MARKET CONDUCT EXAMINATION

MOLINA HEALTHCARE OF WASHINGTON INC.

21540 30th DRIVE SE
BOTHELL, WASHINGTON 98021

January 1, 2004 – March 31, 2005

Exhibit A
Order No. G06-46
Molina Healthcare of WA

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The Honorable Mike Kreidler
Washington State Insurance Commissioner
302 14th Avenue SW
P.O. Box 40258
Olympia, Washington 98504-0258

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.46.120 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

Molina Healthcare of Washington Inc.
21540 30th Drive SE
Bothell, Washington 98021

In this report, Molina Healthcare of Washington Inc. is referred to as Molina or the Company.

This report of examination is respectfully submitted.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Nancy L. Barnes, AIE, ACS; Sandy Ray, CPCU and Jeanette Plitt of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Molina Healthcare of Washington Inc., Highline Medical Services Organization, and Wenatchee Valley Medical Center during the course of this market conduct examination.

I certify that this document is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner and that this report is true and correct to the best of my knowledge and belief.

Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This examination was completed by applying tests to each examination standard. Each test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Scope

Time Frame

The examination covered the Company's operations from January 1, 2004 through March 31, 2005. This was the first market conduct examination of Molina Healthcare of Washington Inc. This examination was performed both in the Seattle OIC office and on-site at the Company's office in Bothell, Washington. In addition, examination of records also took place at two (2) medical group offices in SeaTac, Washington and in Wenatchee, Washington.

Matters Examined

The examination included a review of the following areas:

Company Operations and Management	Administrative Contracts
Claims	Provider Activity
Rate and Form Filing	Underwriting

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance.

Regulatory Standards

Market conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as met. The standards in the area of agent licensing and appointment, and policy and form filings will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were no findings for the standard.
Passed with Comment	Errors in the records reviewed fell within the tolerance level for that standard.
Failed	Errors in the records reviewed fell outside of the tolerance level established for the standard.

COMPANY OPERATIONS AND MANAGEMENT

Company History

Molina Healthcare of Washington Inc. is registered as a Health Maintenance Organization (HMO) in the State of Washington. The certificate of registration was issued by the Office of Insurance Commissioner on June 3, 1985. The original certificate holder was AmeriCare of Washington Inc. On March 11, 1987, AmeriCare changed its name to Foundation Health Plan, Inc. On May 1, 1990, Foundation changed its name to QualMed Washington Health Plan, Inc. Molina Healthcare Inc., the parent company, purchased QualMed Washington Health Plan, Inc. on January 1, 2000. Effective July 1, 2000, the name was changed from QualMed to Molina Healthcare of Washington Inc.

At the time of purchase, the Company assumed 100,000 commercial members and QualMed's Healthy Options (Medicaid) and Basic Health Plan membership. As of May 1, 2000 all commercial membership was transferred to other carriers. Molina's focus of operations is serving the indigent and medically-underserved population.

Company Management and Operations

Molina is governed by an eight (8) member board of directors. The bylaws state that elections to the board are to be held in May of each year at the annual meeting of shareholders. The bylaws also state that if an annual meeting is not held or the directors are not elected at an annual meeting, elections may be held at a special shareholders meeting.

The current members of the Board of Directors are:

Board Member/Position	Company/Community Affiliation	Original Appointment Date
J. Mario Molina, MD Corporate CEO	Molina Healthcare Inc.	1/2000
George S. Goldstien, Ph.D. Corporate Executive VP	Molina Healthcare Inc.	1/2000
Ann Koontz President/CEO	Molina Healthcare of Washington Inc.	1/2000
Peggy Grotte Wanta Director, Government Programs & Compliance	Molina Healthcare of Washington Inc.	1/2000
Karen Slean Director, Provider Services & Operations	Molina Healthcare of Washington Inc.	1/2000
Beverly Court Manager, Critical Access Hospital Program	Department of Health	11/2000

Board Member/Position	Company/Community Affiliation	Original Appointment Date
Fred Riedman Group Manager, Finance Information Technology	Microsoft Corporation	2/2001
Elizabeth Nucci Health Marketing Specialist	CHILD Profile Immunization Registry	3/2001

Territory of Operations

Molina Healthcare of Washington operates in the following Washington counties: Adams, Asotin, Benton, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, King, Kitsap, Kittitas, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, Whitman, and Yakima. The examiners found no evidence of the Company operating outside its stated territory of operations.

