STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45504 • Olympia, Washington 98504-5503

February 29, 2024

Via Electronic Transmission

Case ID Number: OPI-MC-2023-01322-MHW

Jay Fathi, MD, President
Molina Healthcare of Washington, Inc.
Post Office Box 4004
Bothell, WA 98041-4004

Notice of Final Audit Report and Imposition of Corrective Action Plan (CAP)

Dear Dr. Fathi:

Please find the Final Audit Report for the Network Adequacy audit included with this Notice of Final Audit Report (Notice) for Molina Healthcare of Washington, Inc. (MHW).

Summary of Audit
The Health Care Authority (HCA), Division of Audit, Integrity & Oversight (AIO), conducted an audit of network provider data submitted by MHW on their Combined Network Provider Submission to HCA for the first quarter of 2023. HCA selected 84 providers reported to be contracted with MHW between January 1, 2023, and December 31, 2023. HCA analyzed all documentation submitted by MHW and gathered additional data via phone surveys with selected providers.

Summary of Findings
HCA found 35 discrepancies in the information reported by MHW on the Combined Provider Network Submission for Q1 of 2023.

- In six (6) instances HCA was unable to contact providers listed in the report after multiple attempts.
- In nine (9) instances HCA found the provider was no longer providing services at the location listed in the report.
- In eight (8) instances HCA found a discrepancy with the provider status of accepting new Medicaid clients.
- In eight (8) instances HCA found an incorrect address being reported.
- In four (4) instances HCA found incorrect phone numbers being reported.

Corrective Action Plan
Corrective Action is required to address the deficiencies identified above. MHW must devise a CAP that indicates how they plan to update their processes to ensure accurate information is reported to HCA on the Combined Provider Network Submission. HCA requests submission of the CAP no later than 60 days after the receipt of this Notice.

Failure to do so may result in the assessment of sanctions in accordance with Section 5.25 of the contract.

The completed CAP must be submitted to HCA by uploading the document to the Program Integrity folder on the HCA-MCReview MFT. Please include the case number with your submission.

Basis for Correction Action Plan
Per Section 2.45.1 of the Contract, HCA has the authority to require the Contractor to devise a Corrective Action Plan (CAP) whenever HCA concludes that the Contractor is out of compliance with one or more terms or conditions of this Contract. HCA will specify the requirements of any such CAP in a written communication to the Contractor.

Per Section 2.45.2 of the Contract, if HCA concludes that the Contractor has failed to comply with any of the terms of a CAP for which the Contractor has control, then HCA may (i) impose sanctions under the Sanctions section of this Contract, (ii) impose liquidated damages under the Liquidated Damages section of this Contract, or (iii) take any other remedial action allowed by this Contract or by governing law.

Per Section 2.46 of the Contract, all reports, documents, data or other information that the Contractor must submit to HCA (or to a third party designated by HCA) under this Contract must be accurate, complete, truthful and timely.

Per Section 5.25.1 of the Contract, HCA may impose sanctions if the Contractor fails to meet one or more of its obligations under this Contract, a CAP, or applicable law, including but not limited to submitting reports, documents, data, or any other information that is inaccurate, incomplete, untruthful, or untimely. HCA will consider the Contractor's failure in this regard as default. Contractor will be in default, and HCA may impose reasonable sanctions.

Per Section 6.1.8.1 of the Contract, for each quarterly network submission that is not accurate, complete, and submitted in the required format described in the Data Definitions instructions that accompany the Combined Provider Submission template, HCA may charge the Contractor $50,000 for nonperformance.

Dispute Resolution
MHW may request dispute resolution pursuant to Section 2.10 of the Contract. HCA must receive the request within 15 calendar days of MHW's receipt of this Notice. To request dispute resolution, please submit your request in writing to the address listed below and include a detailed description of what you are disputing.

Health Care Authority
Attn: Director
626 – 8th Avenue Southeast
P.O. Box 45502
Olympia, WA 98504-5502

If MHW invokes dispute resolution, imposition of a corrective action plan will be deferred until the process is completed.

Sincerely,

Jodie Polehonka

Jodie Polehonka
Program Integrity Analyst
Audit, Integrity & Oversight
Health Care Authority

Enclosure

cc: Mike Brown, Assistant Director, HCA, AIO
Jason McGill, Assistant Director, HCA, MPD
Annette Schuffenhauer, Chief Legal Officer, HCA

Washington State Health Care Authority

Final Audit Report

Network Adequacy Audit Of Molina Health Plan of Washington

Case Number: OPI-MC-2023-01322-MHW

February 2024

Division of Audit, Integrity and Oversight

Managed Care Oversight Unit

CMS Directive

Current federal rules require states to establish and enforce network adequacy standards for Medicaid Managed Care Organizations (MCOs). States that contract with MCOs to deliver Medicaid services must develop and enforce network adequacy standards consistent with 42 CFR §438.68 Network Adequacy Standards. CMS requires oversight of network adequacy to ensure provider directories are updated, accurate and reflect actual access to services.

