State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

David Friedman, CEO
Health Net Community Solutions, Inc.
11971 Foundation Place, Building D
Rancho Cordova, CA 95670

RE: Department of Health Care Services Medical Audit

Dear Mr. Friedman:

The Department of Health Care Services (DHCS) Audits and Investigations Division conducted an on-site medical audit of Health Net, a Managed Care Plan (MCP), from May 14, 2013 through May 24, 2013. The audit covered the review period of March 1, 2012, through February 28, 2013.

On October 10, 2014, the MCP provided DHCS with its latest response to its Corrective Action Plan (CAP) originally issued on January 9, 2014.

All remaining open items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS's final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, contact Mr. Edgar Monroy, Chief, Plan Monitoring Unit, at (916) 449-5233 or CAPMonitoring@dhcs.ca.gov.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Medical Monitoring and Program Integrity Section

Enclosure:

cc: Yvonne Harden, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413

bcc: Edgar Monroy, Chief
Plan Monitoring Unit
MS 4417

Christina Viernes, Analyst
Plan Monitoring Unit
MS 4417

Health Net
COMMUNITY SOLUTIONS

CORRECTIVE ACTION PLAN

Plan Name: Health Net Community Solutions, Inc.

Review Type: 10-87050 DHCS A&I Medical Review Audit (Medi-Cal NON SPD) **Review Period:** March 1, 2012 - February 28, 2013

Deficiency Identified:

Category 1: Utilization Management (UM); 1.1 UM Program Requirements (Regulation: 2 Plan Contract A.5.1.F)

Recommendation:

1. Amend policies to ensure that utilization review criteria are applied consistently between the Plan and its Participating Provider Groups (PPG).

Description of how correction will be accomplished and compliance monitored and maintained	Date of Completion	Name & Title of Responsible Person(s)	DHS Comments
Health Net believes that the contract requirement A.5.2.C as cited is not appropriate as applied to Health Net's delegated PPG model. Health Net is not in violation of the contract requirement. The delegated PPGs are not mandated to use the same utilization review criteria set as Health Net. The delegated PPGS have to use a nationally recognized criteria set as well as Health Net medical policies and Health Net audits the PPGs for this. The national criteria sets used are generally Interqual, Milliman and Apollo. Therefore, if the PPGs use different criteria set, then the decisions they make may not match ours internally on that fact alone. It needs to be understood that the PPGs take the financial risk for certain services and they control their utilization review/prior auths. Taking the financial risk allows the PPGs the leeway to be more selective. Health Net's Delegation Oversight Department conducts annual delegations audits of the PPG UM performance	n/a	• Peggy Haines, V.P. Quality Management • Rita Lonzo, Director Delegation Oversight	**Recommendation 1:** Please provide an approved and signed policy/procedure and supporting documentation demonstrating its policies have been implemented to ensure utilization review criteria is applied consistently between the plan and its Participating Provider Groups. 7/17/14 – MCP provided its provider delegated agreement and respective detail to ensure PPGs follow Health Net UM review criteria. **This recommendation is deemed closed.**

PLAN OF ACTION			
including files reviews of UM decisions and issuance of NOAs. If Health Net finds that a PPG has denied care that should have been approved, either during an audit, member appeal, or as part of a more in depth review, they are given a CAP and the expectation is that their behavior and process needs to be revised accordingly. Additionally, the PPGs are educated on the Medi-Cal benefits that do not require authorization. This would include for example, PPG denials of, or requiring prior authorization for emergency services or sensitive services/family planning services. How Health Net applies this policy along with other health plans who contract with delegated PPGs that are at risk, is the industry norm and not the exception. Mandating the PPGs follow a specific utilization review criteria would have a major financial impact with contracting arrangements with at risk PPGs for those arrangements that are in place and future contracting arrangements to be negotiated. Health Net asks that DHCS address this with the Industry Collaboration Effort (ICE) if this is a practice DHCS intends to broadly cite as violation of a contract requirement as a result of health plan audits. Health Net may also need to take up this matter with our Legal Department because of the broad potential financial implications to our PPG contracting efforts. ***7-11-14 HN Response to DHCS Comment - Recommendation 1:***			

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CORRECTIVE ACTION PLAN

Plan Name: **Health Net Community Solutions, Inc.**

Review Type: 10-87050 DHCS A&I Medical Review Audit (Medi-Cal NON SPD) **Review Period:** March 1, 2012 - February 28, 2013

PLAN OF ACTION			
Health Net stands by the mitigation response originally submitted and as restated above. The following information is additionally being provided: Health Net is in compliance with the requirements of the GMC/Two-Plan Contract section A.5.2.C. Utilization criteria are consistently applied for utilization decisions that Health Net makes for service decisions that are Health Net's responsibility. Likewise, Health Net through their Delegation Oversight Department monitoring and review process ensures that the delegated PPGs are consistent with their utilization decisions according to their UM responsibilities as called out in their UM Delegation Agreements with Health Net. Health Net has attached policies that describe and inform that delegated PPGs must use evidenced-based nationally recognized clinical review for utilization management decisions and describes the process for ensuring consistent application of utilization review criteria for Health Net utilization review decisions and those of the delegated PPGs, including coordination with the delegated PPGs as required. Also attached is a sample copy of the HN PPG Delegation Agreement section that addresses the PPGs UM program requirements and utilization review responsibilities, and what HN monitors to ensure compliance. **ATTACHMENTS: P&Ps- UM Clinical Criteria Decisions, UM Clinical Information for Determination, sample pages from UM Provider**			

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CORRECTIVE ACTION PLAN

Plan Name: Health Net Community Solutions, Inc.

Review Type: 10-87050 DHCS A&I Medical Review Audit (Medi-Cal NON SPD) **Review Period:** March 1, 2012 - February 28, 2013

PLAN OF ACTION			
Delegation Agreement with Health Net.			
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Deficiency Identified:

Category 1: Utilization Management (UM); 1.2 Prior Authorization Review Requirements (Regulation: 2 Plan Contract A.5.1.F)

Recommendation:

1. Update current tracking and/or monitoring procedures to ensure that Notice of Action letters are sent within required timeframes and with required pending letters when appropriate.
2. Amend policies to ensure that utilization review criteria are applied consistently between the Plan and its Participating Provider Groups (PPGs).
3. Ensure that PPGs are in compliance with the Contract and regulations, and do not require prior authorization for any family planning service and
4. Monitor and counsel the PPGs, as appropriate.

Description of how correction will be accomplished and compliance monitored and maintained	Date of Completion	Name & Title of Responsible Person(s)	DHS Comments
Recommendation 1: • Clinical staffs were re-educated on the letter generation process and tracking methodology to utilize within the Medical Management System (Unity) to meet regulatory turnaround times. • A tickler system was added to the Denial Compliance Letter Unit to track if letters are returned from Medical Directors and clinical team to meet daily compliance TATs.	Ongoing since last audit. New hire training. 2/2014	• Jody Larson, Director Health Care Services • Arleen Huffman, Manager, Systems and Support	**Recommendation 1:** ***This recommendation is deemed Closed.***

Health Net
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PLAN OF ACTION			
• Monthly self-monitoring regulatory audits are conducted and results shared with staff and management during a Monthly Reconciliation Meeting where individual cases are reviewed with Managers, and corrective actions are assigned and implemented. • Audits are conducted according to Health Net National P&P – **Denial, Modification or Deferral of Services for Lack of Medical Necessity - Medi-Cal #UMCM-207, attached**. • Audit functions are centralized and **Monitoring & Reporting Monthly Quality Assurance Functions Desktop AU-01,** was revised. The Desktop, Sections 4.2, 4.5 and 5.0 outlines the audit process specific to Medi-Cal NOAs. • As part of monitoring process, a Report Summary is presented to the UM/QI Committee addressing the Authorization Tracking Process. • **Attachments:** **-Report Summary and Sample Tracking Log** **- Monitoring & Reporting Monthly Quality Assurance Functions Desktop AU-01.**	Ongoing since last audit, with changes to process 6/3/2013 and 2/28/2014	Yvette Urbina, Manager Medical Operations	
• Clinical Quality Assurance process implemented in Clinical Denial Compliance Unit. Prior Authorization NOA language is reviewed, and TAT is checked to meet compliance. A Weekly NOA/Denial Compliance Report is produced by a Senior RN and shared with management to be able to identify compliance issues more readily and be able to institute a more immediately corrective action.	2/3/2014	Cynthia Kirkorian, Manager Health Care Services	

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Plan Name: Health Net Community Solutions, Inc.

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PLAN OF ACTION			
Recommendations 2, 3 & 4: Health Net believes that the contract requirement A.5.2.C as cited is not appropriate as applied to Health Net's delegated PPG model. Health Net is not in violation of the contract requirement. The delegated PPGs are not mandated to use the same utilization review criteria set as Health Net. The delegated PPGS have to use a nationally recognized criteria set as well as Health Net medical policies and Health Net audits the PPGs for this. The national criteria sets used are generally Interqual, Milliman and Apollo. Therefore, if the PPGs use different criteria set, then the decisions they make may not match ours internally on that fact alone. It needs to be understood that the PPGs take the financial risk for certain services and they control their utilization review/prior auths. Taking the financial risk allows the PPGs the leeway to be more selective. Health's Delegation Oversight Department conducts annual delegations audits of the PPG UM performance including files reviews of UM decisions and issuance of NOAs, and if Health Net finds that a PPG has denied care that should have been approved, either during an audit, member appeal, or as part of a more in depth review, they are given a CAP and the expectation is that their behavior and process needs to be revised accordingly. Additionally, the PPGs are educated on the Medi-Cal benefits that do not require authorization. This would include for example, PPG denials of, or requiring prior authorization for emergency services or sensitive services/family planning services.	n/a	• Peggy Haines, V.P. Quality Management • Rita Lonzo, Director Delegation Oversight	**Recommendation 2:** Please provide an approved & signed policy/procedure and supporting documentation demonstrating its policies have been implemented to ensure utilization review criteria are applied consistently between the plan and its Participating Provider Groups. 7/17/14 – MCP provided its provider delegated agreement and respective detail to ensure PPGs follow Health Net UM review criteria. **This recommendation is deemed closed.** **Recommendation 3:** ***This recommendation is deemed Closed.*** **Recommendation 4:** Please provide supporting documentation demonstrating the methodology used to monitor and counsel PPG's. 6/20/14 – MCP provided Policy # WB106-104247/Delegated Entity Evaluation & Delegation Determination. This policy demonstrates the methodology used to monitor & counsel PPG's.