Subsequent Event: The Company withdrew from Island County effective January 1, 2006

Findings

The following Company Operations and Management Standards passed without comment:

	Company Operations and Management Standard	Reference
1	**The Company is required to be registered with the OIC prior to acting as a health maintenance organization in the State of Washington.**	**RCW 48.46.027(1)**
2	**The Company is required to report to the OIC any changes to registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State.**	**RCW 48.46.012**

The following Company Operations and Management Standard failed:

	Company Operations and Management Standard	Reference
3	**At least one-third of the HMO's board of directors is made up of consumers who are representative of the enrolled population.**	**RCW 48.46.070(1)**

Company Operations Management Standard #3:

There are eight (8) members of the Company's board of directors. RCW 48.46.070(1) requires one-third of the board, or three (3) board members, are to represent the enrolled population. Two (2) members are affiliated with a government agency and a government sponsored program. The third member is affiliated with Microsoft and is not representative of the enrolled

population. The Company has stated that he sits on the board for his financial expertise and oversight.

Subsequent Event: Dr. George Goldstein was not reappointed to MHW's board during the Shareholder's meeting in June 2005. Dr. Mario Molina resigned from the board effective January 17, 2006. In response to the exam Ms. Peggy Wanta voluntarily resigned from Molina's Board. Dr. William Bracciodieta was elected as chairman of the board on January 18, These changes reduce the total number of board members to six (6), of which two (2) are consumer representatives.

GENERAL EXAMINATION FINDINGS

The Company's records and operations were reviewed to determine if the Company does business in accordance with the requirements of this state.

The following General Examination Standards passed without comment:

#	General Examination Standard	Reference
1	**The Company does business in good faith, and practices honesty and equity in all transactions.**	**RCW 48.01.030**
2	**The Company facilitates the examination process by providing its accounts, records, documents and files to the examiners upon request.**	**RCW 48.46.120(2)**
3	**The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.**	**WAC 284-30-572(2)**

CLAIMS

Claims Processing

Molina has administrative contracts with six (6) entities for claims processing:

- Molina Healthcare Inc. (MHI)
- Wenatchee Valley Medical Center (WVMC)
- Vision Service Plan (VSP)
- Northwest Physicians Network (NPN)
- Highline Medical Services Organization (HMSO)
- RxAmerica

Molina and its delegates each use different claim processing systems. Eligibility information from DSHS is loaded into each system on a monthly basis and claims are adjudicated accordingly.

The Company provided its claims processing manual for review. The procedures are comprehensive. Each delegated entity has its own claims processing procedures. During annual claims delegation assessments that are conducted by MHW, written procedures are reviewed to ensure acceptability.

Claims Review

The following is a listing of the claims processing entities, the types of claims processed, and the number of claims received during the examination period:

Processing Entity	Type of Claim	Number Received During the Exam Period
Wenatchee Valley Medical Center (WVMC)	Healthy Options	27,174
Vision Service Plan (VSP)	Vision	34,883
Northwest Physicians Network (NPN)	Healthy Options	105,699
Highline Medical Services Organization (HMSO)	Healthy Options	100,387
RxAmerica	Prescription Drugs	1,862,671
Molina Healthcare Inc. (MHI)	Healthy Options	2,422,877
TOTAL		**4,553,691**

Prior to pulling the claim samples for review, the examiners attempted to reconcile the specific monthly line item data with the overall monthly claim counts. Discrepancies were noted. The delegated entities were able to explain any differences. The data provided by MHW had significant differences in the number of claims processed and received. When the examiners asked MHW to explain any discrepancies, the Company informed the examiners that it could not. Since the examiners and MHW could not reconcile the data, the examiners requested that the Company provide written certification of data integrity. The Company provided a short statement saying that the database was accurate but did not provide written explanation as to the reason for the discrepancies.

The examiners randomly selected 100 claims from each of the following entities for review:

- Molina Healthcare Inc. (MHI)
- Wenatchee Valley Medical Center (WVMC)
- Highline Medical Services Organization (HMSO)

Findings

Standard #4 was not tested in this examination. The benefits provided under the Healthy Options program are stipulated by DSHS. Benefits for denturists are not covered.

