DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

MOLINA HEALTHCARE OF CALIFORNIA

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: AUGUST 3, 2016
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Final Report of a Routine Survey
Molina Healthcare of California
A Full Service Health Plan
August 3, 2016

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EXECUTIVE SUMMARY

On June 5, 2015, the California Department of Managed Health Care (the "Department") notified Molina Healthcare of California (the "Plan") that its Routine Survey had commenced, and requested the Plan to submit information regarding its health care delivery system. The survey team conducted the onsite portion of the survey from August 24, 2015 through August 28, 2015.

The Department assessed the following areas:

Quality Management
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Access to Emergency Services and Payment
Prescription (RX) Drug Coverage
Language Assistance

The Department identified **11** deficiencies during the current Routine Survey. The 2015 Survey Deficiencies table below notes the status of each deficiency.

2015 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	QUALITY MANAGEMENT	
1	**The Plan does not consistently identify, review, correct, and follow up on quality of care issues with its providers.** Rule 1300.70(a)(1); Rule 1300.70(b)(1)(B)	**Not Corrected**
	GRIEVANCES AND APPEALS	
2	**The Plan does not have an established and effective mechanism for identifying and documenting the disposition of grievances.** Section 1368(a)(4)(B); Rule 1300.68(a)(1); Rule 1300.68(a)(2); Rule 1300.68(b)(5); Rule 1300.68(d)(8)	**Not Corrected**
3	**The Plan's grievance acknowledgment and resolution letters do not consistently display the Department's toll-free telephone number, the Department's TDD line, the Plan's telephone number, and the Department's Internet Web site address in 12-point boldface type.** Section 1368.02(b); Rule 1300.68(d)(7)	**Not Corrected**

4	**The Plan does not consistently ensure adequate consideration of enrollee grievances and rectification when appropriate.** Section 1368(a)(1)	**Not Corrected**
5	**Upon receipt of an expedited grievance, the Plan does not immediately inform enrollees of their right to contact the Department.** Rule 1300.68.01(a)(1)	**Not Corrected**
6	**Enrollees cannot submit online grievance forms through the Plan's Internet website.** Section 1368.015(a)	**Not Corrected**
	ACCESS AND AVAILABILITY OF SERVICES	
7	**The Plan does not consistently meet timely access standards set forth in its own policies and procedures, as filed with the Department.** Section 1351(b); Section 1386(b)(1)	**Not Corrected**
	UTILIZATION MANAGEMENT	
8	**The Plan does not consistently communicate decisions to deny, delay, or modify health care services based in whole or in part on medical necessity to enrollees in writing within two business days of the decision.** Section 1367.01(h)(3)	**Not Corrected**
	CONTINUITY OF CARE	
9	**The Plan's continuity of care policy does not include a description of its block transfer process.** Section 1373.95(a)(2)(A)	**Not Corrected**
	PRESCRIPTION (RX) DRUG COVERAGE	
10	**The Plan does not consistently use licensed pharmacists to deny or modify requests for non-formulary drugs based on medical necessity.** Section 1367.01(e)	**Not Corrected**

11	**For decisions to deny, delay, or modify pharmacy requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response:** • **A clear and concise explanation of the reasons for the decision;** • **A description of the criteria or guidelines used; and** • **The clinical reasons for the decision.** Section 1367.01(h)(4)	**Not Corrected**

SURVEY OVERVIEW

The Department evaluates each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975.[1] At least once every three years, the Department conducts a Routine Survey of a Plan that covers major areas of the Plan's health care delivery system. The survey includes a review of the procedures for obtaining health services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the Plan in providing health care benefits and meeting the health needs of the subscribers and enrollees in the following areas:

Quality Management – Each plan is required to assess and improve the quality of care it provides to its enrollees.

Grievances and Appeals – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.

Access and Availability of Services – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

Utilization Management – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

Continuity of Care – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Access to Emergency Services and Payment – Each plan is required to ensure that emergency services are accessible and available, and that timely authorization mechanisms are provided for medically necessary care.

Prescription Drugs – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescriptions and ensure benefit coverage is communicated to enrollees.

Language Assistance – Each plan is required to implement a Language Assistance Program to ensure interpretation and translation services are accessible and available to enrollees.

The Preliminary Report was issued to the Plan on February 24, 2016. The Plan had 45 days to file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action.

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

This Final Report addresses the most recent Routine Survey of the Plan, which commenced on June 5, 2015 and closed on December 31, 2015. The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department making the Final Report public.

PLAN BACKGROUND

Molina Healthcare of California is a for-profit health care organization established in 1980. The Plan serves the Medicaid population in fifteen different states, including California. The principal executive office is located in Long Beach, California.

The Plan was licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act on March 14, 1994 under the Department's jurisdiction. The Plan also has a contract with the Department of Health Care Services (DHCS) to provide and administer health care services to California Medi-Cal beneficiaries. The Plan operates as a commercial plan under the two-plan model in providing Medi-Cal managed care for Medi-Cal beneficiaries residing in Riverside and San Bernardino Counties, and under the geographic managed care (GMC) model for beneficiaries residing in Sacramento and San Diego Counties.

Due to the Medi-Cal managed care expansion, as of November 1, 2013, the Plan began providing services to beneficiaries in Imperial County. The Plan provides health care services to members through arrangements with 45 Independent Physician Associations (IPAs), 2,883 Primary Care Physicians (PCPs), 60 hospitals, 8,044 specialists, and 17 Molina Medical Group (MMG) clinics.

As of June 30, 2015, the Plan provided health care services to 584,878 members in California. The membership breakdown per program (not counting Medicare) is as follows:

TABLE 1

LINE OF BUSINESS	NUMBER OF ENROLLEES
Medi-Cal	424,886
Molina Marketplace[2]	19,555
Cal MediConnect Plan	14,276
Contracted from other Plans	122,301

[2] Molina Marketplace is a Covered California Exchange Plan.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On February 24, 2016, the Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to:

(a) Develop and implement a corrective action plan for each deficiency, and
(b) Provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions.

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

DEFICIENCIES

QUALITY MANAGEMENT

Deficiency #1: The Plan does not consistently identify, review, correct, and follow up on quality of care issues with its providers.

Statutory/Regulatory Reference(s): Rule 1300.70(a)(1); Rule 1300.70(b)(1)(B)

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

Rule 1300.70(b)(1)(B)
To meet the requirements of the Act, which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:
(B) quality of care problems are identified and corrected for all provider entities.

