CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Contract Number: H5810
Audit ID: 3321
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PC02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.

Reference:

42 CFR § 423.120(b)(5)(i); § 423.120(b)(5)(iii); § 423.578(d); Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

Molina Healthcare must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. Molina Healthcare currently has a link on their website addressing current formulary changes. However, the website has not been updated since 2/2/07. Additionally, there are not policies and procedures regarding formulary change notices.

Corrective Action Required:

Molina Healthcare must develop and implement policies and procedures to include the following regarding formulary change notices: 1) A provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes, which are defined as assigning a higher cost sharing to a drug, removing a drug from the sponsor's formulary, or adding utilization management tools to a drug at least 60 days prior to the date the change becomes effective. Also, include a provision to provide retrospective notice of formulary change because a Part D covered drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. 2) A description of the method(s) used to provide notification of formulary changes. Notification method(s) must include, at a minimum, posting formulary changes on each affected plan's internet website. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.

Reference:

42 CFR § 423.120(b)(5)(i-iii); § 423.120(b)(7); § 423.578(d); Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

Samples for worksheet WS_MR4_D were not submitted.

Corrective Action Required:

Submit 10 samples of notices regarding formulary changes on worksheet WS_MR4_D.

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Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.

Reference:

42 CFR § 423.120(b)(5)(i); § 423.120(b)(5)(iii); § 423.578(d); Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

Policy and procedure does not include a description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer.

Corrective Action Required:

Revise Policy and Procedure to include a description of the procedures for providing retrospective notice for drugs deemed unsafe by the FDA or removed from the market by the manufacturer. An example would be a Template Notice of Formulary or Cost-Sharing change, a list of covered Part D drugs removed from formulary, a sample of notices sent, or beneficiary communication logs.

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Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PT04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 5/14/2008
Element Release Date: 5/14/2008
Element Projected Completion Date: 9/30/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

P&T Consideration of the Therapeutic Advantages of Prescription Drugs - The P&T Committee must consider whether the inclusion of a particular Part D drug in a formulary or formulary tier has any therapeutic advantages in terms of safety and efficacy.

Reference:

42 CFR § 423.120(b)(1)(v); MA-PD Solicitation

Deficiencies:

Pharmacy and Therapeutic Committee minutes did not reflect a discussion of formulary or formulary tier placement of newly added medications. As stated in Policy and Procedure No. PD-5, paragraph III.C.2, second sentence, "The Committee shall consider the therapeutic advantages of a particular Part D drug, in terms of safety and efficacy, as basis for selecting formulary drugs and their respective formulary tiers."

Corrective Action Required:

Revise Pharmacy and Therapeutic Committee meeting minutes, or other documentation to show if Pharmacy and Therapeutics committee considers inclusion of a particular Part D drug on the formulary based on therapeutic advantages in terms of safety and efficacy. Additionally, document discussions of formulary or formulary tier placement. Submit documentation of committee discussion to ensure the above criteria will be reviewed, included, and placed into Pharmacy and Therapeutics committee meeting minutes. Submit committee meeting minutes to CMS for review from the next 2 quarterly meetings to ensure compliance.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PT06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

P&T Annual Evaluation of Part D Sponsor¿s Plan Treatment Protocols - The P&T Committee evaluates, analyzes and recommends treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products, at least annually in accordance with CMS requirements.

Reference:

42 CFR § 423.120(b)(1)(vii); MA-PD Solicitation

Deficiencies:

Pharmacy and Therapeutic Committee did not review treatment protocols and procedures within the past 12 months.

Corrective Action Required:

Pharmacy and Therapeutic Committee meeting minutes, or other documentation, should capture Pharmacy and Therapeutic Committee's evaluation, analysis and recommendations on treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products. Pharmacy and Therapeutic Committee review treatment protocols and procedures on at least an annual basis. Provide a sample to CMS from the next committee meeting showing evaluation of treatment protocols and how Molina will ensure they will be reviewed annually.

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Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PT07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

P&T Annual Approval of Therapeutic Classes - The P&T Committee will approve inclusion or exclusion of the therapeutic classes in the formulary on an annual basis.

Reference:

MA-PD Solicitation

Deficiencies:

Pharmacy and Therapeutic Committee minutes, or other documentation, did not indicate that the committee had approved the inclusion or exclusion of the therapeutic classes in the formulary in the last 12 months.

