MEDICAL REVIEW – SOUTHERN SECTION V
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE DENTAL AUDIT OF

HEALTH NET
of
CALIFORNIA, INC.

Contract Numbers:	12-89342 13-90116
Audit Period:	March 1, 2019 Through February 29, 2020
Report Issued:	June 29, 2020

TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 3

IV. COMPLIANCE AUDIT FINDINGS
Category 1 – Utilization Management 5
Category 5 – Quality Management 7

I. INTRODUCTION

Health Net of California, Inc. (Plan) has a contract with the California Department of Health Care Services (DHCS) to provide dental services to members in Sacramento and Los Angeles counties. The Plan has a license in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1975.

The Plan is a specialty health plan with its own statewide network of contracted general and specialty dental providers and has been providing dental services for Sacramento under the Geographic Managed Care (GMC) and Los Angeles under the Prepaid Health Plan (PHP) programs.

The Plan has a contract with an Administrator Services Organization (ASO) to administer the Medi-Cal Dental Programs in both Los Angeles and Sacramento counties. ASO areas of responsibilities duties include utilization management, credentialing and provider training, claims processing, language assistance services, cultural competency, access and availability, member services, and exempt grievances. The Plan does not delegate grievance and appeals. The Plan retains the responsibility to provide oversight of ASO's performance.

The Plan has a network of approximately 195 general providers and 82 specialists for Sacramento County and approximately 926 general providers and 319 specialists for Los Angeles County.

The Plan currently serves 291,860 Medi-Cal members in California. As of February 2020, the Plan's membership was composed of 125,166 GMC and 166,694 PHP members.

EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS dental audit for the period of March 1, 2019 through February 29, 2020. The onsite review was conducted from March 16, 2020 through March 19, 2020. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on June 11, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

The audit evaluated four categories of performance: Utilization Management, Access and Availability of Care, Members' Rights, and Quality Management.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to be accountable for all utilization management functions and responsibilities that are delegated to subcontractors. The Plan's ASO is required to send a delay Notice of Action (NOA) to members when it cannot make a decision. This letter must specify the information needed and the anticipated date on which a decision will be made. The Plan did not ensure its ASO's NOA letters included the anticipated date of decision. The Plan's written policy and procedures did not mention this date requirement as stated in the Health and Safety Code and All Plan Letter (APL).

Category 3 – Access and Availability of Care

No findings noted for the audit period.

Category 4 – Member's Rights

No findings noted for the audit period.

Category 5 – Quality Management

The Plan is required to ensure that all providers receive training within ten business days of being placed on active status. The Plan did not have a monitoring and tracking system in place to ensure newly contracted providers received training within the required timeframes.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Medical Review Branch conducted this audit to ascertain whether the dental services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's GMC/PHP Contract.

PROCEDURE

The onsite review was conducted from March 16, 2020 through March 19, 2020. The audit included a review of the Plan's contract with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Delegated prior authorization requests: 18 denied prior authorizations requests were reviewed for timeliness, consistent application of criteria, and appropriate review. The sample was selected to cover the different specialties of dentistry, different age range of members in both Sacramento and Los Angeles counties.

Appeal procedures: 14 prior authorization appeals were reviewed for appropriate and timely adjudication. The sample included the different specialties in dentistry, children and adults, and to reflect both Los Angeles and Sacramento counties.

Category 3 – Access and Availability of Care

None

Category 4 – Member's Rights

Grievance procedures (Quality of Care): Ten quality of care grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Grievance procedures (Quality of Service): 11 quality of service and five exempt grievances were reviewed to verify the reporting time frames and investigation process.

Category 5 – Quality Management

New provider training: 12 new provider training records were reviewed for timely provision of Medi-Cal Dental Managed Care (DMC) program training.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net of California, Inc.
AUDIT PERIOD: March 1, 2019 through February 29, 2020 **DATE OF AUDIT: March 16, 2020 through March 19, 2020**

CATEGORY 1 - UTILIZATION MANAGEMENT	
1.2	**PRIOR AUTHORIZATION REVIEW REQUIRMENTS**

1.2.1 Delay Notice of Action

The Plan is accountable for all utilization management functions and responsibilities that are delegated to subcontractors, including the continuous monitoring, evaluation and approval of the delegated functions.
(*Contract, Exhibit A, Attachment 5(F)*)