Assessment: Plan Policy QM01A, Potential Quality of Care, outlines the quality review process as follows:

Level 2 Review: Medical Director

1. The Medical Director reviews the case summary and all documents of grievances related to medical quality of care issues. Upon completion, an appropriate severity level is assigned. The severity level is a numerical system. The QI Department tracks and trends all cases to identify any trends or issues.
   The QI severity level system is categorized as follows:
   Level 0: No Quality of Care Issue
   Level 1: Potential Quality Issue
   Level 2: Quality of Care Issue without negative outcome
   Level 3: Quality of Care Issue with negative outcome
   Level 4: Gross and flagrant violation of acceptable medical practice or service standard

2. The Medical Director documents his findings, final assessment and signs-off case.
3. If the Medical Director determines a quality of care issue exists, one or more of the following corrective actions including but not limited to:
    a. Off-cycle review by Professional Review Committee (PRC)
    b. Counseling or education by the Medical Director or designee via written or verbal communication
    c. Staff education by Provider Services Department or other department as appropriate
    d. Policy and procedure improvement or protocol submission
    e. Other

The Department selected two groups of Potential Quality Issue (PQI) files for review. The first group contained 30 PQI files. In four (4) out of 30 files (13%), the Plan assigned lower severity levels than was appropriate. In the second group, six (6) files assigned severity Level 2 or above by the Plan were selected for focused review. Of these six (6) files, the Department determined that five (5) files (83%) were assigned lower severity levels than appropriate. For example:

- *File #19:* The enrollee, who had a diagnosis of diabetes mellitus and toe swelling, was diagnosed in the provider's office with gangrenous toe (a condition that might result in loss of the foot or leg if not treated properly) and referred to a vascular surgeon and an ultrasound procedure. The enrollee went to the emergency room the next day. In the emergency room, the enrollee was diagnosed as having a gangrenous toe with cellulitis (a bacterial skin infection) and was subsequently admitted to the hospital. Plan staff initially assigned the case to Level 4, but after review of the enrollee's medical records, the Plan's medical director downgraded the case to Level 0, and no further action was taken. Notes in the file indicated that the enrollee should have had a follow-up appointment within 24 hours of discharge, which was not offered to the enrollee. Due to the seriousness of the enrollee's condition and lack of follow-up, the enrollee's treatment did not meet an accepted standard of care. Therefore, the Department determined that the case should have been assigned a higher severity level and undergone further review for potential corrective action

- *File #1 of focused pull:* The enrollee complained of missing dialysis due to failure of the Plan's transportation unit to deliver the enrollee in a timely manner. The Plan requested a corrective action plan (CAP) from the transportation unit and received a response that committed the unit to a new process. The Plan failed to follow up on the CAP to ensure the implementation of the new process had improved the timeliness of the transportation unit.

- *File #2 of focused pull:* The mother of the enrollee alleged inappropriate touching of her 12-year-old child by the provider. A Plan Medical Director initiated an investigation and reported the allegation to the police. Two weeks later, the Medical Director assigned a Level 3 to the case and reported it to the Continuous Quality Improvement Committee. This committee recommended that the Plan send a letter to the provider, file a report with the medical board, and block the provider from new enrollees. The Plan followed the case at three subsequent

quarterly Peer Review Committee meetings, but failed to get the provider to respond and submit a CAP for committee review and approval. There is no evidence of any further action taken by the Plan.

- *File #3 of the focused pull:* The case involves authorization for out-of-network (OON) services, which was not sent by the Plan to the OON provider until approximately six weeks after the authorization was approved. This led to delayed surgery for an adnexal mass (an abnormal growth/lump next to the uterus) where cancer was considered the probable diagnosis. The case was closed as severity Level 1, then re-opened approximately six months later with documentation in the file stating: "the case is part of the upcoming audit and [an Utilization Management] response is required in order to complete the file." The Medical Director reviewed the case, elevated the severity to Level 2, and asked the Plan's Administrative Services Department (which is responsible for processing OON requests) to review the issue. This case should have been assigned higher than Level 1 upon initial review and received additional assessment and potential corrective action at that time, rather than months later.

The Plan's Chief Medical Director reviewed the cited PQI cases with the Department's physician reviewer and agreed that the Plan assigned inappropriately low severity levels and failed to develop CAPs and follow-up on cases with quality of care issues.

Rule 1300.70(a)(1) requires the Plan to document that quality of care problems are identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. Rule 1300.70(b)(1)(B) requires the Plan's Quality Assurance Program to ensure that quality of care problems are identified and corrected for all provider entities. The Plan does not consistently assign appropriate severity levels to PQIs to ensure that cases with quality of care issues advance through the Plan's quality review process as outlined in Policy QM01A. Furthermore, when appropriate severity levels are assigned, there are instances where the Plan does not follow up on CAPs. Therefore, the Department finds the Plan in violation of these regulatory requirements.

TABLE 2
Adequate Investigation and Corrective Action of PQIs in Random Sample

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Potential Quality Issues	30	PQI underwent adequate investigation and was assigned corrective actions where appropriate	26 (87%)	4 (13%)

TABLE 3
Adequate Investigation and Corrective Action of PQIs in Focused Review

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Potential Quality Issues	6	PQI underwent adequate investigation and was assigned corrective actions where appropriate	1 (17%)	5 (83%)

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: In its response, the Plan indicated that it instituted the following internal improvements designed to ensure consistent and appropriate identification, review, correction and follow up on potential quality of care (PQOC) issues related to providers:

- The Plan redesigned its staffing model to increase the number of Medical Directors assigned to review PQOC cases. The redesign included assignment of a lead Medical Director to oversee the review and reporting process, and provide guidance to the team. The Plan assigned five Regional Medical Directors to review cases concerning providers in their regions, and added a third Registered Nurse to the PQOC team.
- The lead Medical Director is responsible for the following: (i) overseeing the Medical Director review process, (ii) training new Medical Directors and maintaining the ongoing process integrity for all Medical Directors participating in the PQOC reviews, (iii) meeting regularly with review nurses to address routine and urgent concerns, (iv) reporting to the CMO on a regular basis and escalating issues impacting the PQOC process, and (v) ensuring an appropriate Medical Director review process.
- Assigning PQOC cases to be reviewed by Medical Directors familiar with the County or line of business raised in grievances so that patterns of grievances will be more readily identified. Cases involving Medicare and Skilled Nursing Facilities and Long Term Care related PQOC issues will be assigned to dedicated Medical Directors.
- Consistent and regular CMO involvement through scheduled and ad hoc meetings with the PQOC Lead Medical Director.
- To ensure consistency in the Medical Director Review Process, Plan will add PQOC case review training to Medical Director Meetings (twice a year-scheduled for Q3 and Q4 2016). The training material will include cases reflective of actual cases and distributed to all PQOC Medical Directors for their review and assignment of severity level prior to the meeting. The Medical Directors will review the cases as a group at the Medical Director meeting. The Medical Directors will report and align the severity level assignments and review any variations from the appropriate level as a team. Through this process, the PQOC

Lead Medical Director can identify additional training needs. The Chief Medical Officer (CMO) will participate in this process by independently reviewing the training cases and participating in the Medical Director team meeting case discussions.