Corrective Action Required:

Pharmacy and Therapeutic Committee review and approve the inclusion or exclusion of therapeutic classes in the formulary on at least an annual basis, and document the review. Submit Pharmacy and Therapeutics meeting minutes from next meeting to ensure approval of inclusion or exclusion of therapeutic classes onto the formulary and documentation to ensure it will be reviewed on an annual basis.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/3/2008
Element Release Date: 4/3/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.

Reference:

42 CFR § 423.562(a)(3); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist. (1) Policies and procedures do not contain provisions for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist. (2) Policies and procedures do not contain provisions for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices (if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices).

Corrective Action Required:

Molina Healthcare must provide CMS with documentation that it arranges with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist by providing the following: (1) Policies and procedures that contain provisions for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist and (2) Policies and procedures that contain provisions for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices.

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Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/3/2008
Element Release Date: 4/3/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.

Reference:

42 CFR § 423.566(a); § 423.566(b); § 423.566(c); § 423.570(c)(1-2); MA-PD Solicitation; Reporting Requirements Section VII: Appeals Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

Deficiencies:

(1) Policies and procedures do not define coverage determination in accordance with § 423.566(b)(1-5). (2) Policies and procedures do not include provisions for tracking and addressing all requests for redeterminations. (3)Policies and procedures do not include a provision for quarterly reporting of required data.

Corrective Action Required:

Molina Healthcare must submit to CMS policies and procedures that (1) define "coverage determination" in accordance with § 423.566(b)(1-5), that (2) include provisions for tracking and addressing all requests for redeterminations, and that (3) include a provision for quarterly reporting of required data.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 6/4/2008
Element Release Date: 6/5/2008
Element Projected Completion Date: 6/5/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.568(a); § 423.568(e); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

(1) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, was not provided. (2) Upon review of a sample of Molina Healthcare's coverage determination case files, the number of untimely notifications of coverage determination is greater than the defective threshold.

Corrective Action Required:

Molina must provide CMS with the following: (1) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, and (2) Monthly coverage determination case files until sufficient evidence is documented that Molina Healthcare makes timely coverage determinations.

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Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/3/2008
Element Release Date: 4/3/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.

Reference:

42 CFR § 423.568(b); § 423.568(e); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

(1) Policies and procedures do not contain a provision stating that Molina Healthcare must authorize payment within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. (2) Policies and procedures do not contain a provision stating that Molina Healthcare must must make payment within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. (3) Molina Healthcare did not provide a notice template for enrollee notification when request is forwarded to the IRE that is consistent with CMS-issued model notice, Notice of Case Status.

Corrective Action Required:

Molina Healthcare must submit the following to CMS: (1) Policies and procedures that contain a provision stating that Molina Healthcare must authorize payment within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (2) Policies and procedures that contain a provision stating that Molina Healthcare must must make payment within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and (3) A notice template for enrollee notification when request is forwarded to the IRE that is consistent with CMS-issued model notice, Notice of Case Status.

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Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
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Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.

Reference:

42 CFR § 423.568(c-d); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare did not provide a notice template used to inform enrollees of an adverse coverage determination.

Corrective Action Required:

Molina Healthcare must submit to CMS a notice template used to notify enrollees of an adverse coverage determination.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Contract Number: H5810
Audit ID: 3321
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/3/2008
Element Release Date: 4/3/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.

Reference:

42 CFR § 423.570(c)(3); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

(1) Policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations do not identify the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, or a facsimile number to facilitate receipt of requests for expedited coverage determinations. (2) Policies and procedures do not state that all oral requests must be documented in writing and that documentation of the request must be maintained in a case file. (3) Policies and procedures do not discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. (4) Upon review of a sample of Molina Healthcare's expedited coverage determination case files, the number of incorrect decisions to expedite coverage determinations is greater than the defective threshold.

Corrective Action Required:

Molina Healthcare must submit the following to CMS: (1) Policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations that identify the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, or a facsimile number to facilitate receipt of requests for expedited coverage determinations. (2) Policies and procedures indicating that all oral requests must be documented in writing and that documentation of the request must be maintained in a case file. (3) Policies and procedures that discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. (4) Monthly expedited coverage determination case files until sufficient evidence is documented that decisions to expedite coverage determination requests are made correctly.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 6/4/2008
Element Release Date: 6/5/2008
Element Projected Completion Date: 6/4/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.