The Plan is required to notify members of a decision to deny, defer, or modify requests for prior authorization by providing written notification to members and/or their authorized representative, regarding any denial, deferral, or modification of a request for approval to provide a dental care service.
(GMC/PHP Contract, Exhibit A, Attachment 14(H))

If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframes, the Plan shall specify the reason and notify the provider and member of the anticipated date on which a decision may be rendered. (*H&S Code, section 1367.01(h)(5))*

In instances when the Medi-Cal DMC plan cannot make a decision the DMC plan shall send out a delay NOA to the provider and member. The delay NOA shall also include the anticipated date when a decision will be rendered.
(APL 17-003E)

Plan's policy, *Coverage and Authorization of Services (Revision date: 08/12/19)*, states that the NOA or Notice of Adverse Benefit Determination decisions will be given as expeditiously as the member's condition requires and within state-program-established timeframes but no more than 14 calendar days following receipt of the request for service. Further, an extension of up to 14 additional calendar days may be allowed if requested by the member, the provider or a need for additional information is justified and in the best interest of the member. Plan's ASO will provide written notice of the reason for the extension that includes the member's right to file a grievance.

Finding: The Plan did not ensure its ASO's delay NOA letter included the anticipated date of decision. Plan's written policy and procedures did not mention this date requirement as stated in the Health and Safety Code and APL.

DHCS review revealed that 11 delay NOAs letters to members and providers did not include the anticipated date.

The Plan submitted a template for delay NOA letters which has been approved by DHCS. The language states as follows:

[Name of requesting dentist] has asked Health Net Dental to approve *[Service requested].* We cannot make a decision yet. This is because *[Insert a clear and concise explanation of the reasons for the delay, indicating what further information is needed and/or additional steps need be taken. If further information is being requested, input the deadline for receipt of information.]* We expect to let you know the decision on *[date]*. You will get another letter letting you know the decision at that time.

The language in the template was not found in any of the files reviewed.

During the interview, the Plan's Dental Director acknowledged that the incorrect template was used. The Plan identified this deficiency in its annual audit but did not result in effective corrective action for the identified deficiency. The Plan did not effectively monitor and evaluate the functions of its ASO.

Without knowing the anticipated date when a decision will be rendered, members may not be able to make informed decision for their care and may result in member's treatment being delayed.

Recommendation: Develop and implement a process to monitor to ensure the NOA letters include the DHCS approved delay notification template language. Update Plan's policy to include the anticipated date of when a decision will be rendered.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net of California, Inc.
AUDIT PERIOD: March 1, 2019 through February 29, 2020 **DATE OF AUDIT: March 16, 2020 through March 19, 2020**

CATEGORY 5 – QUALITY MANAGEMENT	
5.2	**PROVIDER QUALIFICATIONS**

5.2.1 New Provider Training

The Plan is required to ensure that all providers receive training regarding the Medi-Cal DMC program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. Contractor shall conduct training for all providers within ten business days after the contractor places a newly contracted provider on active status.
(GMC/PHP Contract, Exhibit A, Attachment 9(E))

Plan's policy, *Provider Orientation (Revision date: 12/06/18)* states that the Plan shall conduct provider orientations and distribute any applicable documentation prior to becoming effective on the network or within 30 days of activation on the provider network, or sooner as required by State or client requirements. Further, the Plan's policy included a table reflecting provider orientation timeframes for California per Contract requirements.

Finding: Newly contracted providers did not receive training within the required ten business days. The Plan did not have a monitoring and tracking system in place to ensure providers received training with the required timeframes.

The Plan delegates provider training to its ASO and did not have policies and procedures in place for oversight and monitoring of its ASO to meet contractual provider training requirements.

The Plan did not follow-up with providers who have not attended the provider training. A PowerPoint orientation link goes out with the welcome letters; however it is not obligatory for providers to submit an attestation of provider training completion.

DHCS review revealed that the Plan did not correctly reflect the actual training dates received by the new providers. The reported orientation dates pertain to the initial orientation visit to the provider office. The Plan did not have a system in place to update new provider orientation dates when a provider is added to an existing location.

Without proper monitoring and oversight, the Plan will not be able to track whether new providers received orientation within the required timeframe. The Plan cannot ensure providers have the necessary information to provide proper care to meet member's needs.

Recommendation: Develop a process to monitor new provider training to ensure all providers receive training within ten business days after the Plan places a newly contracted provider on active status.