- Effective Jan 4, 2016, the Plan transitioned from a paper based review process to an electronic based process with a centralized PQOC database. The database is built upon the Compliance HIPAA Management Program (CHAMP) database platform. The CHAMP database platform allows for:
    - Consistent, effective review of PQOC cases and ensures cases advance through the plan review process.
    - Clearly defined severity levels.
    - Electronic file uploading, file review, and Medical Director Case review notation and severity leveling.
    - Electronic reporting of open cases, review and corrective action plan status.
    - PQOC reporting that identify trends in line of business and county. Reports identify outstanding cases, turnaround times and cases pending provider follow-up. The PQOC Lead Medical Director will receive monthly reports.
    - PQOC Lead Medical Director visibility on tracking and trending, status of outstanding cases and turnaround times.

For consistent staff and Medical Director training and reference, the Plan reports that a PQOC Database Desktop Reference Guide is available.

Plan policies and procedures were revised to reflect the updated electronic process, as follows: (i) Quality Management QM 0lA Potential Quality of Care-PQOC, and (ii) QM 0lB Potential Quality of Care - PQOC for CBAS SNF and MSSP were reviewed and revised.

Additionally, severity levels were revised to more precisely identify quality of care issues as follows:

- Level 1: No quality of care issue identified
- Level 2: Adverse occurrence, handled appropriately by provider
- Level 3: Moderate deviation from the standard of care
- Level 4: Significant deviation from the standard of care

In addition, the Plan stated that it is developing a PQOC CAP policy and procedure to clearly define the Plan's processing and follow-up of CAPs, to be presented at its May 24, 2016 QIC meeting for approval. The Plan included a draft of the policy and procedure. The new policy is intended to ensure the Plan is able to clearly define processing and follow-up of a PQOC Corrective Action Plan (CAP). The policy will be presented at the May 24, 2016 QIC meeting for review and approval. The draft policy included, among other things:

- Development of a tracking log for issued CAPs to ensure timely completion and documentation of outcomes, and
- Review of open Tracking Log issues as a standing agenda item for each Peer Review meeting.

Any PQOC cases pending due to non-responsive providers or IPAs, non-closed incomplete CAPs, or incomplete peer reviews will be escalated first to PQOC Lead Medical Director then, as necessary, to CMO as outlined in the CAP policy.

Final Report Deficiency Status: Not Corrected

The Department finds that by redesigning the staffing model, transitioning from a paper based to electronic review process and revising policies and procedures to reflect the updated process, the Plan has taken steps towards correcting this deficiency. However, in order to verify that the Plan has fully implemented these changes and that the changes are effective to correct the deficiency, the Department must assess implementation and conduct a file review of potential quality review cases subjected to the Plan's new processes.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected. The Department will review Plan files and determine compliance at the follow-up survey.

GRIEVANCES AND APPEALS

Deficiency #2: The Plan does not have an established and effective mechanism for identifying and documenting the disposition of grievances.

Statutory/Regulatory Reference(s): Section 1368(a)(4)(B); Rule 1300.68(a)(1); Rule 1300.68(a)(2); Rule 1300.68(b)(5); Rule 1300.68(d)(8)

Section 1368(a)(4)(B)
Grievances received by telephone, by facsimile, by e-mail, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:
(i) The date of the call.
(ii) The name of the complainant.
(iii) The complainant's member identification number.
(iv) The nature of the grievance.
(v) The nature of the resolution.
(vi) The name of the plan representative who took the call and resolved the grievance.

Rule 1300.68(a)(1)
"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Rule 1300.68(a)(2)
"Complaint" is the same as "grievance."

Rule 1300.68(b)(5)
A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to Section 1300.69, and by an officer of the plan or his designee. This review shall be thoroughly documented.

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

Assessment: Plan Policy PO-19, Member Grievance Process states:

> Grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, and a request for reconsideration or appeal made by an enrollee or the enrollee's representative and remains unresolved to the member's satisfaction. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance … a grievance may be presented in person, telephone, fax, e-mail, or in writing to MHC or at any office of a MHC provider and can require an expedited or standard resolution.
>
> …
>
> MHC shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting 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) … For the Medi-Cal category of the report, provide the following additional information: a) The total number of grievances received b) The average time it took to resolve grievances, which includes providing written notification to the member c) A listing of the zip codes, ethnicity, gender, and primary language of members who filed grievances.

1. Exempt grievances

In response to the Department's request for an exempt grievance log, the Plan submitted a memorandum dated June 24, 2015, which states:

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

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

In the absence of an exempt grievance log, the Department requested the Plan's inquiry log to assess whether the entries were appropriately categorized. The inquiry log submitted to the Department contained 395,002 entries. The Department selected a seven-day period (08/01/14 – 08/08/14) for review, which produced a universe of 11,593 entries. A random sample of 350 inquiries was then selected from this focus period. Out of the 350 entries reviewed, the Department determined that 21 entries (6%) should have been classified and resolved as exempt grievances because they were expressions of dissatisfaction that were resolved within 24 hours. For example:

- The enrollee contacted the Plan to find out why she was unable to obtain her medication. Plan staff contacted the pharmacy and arranged for the enrollee to obtain a one-time vacation override. This expression of dissatisfaction was classified as an inquiry.

- The enrollee's parent contacted the Plan because she was unable to obtain the enrollee's medication. The Customer Service Representative contacted the pharmacy and was able to facilitate the dispensing of the medication. This expression of dissatisfaction was classified as an inquiry.

2. Standard grievances

In the following cases, the Plan failed to identify and classify the calls as grievances. In addition, there was no evidence in the file about when or how the issues were resolved:

- Date of call: 08/05/14. Call classification: Auth/Referral. Customer Service Representative notes state: "Member is calling to check on status of MRI … Contacted [imaging center] who stated that request was sent back to follow with the appeals process, said that office was told that request was not going to be processed twice to follow appeals process in order to get it approved. Member upset because she says that office not supporting her in making this request said that she will have to call office to let them know to call us, said that she feels like she's doing their job for them but said she will tell them to call in." The call was classified as an inquiry. There was no documentation of investigation and resolution of the issue.

- Date of call: 08/07/14. Call classification: Prescription Fulfillment. File notes state: "Call Reason: Assistance with a referral for an allergist. Mom stated her son has been in the ER numerous times and she now thinks he should see a specialist for his asthma. Member stated she was told by PCP that they will not give her a referral. Member is a Molina direct member. Called PCP [clinic] and [spoke with staff] who stated she will call back in 10 [minutes] and verify if it will be declined or if they will evaluate member for the referral. Advised member I will follow up with her as soon as I hear something. Advised member she has the right to file a complaint and or change doctors." There was no documentation of additional action taken by Plan staff to resolve the issue.