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PLAN OF ACTION			
How Health Net applies this policy along with other health plans who contract with delegated PPGs that are at risk, is the industry norm and not the exception. Mandating the PPGs follow a specific utilization review criteria would have a major financial impact with contracting arrangements with at risk PPGs for those arrangements that are in place and future contracting arrangements to be negotiated. Health Net asks that DHCS address this with the Industry Collaboration Effort (ICE) if this is a practice DHCS intends to broadly cite as violation of a contract requirement as a result of health plan audits. Health Net may also need to take up this matter with our Legal Department because of the broad potential financial implications to our PPG contracting efforts. ***7-11-14 HN Response to DHCS Comment - Recommendation 2 :*** Health Net stands by the mitigation response originally submitted and as restated above. The following information is additionally being provided: Health Net is in compliance with the requirements of the GMC/Two-Plan Contract section A.5.2.C. Utilization criteria are consistently applied for utilization decisions that Health Net makes for service decisions that are Health Net's responsibility. Likewise, Health Net through their Delegation Oversight Department monitoring and review process ensures that the			**This recommendation is deemed closed.**

PLAN OF ACTION			
delegated PPGs are consistent with their utilization decisions according to their UM responsibilities as called out in their UM Delegation Agreements with Health Net. Health Net has attached policies that describe and inform that delegated PPGs must use evidenced-based nationally recognized clinical review for utilization management decisions and describes the process for ensuring consistent application of utilization review criteria for Health Net utilization review decisions and those of the delegated PPGs, including coordination with the delegated PPGs as required. Also attached is a sample copy of the HN PPG Delegation Agreement section that addresses the PPGs UM program requirements and utilization review responsibilities, and what HN monitors to ensure compliance. **ATTACHMENTS: P&Ps- UM Clinical Criteria Decisions, UM Clinical Information for Determination, sample pages from UM Provider Delegation Agreement with Health Net.**			
6/18/14 HN Response to DHCS Comment - Recommendation 4 : Health Net (HN) previously submitted to the DHCS auditors a copy of HN's Delegation Oversight P&Ps as well as the UM audit tool utilized by Delegation Oversight that demonstrates the methodology used to			

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Plan Name: **Health Net Community Solutions, Inc.**

Review Type: 10-87050 DHCS A&I Medical Review Audit (Medi-Cal NON SPD) **Review Period:** March 1, 2012 - February 28, 2013

PLAN OF ACTION			
monitor and counsel the PPGs on a regular basis. HN has attached another copy of the current PPG oversight P&Ps and the UM Medi-Cal PPG Audit Tool. Also attached is a sample summary of pre-contractual PPG UM Medi-Cal audits conducted. The sample includes the sensitive services section of audits conducted during the audit period. Any PPG that scores less than 100% requires a CAP submission to HN. ***Attachments:*** **Delegation Oversight P&Ps, PPG UM Audit Tool, Sample Summary of PPG UM audit Results**			

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CORRECTIVE ACTION PLAN

Plan Name: Health Net Community Solutions, Inc.

Review Type: 10-87050 DHCS A&I Medical Review Audit (Medi-Cal NON SPD) **Review Period:** March 1, 2012 - February 28, 2013

Deficiency Identified:

Category 1: Utilization Management; 1.3 Tracking Referral (Regulation: 2 Plan Contract A.5.1.F)

Recommendation:

1. Develop a policy to ensure a centralized system-wide process for referral tracking.

PLAN OF ACTION			
Description of how correction will be accomplished and compliance monitored and maintained	**Date of Completion**	**Name & Title of Responsible Person(s)**	**DHS Comments**
Health Net currently has a centralized process for tracking and following up on referrals requiring prior authorization including In Network and Out of Network (OON) requests. Any service that requires prior authorization is entered into our Medical Management system known as the "Unity" system. Screening and review of those referrals is conducted and documented within the system, a decision is rendered and the decision is communicated to all appropriate parties. All OON referrals for care require a prior authorization and are uniquely categorized with a Medical Level Code = Out of Network for purposes of recording and reporting.	The overall process of tracking all services requiring prior authorization has been in place since 2007 when the Unity System was implemented for Medi-Cal. For several years prior to the Unity systems being implemented, another medical management system was used to track very similar date.	• Jody Larson, Director Health Care Services • Dr. Tony Van Goor, Regional Medical Director for Region 3 (Central Valley)	**Recommendation 1:** ***This recommendation is deemed Closed.***

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PLAN OF ACTION			
	The special focus Out of Network database tracking has been in use since Feb 2013.		
Certain categories of OON referrals are additionally tracked in a separate tracking database to allow the plan to focus on any trends such as specialty deficiencies, referral patterns of Primary Care Physicians, and geographic deficiencies. The categories currently being tracked in this database include: • Specialty Consults & Follow Up Visits • Inpatient Facility admissions • Outpatient Facility services Information gathered in this database helps facilitate additional contracting efforts in areas of deficiency as well as provider and member education in locating In Network resources. Vigorous efforts are made by the Plan staff to assist providers and members to be re-directed back into In-Network providers whenever possible and practical. A policy was developed, that describes the process for referral tracking - Specialty Referral System – **Medi-Cal, FS226-144855.** **Attachment: – Medi-Cal FS226-144855- Specialty Referral Tracking P&P**			

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Review Type: 10-87050 DHCS A&I Medical Review Audit (Medi-Cal NON SPD) **Review Period:** March 1, 2012 - February 28, 2013

Deficiency Identified:

Category 1: Utilization Management (UM); 1.5 Delegation of UM (Regulation: 2 Plan Contract A.4.6)

Recommendation:

1. Ensure that Participating Provider Groups (PPGs) are in compliance with the Contract and regulations, and do not require prior authorization for any family planning services.
2. Monitor and counsel the PPGs, as appropriate.
3. Amend policies to ensure that utilization review criteria are applied consistently between the Plan and its PPGs.

PLAN OF ACTION			
Description of how correction will be accomplished and compliance monitored and maintained	**Date of Completion**	**Name & Title of Responsible Person(s)**	**DHS Comments**
Health Net believes that the contract requirement A.5.2.C as cited is not appropriate as applied to Health Net's delegated PPG model. Health Net is not in violation of the contract requirement. The delegated PPGs are not mandated to use the same utilization review criteria set as Health Net. The delegated PPGS have to use a nationally recognized criteria set as well as Health Net medical policies and Health Net audits the PPGs for this. The national criteria sets used are generally Interqual, Milliman and Apollo. Therefore, if the PPGs use different criteria set, then the decisions they make may not match ours internally on that fact alone. It needs to be understood that the PPGs take the financial risk for certain services and they control their utilization review/prior authorizations. Taking the financial risk	n/a	• Peggy Haines, V.P. Quality Management • Rita Lonzo, Director Delegation Oversight	**Recommendation 1:** ***This recommendation is deemed Closed.*** **Recommendation 2:** Please provide supporting documentation demonstrating the methodology used to monitor and counsel PPG's. 6/20/14 – MCP provided Policy # GS318-114855/Delegation Oversight Corrective Action Plan. This policy demonstrates the methodology used to monitor and counsel PPG's. **This recommendation is deemed closed.**

PLAN OF ACTION			
allows the PPGs the leeway to be more selective. Health's Delegation Oversight Department conducts annual delegations audits of the PPG UM performance including files reviews of UM decisions and issuance of NOAs, and if Health Net finds that a PPG has denied care that should have been approved, either during an audit, member appeal, or as part of a more in depth review, they are given a CAP and the expectation is that their behavior and process needs to be revised accordingly. Additionally, the PPGs are educated on the Medi-Cal benefits that do not require authorization. This would include for example, PPG denials of, or requiring prior authorization for emergency services or sensitive services/family planning services. How Health Net applies this policy along with other health plans who contract with delegated PPGs that are at risk, is the industry norm and not the exception. Mandating the PPGs follow a specific utilization review criteria would have a major financial impact with contracting arrangements with at risk PPGs for those arrangements that are in place and future contracting arrangements to be negotiated. Health Net asks that DHCS address this with the Industry Collaboration Effort (ICE) if this is a practice DHCS intends to broadly cite as violation of a contract requirement as a result of health plan audits. Health Net may also need to take up this matter with our Legal Department because of the broad potential financial implications to our PPG contracting efforts.			**Recommendation 3:** Please provide an amended policy/procedure that is approved and signed and supporting documentation demonstrating its policies have been implemented in a manner that ensures utilization review criteria are applied consistently between the plan and its Participating Provider Groups. 7/17/14 – MCP provided its provider delegated agreement and respective detail to ensure PPGs follow Health Net UM review criteria. **This recommendation is deemed closed.**