Reference:

42 CFR § 423.570(d); § 423.572(a); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

(1) Policies and procedures do not include a provision stating that denied requests to expedite a coverage determination must automatically be transferred to the standard coverage determination process. (2) Policies and procedures do not include provisions that give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice. (3) Upon review of expedited coverage determination case files, the number of improper denials of expedited coverage determinations is greater than the defective threshold.

Corrective Action Required:

Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that denied requests to expedite a coverage determination is automatically transferred to the standard coverage determination process. (2) Policies and procedures that give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notices are sent to enrollees following denials of expedited coverage determinations.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Contract Number: H5810
Audit ID: 3321
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD08
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 6/4/2008
Element Release Date: 6/5/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.

Reference:

42 CFR § 423.570(d)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Policies and procedures regarding enrollee notification following a decision to deny requests for expedited coverage determinations do not include the following: (1) A provision stating that oral and written notice must provide an explanation that Molina Healthcare must process the request using the 72 hour timeframe for standard determinations. (2) A provision stating that oral and written notice must inform the enrollee of the right to file an expedited grievance. (3) A provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. (4) A provision stating that oral and written notice must provide instructions about Molina Healthcare's grievance process and its timeframes. (5) Upon review of a sample of Molina Healthcare's expedited coverage determination case files, the number of improper notice of expedited coverage determinations is greater than the defective threshold.

Corrective Action Required:

Molina Healthcare must submit to CMS the following: Policies and procedures regarding enrollee notification following a decision to deny requests for expedited coverage determinations that include (1) A provision stating that oral and written notice must provide an explanation that Molina Healthcare must process the request using the 72 hour timeframe for standard determinations. (2) A provision stating that oral and written notice must inform the enrollee of the right to file an expedited grievance. (3) A provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. (4) A provision stating that oral and written notice must provide instructions about Molina Healthcare's grievance process and its timeframes. Molina Healthcare must also submit to CMS monthly expedited coverage determination case files until sufficient evidence is documented that proper notifices are being sent to enrollees following a decision to deny requests for expedited coverage determinations.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
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Element Release Date: 4/3/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.570(e); § 423.572(a-b); § 423.572(d); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

(1) Policies and procedures do not include a provision stating that Molina Healthcare must inform the enrollee within 24 hours when their requested in forwarded to the Independent Review Entity (IRE). (2) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, was not provided.

Corrective Action Required:

Molina Healthcare must submit to CMS the following (1) Policies and procedures that include a provision stating that Molina Healthcare must inform the enrollee within 24 hours when their requested in forwarded to the Independent Review Entity (IRE). (2) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, for cases that are forwarded to the IRE.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.

Reference:

42 CFR § 423.572(c); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

(1) Policies and procedures do not include a provision stating that if the decision is adverse, then Molina Healthcare must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. (2) Policies and procedures do not include a provision stating that if oral notice is provided for an adverse decision, the notices must: * State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. * Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. * Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. (3) Upon review of a sample of Molina Healthcare's expedited coverage determination case files, the number of improper notice of expedited coverage determinations is greater than the defective threshold.

Corrective Action Required:

Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that if the decision is adverse, then Molina Healthcare must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. (2) Policies and procedures that include a provision stating that if oral notice is provided for an adverse decision, the notices must: * States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. * Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. * Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notice is provided to enrollees concerning expedited coverage determinations.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
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Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.

Reference:

42 CFR § 423.578(a)(1-2); § 423.578(a)(4); MA-PD Solicitation and EP Attestation Addendum; Reporting Requirements for Section VI: Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

Deficiencies:

Molina Healthcare indicated that members are not able to request an exception because the formulary contains only 2 tiers (generic and brand). Therefore, the plan does not need a tiering exception. However, submission of a comprehensive formulary sample to CMS auditors indicated a 4 tier formulary, ie, Humatrope, tier 4 with prior authorization required, while another formulary submission and website formulary sample indicated that the formulary contained only 2 tiers. Molina Healthcare must develop policies and procedures regarding processing requests to its tiered cost-sharing structure whether there are 2 or 4 tiers. The exception process must include but not limited to: 1) A provision that allows an enrollee an appointed representative to file an exception request. 2) A provision stating if the the plan requires a written statement for exception. 3) A provision from the prescribing physician indicating the drug for treatment would not be effective as the requested drug and/or would have adverse effects. 4) A provision stating additional supporting medical documentation may be required for approval. 5) A provision stating Molina Healthcare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. 6) A provision stating that Molina Healthcare is waiting on a physician's statement in support of a tiering exception and must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. 7) A provision granting a tiering exception when it is determined that the drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. A 2-tiered formulary must include a statement to the exception process indicating that Molina Healthcare only has 2 tiers, therefore a tiering exception is not necessary. Additionally, Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.