Rules 1300.68(a)(1) and (a)(2) define "grievance" and "complaint" as "a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative." Section 1368(a)(4)(B) and rule 1300.68(d)(8) require the Plan to maintain a log of exempt grievances. Rule 1300.68(b)(5) requires the Plan's written grievance record to include the disposition of the grievance. The Plan does not identify exempt grievances and does not have an exempt grievance log. Instead, the Plan put all of the exempt grievances into its inquiry log. While reviewing the Plan's inquiry log for exempt grievances, the Department also discovered mis-categorized standard grievances in the inquiry log that did not contain dispositions. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan states in its response that it implemented the following remediation efforts:

- The Plan's Grievance Department and Member Services Contact Support Center (CSC) developed a unique call code to accurately identify exempt grievances. This enabled the Plan to generate an exempt grievance report for tracking purposes. The Plan included a screen shot of the call code. As a result, the Plan stated that it is now able to effectively identify and distinguish between inquiries, complaints and true grievances.
- Exempt grievances identified through the newly created call code are tracked on a daily basis by the CSC leadership and routed to the Appeals and Grievance (A&G) team via the A&G application. Upon receipt of an exempt grievance, the A&G intake unit reviews each exempt case to validate that the disposition of the case is accurately identified and the call is coded correctly. After reviewed and validated, the case is resolved and closed in the A&G application and saved for tracking purposes.
- Beginning in March 2016, an exempt grievance report will be reviewed through the A&G Committee. Any issues or trends identified through the exempt grievance report will be escalated through A&G Committee to other high-level oversight committees within the Plan to ensure immediate follow up and that the appropriate leadership takes corrective action.

- The Plan developed a training module specifically for CSC staff, conducted in March 2016, to ensure accurate identification and coding of exempt grievances during the intake process. In addition, Plan Appeals and Grievances (A&G) Staff were provided refresher training in March 2016 to assist staff in accurately identifying, categorizing and documenting the disposition of grievances. The Plan's A&G staff was also introduced to the new exempt grievance monitoring and tracking processes.
- Additionally, the Plan re-issued to staff its policy that specifically outlines the documentation process (Policy - Appeals and Grievance AG-19) for education and training purposes.

In its response, the Plan submitted a list of exempt grievances it received between March 28, 2016 and April 1, 2016. The list includes a designation that indicates that a grievance was resolved with an Exempt Resolution code (3).

Final Report Deficiency Status: Not Corrected

The Department finds that although the Plan has undertaken efforts to correct the deficiency, the Plan's proposed/implemented corrective actions are not sufficient to demonstrate that the deficiency has been corrected or that the Plan is in compliance with the cited statutes/rules.

Under Section 1368(a)(4)(B), a health plan's exempt grievance log must include specific information, including, but not limited to, the nature of the grievance and the nature of the resolution. The same section includes in the definition of an exempt grievance, those grievances that are "resolved by the next business day following receipt. . . ."

The revised policy and procedure submitted by the Plan (A&G – 19) does not address the specific information required by Section 1368(a)(4)(B). This Plan policy describes the Plan's handling of various types of grievances. The section that addresses exempt grievances shows only that a written acknowledgment and response is not required, but does not include a description of how exempt grievances are to be documented and tracked. On the other hand, with respect to other types of grievances, such as standard and expedited, the policy describes the precise information that must be documented and how those grievances are to be handled.

Similarly, the exempt grievance log submitted by the Plan did not contain the specific information required by Section 1368(a)(4)(B), such as the nature of the grievance and nature of the resolution.

Additionally, the Plan's March 1, 2016 A&G Department Agenda shows the definition of an exempt grievance to be one in which the Plan's call center "is able to resolve their issue at the time of their call." A similar timeframe for resolution was given in the March 2, 2016 training materials presented by the Plan ("….Resolved during the time of the call, to the member's satisfaction.") Under Section 1368(a)(4)(B), however, the timeframe for resolving an exempt grievance is "the next business day following receipt" – a definition accurately captured in the Plan's A&G – 19 policy, but inaccurately reflected on the meeting agenda and training materials.

Nothing in the A&G-19 policy and procedure, training materials, screen shot or Plan submissions as part of its response showed how use of the unique call code (C) enabled the Plan to generate or track its exempt grievance report, or effectively identify and distinguish between inquiries, complaints and true grievances, as stated by the Plan in its response.

Finally, the Plan's corrective action plan was predominantly focused on exempt grievances, and offered little that addressed the second part of the identified deficiency concerning the failure to identify and properly classify standard grievances.

Based upon the foregoing and the corrective actions undertaken, the Department has determined that this deficiency has not been corrected. The Department will reassess the Plan for compliance at the follow-up survey, to include grievance file review in addition to a review of the Plan's exempt call log.

Deficiency #3: The Plan's grievance acknowledgment and resolution letters do not consistently display the Department's toll-free telephone number, the Department's TDD line, the Plan's telephone number, and the Department's Internet website address in 12-point boldface type.

Statutory/Regulatory References: Section 1368.02(b); Rule 1300.68(d)(7)

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

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(insert health plan's telephone number)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical

decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online."

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

Assessment: Plan Policy PO-19, Member Grievance Process states:

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

The Department reviewed 70 standard grievance and appeal files. Out of these 70 files, 68 acknowledgment letters (97%) and 62 resolution letters (89%) did not appropriately display the required statement. The Department also reviewed 31 expedited grievance and appeal files. One file was disqualified because it did not meet the expedited review criteria. Of the remaining 30 files, none of the acknowledgment and resolution letters (100%) appropriately displayed the required statement.

Section 1368.02(b) and Rule 1300.68(d)(7) require the Plan's grievance and appeal acknowledgment and resolution letters to include a quoted statement with the DMHC's toll-free telephone number, the DMHC's TDD line, the Plan's telephone number, and the DMHC's website address. Furthermore, the four items in the statement must be in 12-point boldface type while the rest of the statement is in regular type. As the Plan did not consistently include the required language in the specified format in its acknowledgment and resolution letters to enrollees, the Department finds the Plan in violation of these statutory and regulatory requirements.

TABLE 4
Acknowledgment and Resolution Letters Include Department Language pursuant to Section 1368.02(b)

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances and Appeals	70	Acknowledgment letter includes Department language as required	2 (3%)	68 (97%)
Standard Grievances and Appeals	70	Resolution letter includes Department language as required	8 (11%)	62 (89%)
Expedited Grievances and Appeals	30	Acknowledgment letter includes Department language as required	0 (0%)	30 (100%)
Expedited Grievances and Appeals	30	Resolution letter includes Department language as required	0 (0%)	30 (100%)

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: In response this deficiency, the Plan provided copies of its template letters that display the Department's toll-free telephone number, the Department's TDD line, the Plan's telephone number, and the Department's Internet website address in 12-point boldface type and policies which direct its staff to use templates located on the Plan's SharePoint site. The Plan also indicated that it implemented the following corrective actions:

- All acknowledgement and resolution letter templates were updated to reflect Department's toll-free telephone number, the Department's TDD line, the Plan's telephone number, and the Department's Internet website address in 12-point boldface type.
- In January 2016, the Plan held a meeting with the Appeals and Grievance team specifically to review the letters, to ensure that staff are aware of the legal requirements, and to ensure staff use the updated templates in a consistent and accurate manner. The Plan included in its response a meeting sign-in sheet and agenda.
- On May 16, 2016, the Plan conducted training for all A&G staff to confirm they are using the accurate letter templates.