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PLAN OF ACTION			
6/18/14 HN Response to DHCS Comment - Recommendation 2: Health Net (HN) previously submitted to the DHCS auditors a copy of HN's Delegation Oversight P&Ps as well as the UM audit tool utilized by Delegation Oversight that demonstrates the methodology used to monitor and counsel the PPGs on a regular basis. HN has attached another copy of the current PPG oversight P&Ps and the UM Medi-Cal PPG Audit Tool. Also attached is a sample summary of pre-contractual PPG UM Medi-Cal audits conducted. The sample includes the sensitive services section of audits conducted during the audit period. Any PPG that scores less than 100% requires a CAP submission to HN. ***Attachments:*** **Delegation Oversight P&Ps, PPG UM Audit Tool, Sample Summary of PPG UM audit Results** ***7-11-14 HN Response to DHCS Comment - Recommendation 3:*** Health Net stands by the mitigation response originally submitted and as restated above. The following information is additionally being provided: Health Net is in compliance with the requirements of			

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Plan Name: **Health Net Community Solutions, Inc.**

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PLAN OF ACTION			
the GMC/Two-Plan Contract section A.5.2.C. Utilization criteria are consistently applied for utilization decisions that Health Net makes for service decisions that are Health Net's responsibility. Likewise, Health Net through their Delegation Oversight Department monitoring and review process ensures that the delegated PPGs are consistent with their utilization decisions according to their UM responsibilities as called out in their UM Delegation Agreements with Health Net. Health Net has attached policies that describe and inform the delegated PPGs must use evidenced-based nationally recognized clinical review for utilization management decisions and describes the process for ensuring consistent application of utilization review criteria for Health Net utilization review decisions and those of the delegated PPGs, including coordination with the delegated PPGs as required. Also attached is a sample copy of the HN PPG Delegation Agreement section that addresses the PPGs UM program requirements and utilization review responsibilities, and what HN monitors to ensure compliance. **ATTACHMENTS: P&Ps- UM Clinical Criteria Decisions, UM Clinical Information for Determination, sample pages from UM Provider Delegation Agreement with Health Net.**			

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Plan Name: Health Net Community Solutions, Inc.

Review Type: 10-87050 DHCS A&I Medical Review Audit (Medi-Cal NON SPD) **Review Period:** March 1, 2012 - February 28, 2013

Deficiency Identified:

Category 2: Continuity of Care; 2.1 Coordination of Care; Within and out-of-plan (two parts)

1. Comprehensive Case Management and Coordination of Care Services (Regulation: 2 Plan Contract A.11.1)
2. Out of Plan Case Management and Coordination of Care Services (Regulation: 2 Plan Contract A.11.4)

Recommendation:

1. Ensure that eligible Members are monitored and tracked for case management and that coordination of care between PCPs (Primary Care Providers) and specialty providers occurs.

PLAN OF ACTION			
Description of how correction will be accomplished and compliance monitored and maintained	**Date of Completion**	**Name & Title of Responsible Person(s)**	**DHS Comments**
This CAP pertains to members not eligible for CCS services, or CCS eligible members with non-CCS related conditions that require case management. Members that have a need for case management services are identified via referral or predictive modeling. Outreach is completed to the member to explain the case management program opportunity and engage the member in the program. The case manager collaboratively works with the primary care physician, member and other members of the interdisciplinary care team including specialists to develop a care plan and achieve the member's goals. All members receive reminders regarding preventive care such as immunizations and routine primary care visits. The Health Net Provider Manual speaks to the Primary Care	9/12/2013 and ongoing	• Linda Wade-Bickel, Director, Care Management • Chris Hill, VP Clinical Services	**Recommendation 1:** ***This recommendation is deemed Closed.***

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PLAN OF ACTION			
Physician requirement to monitor, coordinate and provide necessary services to their assigned members. Members who are referred to Case management that belong to a delegated PPG are referred back to the PPG following the Coordination of Care process. HN CM will contact the PPG and attempt to locate a PPG CM for the member. Member will be transitioned over to the PPG CM. If no response back from the PPG, the member will be referred to HN Health plan Case Management program for further follow up. All communications between the HN CM and the PPG will be documented in the member's HN electronic record including the disposition of the member. Compliance monitoring occurs via: • Monthly tracking of volume of members who receive case management outreach and engage with the case management program. • Case Rounds with Health Net Medical Director to address barriers to member goal achievement.			
Health Net's comprehensive member case management and coordination of care processes are documented within the following P&Ps: • UMCM -215L: Care Management • UMCM-230ML: Case Management Identification of Members with Serious/Complex Condition • UMCM-231ML: Complex Case Management Program Effectiveness • UMCM-234ML: Screening Criteria for Ambulatory Case Management,			

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PLAN OF ACTION			
• UMCM -235ML: Referral to Case Management • UMCM-237ML: Development, Implementation and Monitoring of the Complex Case Management Plan of Care • CM 11: Coordination of Care (COC) Case Management Process			
Health Net delegates certain functions to PPGs and/or vendors. The PPGs are delegated for Ambulatory Case Management. Any cases that meet the Complex Case Management criteria are managed by McKesson. Delegation Oversight reviews the delegate policies and procedures for case management and randomly selects files during the annual review. This includes members not eligible for CCS services, or CCS eligible members with non-CCS related conditions that require case management. Any member case management file is available for review upon request.		Rita Lonzo, Director, Delegation Oversight	

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Deficiency Identified:

Category 2: Continuity of Care; 2.2 California Children's Services (CCS)

1. California Children's Services (CCS); (Regulation: 2 Plan Contract A.11.9.A.B.)

Recommendation:

1. Ensure that CCS-eligible Members are monitored and tracked for case management and that coordination of care between PCPs and specialty providers occurs.

Description of how correction will be accomplished and compliance monitored and maintained	Date of Completion	Name & Title of Responsible Person(s)	DHS Comments
This CAP pertains to CCS eligible members that require case management and coordination of care. Health Net has had the following process in place to ensure continuity of care and care coordination. The Public Programs Coordinators (PPCs) are imbedded in the Member Services department to triage and coordinate services with "carved-out" programs such as California Children's Services (CCS). Once the member's CCS eligibility is established and the member is accepted into the CCS Program, the CCS Case Manager initiates contact with the child's family/legal guardian. CCS assumes case management, including prior authorization of all services related to the CCS condition.	Ongoing 3/1/2014	• Ana Clark, Manager of Public Programs • Janice Milligan, Director Strategy & Development (Public Health)	**Recommendation 1:** ***This recommendation is deemed Closed.***

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PLAN OF ACTION			
Health Net: • Monitors CCS members by reviewing service requests, updating the CCS member information in Health Net's CCS database and monthly CCS reconciliation report. • Continues to coordinate non-CCS services, confers with the local CCS Case Manager to facilitate coordination of CCS services and continuity of care as needed. • Accesses CCS member information through the Children Medical Services (CMS) website and enters the information in Health Net's system to facilitate care coordination • Meets with CCS quarterly and more often as needed to coordinate services for CCS eligible members. • Assists the PCP or specialist with coordination of care for non-CCS-related conditions, CCS services and additional services as appropriate. • Coordinates services with the CCS panel providers, CCS approved facilities both in and out of network. • Will mail copies of the CCS authorizations to the PCP to facilitate the communication and care coordination between the PCP, CCS paneled providers, CCS case manager and Health Net. This process will ensure that the PCP knows who the CCS panel providers are, the name of the CCS case manager and Health Net PPC. The PCP will have the ability to communicate directly with the CCS paneled providers and discuss the member's treatment plan.			

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Deficiency Identified:

Category 2: Continuity of Care; 2.3 Early Intervention Services/Developmental Disabilities (two parts)

1. Services for Persons with Developmental Disabilities (Regulation: 2 Plan Contract A.11.9.A.B.C.D)
2. Early Intervention Services (Regulation: 2 Plan Contract A.10)

Recommendation:

1. Develop and implement procedures for the identification of EI/DD (Early Intervention/Developmentally Disabled) members and ensure coordination of care with the Regional Center.
2. Develop a monitoring system to ensure that the EI/DD eligible members receive primary care services and coordination of care occurs between Primary Care Provider (PCP) and EI/DD specialists.

Description of how correction will be accomplished and compliance monitored and maintained	Date of Completion	Name & Title of Responsible Person(s)	DHS Comments
Health Net has had the following process in place to identify members with developmental disabilities and children under the age of 3 who would benefit from the Early Intervention Program. The Public Programs Coordinators (PPCs) are imbedded in the Member Services department to triage and coordinate services with "carve-out" programs such as the Regional Center (RC). Additionally PPCs are co-located at Regional Centers for the purpose of facilitating care coordination between the plan, PCP and the Regional Center. In addition there is ongoing communication between the PPCs and the Regional Center liaison, service coordinators and case managers for the purpose of care coordination.	Ongoing 3/1/2014	• Ana Clark, Manager of Public Programs • Janice Milligan, Director Strategy & Development (Public Health)	**Recommendation 1:** Please provide an approved and signed policy/procedure developed for the identification of EI/DD (Early intervention/Developmentally Disabled) members and ensure coordination of care with the Regional Center. Please also provide supporting documentation demonstrating this policy has been implemented. 6/20/14 – MCP provided Policy# LR1119-144244/Early Start Program and Policy # LR1119-1513471/Regional Centers Coordination. These policies

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Description of how correction will be accomplished and compliance monitored and maintained	Date of Completion	Name & Title of Responsible Person(s)	DHS Comments
Health Net's monitoring process includes: • Quarterly meetings between the plan and RC. • Health Net is receiving a monthly RC file of all members receiving RC services including members in the Early Start Program. • A PPC is on site at the RC to ensure care coordination for all members receiving services at the RC. • Beginning March 1, 2014, Health Net will notify the PCP in writing that the member is receiving services from the RC. This process will ensure that the PCP knows the services provided by the RC and have the ability to communicate directly with the RC service coordinator and case manager for the purpose of care coordination.			identify the EI/DD members and ensure that coordination of care with the Regional Center. **This recommendation is deemed closed.** **Recommendation 2:** ***This recommendation is deemed Closed.***
6/18/14 HN Response to DHCS Comment - Recommendation 1: HN previously submitted to the DHCS auditors a copy of HN's DHCS approved Regional Center (RC) and Early Start (EIS/DD) P&Ps. HN has attached another copy of the approved P&Ps and sample copies of quarterly liaison meetings with the RCs as evidence of coordination activities. ***ATTACHMENTS:*** **HN P&Ps, Sample Evidence of HN Quarterly Meeting Coordination with the RCs**			

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Deficiency Identified:

Category 2: Continuity of Care; 2.4 Initial Health Assessment (two parts)

1. Provision of Initial Health Assessment (Regulation: 2 Plan Contract A.10.3.A.B.C)
   a. Provision of IHA for members under 21 (Regulation: 2 Plan Contract A.10.4.A)
   b. IHA's for members 21 and over (Regulation: 2 Plan Contract A.10.5.A)

Recommendation:

1. Develop a system to document the 3 attempted contacts with Members to schedule their IHA to increase contract compliance.
2. Educate providers in the ways and means to access Member assignments so they can contact their Member list for IHA completion.
3. Ensure that providers document the exceptions from the IHA requirements found on LR1129-14550 in the Members' medical records
4. Develop a process to effectively monitor the completion rate of IHAs within the required timeframe.

Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
Recommendation 1: Per the DHCS contract, Exhibit A, Attachment 10, provision 3.D: *Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.* Following the previous DHCS audit finding in 2008, HN put in place a process to document the 3 outreach attempts, which satisfied the DHCS CAP for this finding.	Carol Spencer RN, FSR Department Manager	Developed in 2011 for implementation; now ongoing.	**Recommendation 1:** ***This recommendation is deemed Closed.***

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1. Health Net provides the IHA requirement notification in the new member packet, 2. A welcome call is made to the members after 2 weeks of enrollment, and 3. A postcard reminder is sent at 30 days of enrollment. DHCS accepts proof of 3 contracts as documentation. Many Plans are using the 3 outreaches as proof of the contact. Reports for the IHA 3 contacts to new members are submitted to the HNCS UM/QI Committee for review at least annually. **ATTACHMENT: Annual outreach reports for 2012 and 2013.**			
Recommendation 2: Providers are sent monthly lists of their assigned members. In addition, the eligibility list is posted on the provider website and updated twice per month. The eligibility list includes the enrollment effective date for new members. At each initial and periodic (every 3 years) FSR/MRR audit, the IHA and its process is audited. Providers are shown how to use the eligibility list to contact new members to come into the office for the IHA. Additionally providers are mailed an IHA member aging	Carol Spencer RN, FSR Department Manager	Ongoing	**Recommendation 2:** ***This recommendation is deemed Closed.***

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report that includes members who 120 days after their enrollment date have no evidence in our system of an IHA based on claims and encounters data procedure code and secondary diagnosis codes. **ATTACHMENT: Sample copy of an IHA aging report** DHCS PL 08-003 section IV.C states, "Plans may assist provider in contacting new member for scheduling the IHA appointment." The 3 outreach attempts to new members also meet this requirement.			
Recommendation 3: This is included in the new provider training, FSR pre-audit education, and in the provider operations manual for medical record documentation. Additionally, a sheet for tracking provider outreach to schedule an IHA is available for the providers' use. Providers are to obtain previous medical records to review for IHA within the past 12 months. Any refusal of the IHA/appointment for IHA, is to be documented in the member's medical record. As part of the DHCS PL 02-002 MRR and FSR audit tools, assessment of IHA, IHEBA (aka SHA) completion, missed appointments is scored. Corrective actions are required if the provider is not meeting requirements. The corrective action process is followed.	Carol Spencer RN, FSR Department Manager	Ongoing New provider orientation is conducted by the National Provider Communications Department FSR Department conducts new provider trainings and	**Recommendation 3:** ***This recommendation is deemed Closed.***

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Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
Attachments: • **Medical Record Documentation section of the Operations Manual** • **IHA Tracking Log**		provides supporting materials.	
Recommendation 4: Per the DHCS contract, 3 attempts to reach the member for the IHA shall be evidence for meeting this recommendation. Following the previous DHCS Audits and Investigation audit finding in 2008, HN put the 3 outreach attempts in place, which satisfied the DHCS CAP for this finding. Many plans are using the 3 outreaches as proof of the contact. HN provides the IHA requirement notification in the new member packet, at the 2 weeks welcome call, and a postcard reminder at 30 days of enrollment. Reports for the IHA 3 contacts to new members are submitted to the QI Workgroup for review at least annually. **ATTACHMENT: Annual outreach reports for 2012 and 2013.**	Carol Spencer RN, FSR Department Manager	Developed in 2011 for implementation, now ongoing.	**Recommendation 4:** ***This recommendation is deemed Closed.***

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Deficiency Identified:

Category 3: Access and Availability; 3.1 Appointment Procedures and Monitoring Waiting Times

1. Appointment Procedures (Regulation: 2 Plan Contract A.9.3.A.)
2. Prenatal Care (Regulation: 2 Plan Contract A.9.3.B)
3. Monitoring of Waiting Times (Regulation: 2 Plan Contract A.9.3.C)

Recommendation:

1. Develop procedures to ensure monitoring of in-office waiting times in provider offices

Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
At the DHCS Audit Exit Conference on August 28, 2013, Health Net obtained clarification of the finding from Edgar Monroy, DHCS Monitoring Unit at the DHCS Audit as follows: Although Health Net does have a monitoring process in place, DHCS considers monitoring in-office wait times through member grievances a "passive monitoring process" and requires a more "active monitoring process" such as through the use of a member satisfaction or provider appointment access survey/audit. Based on this information, Health Net confirmed with Mr. Monroy that adding a supplemental question to the CAHPS Medicaid Member Satisfaction Survey tool to confirm specific in-office wait times with members would be sufficient to meet compliance. Thereby, Health Net added the following supplemental question to its 2014 Medicaid CAHPS Tool to meet compliance:	• Jenny Anderson, QI Program Manager - Access • Leah Smith, Manager - HEDIS/CAHPS Compliance & Reporting	1/10/2014	**Recommendation 1:** ***This recommendation is deemed Closed.***

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Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
☐ 15 minutes or less ☐ 16 - 30 minutes ☐ 31 - 45 minutes ☐ 46 minutes to 1 hour ☐ Over 1 hour ☐ Does not apply, I did not have any appointments in the last 6 months The above referenced Medicaid CAHPS survey tool revision was submitted to DHCS on 12/20/2013 for review and approval. DHCS approval was received on 01/03/2014. Final tool has been implemented with the CAHPS Survey Vendor. The Medicaid CAHPS survey pre-notification postcard is expected to be mailed out by Monday, January 27, 2014 and the mailing of the 1st survey is expected to begin by Friday, January 31, 2014. Once the 2014 Medicaid CAHPS is completed, Health Net will review, analyze and evaluate the results to identify opportunities for improvement. **ATTACHMENTS - Evidentiary support documentation attached within the CAP email to DHCS:** • External Request for DHCS Approval			

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<table>
<tr><th>Description of how correction will be accomplished and compliance monitored and maintained</th><th>Name & Title of Responsible Person(s)</th><th>Date of Completion</th><th>DHS Comments</th></tr>
<tr><td>• DHCS Approval
• Final 2014 Medicaid CAHPS tool</td><td></td><td></td><td></td></tr>
<tr><td>Additionally, Health Net revised its Appointment Access policy and procedure AJ107-103034, Medi-Cal Accessibility of Services Standards & Monitoring Activities Addendum to include an In-office wait time standard for scheduled appointments and performance goal to measure the results to the new CAHPS supplemental question against and implement appropriate corrective actions when deficiencies are identified. New Standard as follows:
<table>
<tr><th>Access Measure</th><th>Standard</th><th>Rate of Compliance</th></tr>
<tr><td>Access to in-office wait time for scheduled appointments</td><td>Wait time not to exceed 30 minutes</td><td>≥ 80% of members indicate that usually or always the in-office wait time does not exceed 30 minutes for scheduled appointments</td></tr>
</table></td><td>• Jenny Anderson, QI Program Manager - Access</td><td>10/08/2013</td><td></td></tr>
</table>

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Deficiency Identified:

Category 3: Access and Availability; 3.7 Access to Pharmaceutical Services

1. Pharmaceutical Services and Prescribed Drugs (Regulation: 2 Plan Contract A.10.8.G.1)

Recommendation:

1. Develop monitoring procedures to ensure the provision of drugs prescribed in emergency circumstances.

Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
Health Net will continue to monitor member grievances for problems related to a member's ability to receive a provision of drugs and/or get a prescription filled following an emergency room visit. This is described in Health Net's policy Rx-210, Emergency Medication Provisions. Health Net will create and distribute a provider educational update to hospitals to remind them of the DHCS requirement for the provision of drugs in emergency circumstances. Additionally, Health Net's Provider Operation Manuals are supplemental to the Participating Provider Agreements and must be adhered to. The hospital operations manual contains language that addresses dispensing a supply of medication in a medical emergency situation; however the requirement will be reiterated more prominently in the Emergency Services requirements section of the hospital operations	• James Gerson, VP & Senior Medical Director • Danielle Henderson, Director Appeals & Grievances • Christine Keating, Manager Provider Communications	Ongoing 2nd quarter 2014	**Recommendation 1:** Please provide supporting documentation demonstrating that planned actions have been completed. Planned actions are expected to be completed on the upcoming 2nd quarter of 2014. 7/15/14: The MCP submitted "Accessibility Analysis – CareChoice 24 HR Network and Access Analysis – CareChoice Network (all), and HN CAP Response- Sect3.7 – 2013 DHCS Medical Audit (NON-SPD)." **This recommendation is deemed closed.**