Corrective Action Required:

Molina Healthcare must develop policies and procedures regarding processing requests to its tiered cost-sharing structure whether there are 2 or 4 tiers. The exception process must include but not limited to: 1) A provision that allows an enrollee an appointed representative to file an exception request. 2) A provision stating if the the plan requires a written statement for exception. 3) A provision from the prescribing physician indicating the drug for treatment would not be effective as the requested drug and/or would have adverse effects. 4) A provision stating additional supporting medical documentation may be required for approval. 5) A provision stating Molina Healthcare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. 6) A provision stating that Molina Healthcare is waiting on a physician's statement in support of a tiering exception and must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing a determination on tiering exception. 7) A provision granting a tiering exception when it is determined that the drug for treatment of the enrollee's condition wuld not be as effective for the enrollee as the requested drug and/or would have adverse effects. A 2-tiered formulary must include a statement to the exception process indicating that Molina Healthcare only has 2 tiers, therefore a tiering exception is not necessary. Additionally, Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.

CMS Part D Audit Report

Auditing Results (Public Website Version)

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Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
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Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.

Reference:

42 CFR § 423.578(b); § 423.578(b)(1); § 423.578(b)(2); § 423.578(b)(5); MA-PD Solicitation and EP Attestation Addendum; Reporting Requirements for Section VI: Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

Deficiencies:

Molina Healthcare does not have established policies and procedures for Exceptions Procedures of Non-Formulary Drugs. Additionally, there is no evidence in which Molina Healthcare has a notice template for requesting additional information from enrollee's prescribing physician.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to include a provision stating: 1) An enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception. 2) The prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be efffective because all covered Part D drugs on any tier would not be as effective, clinical evidence would indicate the current drug regimen is ineffective or adversely affect effectiveness or patient compliance, prescription alternative(s) on formulary have been ineffective. 3) If Molina Healthcare makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. 4) Exception requests must not be kept open indefinitely when a physician does not submit a supporting statement. 5) If Molina Healthcare is waiting on a physician's statement in support of a formulary exception request, they must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. 5)Molina Healthcare must grant a formulary exception when it determines that one of the three factors discussed in Number 2 above have been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. 6) Molina Healthcare does not restrict the number of exception requests submitted per enrollee. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Refer to Section 30.2 (Exceptions) in Chapter 18 of the Prescription Drug Manual for guidance. The notice template in Appendix 11 in the same chapter, although intended for members, may be helpful in developing a notice for requesting information from prescribing physicians.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
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Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.

Reference:

42 CFR § 423.578(c)(3); § 423.578(c)(4)(i-ii); EP Attestation Addendum; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare currently does not have policies and procedures in place regarding determining cost-sharing for approved exceptions. Molina Healthcare must develop and implement policies and procedures regarding Approval of Tiering and Non-formulary Exceptions Requests. Molina Healthcare indicated that for worksheet WS-CD2_D there were no samples for this universe because all formulary exceptions were approved. Documentation must still be maintained for every non-formulary and tiering exception request.

Corrective Action Required:

Molina Healthcare must develop and implement policies and procedures regarding Approval of Tiering and Non -formulary Exceptions Requests. Provisions in the policies must include: 1) Coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. 2) Enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. 3) All approved non-formulary drugs must be placed in existing cost-sharing tier(s). Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina Healthcare must provide an analysis and explanation of why the universe submitted for WS-CD2_D contained no information. Provide CMS with a detailed corrective action plan to ensure that this element and universe population will be met consistently.

CMS Part D Audit Report

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Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Contract Number: H5810
Audit ID: 3321
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/10/2008
Element Release Date: 4/10/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.

