Members for sterilization, consistent with requirements of 22 CCR 51305.1 and 51305.3 (as required by GMC Contract A.9.9.A.1). Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3 (as required by 2-Plan Contract A.9.9.A.1).			
5.6.1 Without reliable identification of members undergoing sterilization procedures, the Plan was unable to demonstrate it effectively monitored	See response to 5.5.1		To address this deficiency, the MCP must submit: • Evidence, the MCP is effectively monitoring

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compliance with the requirements for informed consent. The requirement for informed consent was not met.			compliance with the requirements of informed consent. **Update 6/20/14:** The MCP submitted "Informed Consent Monitoring Process 6-18-14." In order to close this deficiency, the MCP must submit its finalized P&P (signed & dated). **Update 6/24/14:** The MCP submitted "Memo – Informed Consent." **Update 7/17/14:** The MCP submitted an approved, signed P&P UM-90 relating to informed consent.. **This deficiency is closed.**

4. Deficiencies Identified	5. Plan of Action	6. Date of Completion	DHCS Comments
6.1 MEDICAL DIRECTOR			
Medical Director: Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53913.5 whose responsibilities shall include, but not be limited to... (as required by GMC Contract A.1.6). Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to… (as required by 2-Plan Contract A.1.6). A. Ensuring that medical decisions are: 1) Rendered by qualified medical personnel 2) Are not influenced by fiscal or administrative management considerations B. Ensuring that the medical care provided meets the standards for acceptable medical care C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed D. Developing and implementing medical policy E. Resolving grievances related to medical quality of care. F. Direct involvement in the implementation of Quality Improvement activities G. Actively participating in the functioning of the plan grievance procedures (as required by GMC/2-Plan Contract A.1.6).			
6.1.1 The CMO/Medical Director does not ensure standards for acceptable medical care.	Actions taken to ensure correction of the deficiency include: - A new Chief Medical Officer (CMO) has been appointed. The CMO is receiving training from the Corporate, Sr. VP Chief Clinical Programs as well as from the Corporate, VP of Quality. - 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 QI Work plan and Monitors and Indicators have been revised to include quarterly analysis of barriers, identify opportunities and interventions required to improve the quality of medical care. -The development of a new QI policy QM-50 Quality Improvement Monitoring, defines semiannual interdepartmental monitoring of compliance with the Plan's policies that will ensure adherence to quality of medical care, standards and guidelines, including, but not limited to, the appropriate handling of the following: o UM Denials, o UM Appeals, o Accepted PQOC's and Grievances, and o MHC Focused Medical Record Review Audits. - The audit will review a sample based on the 8/30 NCQA Sampling Methodology rule.	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	This deficiency remains open. To achieve compliance, the MCP must provide the following: • An approved, signed copy of P&P QM-50 Quality Improvement Monitoring. • Confirmation of an approved medical record review audit tool. • Evidence of ongoing monitoring to ensure the standards for acceptable medical care is being met. **Update 6/18/14:**

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

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			(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.**

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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**