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Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
manual.			
Health Net will conduct a geo-access review to ensure and demonstrate adequate availability of contracted pharmacies within appropriate distance of member residences and/or adequate availability of 24 hour pharmacies within appropriate distance of contracted hospitals. Any potential gaps in access found, will be evaluated and addressed as appropriate.	• Shannon Redline, Manager Clinical Pharmacy Operations	2nd quarter 2014	
Health Net will research and explore the feasibility of conducting member outreach to ascertain any barriers or problems related to members receiving a provision of drugs or ability to get a prescription filled within a reasonable time frame following their emergency room services.	• James Gerson, VP & Senior Medical Director	2nd quarter 2014	
Health Net requests that DHCS addresses the inconsistency of the emergency drug provision requirement between the Medi-Cal GMC and Two Plan contracts. The difference in the requirements creates challenges for Health Net with communicating and administering the requirement internally and externally for providers throughout our collective service area. Health Net understands that the GMC contract is to be brought in line with the requirements of the Two Plan contracts via amendment or policy letter to align the GMC contract requirements were differences currently exist. Health Net requests that DHCS proceed with the			

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GMC amendment process as soon as possible.			
6/18/14 HN Response to DHCS Comment - Recommendation 1: On April 29, 2014, HN created and distributed the educational Provider Update 14-170, to remind hospitals of the emergency provision of drugs requirement. A copy of the provider update is attached. Following research and internal discussion, HN determined it is not feasible to conduct member outreach concerning the provision of drugs or ability to get a prescription filled following a member's emergency room services. HN is in the process of completing a geo-access analysis report that will ascertain there is sufficient number of 24 hour and non 24 hour pharmacies within appropriate distance of contracted hospitals within HNs service area. HN anticipates completion of the report by 6/27/14, and will send DHCS a copy of the report and summary analysis of the report results. ***Attachments***: **Provider Update 14-170: Emergency Medication Provisions**			

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7/15/14 HN Response to DHCS Comment – Recommendation 1: Health Net contends that members have adequate access to pharmacy services following an emergency room visit. In addition to the distribution of the educational provider update, HN conducted a geo analysis of access from the Plan's contracted hospitals to a Caremark 24 hour pharmacy. As summarized below, the analysis indicates that 83 out of 90 hospitals (92%) are within 10 miles of a network 24 hour pharmacy. The average distance from the hospital to a 24 hour network pharmacy is less than 5 miles.			

Caremark CareChoice 24-hour Network	83 of 90 hospitals* (92.2%)	7 of 90 hospitals (7.8%)
Caremark CareChoice Network (All)	92 of 92 hospitals* (100%)	0 of 92 hospitals (0%)

To determine pharmacy access for the 7 hospitals

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without a 24 hour pharmacy within 10 miles, an additional analysis was conducted to measure access to any network pharmacy. That analysis confirms that a network pharmacy is located within 10 miles of all of the contracted hospitals, with the average distance from any hospital to any network pharmacy less than 1 mile. This analysis demonstrates that there are no barriers to a member being able to get their prescription filled if required following an emergency room visit to a Health Net contracted hospital. This is the case whether the hospital emergency room provides the member with a limited supply drugs and a prescription, or a prescription only. Cursory research has found that some contracted hospitals have a policy that prohibits them from issuing take away drugs to patients, and instead the member is only given a drug prescription to get filled following their visit. Health Net will continue to identify problems related to a member's ability to receive a provision of drugs and/or get a prescription filled following an emergency room visit through complaints and grievances, as described in the Emergency Medication Provisions policy. ***Attached Accessibility Analyses:*** • **CVS Caremark CareChoice 24 Hour Network**			

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Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
• CVS Caremark CareChoice Network (All)			

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Deficiency Identified:

Category 4: Member's Rights and Responsibilities; 4.1 Grievance System

1. Member Grievance System and Oversight (Regulation: 2 Plan Contract A.14.1; 2 Plan Contract A.14.2; 2 Plan Contract A.14.3.A; 2 Plan Contract A.14.2.C)

Recommendation:

1. Institute routine clinical oversight of the grievance log and grievance classification process by clinical personnel to ensure appropriate disposition of all grievances.
2. Ensure grievance cases are not closed and resolution letters are not sent to members prior to the completion of a full investigation into the issue.
3. Ensure the suspended provider issue is resolved.

Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
Recommendation 1: Health Net will implement a quality review process to ensure that grievances received through all channels (including but not limited to call center, mail, and fax) determined to be administrative and not subject to clinical review are properly categorized and reviewed. 1. HN Clinician will review Quality of Service (QOS) cases on a weekly basis. 2. Monitoring & Reporting Team will receive QOS log every week 3. Eight (8) QOS cases will be randomly selected for CalViva, 4. If any of the initial 8 cases fail, additional cases (no more then 30) will be randomly selected	• Danielle Henderson, Director, Appeal & Grievances • Leticia Carrera, Mgr. Appeals • Yvette Urbina, Mgr. Medical Operations	October 2013	**Recommendation 1:** Please provide supporting documentation indicating the completion of planned actions. Planned actions are expected to be completed on the upcoming 2nd quarter of 2014. 6/20/14 – The MCP provided Health Net Medical Management Desktop Procedure/AU-02. This document ensures routine clinical oversight of the grievance log and grievance classification process. **This recommendation is deemed closed.**

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Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
5. Monitoring & Reporting Team will obtain the initial documentation files from the Appeals and Grievances Team common drive. 6. The cases will be reviewed using audit questionnaire worksheet 7. Results will be shared weekly NO LATER than the following working day with the Appeals and Grievance Clinical and Non Clinical Management Teams. 8. Immediate action is to take place for any case identified needing re-classification changes prior to case closure. 9. Results will be reported in a monthly summary report. ***6/18/14 HN Response to DHCS Comment - Recommendation 1:*** As previously stated, HN implemented the above process to ensure proper classification of grievances cases in October 2013. Attached is a sample copy of a monthly QOS and QOC audit report and the A&G audit desktop P&P. ***Attachments:*** **Monthly grievance case audit sample, audit desktop P&P**			

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Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
Recommendation 2: Training will be conducted for associates regarding full case investigation. The A&G Management Team will conduct monthly case reviews. In addition, A&G will also initiate quarterly letter review workshops to identify trends and training opportunities by 2nd quarter of 2014.	• Danielle Henderson, Director, Appeal & Grievances • Leticia Carrera, Mgr. Appeals	3/31/2014 2nd quarter 2014	**Recommendation 2:** Please provide supporting documentation demonstrating planned actions have been completed. Planned actions expected to be completed on the upcoming 2nd quarter of 2014. ***This recommendation is deemed Closed.***
Training will be conducted for the associates regarding viewing the exclusion list on the Office of Inspector General (OIG) website. If the provider displays on the exclusion list, the A&G associate will notify the Adverse Action Department and Credentialing for further investigation. Training will be conducted in the 2nd quarter of 2014. ***6/18/14 HN Response to DHCS Comment - Recommendation 2:*** A&G associate training regarding proper full case investigation and case closure and will commence on 6/25/14, and continue ongoing for new associates. Additionally, the A&G Management Team will continue to conduct monthly case reviews. A copy of the associate training is attached. A&G also conducted the initial quarterly letter review workshops on 3/31/14, to identify trends and training opportunities. A copy of the quarterly review workshop documentation is attached.	• Danielle Henderson, Director, Appeal & Grievances • Leticia Carrera, Mgr. Appeals	2nd quarter 2014	6/20/14 – The MCP provided a copy of its training slides to ensure grievance cases are not closed and resolution letters are not sent to members prior to the completion of a full investigation into the issue. **This recommendation is deemed closed.**

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Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
Attachments: **A&G Training Presentation, Quarterly Review Workshop Agenda & Meeting Minutes**			
Recommendation 3: Ensure suspended provider issue is resolved: a. Provider office was notified and the physician in question is no longer working in the office. b. Notification letter was sent to all Health Net providers stating if they hire a physician that is not contracted with Health Net, they will be responsible for their credentialing. c. Added a new requirement to the Credentialing/Recredentialing Policy and Peer Review Committee Policy. d. Added a new requirement to the Provider Operations Manual e. Added to the policy the review and investigation of all non-Health Net physicians and the hiring physician if identified with a sanction by A&G. **ATTACHMENT: Copies of the revised policies.**	Laurie Jurado, Director Credentialing	Provider Notification and Provider Operations Manual completed 11/2013. Policy approval to be completed 2/2014	**Recommendation 3:** ***This recommendation is deemed Closed.***
A Quick reference guide document will be created by March 31, 2014 to reflect the following: If the provider in question is not the members PCP or a contracted provider with HN, A&G will notify the Adverse Action Department	• Leticia Carrera, Mgr. Appeals • Laurie Jurado, Director	3/31/2014	

and Credentialing for further investigation.	Credentialing		

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Deficiency Identified:

Category 4: Member's Rights and Responsibilities; 4.3 Members Right to Confidentiality

1. Members Right to Confidentiality (Regulation: 2 Plan Contract A.13.1.B)
2. Health Insurance Portability and Accountability Act (HIPAA) Responsibilities (Regulation: 2 Plan Contract G.3.G, H, and I)

Recommendation:

1. Ensure that both the 24-hr. DHCS Initial Notification of Breach and the 72-hr. DHCS Notification of Investigation are submitted to the required DHCS personnel within the required time frame.
2. Update the Plan's "Desktop Procedures" to include the contractual stipulation that the initial notification of HIPAA breach to be reported within 24 hours, and the notification of investigation within 72-hours be submitted to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer.
3. Ensure that the correct address for the DHCS Privacy Officer is indicated in the Member Services Guide/Notice of Privacy Practices.

Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
In order for Health Net to meet the 24 hour and 72 hour notification requirements, the Privacy Department will immediately identify key personnel within the department to be on call after hours, weekends, and holidays (excluding federal and state holidays). The Desktop Procedure has been updated as required. **Attachment: Privacy breach case reporting desktop P&P**	Cynthia Snyder, Director Information Privacy	3/31/2014	**Recommendation 1:** ***This recommendation is deemed Closed.*** **Recommendation 2:** ***This recommendation is deemed Closed.***

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Both Health Net's 2012 and 2013 Member EOC reference the same address for the DHCS Privacy as is stated in the Two Plan/GMC Contract Exhibit G A14. The "MS" part of the address was not included in the EOC because HN was informed that the "MS 0011" location may not be correct and locations can change. Additionally, an email from the DHCS Privacy Officer and Senior Attorney, Patricia Pechtel, validated the address in the EOC is correct. HN acknowledges that the DHCS phone number in the EOC differs from what is shown in the contract. However, the Plan has confirmed that the number in the EOC does in fact connect to the Department's Privacy Hotline. The Plan will correct this number as needed. **HN's 2012 and 2013 EOC states**: Privacy Officer c/o Office of Legal Services California Department of Health Care Services 1501 Capitol Avenue P.O. Box 997413 Sacramento, CA 95899-7413 (916) 255-5259 or (877) 735-2929 TTY/TDD E-mail: Privacyofficer@dhcs.ca.gov **Two Plan Contract 03-76182 A14 states:** Privacy Officer	Cynthia Snyder, Director Information Privacy	n/a	**<u>Recommendation 3:</u>** Please provide supporting documentation indicating the Member Services Guide/Notice of Private Practices contain the correct address for the DHCS Privacy Officer. 7/18/14 – discussed via conference call with MCP. Per MCP, will submit the current Privacy Officer contact information from their 2014 EOC. This recommendation will stay open until above mentioned documentation is received. 8/5/14 – Per Email attachment: HN states that they will revise the Notice of Privacy Practices in the next printing of the Member Handbook/EOC to ensure that the address and phone number for the DHCS Privacy Officer that appears in the Medi-Cal contracts is provided to members as an alternative means for beneficiaries to lodge privacy complaints. ***This recommendation is deemed Closed.***

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Plan Name: **Health Net Community Solutions, Inc.**

Review Type: 10-87050 DHCS A&I Medical Review Audit (Medi-Cal NON SPD) **Review Period:** March 1, 2012 - February 28, 2013

Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
c/o Office of Legal Services Department of Health Care Services P.O. Box 997413, MS 0011 Sacramento, CA 95899-7413 Telephone: (916) 440-7750 Email: privacyofficer@dhcs.ca.gov **Attachments: Correct Privacy address contained within HN's EOCs and DHCS Contract.** ***6/18/14 HN Response to DHCS Comment - Recommendation 3:*** In HN's CAP response submitted on 3/14/14, HN provided supporting documentation showing the correct DHCS Privacy Officer address within the 2012 and 2013 Member EOCs. HN has attached another copy. As previously responded, HN has confirmed with the DHCS Privacy Officer that the address and telephone number [(916) 255-5259] as shown within the EOC is the correct number for members to use to contact the Privacy Office. The (916) 440-7750 telephone number shown within the 2-Plan and GMC Medi-Cal contracts in effect during the audit period is not the appropriate telephone number to include in the Member EOC because it is the Privacy Officer's direct telephone line.			

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Please also note that the DHCS Privacy Office address provided within the current version 2-Plan and GMC Contract is inconsistent with the DHCS Privacy Office address published on the DHCS.ca.gov website and DHCS Notice of Privacy Practices document. ***Attachment:*** **Correct Privacy address shown in HN's 2012 & 2013 Member EOCs in accordance with DHCS Contracts**			

Deficiency Identified:

Category 5: Quality Improvement System; 5.5 Medical Records

1. Medical Records (Regulation: 2 Plan Contract A.4.13.A, B, C, D)

Recommendation:

1. Ensure that a complete medical record is maintained for each Member.
2. Ensure that the monitoring system of record keeping is maintained.
3. Continue to monitor provider compliance with Facility Site Reviews including medical record reviews.

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Health Net follows the process to review provider medical records established in DHCS Policy Letter 02-002. Reviews follow the initial and then periodic 3 year cycle with a mid-cycle interim review. Pre- FSR/MRR audit educations and materials to meet the Medical Record documentation requirements are provided at each initial and periodic cycle audit. Criteria in the Medical Record Review tool address complete medical record for each Member and allow for scoring/tracking/monitoring of the criteria results. **Attachment: Criteria from PL 02-002** Providers that do not meet the established thresholds must complete Corrective Actions Plans with in DHCS required time frames that the health plan Certified Site Reviewer verifies as corrected. As needed additional "focused reviews" are conducted to be sure the provider holds the gains that were documented in the corrective action plan. These are documented in the Facility Site Review Database systems. The Provider Operations Manual additionally contains the Medical Record standards. A report for the MRR/FSR results is submitted to the HNCS UM/QI Committee at least annually.	Carol Spencer, RN (Manager QI/FSR)	These are ongoing FSR and MRR audits that occur for new providers and on periodic cycles for all provider sites. Reviews of both hard copy medical records and electronic medical records are completed. A Provider Update for Medical Record Documentation education was distributed to providers November 2013	**Recommendation 1:** The MCP must follow the contract language for this review period and not the Policy Letter 02-002 which was produced in 2002. Please provide evidence of a policy/ procedure that is approved and signed to ensure that a complete medical record is maintained for each Member – and respective documentation demonstrating this policy has been implemented. 6/20/14 – The MCP provided Medical Record Review Survey 2012, Medical Review Guidelines 2012, Policy # KK118-141356/Medi-Cal PCP Facility Site and Medical Record Review Process. These documents submitted ensure that a complete medical record is maintained for each member. **This recommendation is deemed closed.** **Recommendation 2:** ***This recommendation is deemed Closed.*** **Recommendation 3:** ***This recommendation is deemed Closed.***

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Attachment: **-SHPQI FSR Activity Report for Q3 and Q4 2012** **-Provider Update 13-482** Additional reports are available as needed ad hoc to look at focused areas of the MR tool. The Format Section that addresses the above findings for the counties was aggregated to show drill down monitoring.			
6/18/14 HN Response to DHCS Comment - Recommendation 1: HN requires clarification on DHCS comment. HN's 2-Plan and GMC contract MRR requirement in place during the audit period states that the MRR be conducted in accordance with MMCD Policy Letter 02-002. The contract language is shown as follows: **2 Plan and GMC Medi-Cal Contract Language:** **13. Medical Records** A. General Requirement Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861 and **MMCD Policy Letter 02-02.**			

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The FSR is the process for plans to determine proper medical record documentation by providers. The FSR and use of the MRR tool validates that a medical record is established for each member. Per HN's P&P medical records are reviewed at each full scope FSR/MRR at the periodic cycle every 3 years. HN FSR and MRR scores are submitted to the DHCS Medical Monitoring Unit 2 times per year by January 31 and July 31 of each year. This is evidence that HN's policy has been implemented. The process was previously described within HN's original CAP response submitted on 3/14/14. Attached is a copy of HN's current approved version of the FSR & MRR P&P and a copy of DHCS' approval of the P&P.			
Attachments: HN's current approved FSR & MRR P&P, DHCS approval of the current version of HN's FSR P&P			

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Deficiency Identified:

Category 5: Quality Improvement System; 5.6 Informed Consent

1. Informed Consent (Regulation: 2 Plan Contract A.4.13.D.6; 2 Plan Contract A.9.8.A.1)
2. Family Planning (Payment); (Regulation: 2 Plan Contract A.8.5)

Recommendation:

1. Educate providers and the claims department on the proper completion of the PM330 and develop a system to monitor compliance with the training
2. Educate providers about the documentation requirements for the discussion regarding sterilization contained in both the Operations Guide and Provider Library
3. Ensure that the PM 330 Sterilization Consent forms are completed appropriately for claim submission
4. Ensure each Member has access to sterilization procedures including Essure and the required hysterosalpingogram without Prior Authorization.

Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
Provider Education: Every medical group to which Medi-Cal members are assigned is audit annually for adherence to the requirements for sensitive services. The intent of Section 5 of the audit tool is "to ensure that Medi-Cal members may self-refer to any qualified provider of their choice (in or out-of network) for "sensitive" services." • Section 5A monitors whether the organization has a written description that defines the following sensitive services that includes: 1) family planning,	Rita M. Lonzo, Director Delegation Oversight	This has been in the audit tool since 2003 and is current in the 2014 audit tool effective 1/1/2014	**Recommendation 1:** Please provide supporting documentation demonstrating the MCP's claims department has been educated on the proper completion of the PM 330. Also, please provide documentation demonstrating how Health Net has developed a system to Monitor compliance with the training. 7/18/14 – discussed via conference call with MCP. A&I recommends MCP to develop a system to monitor

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2) diagnosis and treatment of sexually transmitted infections (STIs), 3) confidential HIV testing and counseling, 4) pregnancy termination, 5) sexual assault services, 6) prenatal care - Note: members may self-refer without prior authorization, but services must be obtained through an in-network provider, 7) Preventive services: Members may self-refer without prior authorization for preventive services. 5A also monitors whether the policy states that the organization is responsible for payment of all self-referral sensitive services, including services received without a referral or prior authorization and/or performed by a non-participating provider. • Section 5B audits for evidence of implementation of the policy.			compliance with the Provider training on the completion of PM330 form. This recommendation will stay open until corrective action is received from MCP. 10/1/14 – MCP provided Policy # GR106-135753/Provider Relations New Provider Training, 2014 Provider Operational Training Presentation and Provider Training 2014 attendance sign in sheet. The MCP has incorporated training on the completion of the PM 330 form and the submission requirements into the training for all new providers that is conducted within 10 days of the provider being placed on active status. Provider Relations will maintain a tracking database for the training. ***This recommendation is deemed Closed.***
Section 8 of the UM annual audit tool ensures "that informed consent will be obtained from Medi-Cal enrollees for all invasive procedures and contraceptive methods, including sterilization, consistent with requirements".	Rita M. Lonzo, Director Delegation Oversight	This has been in the audit tool since 2003 and is current in the 2014 audit tool	