Reference:

42 CFR § 423.564(b); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Unable to determine compliance with this element. Plan did not submit any phone scripts, enrollee notices informing members whether their complaints are grievances or coverage determinations, and the Notice of Inquiry Regarding an Excluded Drugs.

Corrective Action Required:

The Plan needs to develop and submit phone scripts, enrollee notices informing members whether their complaints are grievances or coverage determinations, and the Notice of Inquiry Regarding an Excluded Drugs. Please explain how staff have been updated and trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
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Element Release Date: 5/4/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.

Reference:

42 CFR § 423.562(a)(1)(i); § 423.564(a-b); § 423.564(g); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Reporting Requirements for Section V: Grievances

Deficiencies:

The Grievance Policy does not describe the requirement for prompt appropriate investigation of grievances and does not adequately describe what specific information will be kept as described in CFR 42 423.564 (g).

Corrective Action Required:

The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe the minimum grievance data to be maintained and a record retention time frame of 10 years. Please refer to 42 CFR 423.456(g) and 42 CFR 423.505(e). The Policy must also state that the Plan will take prompt appropriate action including a full investigation of the complaint.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Contract Number: H5810
Audit ID: 3321
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/10/2008
Element Release Date: 4/10/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.

Reference:

MA-PD Solicitation

Deficiencies:

The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe the minimum grievance data to be maintained based on the above mentioned regulation. The Policy must also state that the Plan will take prompt appropriate action including a full investigation of the complaint.

Corrective Action Required:

The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe how the Plan will train relevant staff. Please describe in detail how staff are trained and monitored.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/10/2008
Element Release Date: 4/10/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.

Reference:

42 CFR § 423.564(e)(1-2); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

The Grievance policy states that if the plan takes the 14 day extension it will notify the beneficiary within three days of its decision. Generally, CMS expects that Plans notify beneficiaries on the same day it makes a decision to extend the deadline. The Notice of Plan¿s Decision to Extend the Deadline for Making a Decision Regarding a Grievance was not submitted for review.

Corrective Action Required:

Please update the policy to reflect that when the Plan decides to extend the response deadline it will notify beneficiaries the same day or as soon as possible. Please submit the Notice of Plan¿s Decision to Extend the Deadline for Making a Decision Regarding a Grievance.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Contract Number: H5810
Audit ID: 3321
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/10/2008
Element Release Date: 4/10/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.

Reference:

42 CFR § 423.564(e)(3)(i-ii); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Plan did not submit its Notice of Plan¿s Decision Regarding a Grievance. Therefore, review was not completed.

Corrective Action Required:

Please submit your Notice of Plan¿s Decision Regarding a Grievance.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/10/2008
Element Release Date: 4/10/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.

Reference:

42 CFR § 423.564(e)(3)(iii); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Plan did not submit its Notice of Plan¿s Decision Regarding a Grievance. Therefore, review was not completed.

Corrective Action Required:

Please submit your Notice of Plan¿s Decision Regarding a Grievance.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/10/2008
Element Release Date: 4/10/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.

Reference:

42 CFR § 423.564(f); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

The Grievance Policy and Procedures are incorrect relating to the reasons and time frames for responding to Expedited Grievances.

Corrective Action Required:

On page 3 of the grievance Policy and Procedure, section 2 refers to expediting a grievance related to provider availability. There is no such provision for expedited grievances. The two examples under this paragraph are correct. Please eliminate the references to provider availability being a reason for an expedited grievance. Section 6 in this policy and procedure refers to notifying the beneficiary within 30 days. Expedited grievances must be responded to within 24 hours. Please correct the Plan response time frames for expedited grievances.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.

Reference:

42 CFR § 423.582(a-b); § 423.586; MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare did meet this requirement but their policies and procedures did not mention about accepting written requests for standard redeterminations of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination. Molina does not meet this requirement because their policies and procedures did not include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. CMS reviewed Molina's documentation and it did not demonstrate a system to accept written requests from the enrollee for a redetermination within the 60 calendar day timeframe.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to include a provision for accepting written requests for standard redetermination of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination. Molina must revise its policies and procedures to include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Molina must provide CMS with documentation demonstrating its system for accepting requests for standard redeterminations which documents the ability to accept written request from the enrollee for a redetermination within the 60 calendar day timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. Since the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.