Authority

The Health Care Authority (HCA) conducts this Network Adequacy review in accordance with requirements under the United States Code (USC), the Code of Federal Regulations (CFR), and the Apple Health-Integrated Managed Care contract (IMC).

Scope of the Network Adequacy Audit

The scope of this network adequacy audit focuses on the data submitted as required by section 6.1 of the IMC contract, concerning the MCO's network capacity on the Combined Provider Submission report for Quarter 1 of 2023.

The review seeks to validate the accuracy of the data submitted and focuses on the critical provider type of primary care physician.

Network Adequacy Review Process

The HCA Program Integrity Managed Care Oversight Unit (PIMCO) conducted this Network Adequacy audit in the following manner:

Random Sample Selection

HCA selected a random sample of eighty-four (84) primary care providers located in the Southwest region from the Combined Provider Submission report submitted by Molina Health Plan of Washington (MHW) for Quarter 1 of 2023. The report reflects providers contracted with MHW between January 1, 2023 and March 31, 2023.

Information Gathering

HCA reviewers used information submitted on the First Quarter 2023 Combined Provider Submission report to conduct telephone inquiries to providers. Reviewers asked the providers a series of questions to verify the provider's status, location, and to determine if the provider was accepting new Medicaid clients.

Analysis

HCA reviewed the information received from the calls to verify the validity and accuracy of the information provided on the Combined Provider Network Submission report.

Findings

HCA found 35 discrepancies in the information reported by MHW on the Combined Provider Network Submission for Q1 of 2023.

- In six (6) instances HCA was unable to contact providers listed in the report after multiple attempts.

- In nine (9) instances HCA found the provider was no longer providing services at the location listed in the report.
- In eight (8) instances HCA found a discrepancy with the provider status of accepting new Medicaid clients.
- In eight (8) instances HCA found an incorrect address being reported.
- In four (4) instances HCA found incorrect phone numbers being reported.

Conclusion

HCA found thirty-five (35) discrepancies in the information reported in the Combined Provider Network Submission. MHW must ensure the information submitted on all reports is accurate, complete, and truthful. See IMC contract sections 2.46 and 6.1.8.

The discrepancies found are in violation of the Apple Health Integrated Managed Care (IMC) Contract 1/1/2023-12/31/2023 per section 2.46.1, which states that all reports, documents, data, or other information that the Contractor must submit to HCA (or to a third party designated by HCA) under this Contract must be accurate, complete, truthful, and timely.

Per Section 5.25.1, HCA may impose sanctions if the Contractor fails to meet one or more of its obligations under this Contract, a CAP, or applicable law, including but not limited to submitting reports, documents, data, or any other information that is inaccurate, incomplete, untruthful, or untimely. HCA will consider the Contractor's failure in this regard as default. Contractor will be in default, and HCA may impose reasonable sanctions.

Per Section 6.1.8.1, For each quarterly network submission that is not accurate, complete, and submitted in the required format described in the Data Definitions instructions that accompany the Combined Provider Submission template, HCA may charge the Contractor $50,000 for nonperformance.

References

Code of Federal Regulations (CFR)

- **42 CFR §438.68 Network adequacy standards.**
  General rule. A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards….

Apple Health Integrated Managed Care (IMC) Contract 1/1/2023-12/31/2023.

- 2.46.1 All reports, documents, data or other information that the Contractor must submit to HCA (or to a third party designated by HCA) under this Contract must be accurate, complete, truthful and timely.
- Section 5.25.1 Sanctions HCA may impose sanctions if the Contractor fails to meet one or more of its obligations under this Contract, a CAP, or applicable law, including but not limited to submitting reports, documents, data, or any other information that is inaccurate, incomplete, untruthful, or untimely. HCA will consider the Contractor's failure in this regard as default.

- Section 6.1.2 On a quarterly basis, the Contractor shall provide documentation of its Provider network, including Critical Provider types and all contracted specialty Providers. … Submitted documentation shall provide evidence that the Contractor has adequate Provider capacity to deliver services that meet the timeliness standards described in Subsection 6.11 to all Enrollees and shall ensure sufficient choice and number of community health centers (FQHCs/RHCs) and/or private Providers to allow Enrollees a choice of service systems or clinics. The quarterly documentation shall include:
    - 6.1.2.2 The Combined Provider Submission report template, completed using the Data Definitions instructions, herein incorporated by reference.
- Section 6.1.8 Inaccurate or Incomplete Submissions: The documentation submitted by the Contractor must be accurate and complete.
    - Section 6.1.8.1 For each quarterly network submission that is not accurate, complete and submitted in the required format described in the Data Definitions instructions that accompany the Combined Provider Submission template, HCA may charge the Contractor $50,000 for nonperformance. HCA shall notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.