DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF MOLINA HEALTHCARE OF CALIFORNIA, INC. 2024

Contract Number: 06-55498, 07-65851, 09-86161

Audit Period: March 1, 2023 – February 29, 2024

Dates of Audit: March 18, 2024 – March 29, 2024

Report Issued: July 31, 2024

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I. INTRODUCTION

Molina Healthcare of California, Inc. (Plan) has contracted with the State of California Department of Health Care Services (DHCS), since April 1996, under the provisions of Welfare and Institutions Code section 14087.3. The Plan provides medical managed care services to Medi-Cal members and is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act.

The Plan is a full-risk managed care plan that serves government-sponsored programs such as Medi-Cal, Medicare, Integrated Medicaid-Medicare (Duals), and Marketplace (Covered California) population.

The Plan delivers care to members under the Two-Plan model in Riverside and San Bernardino Counties. The Plan provides services in Sacramento and San Diego Counties under the Geographic Managed Care model.

As of February 15, 2024, the Plan provided services to approximately 558,080 members across the four counties. The Plan's enrollment totals for the Medi-Cal line of business by county are Riverside (116,898 members), San Bernardino (108,891 members), Sacramento (62,151 members), and San Diego (270,140 members).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS' medical audit for the period of March 1, 2023, through February 29, 2024. The review was conducted from March 18, 2024, through March 29, 2024. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on June 19, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit report issued on June 27, 2023, did not identify any findings of non-compliance. However, the 2022 medical audit did have findings and the Corrective Action Plan (CAP) was still open during the audit period. The CAP closed on October 30, 2023. This audit examined documentation for compliance to determine to what extent the Plan operationalized the CAP.

The summary of findings by category follows:

Category 1 – Utilization Management

The Plan is required to make a decision on routine medical authorizations within five working days from receipt of information. The Plan did not ensure a decision was made for routine medical Prior Authorizations (PAs) within five working days.

The Plan is required to obtain written consent from the member when a provider files an appeal on behalf of the member. The Plan did not obtain the member's written consent when a provider filed an appeal on their behalf.

Category 2 – Case Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Access and Availability of Care

There were no findings noted for this category during the audit period.

Category 4 – Member's Rights

The Plan is required to provide written acknowledgment to the member within five calendar days of receipt of the grievance. The Plan did not ensure written acknowledgments were provided to members within five calendar days of receipt of grievances.

The Plan is required to send written resolution to the member within 30 calendar days of receipt of the grievance. The Plan did not ensure written resolutions were sent to members within 30 calendar days of receipt of grievances.

The Plan is required to ensure that the written resolution sent to members contains the Plan's decision. The Plan did not ensure that written resolutions sent to members contain the Plan's decision.

Category 5 – Quality Management

There were no findings noted for this category during the audit period.

Category 6 – Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Contracts.

PROCEDURE

The review was conducted from March 18, 2024, through March 29, 2024. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: 26 PA requests (2 approved, 2 modified, and 22 denied) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 22 appeals related to denied PAs were reviewed for appropriate and timely adjudication. These appeals were eventually all overturned and approved.

Category 2 – Case Management and Coordination of Care

Initial Health Appointment (IHA): Five medical records were reviewed for appropriate documentation, timely completion, and fulfillment of all required IHA components.

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): 30 records (15 NEMT and 15 NMT) were reviewed to confirm compliance with transportation requirements for timeliness and appropriate adjudication.

Category 4 – Member's Rights

Grievance Procedures: 47 standard grievances (25 quality of care and 22 quality of service), 10 exempt grievances, and 10 call inquiries were reviewed for classification, timely resolution, response to the complainant, submission to the appropriate level for review, and translation in member's preferred language (if applicable).

Category 5 – Quality Management

Potential Quality Issues: 17 files were reviewed for evaluation and effective action taken to address needed improvement.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Ten fraud and abuse cases were reviewed for processing and reporting requirements.

Encounter Data: Five encounter data records were reviewed for complete, accurate, reasonable, and timely encounter data submissions.

A description of the findings for each category is contained in the following report.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Timely Decision on Prior Authorization

The timeframe for routine medical authorizations is five working days from receipt of the information reasonably necessary to render a decision but, no longer than 14 calendar days from the receipt of the request.

The decision may be deferred, and the time limit extended an additional 14 calendar days only where the member or the member's provider requests an extension, or the Plan can provide justification upon request by the State for the need for additional information and how it is in the member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

(Contract Exhibit A, Attachment 5, (3), GMC-(H)/Two-Plan-(G))

The Plan's policy, *CA-HCS-325.01 Authorization Process* (revised November 17, 2023), states that decisions for PAs shall be made as expeditiously as the member's condition requires but within five business days from receipt of the information reasonably necessary to render a decision, but no longer than 14 days from the date of receipt.