Final Report Deficiency Status: Not Corrected

The Department finds that although the template letters provided by the Plan satisfy the 12-point boldface font requirement set forth in Section 1368.02(b) and Rule 1300.68(d)(7), the Department will need to conduct file review of actual case files to determine whether the deficiency has been corrected and the Plan is in compliance with the cited statute and regulation. Moreover, the Department notes that although the Plan submitted policies, procedures, and training materials in response to this deficiency, those items did not include information specific to the correction of this deficiency, but rather included other grievance process information. In order for the Department to conclude that appropriate training took place, training materials and sign-in sheets relevant to the deficiency should have been submitted.

Based on the corrective actions undertaken, the Department has determined that this deficiency has not been corrected and reassessment, to include grievance file review, will be conducted at the follow-up survey.

Deficiency #4: The Plan does not consistently ensure adequate consideration of enrollee grievances and rectification when appropriate.

Statutory/Regulatory Reference: Section 1368(a)(1)

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

Assessment: The Department reviewed 53 standard grievance and appeal files. The Department found that the Plan failed to consistently identify and address all issues raised in the grievance in seven (7) of the files[3] (13%) reviewed. For example:

- *File #6:* The enrollee was scheduled to receive interpreter services, but the Plan canceled the interpreter. The enrollee reported trying to call the Plan several times between 8:30 a.m. and 9:00 a.m. and was unable to get through. Plan staff identified the interpreter service cancellation as an issue, but failed to recognize and follow up on the access issue, i.e., the enrollee was unable to reach the Plan.

- *File #14:* The enrollee complained about the length of time to get a gastroenterologist referral. “Member stated that he was told it was going to take an additional 2 weeks to get an answer for a referal [sic] to see a Gastroentorologist [sic]. He stated he’s already waited about 5 weeks. Member

[3] Files #2, 3, 6, 8, 11, 14, 21.

complaining about dihonest [sic] phone practice. Making you stay on hol[d] for about 20 minutes and then to say unable to assist [or] leave message." The Grievances and Appeals Department referred the gastroenterologist access issue for follow-up and for tracking and trending. However, the enrollee's complaint about the telephone hold and wait time was not identified or addressed as part of the grievance.

- *File #21:* The enrollee was dissatisfied with the service provided by [physician] and the Plan. The file states: "Member not happy with Molina Healthcare Administrative work, not satisfied with Molina Health Care agents assisting her in questions or coverage questions and PCP administrative work." The resolution letter states: "The Office Manager informed us that after reviewing the office appointment time book and computer schedule generator, there is no record of an appointment scheduled for you on August 13, 2014. In addition, records show that the original appointment was scheduled for August 19, 2014. Lastly, the office of [physician] apologizes for any inconvenience this may have caused you." Neither the case notes nor the resolution letter address the enrollee's concerns about the Plan's service.

Section 1368(a)(1) requires the Plan's grievance system to ensure adequate consideration of enrollee grievances and rectification when appropriate. When a grievance has multiple issues, the Plan does not consistently detect and resolve all underlying issues, which may prevent the Plan from identifying and addressing opportunities for improvement. Therefore, the Department finds the Plan in violation of this statutory requirement.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan's response stated that it undertook several efforts to ensure that enrollee grievances are consistently and adequately considered and that all issues are identified, coded and appropriately rectified. Plan efforts include the following:

- The Appeals and Grievances (A&G) Department developed an internal quality monitoring and review process to permit the Plan to conduct an independent, secondary review of all acknowledgement and resolution letters. The process includes an assessment of whether issues were accurately identified, documented and resolved. The process will also include confirmation that all issues were routed to the appropriate department for corrective action, and that resolution actions are documented in the grievance database and enrollee resolution letter. The quality-monitoring tool is reviewed by A&G leadership on a bi-weekly basis to address any potential staff performance issues and to ensure continued improvement.
- An A&G team meeting was held in January 2016 to provide refresher training to ensure consistent and adequate consideration of enrollee grievances.

- Additional refresher training was scheduled for May 2016 for all A&G staff to review the Plan's policies and procedures concerning identification, documentation and rectification of enrollee grievances.
- On a quarterly basis, the grievance trend report is reviewed through A&G Committee for follow up and corrective action. Additionally, any issues or trends identified from the exempt grievance report will be escalated through the A&G Committee to other high- level oversight committees within the Plan to ensure immediate follow up and corrective action is taken by the appropriate leadership in those functional areas.

Final Report Deficiency Status: Not Corrected

The Department finds that the Plan has taken steps toward correcting this deficiency. However, the Department will, at the follow up survey, verify implementation of all the Plan's proposed corrective actions and conduct file review to assess whether the Plan's actions have corrected the deficiency.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

Deficiency #5: Upon receipt of an expedited grievance, the Plan does not immediately inform enrollees of their right to contact the Department.

Statutory/Regulatory References: Rule 1300.68.01(a)(1)

Rule 1300.68.01(a)(1)
(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:
(1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.

Assessment: Plan Policy PO-19, Member Grievance Process, and Plan Policy PO-20, Member Appeal Process, confirm this Rule: "Members are informed in writing of their right to contact the DMHC immediately and no later than twenty-four (24) hours of MHC's receipt of the denial." During interviews, Plan staff indicated that they notify the enrollees of their right to contact the Department only through the acknowledgement letter, which could be sent more than 24 hours after the Plan receives the grievance. No attempt is made to contact the enrollee immediately by telephone.

The Department reviewed 31 expedited grievance and appeal files. One file was eliminated from the sample because it did not meet the expedited review criteria. Of the remaining 30 files, the Plan sent 25 acknowledgment letters within 24 hours of receipt of the expedited grievance. The remaining five acknowledgment letters (17%) were sent more than 24 hours after the Plan received the expedited grievance.[4]

Rule 1300.68.01(a)(1) requires the Plan to immediately notify enrollees of their right to contact the Department regarding expedited grievances. Although Rule 1300.68.01(a)(1) does not provide a timeframe for "immediate notification," the Plan determined that its enrollees would be notified of this right within 24 hours upon the Plan's receipt of the expedited grievance. Plan staff interviews and file review by the Department show that the Plan notifies enrollees of this right in acknowledgment letters, sent via first class mail. However, since the Plan does not consistently send acknowledgment letters to enrollees within 24 hours of receiving expedited grievances, the Department finds the Plan in violation of this regulatory requirement.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan's response states that the Plan revised related policies and procedures and instituted a new process to correct the issue.

- The Plan submitted its Appeals and Grievances AG-19 policy, which was revised to provide the timeframe for "immediate notification" and states that in instances where the Plan is unable to send the acknowledgement letter within 24 hours of receipt of an expedited grievance that the Plan will make an immediate outbound call to notify the enrollee of their right to contact the Department.
- The Plan provided a sign in sheet evidencing that on May 3, 2016, the Plan's appeals and grievance staff received training regarding the outbound call process. The training was based on the Plan's procedure, SOP No. 11-Expedited Grievance Process. SOP No. 11 was revised on March 23, 2016.