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Section 8A monitors whether the organization has a written policy and procedure to ensure that an informed consent is signed and present for any invasive procedure or treatment.		effective 1/1/2014	
Section 8B of the UM audit tool monitors whether the PPG has written policy and procedure: • To ensure the Human Sterilization Consent Form (PM 330) is completed, and signed 30 days prior to a sterilization procedure. • To ensure that a PM330 (sterilization consent) is reviewed at the time of claims payment. **Attachment:** PPG UM Audit Tool ***7-11-14 HN Response to DHCS Comment - Recommendation 1:*** Health Net stands by the mitigation response originally submitted for this recommendation as it pertains to Claims Department education on the proper completion of the PM330 form. Additionally, Health Net is providing the following information: In the audit report "Summary of Findings" section following submission of our original mitigation response, the DHCS auditor actually acknowledged our position and stated the following…	Rita M. Lonzo, Director Delegation Oversight	This has been in the audit tool since 2003 and is current in the 2014 audit tool effective 1/1/2014	

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"In the Plan's response to the audit findings subsequent to the Exit Conference, the Plan asserts that Health Net's claims examiners have the responsibility to determine that a copy of the PM 330 is attached prior to paying the sterilization claims. However, the claim examiner does not have the responsibility or capability to review the PM330 completion requirement. *Although Health Net's claims examiners have the responsibility to determine that a copy of the PM330 is attached prior to paying the sterilization claims, the Plan does not have a system of monitoring compliance with the PM330 requirement".* Recommendation 1 should have been revised by the auditor to remove the "claims department" reference from their comment on education of the proper completion of the PM330 form. Monitoring Provider Compliance: Health Net's original 3/14/14 response above provided a description and documentation that describes our process of monitoring provider compliance with the PM330 completion requirement via the Delegation Oversight audits of the PPGs, and was described below under Recommendations 3 and 4 , via the provider MRR & FSR reviews conducted. However, DCHS has left Recommendation 1 open,			

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and is again asking Health Net to provide supporting documentation demonstrating the MCPs claims department has been educated on the proper completion of the PM330. Claim Department Responsibility: It is not appropriate or feasible for Health Net to conduct or develop training and a monitoring system for the claims department on proper completion of the PM 330 form. This type of claims department training for claims examiners will not occur. The attached sterilization procedure PM 330 claim processing edit/policy was previously provided to the Auditors, and another copy is being provided. This is the policy that the claims examiners follow to ensure that the PM 330 form is attached prior to paying the claim. **ATTACHMENT: Claims Sterilization procedure PM 330 Form**			
10/1/14 HN Response to DHCS Comment, Recommendation 1: Health Net has incorporated training on the completion of the PM 330 form and the submission requirements into the training for all new providers that is conducted within 10 days of the provider being placed on active			

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status. Provider Relations will maintain a tracking database for the training. The policy and presentation materials for the training are attached. **ATTACHMENTS:** • Provider Relations New Provider Training P&P (draft pending approval) • HN ML Ops Training Presentation • Training sign-in sheet			
Health Net developed and distributed Provider Update #13-500 *Informed Consent and PM 330 Form Completion,* on 12/2/13, to all participating Medi-Cal providers. The update reminded providers about requirements for informed consent for sterilization, including: documentation of the discussion regarding sterilization, distribution of the required DHCS-published brochures, and proper completion of the PM330 form.	Chris Keating, Manager, Provider Communications	12/3/2013	**Recommendation 2:** ***This recommendation is deemed Closed.***
The Medi-Cal Provider Operations Manuals document *Certification of Informed Consent for Reproductive Sterilization*, located in the *Consent >Human Sterilization and Informed Consent* section, contains instructions on completing the PM330 form. This document was revised on 12/3/13 to include additional details for documentation, including identification of PM330 form sections where typewriting is allowed and instructions to cross out unused sections. Health Net has also revised the Medi-Cal Operations Guide to include basic information on the required use of	Chris Keating, Manager, Provider Communications	12/2/2013	

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the DHCS-published brochures on sterilization and PM 330 form documentation. Health Net claims examiners review the sterilization claims to ensure the Informed Consent PM 330 form is attached prior to payment of the claim. Health Net members have access to all Medi-Cal approved sterilization benefits and procedures without requiring prior authorization as explained to the member in their Evidence of Coverage. This would include the Essure and hysterosalpingogram. **ATTACHMENTS:** -Provider Update #13-500 *Informed Consent and PM 330 Form Completion* -Medi-Cal Provider Operations Manuals document *Certification of Informed Consent for Reproductive Sterilization*, located in the *Consent >Human Sterilization and Informed Consent* section - Medi-Cal Operations Guide information on the PM330 form			
Medical Records Reviews: Documentation of signed informed consent forms is an element in the DHCS FSR tool (Section II, D). Health Net's Facility Site Review (FSR) nurses conduct FSR/MRR reviews on Health Net's primary care physicians per the regular 3-year period review cycle (per MMCD Policy Letter 02-02).	Carol Spencer, RN (Manager QI/FSR)	FSR/MRR report, produced twice annually.	**Recommendation 3:** ***This recommendation is deemed Closed.*** **Recommendation 4:** ***This recommendation is deemed Closed.***

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Health Net's FSR nurses provide Health Net's primary care physicians with office policy information to assist with FSR/MRR compliance, which includes a policy for Informed Consent documentation and also addresses the PM 330 for human sterilization.	Carol Spencer, RN (Manager QI/FSR)	ongoing	

Deficiency Identified:

Category 6: Organization & Administration of Plan; 6.4 Provider Training

1. Medi-Cal Managed Care Provider Training (Regulation: 2 Plan Contract A.7.5)

Recommendation:

1. Ensure that all new providers receive training within 10 working days after the Plan places a newly contracted provider on active status

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Health Net respectfully disagrees with the DHCS auditor finding for Provider Training. The DHCS recommendation states *"Ensure that all new providers receive training within 10 working days after the Plan places a newly contracted provider on active status."* The DHCS findings accurately state "The Plan personnel confirmed that the Plan submits a welcome	Christine Keating, Mgr. Provider Communications	Ongoing	**Recommendation 1:** Please provide supporting documentation demonstrating how Health Net ensures that the Plan has a tracking system to verify whether the provider obtained the training within 10 working days as required by contract

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package and other brochures to the new providers within (10) working days…" The findings inaccurately state that *"…once the packet is sent… [the Plan] provides instruction for the provider to create a username and password to access the training materials."* The DHCS seems to imply that the written materials contained in the orientation packet and other training resources provided, including the Medi-Cal Operations Guide, is not considered instructional. Health Net disagrees and contends that written information is a primary mode of education and instruction. The distribution of the orientation packet, therefore, can and should be considered to demonstrate compliance with the contractual requirement. The auditor statement *"…once the packet is sent… [the Plan] provides instruction for the provider to create a username and password to access the training materials"* also inaccurately implies that instructions are provided after the packet is sent. In fact, the packet includes both training materials as well as instructions to create an account on Health Net's website to access additional policy information (such as the complete provider operations manuals) and supplemental training modules. The DHCS contract language states that *"contractor shall conduct training for all providers within (10) working days after the Contractor places a newly contracted provider*			requirements. 7/18/14 – discussed via conference call with MCP. Per A&I, MCP had insufficient data to ensure that the MCP has a tracking system to verify whether the provider obtained the training within 10 working days. As required by the contract. This recommendation will stay open until corrective action is received from MCP. 10/1/14 – MCP provided Policy # GR106-135753/Provider Relations New Provider Training, 2014 Provider Operational Training Presentation and Provider Training 2014 attendance sign in sheet. The MCP requires the training for all new providers that is conducted within 10 days of the provider being placed on active status. Provider Relations will maintain a tracking database for the training. ***This recommendation is deemed Closed.***

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on active status…" As explained to the DHCS auditors during the audit, in early 2001, DHCS approved Health Net's plan to revamp provider communications methods for the Medi-Cal provider community. The goal was to replace the paper operational manuals with a less costly paper guide and an electronic operations library, containing the operations manuals and far more content, and to replace in-person training workshops (that were sparsely attended and prohibitively expensive) with computer-based training (CBT) and video training. The plan included the distribution of the orientation packet. Health Net and DHCS agreed that this methodology of reaching the providers with extensive training and reference materials was far more effective than holding in person training sessions where we could not enforce provider attendance. Health Net has attached with the CAP response a copy of results we found from a previous Health Net DHCS medical audit conducted in 2003, where DHCS accepted Health Net's corrective action plan (CAP) as meeting the 10-day training requirement. The CAP involved receiving the daily IS report (that still occurs now) of new providers and mailing the provider training material. At that time, the packet contained a CD-ROM with the electronic training modules. Since that time, Health Net has adopted more efficient and versatile delivery methods of the CBT			

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and video training, via the Web, in lieu of the CD within the packet. Health Net agrees with the DHCS requirement and expectation that providers are educated about the Medi-Cal Managed Care Program, and has implemented a wide variety of methods to do so, including the orientation packet, online trainings, in-person trainings conducted by various other Departments within Health Net (including Provider Network Management, Provider Relations, Delegation Oversight, Public Programs, Facility Site Review, Health Education, Credentialing, Community Solutions), and regular communications to the providers. Health Net does not believe that it is practical, reasonable or cost-effective to track and enforce use of a specific method – such as completion of an online training CBT, viewing of the online training video, reading the complete operations manual, or reading the operations guide. In addition, Health Net does not believe that is practical, reasonable or cost-effective to revert to an expectation of in-person training for all new providers. Additionally, Health Net does not agree that it is reasonable for DHCS' findings to establish a definition or scope of training that excludes the validity of written materials as educational. In the Summary of Findings, DHCS made the following comment, *"In addition, sign-in sheets were provided, but no agendas were provided for in-service trainings to the new providers. The Plan staff indicated that they do not*			