Reference:

42 CFR § 423.584(c)(1); § 423.586; MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement because CMS reviewed Molina's policies and procedures and found that they do not include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals. - a provision for documenting all oral requests in writing. - a provision for maintaining documentation of expedited redetermination requests in a case file. CMS reviewed Molina's documentation and it did not demonstrate a system for accepting oral and written requests for expedited redeterminations.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. Molina must provide CMS with documentation demonstrating its system for maintaining documentation of expedited redetermination requests in case files, accepting requests for expedited redeterminations, and documenting all oral requests in writing. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.

Reference:

42 CFR § 423.584(d-e); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not include provisions stating: - Molina must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - Molina must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to include provisions stating: - Molina must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - Molina must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.590(a)(1-2); § 423.590(c); § 423.590(g)(1-4); § 423.636(a)(1); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not include provisions: - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Molina to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. - stating that Molina must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. CMS requested Molina's CMS-approved notice template for notifying enrollees of an adverse standard redetermination. Molina was unable to provide this notice template. CMS requested Molina's notice template for requesting a reconsideration. Molina was unable to provide a CMS-approved notice template for requesting a reconsideration.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to include provisions: - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.590(b-c); § 423.590(g)(1-4); § 423.636(a)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not: - state that for a redetermination favorable to the enrollee, Molina must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. CMS requested Molina's CMS-approved notice template for notifying enrollees of an adverse standard redetermination. Molina was unable to provide this notice template. CMS requested Molina's notice template for requesting a reconsideration. However, Molina was unable to provide a CMS-approved notice template for requesting a reconsideration.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to: - state that for a redetermination favorable to the enrollee, Molina must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
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Element Release Date: 5/9/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.584(e); § 423.590(d-e); § 423.638(a); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not include provisions: - indicating that notification of a favorable decision may be made orally or in writing. - indicating that notificaiton of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification. - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. - stating that Molina must inform the enrollee, within 24 hours when the case is forwarded to the IRE. CMS requested Molina's CMS-approved notice template for notifying enrollees of an adverse expedited redetermination. Molina was unable to provide this notice template. CMS requested Molina's notice template for requesting a reconsideration. Molina was unable to provide a CMS-approved notice template for requesting a reconsideration.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing. - indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification. - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. - stating that Molina must inform the enrollee, within 24 hours when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE08
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrolleeís health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.

Reference:

42 CFR § 423.638(a); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not include a provision for authorizing or providing the benefits in dispute within the 72-hour timeframe. Molina's documentation did not demonstrate its systems for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically, the documentation did not demonstrate Molina has a system for expedited coverage determination reversals.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to include a provision for authorizing and providing the benefit in dispute within the 72-hour timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically that Molina has a system for expedited coverage determination reversals.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.

Reference:

42 CFR § 423.590(f)(1-2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Molina's policies and procedures do not include a provision stating that if the denial based on lack of medical necessity, then Molina must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Molina must revise its policies and procedures to include a provision stating that if the issue is denial based on lack of medical necessity, then Molina must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina uses appropriate personnel to conduct redeterminations.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 5/9/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.

Reference:

Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not include provisions stating: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number.

Corrective Action Required:

Molina must revise its policies and procedures to include a provision stating: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax to its designated fax number. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina forwards untimely cases to the IRE.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

42 CFR § 423.636(b)(1); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

42 CFR § 423.636(b)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision. - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision. - requiring a notice to be sent informing the IRE of the effectuation.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision. - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision. - requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3321
Contract Number: H5810
Part D Sponsor Name: MOLINA HEALTHCARE OF CALIFORNIA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 1/28/2008
Date Report Due: 3/13/2008
Element Accepted Date: 4/8/2008
Element Release Date: 4/8/2008
Element Projected Completion Date: 3/13/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 11/17/2007
Estimated Visit Start Date: 12/28/2007
Actual Visit Start Date: 11/17/2007
Actual Visit End Date: 12/14/2007
Part D Sponsor Response Received Date: 3/7/2008
Part D Sponsor Response Due Date: 3/13/2008
CAP Release Date: 6/18/2008
CAP Accepted Date: 6/4/2008

Requirement:

Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

42 CFR § 423.638(b); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Molina Healthcare does not meet this requirement. CMS reviewed Molina's policies and procedures and found they do not: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation.

Corrective Action Required:

Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.