The following Claims Standards passed without comment:

#	Claims Standard	Reference
1	**The Company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area.**	**RCW 48.01.235(3)**
2	**The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization.**	**RCW 48.43.525(1)**
3	**The Company shall not deny an individual prescription drug claim that had prior authorization.**	**RCW 48.46.535**
7	**The Company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined.**	**RCW 48.43.520, WAC 284-43-410**
9	**All plans must include every category of provider.**	**RCW 48.43.045, WAC 284-43-205**

The following Claims Standards passed with comment:

#	Claims Standard	Reference
5	**The Company pays or denies all claims according to the prescribed minimum standards.**	**WAC 284-43-321(2)**
6	**The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied.**	**WAC 284-43-321(4)**

Claims Standard #5:

WVMC implemented a new claims processing system on July 1, 2004. Based on average days reflected in the report provided by the delegates, WVMC failed to promptly pay or deny claims in three (3) of the 15 months of the examination period. During the system conversion, parallel systems were run. This resulted in decreased productivity. An audit of WVMC that was done by MHW indicates compliance in this area per WVMC's self-evaluation. However, MHW relies strictly on the results of WVMC's internal audits and does not conduct its own audits of its delegated entities.

Claims Standard #6:

There were two (2) denied claims that did not include an explanation for the denial (HMSO #51 and HMSO #94). These were isolated processing errors. All other denied claims that were reviewed included adequate explanations.

The following Claims Standard failed:

#	Claims Standard	Reference
8	**The Company administers Coordination of Benefits provisions as required.**	**Chapter 284-51 WAC**

Claims Standard #8:
The examiners found two (2) issues resulting in failure of this standard:

- **WAC 284-51-050(7):** An audit of WVMC that was done by Molina indicates compliance in this area. However, review of WVMC's claims shows that savings are not tracked.
- **WAC 284-51-100:** The MAA contract requires that the Company pay and pursue on prenatal care and preventive pediatric care services. The examiners found that the delegates that process claims on behalf of Molina do not pay and pursue. The examiners also noted that Section 3.8.5 of the MAA contract requires that Molina communicate COB requirements to its subcontractor and to assure compliance with the COB rules. MHW does communicate COB requirements to its delegates. However, it does not require each of the delegates to administer COB in the same manner.

Subsequent Event: Instructional notice has been sent to the Company's delegates outlining the proper pay and pursue requirements.

RATE AND FORM FILING

Rate and Form Filing Review

There were seven (7) forms filed by the Company during the examination period. Molina's rates and contracts are dictated by the Medical Assistance Administration (MAA) through the Department of Social and Health Services (DSHS). The forms were filed with the OIC for informational purposes only.

Findings

Rate and Form Filing Standard #2 was not tested in this examination. Since the Company only writes government-sponsored plans, its rates are provided by the government programs and cannot be changed by the Company.

The following Rate and Form Filing Standards passed without comment:

#	Rate and Form Filing Standard	Reference
1	**All contract forms have been filed with and approved by the OIC prior to use.**	**RCW 48.46.030(7)(g), RCW 48.46.030(7)(h), WAC 284-43-920**
3	**All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner.**	**WAC 284-43-925**

UNDERWRITING

Because of the nature of Molina's business, the examiners did not review samples of underwriting files or test standards. Rather, the examiners reviewed the Company's policies and procedures regarding eligibility and enrollment. The policies and procedures are comprehensive and demonstrate Molina's intent to follow statutes and regulations during the enrollment process.

PROVIDER ACTIVITY

Provider Contracting Process

The Company's Healthcare Credentialing Department is responsible for credentialing, recredentilaing, and performing site and medical record reviews for providers joining or participating in the Molina Healthcare Network. Before a contract is effective, a provider must be credentialed and approved by a peer review committee. Once approved, recredentialing occurs every three (3) years.

Provider Manual

Molina submitted its provider manual that was in use during the examination period for review. The manual was comprehensive, complete, and accurately describes the Company's policies and procedures for contracted providers.

Provider Directories

Molina provided two directories: Primary Care Provider Directory (HO) East and Primary Care Provider Directory (HO) West. Both directories include sections for women's health care, hospitals, urgent care and pharmacies.

Provider Activity Review

The Company provided the examiners with a listing of seven (7) provider contract forms that were in use during the examination period. A random sample of 50 providers was selected for review.