Finding: The Plan did not ensure a decision was made for routine medical PAs within five working days.

A verification study revealed that for 15 of 26 PAs reviewed, the Plan did not render a decision within five working days from receipt of information. The Plan made decisions ranging from one through three days past the required timeframe.

The Plan provided an explanation for each of these 15 PA cases. For three cases, the Plan cited ineffective communication between clinical staff as the cause of missing the turnaround time. The nurse reviewing the case did not communicate the case clearly and timely to the Medical Director.

However, for all 15 cases, the Plan did not include the day of receipt of information when counting the five working day requirement. The Plan's interpretation of the Contract language "within five working days from receipt of the information" to mean the first of the five working days begins one day after receipt of the information.

Failure to make timely PA decisions may delay medically necessary services and result in poor health outcomes for members.

Recommendation: Implement policies and procedures to ensure that the Plan meets the five working day timeframe to make a decision on PAs.

1.3 PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Member's Written Consent for Appeals Filed by a Provider

All final Policy and All Plan Letters (APLs) issued by DHCS shall be complied with by the Plan. *(Contract, Exhibit E, Attachment 2(1)(D))*

Appeals filed by the provider on behalf of the member require written consent from the member. *(APL21-011, Grievance and Appeals Requirements, Notice and Your Rights Templates)*

The Plan's policy, *AG 67 Member Appeal of Medical Necessity Adverse Benefit Determination* (revised November 1, 2021), states that a member's appeal may be requested by a provider acting on behalf of a member and with the member's written consent.

Finding: The Plan did not obtain the member's written consent when a provider filed an appeal on their behalf.

In a verification study, six of 22 appeals reviewed were filed by the provider on the member's behalf. All six provider-initiated appeals did not have written consent from the members.

The Plan stated that it has reviewed the six provider-initiated appeals and verified that written consent was not obtained from the provider. Further, there were no documented outreach attempts to obtain the member's written consent.

During the interview, the Plan stated that it sends a consent form for the member to complete and return to the Plan along with the appeal acknowledgement letter. If the member has not returned the completed form, the Plan will continue to try to obtain the member's consent. However, the Plan does not have a process to ensure receipt of the member's consent.

Failure to obtain written consent from a member when a provider files an appeal on the member's behalf may interfere with patient autonomy, which is the right of members to make a decision about their medical care without their health care provider's influence.

Recommendation: Revise and implement policies and procedures to ensure that written consent is obtained when a provider files an appeal on the member's behalf.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 GRIEVANCE SYSTEM

4.1.1 Timely Acknowledgement

The Plan shall implement and maintain a Member Grievance system in accordance with California Code of Regulations (CCR), Title 28, section 1300.68 (except Subdivision 1300.68(g)), and 1300.68.01; CCR, Title 22, section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12; and Code of Federal Regulations (CFR), Title 42, section 438.420(a)-(c). *(Contract, Exhibit A, Attachment 14.1)*

A grievance system shall provide for a written acknowledgment within five calendar days of receipt. *(CCR, Title 28, section 1300.68 (d)(1))*

In accordance with state law, Managed Care Plans (MCPs) must provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the grievance. *(APL 21-011, Grievance Acknowledgement Letter, Notice and "Your Rights" Templates)*

Plan policy, *AG-19A Member Grievance Process (Medi-Cal),* (revised May 31, 2022), states that the member is sent a written acknowledgment within five calendar days of receipt of a grievance.

Finding: The Plan did not ensure written acknowledgment was provided to members within five calendar days of receipt.

A verification study of 47 grievances (22 quality of service grievances and 25 quality of care grievances) found that the Plan did not send timely acknowledgement letters to the members. Of these, all 22 quality of service grievances and two of the 25 quality of care grievances had acknowledgement letters sent between six and 95 calendar days.

In an interview, the Plan stated that it was aware of the issue involving the sample cases with acknowledgement letters sent late to the members. In 19 cases, late routing from the Plan's Call Center to the Appeals and Grievances (A&G) Department was the root cause for the delay, while for five cases, the cause related to intake process deviations in the A&G Department.

The first cause, the late routing of cases from the Call Center to the A&G Department, (system cross-over issue), is attributed to the Contact Center Representative not

following the appropriate documented process, and/or a system configuration error that was later identified. These issues were identified through routine collaborative meetings between the Contact Center and the A&G Team, which resulted in an internal CAP.