Final Report Deficiency Status: Not Corrected

The Department finds that by updating its policy for the handling of expedited grievances to require that staff notify enrollees of the right to contact the Department regarding the grievance the same day the grievance is received, and training its staff on the revised policy, the Plan has taken steps toward correcting this deficiency. However, the Department will need to conduct file review at the follow-up survey in order to assess whether implementation of the corrective action has corrected the deficiency.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

[4] Files #1 (3 calendar days); 6 (2 calendar days); 21 (10 calendar days); 22 (3 calendar days); 30 (5 calendar days).

Deficiency #6: Enrollees cannot submit online grievance forms through the Plan's Internet website.

Statutory/Regulatory References: Section 1368.015(a)

Section 1368.015(a)
Effective July 1, 2003, every plan with an Internet web site shall provide an online form through its Internet Web site that subscribers or enrollees can use to file with the plan a grievance, as described in Section 1368, online.

Assessment: The Plan's document, Molina Healthcare Instructions: How to File a Grievance, states that enrollees can file a grievance "by 1) calling Member Services, 2) submitting a written grievance by mail, 3) submitting a written grievance by fax, or 4) filing electronically via the internet at [email address]." During the website demonstration, Plan staff confirmed that there was an online grievance form. Enrollees can fill out the form, print it out, and mail it to the Plan or email the completed form to a Plan email address. There was no automatic submission button for enrollees to submit the completed forms online.

Section 1368.015(a) requires the Plan to provide an online grievance form through its website. As enrollees are unable to submit grievances online through the Plan's website, the Department finds the Plan in violation of this statutory requirement.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan's response stated that the Plan took the following actions to address the deficiency:

- The Plan redesigned its website to include a direct link for users to access the online member grievance forms on the front page of the website. The Plan stated that online grievance forms in all of the required threshold languages are accessible to members through this link.
- The Plan scheduled refresher training for its staff regarding the online grievance process and the newly created link to occur by June 27, 2016. The training materials will also be incorporated into ongoing refresher trainings for current staff and into the new hire training packet for new CSC staff.
- Appeals and Grievances leadership will provide training and education to occur by June 27, 2016, to HealthCare Services for distribution to all Case Management staff to ensure they can assist members with accessibility to the online grievance forms and can effectively communicate the process for submitting online grievances.

Final Report Deficiency Status: Not Corrected

To assess the Plan's compliance with Section 1368.015(a), the Department reviewed the Plan's website.[5] In its review, the Department found that the Plan's online grievance procedure did not meet all the requirements outlined in Section 1368.015, and only included a mechanism for the Plan's MediCal members and not its commercial members.

More specifically, there was no evidence of an online grievance procedure for the Plan's commercial members, and the Plan's online grievance procedure for MediCal enrollees failed to comply with the following requirements:

- Section 1368.015(b) (requiring accessibility through a hyperlink on the home page or member services portal that is clearly identified as "GRIEVANCE FORM"),
- Section 1368.015(c)(2) (requiring the online process to allow the subscriber or enrollee to preview the grievance and have an opportunity to edit the form prior to submission), and
- Section 1368.015(c)(3) (requiring the grievance submission process to include a current hyperlink to the Department's website).

The Department finds that although the Plan has redesigned its website to allow MediCal members to submit a grievance online, the Plan's online grievance submission process does not comply with all of the requirements of Section 1368.015, and fails to include a process for its commercial members. The Department will need to reassess the Plan's compliance with the requirements of Section 1368.015 at the follow-up survey.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected. Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a corrective action plan which addresses all elements of this deficiency, and provide a status report on the Plan's compliance efforts.

ACCESS AND AVAILABILTY OF SERVICES

Deficiency #7: The Plan does not consistently meet timely access standards set forth in its own policies and procedures, as filed with the Department.

Statutory/Regulatory Reference(s): Section 1351(b); Section 1386(b)(1)

Section 1351(b)
Each application for licensure as a health care service plan or specialized health care service plan under this chapter shall be verified by an authorized representative of the applicant, and shall be in a form prescribed by the department. This application shall be accompanied by the fee prescribed by subdivision (a) of Section 1356 and shall set forth or be accompanied by each and all of the following:

[5] http://www.molinahealthcare.com/members/ca/en-us/Pages/home.aspx.

(b) A copy of the bylaws, rules and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.

Section 1386(b)(1)
(b) The following acts or omissions constitute grounds for disciplinary action by the director:
(1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

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

TABLE 5

Appointment Type	Regulatory Requirement	Plan's Appointment Access Standard	Plan's Rate of Compliance Goal	Plan's Actual Rate of Compliance[6]
Urgent care appointments without prior authorization	Within 48 hours of the request	PCP: Within 24 hours of the request	90%	78.7%
Urgent care appointments without prior authorization	Within 48 hours of the request	Specialist: Within 24 hours of the request	85%	74.8%
Non-urgent appointments with specialist physicians	Within 15 business days of the request	Within 10 business days of the request	85%	75.2%
Non-urgent appointments with non-physician mental health care providers	Within 10 business days of the request	Within 10 business days of the request	80%	60.9%

[6] The Plan's actual compliance rates are based on the requirements set forth in rule 1300.67.2.2(c)(5).

Behavioral health urgent care appointments with prior authorization	Within 96 hours of the request	Within 48 hours of the request	80%	40.9%
Behavioral health urgent care appointments without prior authorization	Within 48 hours of the request	Within 48 hours of the request	80%	59.3%

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

Section 1351(b) requires the Plan to file documents regulating the conduct of its internal affairs with the Department. Pursuant to Section 1386(b)(1), the Plan may be subject to disciplinary action when it operates at variance with basic organizational documents filed with the Department. Since Policy QM-09 is filed with the Department, the Plan may be subject to disciplinary action for failing to meet its appointment access goals.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan stated in its response that it updated the standards in the Access to Health Care Policy and Procedure (QM-09) in August 2015 to align with the state's regulatory standards for timely access to care. The Plan is also analyzing its 2015 Timely Access survey results with the updated access to care standards to determine rate of compliance. The Plan will evaluate results to determine if further updates should be made to QM-09.

The Plan also proposed development of training for its provider community to include:

- A timely access job aid for timely access to health care standards to be included in the Plan's quarterly communication to providers as well as in any materials generated for routine provider visits.

- Ensuring that access to health care standards is a standing agenda item at the provider joint operations meetings.
- Sharing survey data with its IPAs/MSOs to identify providers who need further education in regards to access.
- Identifying providers who did not meet the access to health care standards and issue a corrective action plan. These providers are also automatically resurveyed for the following year's annual survey.