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keep those documents on file and are provided only upon request." It's important to clarify that the sample sign-in sheets and proof of provider trainings conducted by the Health Education, Public Health and Community Solutions departments represent various additional supplemental provider trainings that are occurring throughout the year, and these supplemental trainings are not tied to the 10 day new provider training requirement. These samples were provided to the auditor to demonstrate the additional types of provider training that is available and being performed. The documentation and sign in sheets for these trainings are kept on file by the departments. Also, it was not required that Health Net provide an "agenda" for these various supplemental training sessions that are conducted by the other noted departments. Health Net respectfully asks DHCS to consider the complexities and prohibitive expense of the expectation of in-person delivery methods and resources required to monitor enforcement, as well as an undue unnecessary burden the training tracking expectation would put on providers and the Plans. As DHCS is acutely aware, the California budget issues is resulting in unprecedented efforts to move more of the state's underserved populations into Medi-Cal Managed Care, through initiatives such as the Duals Demonstration, the transition of Healthy Families program and Low Income Health Program (LIHP) members into Medi-Cal, and the Medi-Cal 133 expansion in conjunction with the implementation of			

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the Affordable Care Act. The state is also aware that the large influx of these newly eligible Medi-Cal recipients necessitates the recruitment of new providers that will accept Medi-Cal patients in order to develop an adequate network to serve this population. Many individual providers that accept Medi-Cal contract with multiple health plans. To institute a requirement for a provider to complete similar trainings with multiple health plans to orientate them to the Medi-Cal Managed Care program is redundant, and enforcement could prove a further disincentive for qualified providers to join the Medi-Cal Managed Care network. The use of a delegated network model, as used by Health Net, necessitates further versatility in the mode of educating providers, as well as further challenges and expense with oversight and enforcement. Health Net makes all efforts to keep administrative expenses at a minimum in order to maximize the savings realized by the state of California through the Medi-Cal Managed Care Program. The expense of oversight and enforcement to ensure that **all** providers complete a specific mode of training within 10 days – moreover to conduct in person training – would prove counterintuitive to the State's Medi-Cal Managed Care financial objectives. Health Net also respectfully asks DHCS consider modification of the Two Plan and GMC contract language regarding the Provider Training requirement to more practically specify the training of "primary care physicians			

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(PCPs)" versus **"all providers"**. The COHS plan Medi-Cal contracts require the 10 day provider training for **PCPs.** We believe this more accurately reflects the intent and target audience for this requirement, as it is the PCP who is primarily responsible for directing the course of the patient's care and directing the patient to the multitude of services available to them through the public health programs, more so than other provider types (facilities, ancillary, and specialists). This revision would not change Health Net's commitment to communicate with all providers; Health Net would continue to provide comprehensive information about the Medi-Cal Managed Program and operational requirements and procedures. However, the focus on the PCP for initial provider training requirements could potentially alleviate some of the prohibitive expense and administrative burden of further enforcement requirements. **Attached: HN's 2003 Medical Audit provider training finding CAP approved by the DHCS.**			
To ensure providers are fully aware of the various sources of training available to them, the Plan has revised the provider orientation packet Welcome Letter to include more information on the additional materials and resources that can be accessed from the Provider Website, such as the full version of the Medi-Cal provider operations manuals, computer-based trainings and videos and provider updates. The website is updated as needed. The providers are additionally informed that the	Christine Keating, Mgr. Provider Communications	May 2014	

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materials included in the packet we send them and the trainings available online supplement the Medi-Cal operations manuals. The revised new provider orientation Welcome Letter will be sent out in the May 2014 new provider training packets. **Attached: Draft copy of the revised new provider orientation Welcome Letter.**			
7-11-14 HN Response to DHCS Comment - Recommendation 1: Health Net stands by the mitigation response originally submitted and as restated above. Additionally, Health Net is providing the following information: Health Net has ensured compliance with the requirement that all new providers receive training within 10 working days through these measures: Compliance is ensured through the delivery of a new provider welcome packet which includes the following training materials for self-study: • New Provider Welcome Letter			

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• Medi-Cal Operations Guide • Provider Library Brochure • Unlock the Advantages of Healthnet.com brochure • Medi-Cal Quality Management Program Provider Update • ICE Tool kit – *Better Communication, Better Care: Provider Tools to Care for Diverse Populations* • Interpreter Services flyer Participating providers are strongly encouraged to complete all training Health Net makes available in order for them to carry out critical functions to ensure Medi-Cal members appropriate access to services and care needed. Health Net will explore the feasibility of being able to formally offer additional in person/office trainings to PCPs only. As DHCS can understand, this presents legitimate administrative resource and financial considerations due to the size/number of counties within Health Net's service area, and the number of contracted providers. Health Net has attached a copy of the contents of the Medi-Cal new provider self-study training packet. **ATTACHMENTS: Health Net's 2014 new Medi-Cal provider self-study training materials**			

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Description of how correction will be accomplished and compliance monitored and maintained	Name & Title of Responsible Person(s)	Date of Completion	DHS Comments
<u>10/1/14 HN Response to DHCS Comment, Recommendation 1:</u> Health Net has developed a policy and procedure to address training for new providers within 10 days of the provider being placed on active status. The training begins with the Welcome-Orientation packet of materials mailed by Provider Communications. Provider Relations Representatives will follow-up with the provider to ensure the materials were received, answer any questions and offer to visit the provider's office to conduct additional training. Documentation of all training(s) will be maintained in a tracking database. The policy and presentation materials for the training are attached. **ATTACHMENTS:** • Provider Relations New Provider Training P&P (draft pending approval) • HN ML Ops Training Presentation • Training sign-in sheet			

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Deficiency Identified:

Category 6: Organization & Administration of Plan; 6.5 Fraud and Abuse
1. Fraud and Abuse Reporting (Regulation: 2 Plan Contract E.2.26.B)

Recommendation:

1. Ensure that the results of the preliminary investigation of a suspected fraud case be reported to DHCS within the required timeframe of 10 working days

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The Health Net (HN) Special Investigations Unit (SIU) was informed by the DHCS FWA Unit that fraud referrals sent to them without substantiating the allegation are immediately closed because there is not enough information for them to work with. DHCS FWA additionally questioned why HN was submitting referrals prior to substantiating the allegation. As a result, HN's SIU implemented the following process: HN has an internal goal to triage each referral within 3 days of receipt. This involves taking a cursory look at the allegation (including data supplied with the referral and claims reports for the subject) and prioritizing it in the context of all other referrals. Instruction will be given to the SIU Investigators (completed as of August 9, 2013) emphasizing that they specifically review referrals related to Medi-Cal within the first 3 days to determine if sufficient information exists to substantiate the allegation	Matthew Ciganek, Director of Special Investigations Unit	8/9/2013	**Recommendation 1:** Please provide a written policy/procedure that is approved and signed to ensure that the results of the preliminary investigation of a suspected fraud case be reported to DHCS within the required time frame of 10 working days. 7/18/14 – discussed via conference call with MCP. Per MCP, will submit revised policy and procedure to reflect that the results of the preliminary investigation of suspected fraud case be reported to DHCS within the required time frame of 10 working days. This recommendation will stay open until corrective action is received from MCP.

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of fraud, waste or abuse. If the allegation can be substantiated at that point (using the data supplied with the referral and claims reports generated for the subject), a referral to DHCS will occur within 10 business days of the allegation being substantiated (not the date the referral was received). If the allegation cannot be substantiated within the first 3 days of receipt as part of the triaging process, the SIU will continue to work on the referral (based on its prioritization), and initiate a formal investigation, if necessary. Once the allegation is substantiated, a referral to DHCS will occur, which will be within 10 business days of the allegation being substantiated (not the date the referral was received). Note that the SIU considers the date that the allegation has been substantiated (meaning the allegation appears to have significant merit, but may not have been absolutely confirmed) as the date that the SIU first becomes aware of the improper activity. The receipt of an allegation, or the opening of an investigation, does not necessarily mean that the allegation has been substantiated. In many instances, an investigation of medical records must occur in order to substantiate the allegation. To prevent potential conflict, HN requests that DHCS MMCD confer with the DHCS FWA Unit to clarify at what stage within the case building process, the 10 business day reporting timeframe should occur.			8/5/14 – Per Email attachment: Per HN, HN SIU has immediately modified its processes to ensure that all cases of suspected fraud are reported to the DHCS FWA Unit as required within HN's Medi-Cal Two Plan and GMC contracts, Exhibit E, Att 2. HN and DHCS agree that there is no obligation for HN to re-report any cases of substantiated fraud for any case that DHCS may have closed or returned for lack of initial evidence submitted to DHCS. ***This recommendation is deemed Closed.***

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Additionally, the SIU generates a report 3 times a week (Monday, Wednesday and Friday) that identifies the aging of referrals. This report is distributed to the SIU Investigators so that they may prioritize their referrals. This report has been amended (completed as of August 9, 2013) to include a specific section for Medi-Cal referrals, so that the SIU Investigators and SIU Director can easily identify those referrals and focus on them. ***7-11-14 HN Response to DHCS Comment - Recommendation 1:*** Health Net stands by the mitigation response originally submit, and as restated above and below with additional attachments: The Health Net (HN) Special Investigations Unit (SIU) was informed by the DHCS FWA Unit that fraud referrals sent to them without substantiating the allegation are immediately closed because there is not enough information for them to work with. DHCS FWA additionally questioned why HN was submitting referrals prior to substantiating the allegation. As a result, HN's SIU implemented the following process: HN has an internal goal to triage each referral within 3 days of receipt. This involves taking a cursory look at the allegation (including data supplied with the			

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