The second cause was due to the assigned A&G Intake Coordinator not following the documented intake process, which requires the acknowledgement letter to be generated and mailed within five calendar days. The unsent acknowledgment letters were identified during the Plan's quality audits and were mailed immediately.

When the Plan does not send written acknowledgment to members within the five calendar days of receipt, members may not know if their grievances are processed in a timely manner, and it may delay their ability to address Potential Quality of Care (PQOC) issues.

Recommendation: Implement policies and procedures to ensure the Plan acknowledges members' grievances within five calendar days of the grievance receipt.

4.1.2 Timely Resolution

The Plan shall implement and maintain a Member Grievance system in accordance with CCR, Title 28, section 1300.68 (except Subdivision1300.68(g)), and 1300.68.01; CCR, Title 22, section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12; and CFR, Title 42, section 438.420(a)-(c). *(Contract, Exhibit A, Attachment 14.1)*

The Plan's resolution, containing a written response to the grievance, shall be sent to the complainant within 30 calendar days of receipt. *(CCR, Title 28, section 1300.68 (d)(3))*

Timeframes for resolving grievances and sending written resolutions to the member are defined in federal and state law. The State's established timeframe is 30 calendar days. MCPs must comply with the State's established timeframe of 30 calendar days for grievance resolution. *(APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan's policy, *AG-19A Member Grievance Process (Medi-Cal),* (revised May 31, 2022), states that members are notified in writing of the final resolution to their grievance as quickly as the member's health condition requires or not to exceed 30 calendar days of the plan's initial receipt of the grievance. A&G staff sends a written resolution of the grievance to the member within 30 calendar days.

Finding: The Plan did not ensure written resolution letters were sent to members within 30 calendar days of receipt of grievances.

A verification study of grievances found that the Plan did not have timely resolution letters. Three of 22 quality of service grievances and 2 of 25 quality of care grievances had resolution letters sent between 46 to 99 calendar days.

In an interview, the Plan stated that it was aware of the issue involving the sample cases with resolution letters sent late to the member. The root cause was late routing from the Plan's Call Center to the A&G Department (system cross-over issue). This is attributed to the Contact Center Representative not following the appropriate documented process, and/or a system configuration error that was later identified.

Delays in resolving grievances could potentially impact member treatments and the Plan's quality of service.

Recommendation: Implement policies and procedures to ensure all written resolutions are sent to members within 30 calendar days from receipt of the grievance.

4.1.3 Plan's Decision in Resolution Letter

The Plan shall implement and maintain a Member Grievance system in accordance with Title 28, CCR, section 1300.68 (except Subdivision1300.68(g)), and 1300.68.01; Title 22 CCR section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12; and Title 42, CFR, section 438.420(a)-(c). *(Contract, Exhibit A, Attachment 14.1)*

"Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. If the Plan has multiple internal levels of grievance resolution, all levels must be completed within 30 calendar days of the Plan's receipt of the grievance. *(CCR, Title 28, section 1300.68 (a)(4A))*

The Plan's written resolution must contain the Plan's decision. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan's policy AG-19A, *Member Grievance Process (Medi-Cal)*, (revised May 31, 2022), states that any issues found to be PQOC issues are immediately referred to the Plan's Quality Improvement (QI) Department. QI will work with the Medical Director to investigate and resolve the PQOC case within 30 calendar days. Once the investigation is completed, QI sends the resolution information back to A&G. A&G sends a resolution letter to the member within 30 calendar days with information received from QI.

Finding: The Plan did not ensure that written resolution letters sent to members contain the Plan's decision.

A verification study found that in six of 17 PQOC cases reviewed, the Plan did not send members resolution letters with the Plan's decision.

The Plan sent resolution letters within 30 days. However, the letters stated that the quality of care issue is being reviewed and cannot be shared with the member while the service issue is being researched separately and the member will receive a separate resolution letter for the service issue.

During the interview, the Plan confirmed that the process is to refer a quality of care grievance to the quality team where it is investigated by a Medical Director. The Plan stated that while it internally tracks if the final decision is different than the resolution sent to the member, no other information is provided to the member. The Plan did not follow its policy to send the member within 30 calendar days the information received from the QI Department.

The lack of the Plan's decision in the resolution letter could result in unnecessary delay or denial in the delivery of medically necessary services for members.

Recommendation: Revise and implement policy and procedures to ensure that members are sent grievance resolution letters that include the Plan's decision.