In addition, the Plan represented that the Plan's Quarter 2 2014 Provider Access and Availability survey was conducted using a modified survey tool and that in July 2014, the Plan was informed by DMHC that this tool was not compliant with the DMHC Provider Access and Availability methodology. The Plan further stated that it conducted a second Provider Access and Availability Survey in Quarter 4 2014 using the Model Provider Appointment Availability Survey Methodology and survey tool, which resulted in a shortened survey period and may have contributed to low compliance rates due to lower provider response rates.

Final Report Deficiency Status: Not Corrected

The Plan proposed several corrective actions in response to the cited deficiencies. However, the Department has not had an opportunity to assess whether the Plan has fully implemented the corrective action, or whether the corrective action will be effective to correct the deficiency. The Plan's response provides little detail on how the corrective action will ensure improved rates of timely access. For example, it is unclear to the Department how the proposed provider training will improve access or what corrective actions will be taken with providers who fail to meet accessibility standards in order to ensure timely access.

At the follow-up survey, the Department will review the Plan's implementation of corrective action, any related policies and procedures and rates of access compliance. The Department may also examine how the Plan audited its timely access for compliance following implementation of its corrective action.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected. Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a corrective action plan which addresses all elements of this deficiency, and provide a status report on the Plan's compliance efforts.

UTILIZATION MANAGEMENT

Deficiency #8: The Plan does not consistently communicate decisions to deny, delay, or modify health care services based in whole or in part on medical necessity to enrollees in writing within two business days of the decision.

Statutory/Regulatory Reference(s): Section 1367.01(h)(3)

Section 1367.01(h)(3)
Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

Assessment: Plan Policy CA-HCS-CAM-325, Authorization Process states, "written notification of denial and/or modification to practitioner and member" is to be "within two business days of making the decision." Based on a review of 72 UM denial files, the Department determined that the Plan exceeded the two-business day timeframe for written notification to the enrollee in eight (8) files[7] (11%). File #65 is particularly noteworthy because the written denial notification letter was sent over seven weeks after the decision.

Section 1367.01(h)(3) requires the Plan to ensure that "decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision." Since UM denial letters are not consistently sent to enrollees within two business days of the decision, the Department finds the Plan in violation of this statutory requirement.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: In response to this deficiency, the Plan implemented the following corrective actions:

- The Plan conducted review of two of its policies – Notification of Denial, Deferral, or Modification Request for Plan Authorization of Services (CA-HCS-CAM 351) and Authorization Process (CA-HCS-CAM 325), to verify each policy correctly identifies current regulatory and contractual obligations.
- The Plan created a report to track the time from the date of the authorization decision to the time the provider and member are notified both verbally and in writing. This corrective action component was scheduled to be implemented April 1, 2016.
  The Plan will require the time-tracking report to be run by supervisors who oversee operation of the Plan's authorization process, and shall share the report with Health Care Services leadership on a daily basis to identify errors and potential barriers to compliance and allow for immediate corrective action. For staff who fail to meet these requirements disciplinary action will take place up to

[7] Files #5, 22, 32, 34, 43, 56, 58, 65.

and including termination. This information will be reported to the Utilization Management Committee (UMC) on a quarterly basis.
- The Plan scheduled three trainings concerning regulatory and contractual obligations for notifying providers and enrollees.

Final Report Deficiency Status: Not Corrected

The Department finds that the corrective action proposed by the Plan was not fully implemented so as to allow the Department to verify the implementation or whether the Plan has achieved compliance. In order to assess whether the Plan has corrected this deficiency, the Department will need to conduct a file review at the follow-up survey.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

CONTINUITY OF CARE

Deficiency #9: The Plan's continuity of care policy does not include a description of its block transfer process.

Statutory/Regulatory Reference(s): Section 1373.95(a)(2)(A)

Section 1373.95(a)(2)(A)
A health care service plan shall include all of the following in its written continuity of care policy:
(A) A description of the plan's process for the block transfer of enrollees from a terminated provider group or hospital to a new provider group or hospital.

Assessment: Section 1373.95(a)(2)(A) requires the Plan's continuity of care policy to include a description of its block transfer[8] process. The Plan did not provide the Department with a copy of its block transfer policy when requested both pre-site and onsite. During interviews, Plan staff stated that they would try to find a policy, and provided the Department with Policy UM-79A: Continuity of Care – New Members and Current Members. This policy states: "Molina will also make provisions for continuity of care for existing members who are in an active course of treatment with a provider whose contract has terminated with MHC or a provider that has changed provider groups and who are eligible for continuation of care." Since this broad provision does not describe the Plan's block transfer process, the Department finds the Plan in violation of this statutory requirement.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

[8] Rule 1300.67.1.3(a)(3) defines block transfer as "a transfer or redirection of two thousand (2,000) or more enrollees by a plan from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract."

Plan's Compliance Effort: In response to this deficiency, the Plan submitted policies and procedures, which it stated had been revised, including:

- The Plan's Government Contracts (GC) Department P&P GC-06 policy, which the Plan stated outlines regulatory requirements for block transfer filings and identifies parties responsible for administering the block transfer process.
- The Plan's Health Care Services Department P&P UM-79A, Continuity of Care policy. The Plan stated this policy was updated to cross-reference GC-06 Provider Network Terminations of Subcontracting Providers policy and was scheduled to be presented to the Utilization Management Committee meeting on May 18, 2016 for formal review and approval. Under the revised policy, all authorizations listed in the block transfer will be evaluated and processed as indicated for Continuity of Care (COC). Any prior authorization or concurrent review authorizations received in a block transfer will be accepted and managed by the Plan.
- The Plan's Provider Contracting P&P PC-22 policy, which the Plan stated was developed to describe the end to end process, including the continuity of care process and the appropriate notifications to internal departments and external stakeholders and Molina members.

Final Report Deficiency Status: Not Corrected

Upon approval by its Utilization Management Committee, the Plan is required to file revised and approved policies and procedures with the Department's Office of Plan Licensing. At the follow-up survey, the Department will reassess to determine whether the Plan has filed a compliant policy with the Department and whether the deficiency has been corrected.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

PRESCRIPTION (RX) DRUG COVERAGE

Deficiency #10: The Plan does not consistently use licensed pharmacists to deny or modify requests for non-formulary drugs based on medical necessity.

Statutory/Regulatory Reference(s): Section 1367.01(e)

Section 1367.01(e)
No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

Assessment: Plan Policy CA-HCS-CAM-325, Authorization Process states, "Only licensed, qualified health professionals (e.g., MD or DO, dentist, pharmacist (R.Ph. or

Pharm D. for pharmaceuticals only), are responsible for the review of cases regarding medical necessity and/or appropriateness that the UM staff cannot approve, and are responsible for and may render denial determinations."

The Department reviewed 72 pharmacy denial files and found that in 41 files (57%), the Plan used pharmacy technicians instead of pharmacists to review the medical necessity cases. In addition, Plan staff acknowledged in interviews that pharmacy technicians also modify non-formulary medication requests. Plan staff was unaware that a modification of a request has the same statutory requirements as a denial, and stated that they intend to change this practice and use a pharmacist to modify or deny non-formulary drug requests based on medical necessity.