Findings

The following Provider Activity Standards passed without comment:

#	Provider Activity Standard	Reference
1	**All plans allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers.**	**RCW 48.43.515, WAC 284-43-251**

#	Provider Activity Standard	Reference
3	**Company standards for selection of participating providers do not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas.**	**WAC 284-43-310(1)(a), WAC 284-43-310(1)(b)**

The following Provider Activity Standards failed:

#	Provider Activity Standard	Reference
2	**All provider contract forms must be filed with and approved by the OIC prior to use.**	**RCW 48.46.243(3), WAC 284-43-330**
4	**All provider contract forms must contain and adhere to the prescribed minimum standards.**	**WAC 284-43-320 through WAC 284-43-340**

Provider Activity Standard #2:

Molina did not file any provider contracts or amendments during the examination period. The contracts that are in use were filed in 2000 by QualMed Washington Health Plan. In addition, the examiners found that 31 providers in the sample reviewed were issued contracts that had not been filed. Molina did submit a contract filing to the OIC on December 15, 2003; however, the Company withdrew the filing and it was not subsequently re-filed.

Subsequent Event: The Company has filed its provider contracts with the OIC effective January 2006.

Provider Activity Standard #4:

WAC 284-43-330(2) requires that any contract with material changes must be submitted to the OIC 15 working days prior to use. The examiners found that substantive contractual changes were made concerning claims submission requirements, provider notice requirements, compensation recovery language, appeals, fair hearings and discipline, and grievance procedures. In addition, WAC 284-43-331 requires that all contracts be in compliance by January 1, 2001. The changes noted by the examiners occurred between June 19, 2000 and August 1, 2004. None of these contracts were filed prior to use.

INSTRUCTIONS

	INSTRUCTIONS	PAGE #
1	The Company is instructed to ensure that one-third of its board of directors is made up of consumers representative of the enrolled population. Reference: RCW 48.46.070(1). (Company Operations and Management Standard #3.)	8
2	The Company is instructed to ensure that its claim processing delegates track COB savings as required. Reference: WAC 284-51-050(7). (Claims Standard #8.)	11
3	The Company is instructed to implement and communicate procedures to its delegated entities to ensure that claims subject to coordination of benefits are processed in the same manner. Reference: WAC 284-51-100. (Claims Standard #8.)	11
4	The Company is instructed to discontinue use of provider contract forms that have not been approved by OIC, to file for approval with the OIC all provider contract forms, and to re-contract all providers using the new form(s) when approved for use by the OIC. Reference: RCW 48.46.243(3), WAC 284-43-330. (Provider Activity Standard #2 and Provider Activity Standard #4.)	14
5	The Company is instructed to inform the OIC of its plan for distribution of filed and approved provider contracts to its provider network within 90 days of adoption of the examination report. Reference: WAC 284-43-331. (Provider Activity Standard #4.)	14

RECOMMENDATIONS

	RECOMMENDATIONS	PAGE #
1	Due to the Company's inability to retrieve consistent data with identical parameters and its inability to adequately explain discrepancies in its claims database, it is recommended that the Company implement system and audit controls to ensure the integrity of the information maintained in its database. (Claims Review.)	10
2	It is recommended that the Company implement procedures and reporting requirements to ensure that all delegated entities are adhering to prompt pay standards. Reference: WAC 284-43-321(2). (Claims Standard #5.)	11
3	It is recommended that the Company actually test the records of its delegates rather than rely on self-audits performed by the delegates. Reference: WAC 284-43-321(2). (Claims Standard #5 and Claims Standard #8.)	11

SUMMARY OF STANDARDS

Company Operations and Management:

#	STANDARD	PAGE	PASS	FAIL
1	The company is required to be registered with the OIC prior to acting as a health maintenance organization in the State of Washington. Reference: RCW 48.46.027(1).	8	X	
2	The company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State. Reference: RCW 48.46.012.	8	X	
3	At least one-third of the HMO's board of directors is made up of consumers who are representative of the enrolled population. Reference: RCW 48.46.070(1).	8		X

General Examination Findings:

#	STANDARD	PAGE	PASS	FAIL
1	The company does business in good faith, and practices honesty and equity in all transactions. Reference: RCW 48.01.030.	9	X	
2	The company facilitates the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.46.120(2).	9	X	
3	The company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2).	9	X	

Claims:

#	STANDARD	PAGE	PASS	FAIL
1	The company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area. Reference: RCW 48.01.235(3).	11	X	
2	The company shall not retrospectively deny emergency or non-emergency care that had prior authorization. Reference: RCW 48.43.525(1).	11	X	
3	The company shall not deny an individual prescription drug claim that had prior authorization. Reference: RCW 48.46.535.	11	X	
4	The company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist. Reference: RCW 48.43.180, RCW 48.46.570.	10	NA	NA

#	STANDARD	PAGE	PASS	FAIL
5	The company pays or denies all claims according to the prescribed minimum standards. Reference: WAC 284-43-321(2).	11	X	
6	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied. Reference: WAC 284-43-321(4).	11	X	
7	The company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined. Reference: RCW 48.43.520, WAC 284-43-410.	11	X	
8	The company administers coordination of benefits provisions as required. Reference: Chapter 284-51 WAC.	11		X
9	All plans must include every category of provider. Reference: RCW 48.43.045, WAC 284-43-205.	11	X	

Rate and Form Filing:

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms have been filed with and approved by the OIC prior to use. Reference: RCW 48.46.030(7)(g), RCW 48.46.030(7)(h), WAC 284-43-920.	12	X	
2	All rates have been filed with the OIC prior to use. Reference: RCW 48.46.062(3), WAC 284-43-920.	12	NA	NA
3	All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner. Reference: WAC 284-43-925.	12	X	

Provider Activity:

#	STANDARD	PAGE	PASS	FAIL
1	All plans allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers. Reference: RCW 48.43.515, WAC 284-43-251.	13	X	
2	All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.46.243(3), WAC 284-43-330.	14		X
3	Company standards for selection of participating providers do not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas. Reference: WAC 284-43-310(1)(a), WAC 284-43-310(1)(b).	14	X	

#	STANDARD	PAGE	PASS	FAIL
4	All provider contract forms must contain and adhere to the prescribed minimum standards. Reference: WAC 284-43-320 through WAC 284-43-340.	14		X

MOLINA℠

Molina Healthcare of Washington, Inc.
P.O. Box 1469
Bothell, WA 98041-1469
425•424•1100 800•869•7175

April 18, 2006

RECEIVED
APR 20 2006
INSURANCE COMMISSIONER
COMPANY SUPERVISION

Office of Insurance Commissioner
James T. Odiorne, CPA, JD
Deputy Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

RE: Molina Healthcare of Washington, Inc. Market Conduct Examination Response – January 1, 2004-March 31, 2005.

Dear Mr. Odiorne:

Thank you for the opportunity to review and comment on the above referenced report. Enclosed is our response to the draft. Our comments can be identified by the standard number and the page of the examination report, and follows the order and sequence of the findings in the draft report.

Company Management and Operations

1.) As a result of our review, we draw to your attention the following details for correction and ask for the draft to be revised accordingly:

- Pages 7-Please revise the name change effective date from QualMed to Molina Healthcare of Washington, Inc. to **July 1, 2000.**
- Pages 8- Please add **Asotin County.** This county was omitted from 'Territory of Operations'.
- Page 8-Please add as a point of clarification: **"As of 1/1/06, Molina Healthcare of Washington no longer operates in Island County."**

We would like the report amended with the following comments:

2.) Company Operations and Management Standard Number 3-Page 8 – *(At least one-third of HMO's Board of Directors is made up of consumers who are representative of the enrolled population.)*

We request the following bolded language is added to the OIC statement:

- "There are eight (8) members of the Company's board of directors. RCW 48.46.070(1) requires one-third of the board, or three (3) board members, are to represent the enrolled population. Two (2) members are affiliated with a government agency and a government sponsored program. The third member is affiliated with Microsoft and is not representative of the enrolled population. The Company has stated that he sits on the board for his financial expertise and oversight. **Molina Healthcare is seeking to remedy this issue and anticipates appropriate allocation on the Board of Directors will occur no later than the August 2006 Board of Directors meeting. Please be advised that J. Mario Molina and George Goldstein are no longer members of the Board. William P. Bracciodieta, MD. is the new chairman of the Washington Board and the Chief Medical Officer of Molina Healthcare, Inc., Molina Healthcare's parent company. This reduces the total number of members of the Board of Directors to seven, of which two are consumer representatives."**

3.) Claims Standard Number 6-Page 11 – *(The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied.)*

Molina Healthcare is working diligently with our delegated groups to ensure compliance with standards.