Section 1367.01(e) requires the Plan to use licensed and competent health care professionals to deny or modify authorization requests for medically necessary health care services. Since the Plan does not consistently use pharmacists to deny or modify non-formulary medication requests based on medical necessity, the Department finds the Plan in violation of this statutory requirement.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: In response to this deficiency, the Plan identified its Policy P-07 (Prior Authorization Request Procedures – Pharmacy) and stated this policy requires that only licensed Pharmacists can deny or modify requests for non-formulary drugs based on medical necessity. The Plan further stated that to ensure that Plan staff is aware of all applicable requirements, the Plan's Pharmacy Department will conduct training sessions during the second quarter of 2016 to re-educate all Pharmacy staff of this requirement.

In addition, the Plan stated its Pharmacy Department will work with its IT Department to clearly identify the name and credentials of licensed Pharmacists to ensure that future reports clearly identify the Pharmacist who denied or modified the request.

Final Report Deficiency Status: Not Corrected

The Department notes that although the Plan's narrative response stated that its Policy P-07 requires "that only licensed Pharmacists can deny or modify requests for non-formulary drugs based on medical necessity," the Department reviewed the P-07 Policy provided by the Plan and found that the policy states that either "a plan pharmacist or Medical Director will review all relevant criteria" and "may approve, defer, modify or deny prior authorization requests for pharmaceutical services…."

The Department is not able to determine whether the Plan has corrected the deficiency, and will need to conduct file review at the follow-up survey to assess compliance.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

Deficiency # 11: For decisions to deny, delay, or modify pharmacy requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response:

- **A clear and concise explanation of the reasons for the decision;**
- **A description of the criteria or guidelines used; and**
- **The clinical reasons for the decision.**

Statutory/Regulatory Reference(s): Section 1367.01(h)(4)

Section 1367.01(h)(4)
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

Assessment: Plan Policy CA-HCS-CAM-351: Notification of Denial, Deferral or Modification Request for Plan Authorization of Services states, "Written notification of the denial will contain the following: 1. the specific reasons for the denial, in easily understandable language as defined by regulatory guidelines and NCQA accreditation requirements. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based."

The Department reviewed 72 Plan pharmacy denial files and found that 57 out of 72 denial letters (79%) did not include a clear and concise explanation of the reasons for the Plan's decision; 51 out of 72 denial letters (71%) did not include a description of the criteria or guideline; and 53 out of 72 denial letters (74%) did not include the clinical reasons for the Plan's decision. The guidelines used to make the denial determination are not described in the letters, but is offered to enrollees if they call member services. In addition, many of the pharmacy denial letters reviewed did not provide clinical rationale for denial; just that drug cannot be approved as requested and then offers the formulary alternatives. For example:

- *File #8:* "[Member] has asked Molina Healthcare of California Partner Plan, Inc. (Molina Healthcare) to approve a medication request for **Protonix Cap (pantoprazole)**. We cannot approve this treatment as asked. We will approve formulary alternative: ranitidine or famotidine. If the member continues to require a PPI, provide GI/ENT consult or chart notes documenting the member's condition or chart notes documenting pathological hypersecretory conditions such as: Zollinger-Ellison syndrome, multiple endocrine adenomas, or systemic mastocytosis, or GI bleeding. Long-term use of Proton Pump Inhibitors (PPIs), may have side effects such as increased risk of infection, bone fracture, low vitamin B12, and low magnesium. Therefore, effective August 1, 2013, all Proton Pump Inhibitors (PPIs) will require prior authorization after 6 months of use."

This letter does not include a description of the criteria or guidelines or the clinical rationale or the denial. In addition, the letter contains medical terms and abbreviations, which would most likely be unclear and not understandable to those without medical training.

Section 1367.01(h)(4) requires the Plan to provide enrollees with clear and concise explanations, descriptions of the criteria or guidelines used, and the clinical reasons for the Plan's decisions to deny, delay, or modify provider requests based on medical necessity. Review of the Plan's pharmacy denial letters revealed that the letters did not consistently include clear and concise explanations, criteria or guidelines, and clinical reasons for its decisions. Therefore, the Department finds the Plan in violation of this statutory requirement.

TABLE 6
Pharmacy Denial File Review

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Pharmacy Denials	72	Clear and concise explanation of the reasons for the denial	15 (21%)	57 (79%)
Pharmacy Denials	72	Description of criteria used to make the determination	21 (29%)	51 (71%)
Pharmacy Denials	72	Clinical reasons for the denial	19 (26%)	53 (74%)

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: In response to this deficiency, the Plan revised and updated the following policies and documents for the purpose of ensuring compliance with Section 1367.0l(h)(4) and Rule 1300.68(d)(4):

- Policy P-07, which the Plan stated was revised to reflect the relevant standards.

- A template for Plan reasons for decisions to deny, delay, or modify pharmacy requests, and planned implementation of regular, ongoing training sessions on the use of the new template.
- Creation of Pharmacy P&P P-25 Non Formulary Exceptions Process policy that describes a medical necessity guideline when there is no drug-specific clinical guideline approved by the Plan's Pharmacy & Therapeutics Committee for a non-formulary drug.

The Plan also addressed the need for greater training and education on standards and requirements in connection with denial letters, by creating a 'Pharmacy Denial Language Seminar.' The Plan scheduled the first seminar to take place on May 15, 2016, to include an examination for participants at the conclusion of the event.

Final Report Deficiency Status: Not Corrected

The Department reviewed the policies and documents identified by the Plan in response to this deficiency and is unable to ascertain what "relevant standards" or changes the Plan made to its Policy P-07 in order to ensure compliance with Section 1367.02(h)(4) and Rule 1300.68(d)(4). In order to determine whether the Plan has corrected the deficiency, the Department will need to conduct file review and may conduct interviews at the follow-up survey to assess compliance.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected. Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a corrective action plan which addresses all elements of this deficiency, and provide a status report on the Plan's compliance efforts.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Survey. The Department will conduct a Follow-Up Review of the Plan and issue a Report within 14-16 months of the date of this Final Report.

Prior to commencement of the follow-up survey, the Plan shall file with the Department's Office of Plan Licensing an amendment to its license application if changes to Plan policies and procedures necessitate an amendment pursuant to Sections 1351 or 1352, or Rules 1300.51 or 1300.52. A summary of filing information (Exhibit E-1) shall accompany any such filing and must indicate that changes are in connection with a deficiency in a routine survey.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, **DMHC Web Portal.**

Once logged in, follow the steps shown below to submit the Plan's response to the Final Report:

- Click the "eFiling" link.
- Click the "Online Forms" link
- Under Existing Online Forms, click the "Details" link for the **DPS Routine Survey Document Request** titled**, 2015 Routine Full Service Survey - Document Request.**
- Submit the response to the Final Report via the "DMHC Communication" tab.