4.) Claims Standard Number 5-Page 11 – *(The company pays or denies all claims according to the prescribed minimum standards.)*

We request the following bolded language is added to the report's comments:

- "The examiners reviewed claim payment reports for MHW and its delegates. The reports include the number of claims paid or denied within 30, 60, and 90 days. However, the reports for the delegates do not provide sufficient information to calculate the percentage of clean claims paid or denied, and the standard could not be tested. Calculations on the reports represent the processing totals for that particular month and do not take into account the date a claim was actually opened.

  Molina Healthcare's full risk delegates do not track claims payment timeliness separately for clean claims, rather they track the timeliness of claims payments for all claims. As clean claims are a subset of all claims paid within 30 days, the prescribed minimum standard of 99% clean claims paid within 30 days is met or exceeded. By holding full risk delegated groups to measuring timely payment or denial of all claims, they are held to a more stringent standard then just evaluating clean claims.

  Regardless of whether the claim was correctly submitted directly to the delegated group or incorrectly submitted to Molina Healthcare, the full risk delegates are required to use the date the claim was received by either entity to calculate and self-report aggregate claims payment timeliness compliance. Therefore, regardless of where the claims are received they are logged by the earliest receipt date and all calculations are based on this date. Molina Healthcare is considering requesting data from the delegates for internal analysis purposes.

Although Molina Healthcare has not historically, directly audited claims paid by the delegated groups, other indicators of deficient claims performance is looked for and maintained. For example, member and provider complaints are monitored on an ongoing basis to identify a variety of issues. Any delegate claims payment issues are promptly reported by providers and investigated by Molina Healthcare. Molina Healthcare did not receive provider complaints suggesting a delegate claims payment issue.

Regarding the specific example of claims payment timeliness by the delegated group, WVMC, the providers affected by these delays were aware of the ongoing system conversion and were tolerant of the delays caused by this effort. While it would have been optimal for WVMC to have maintained their excellent record of claims payment timeliness during this conversion, the reality of any systems implementation includes delays and surprises that make it difficult to meet all timeliness standards.

Molina Healthcare is considering initiating an internal claims audit process to ensure even greater adherence to the prescribed standards."

5.) Claims Standard Number 8-Page 11 – *(The Company administers Coordination of Benefits provisions as required.)*

We request the following bolded language is added to the report's comments on Page 12:

- "WAC 284-54-050(7): An audit of WVMC that was done by Molina indicates compliance in this area. However, review of WVMC's claims shows that savings are not tracked. **WVMC converted their claims system in June 2004 and lost the ability to track COB savings. WVMC is currently working on resolving this with their claims system vendor and expects to correct this with a system upgrade by fall of 2006."**

- "WAC 284-51-100: The MAA contract requires that the Company pay and pursue on prenatal care and preventive pediatric care services. The examiners found that the delegates that process claims on behalf of Molina do not pay and pursue. The examiners also noted that Section 3.8.5 of the MAA contract requires that Molina communicate COB requirements to its subcontractors and to assure compliance with the COB rules. MHW does communicate COB requirements to its delegates. However, it does not require each of the delegates to administer COB in the same manner.

  The issue of delegates not paying and pursuing prenatal care and preventative pediatric services was true during the examination period. However, Molina Healthcare had already identified this as an issue during the annual claims system audits conducted Q3 2005 and has worked with the delegated groups to create corrective action plans to remedy this failing. Molina Healthcare fully expects to see complete compliance with this requirement in the 2006 annual claims settlement audits."

6.) Provider Activity Standard Number 2-Page 14 – *(All provider contract forms must be filed with approved by the OIC prior to use.)*

Molina Healthcare is required to meet both state and federal regulatory requirements, which can be overlapping in nature, in order to comply with the oversight of multiple state agencies. This multiple agency oversight can sometimes be confusing.

We would like this recognized in your report. Therefore we would like the following bolded language added:

- "Molina did not file any provider contracts or amendments during the examination period. The contracts that are in use were filed in 2000 by QualMed Washington Health Plan. In addition, examiners found that 31 providers in the sample reviewed were issued contracts that had not been filed. Molina did submit a contract filing to the OIC on December 15, 2003; however, the Company withdrew the filing and it was not subsequently re-filed.

  Molina Healthcare is contracted with the State of Washington for two lines of business; Healthy Options and Basic Health. As such, Molina Healthcare is required to meet regulatory oversight requirements of both Department of Social and Health Services (DSHS) and the Office of the Insurance Commissioner (OIC). This is further complicated by the fact that the Healthy Options line of business is regulated by federal Medicaid law. At times the regulations conflict with each other. By revising the contract templates to meet the federal Balanced Budget Act Molina felt regulatory requirements had been satisfied.

  When the provider contracts were filed with the OIC in December 2003, DSHS was in process of conducting a lengthy review of the provider templates. OIC and Molina Healthcare agreed to wait for DSHS to conclude their review before re-filing; therefore, Molina Healthcare withdrew its filing with the consent of the OIC. The DSHS review took well over a year, during which time, Molina Healthcare prepared new provider templates.

  Molina Healthcare's new provider contract templates were filed and approved by the OIC. Molina Healthcare has begun using these filed and approved templates for all new contracts going forward, beginning April 17, 2006. In addition, Molina Healthcare has a formal plan to move existing contracts to the new templates in a systematic rollout over the next 12 months."

7.) Provider Activity Standard Number 4-Page 14 – *(All provider contract forms must contain and adhere to the prescribed minimum standards.)*

As stated above, Molina Healthcare is required to meet both state and federal regulatory requirements, which can be overlapping in nature, in order to comply with the oversight of multiple state agencies. This multiple agency oversight and potentially conflicting federal versus state law can sometimes be confusing.

We would like this recognized in your report. Therefore we would like the following bolded language added:

- **"Molina Healthcare is contracted with the state of Washington for two lines of business; Healthy Options and Basic Health. As such we are required to meet regulatory requirements to meet the oversight requirements of both DSHS and the OIC. This is further complicated by the fact that our Healthy Options line of business is regulated by federal Medicaid law. At times the regulations conflict with each other. By revising our contract templates to meet the federal Balanced Budget Act we felt we had satisfied our regulatory requirements. As stated above our new provider templates have been filed and approved by the OIC.**

  Molina Healthcare is now aware that even changes dictated by Federal Law must be submitted to the OIC for approval prior to use; this step will be added to Molina Healthcare's process. Molina anticipates the OIC will make every effort to review and approve these types of changes timely so all regulatory requirements can be met."

Once again, may we thank you and your team for the examination of our market conduct practices and the opportunity to review and comment on your findings. Please do not hesitate to contact us if there is anything else we can provide.

Sincerely,

Dale Ahlskog
Executive Director

Attachment(s)

cc: Kelly Ryan, Associate General Council
Molina Healthcare, Inc.

Molina Healthcare of Washington, Inc.
Attachment to Formal Response to Draft Market Conduct Examination
April 17, 2006

Summary of Actions taken:

INSTRUCTIONS

1. **Board of Directors – Company Operations Standard #3**
   Molina Healthcare of Washington, Inc (Molina Healthcare) will have in place the appropriate allocation of Board members by the August 17, 2006 Board of Directors meeting.

2. **Claims prompt pay standards – Claims Standard #5**
   Molina Healthcare has begun the development of a process for receipt of claims data from the delegates for internal analysis purposes.

3. **COB Savings – Claims Standard #8**
   This provision will be included in future claims processing audits. In addition, WVMC expects to correct this with a system upgrade by fall of 2006.

4. **Coordination of Benefits Communications - Claims Standard #8**
   Molina Healthcare has worked with the delegates to create corrective actions plans regarding processing of claims subject to Coordination of Benefits. Molina Healthcare will include Review of Coordination of Benefits procedures in future claims audits.

5. **Provider Contracts – Provider Activity Standard #2 and Provider Activity Standard #4**
   The OIC has approved new provider templates filed by Molina Healthcare.
   Molina Healthcare has begun using filed and approved templates for all new contracts going forward, beginning April 17, 2006.

6. **Distribution plan for Provider contracts – Provider Activity Standard #4**
   Molina Healthcare has a formal plan to move existing contracts to the new templates in a systematic rollout over the next 12 months and will share it with the OIC within the requested timeframe.

RECOMMENDATIONS

1. **Claims Review**
   A more accurate claims payment report has been developed. Molina Healthcare will design and implement further audit controls to ensure the integrity of the information.

2. **Delegated Claims Audits Claims Standard #5 and Claims Standard #8**
   A more robust claims audit process for our delegates is being considered.