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

REPORT ON THE DENTAL AUDIT OF

HEALTH NET OF CALIFORNIA, INC.

2022

Contract Numbers:	12-89342 13-90116
Audit Period:	April 1, 2021 Through March 31, 2022
Dates of Audit:	March 21, 2022 Through April 1, 2022
Report Issued:	October 31, 2022

TABLE OF CONTENTS

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 and duties include utilization management, credentialing, claims processing, access and availability, provider network, member services and exempt grievances, and cultural competency and language assistance services. The Plan does not delegate grievances and appeals. The Plan retains the responsibility to provide oversight of the ASO's performance.

The Plan has a network of approximately 375 general providers and 96 specialists for Sacramento County and approximately 808 general providers and 333 specialists for Los Angeles County.

As of February 2022, the Plan served 369,675 Medi-Cal members in California. The membership was composed of 162,849 GMC and 206,826 PHP members.

EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS dental audit for the period of April 1, 2021 through March 31, 2022. The audit was conducted from March 21, 2022 through April 1, 2022.The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on September 30, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On October 14, 2022, the Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management, Administrative and Organizational Capacity.

The summary of the findings by category are as follows:

Category 1 – Utilization Management

The Plan is required to utilize a DHCS Notice of Appeal Resolution (NAR) template for appeals that are overturned or upheld. The Plan did not utilize the DHCS NAR template. The NARs did not include "overturn" or "uphold" printed in the upper right hand corner. In addition, the NARs did not have signatures and names of a Dental Director as required by the NAR template.

The Plan is required to provide a written NAR that includes the reason for the action and other relevant information. The NARs did not contain relevant information in the explanation of the Plan's decision.

Category 2 – Case Management and Coordination of Care

The Plan is required to develop and implement an initial health screening policy and conduct an initial screening for each new member within 90 days of enrollment. The Plan did not conduct initial health screenings for new members within the required time frame.

The Plan is required to submit to DHCS any changes to their initial screening policy within ten calendar days of any changes, and annually no later than 30 days after the first day of every calendar year. The Plan did not report to DHCS of any changes to their initial health assessment or screening policy within ten calendar days and annually after the first day of every calendar year.

The Plan is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. The Plan did not implement mechanisms to identify, assess and treat members with Special Health Care Needs

(SHCN) or Children with Special Health Care Needs (CSHCN).

Category 3 – Access and Availability of Care

No findings noted for the audit period.

Category 4 – Member's Rights

The Plan's written grievance resolution is required to contain a clear and concise explanation of its decision. The Plan's Quality of Care (QOC) grievance resolution letters did not contain a clear and concise explanation of the Plan's decisions.

Category 5 – Quality Management

The Plan is required to conduct training for all new providers within ten business days after the Plan places a newly contracted provider on active status. The Plan did not ensure newly contracted providers received training within ten business days.

Category 6 – Administrative and Organizational Capacity

No findings noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Medical Review Branch conducted this audit to ascertain whether the dental services provided to Plan members complied with federal and state laws, Medi-Cal regulations and guidelines, and the State contract.

PROCEDURE

The audit review period was from April 1, 2021 through March 31, 2022. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. DHCS reviewed the Plan's documents and interviewed the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Delegated Prior Authorization requests: 17 prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review. The sample was selected to cover the different specialties of dentistry and the different age ranges of members in both Sacramento and Los Angeles counties.

Appeal procedures: 13 standard appeals and one expedited appeal were reviewed for appropriate and timely adjudication. The sample was selected to cover the different specialties of dentistry and the different age ranges of members in both Sacramento and Los Angeles counties.

Category 2 – Case Management and Coordination of Care

Services for SHCNs and California Children's Services: ten cases for all members over and under 21 years old were reviewed for evidence of coordination and compliance with applicable requirements.

Category 3 – Access and Availability of Care

None.

Category 4 – Member's Rights

Grievance procedures - QOC: 13 QOC grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Grievance procedures - Quality of Service: 25 grievances, including ten standard, five exempt, five expedited, and five call inquiry files were reviewed to verify the processing

timeframes, investigation process, timely notifications, acknowledgements, resolution, appropriate processing, classification, and categorization.

Category 5 – Quality Management

New provider training: 15 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: April 1, 2021 through March 31, 2022 **DATES OF AUDIT: March 21, 2022 through April 1, 2022**

CATEGORY 1 - UTILIZATION MANAGEMENT

1.3	Prior Authorization Appeal Process

1.3.1 Appeal Procedures:

The Plan is required to comply with All Plan Letters (APL) issued by Medi-Cal Dental Services Division (MDSD) and Dental Managed Care (DMC). *(GMC/PHP Contracts, Exhibit E, Section 5(d))*

DMC Plans are required to use the appropriate DHCS NAR templates for upheld and overturned decision. *(Dental APL (D-APL) 20-003, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)*

The Plan's policy and procedure, *GA-202ML: Medi-Cal Member Appeal Process* (reviewed 9/1/2021), stated that a designated Case Coordinator shall forward copies of the NAR to DHCS on a weekly basis for any appeal cases partially or fully upheld by electronic mail to: dmcdeliverables@hscs.ca.gov (DHCS Dental APL 17-033 pg.12 NAR)

Finding: The Plan did not utilize the DHCS NAR template for appeals that are overturned or upheld.

The verification study identified all 14 reviewed NARs did not utilize the DHCS NAR template. None of the NARs contained "overturn" or "uphold" printed in the upper right hand corner. In addition, they did not have signatures and names of the Dental Director as required by the NAR template.

The Plan's appeal policy and procedures referred to a D-APL 17-003 which does not exist. The Plan could not explain why the required templates were not used.

Without utilizing the DHCS NAR template, members may have difficulty in recognizing the determination results when reviewing the NARs.

Recommendation: Revise policy and procedures to ensure the DHCS NAR template is used for the member appeal process.

1.3.2 Notice of Appeal Resolution (NAR)

A written NAR shall include the reason for the action, including notification to the member of the right to request, free of charge, all documents and records, and other relevant information. (*GMC/PHP Contracts*, *Exhibit A, Attachment 15, Section 5(b)(2))*

If the DMC plan's determination specifies the requested service is not a covered benefit, the DMC plan shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific dental service or benefit requested. *(D-APL 20-003, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)*

The Plan's policy and procedure, *GA-202ML: Medi-Cal Member Appeal Process* (reviewed 9/1/2021), stated that the Chief Medical Officer is responsible for oversight of the administration of the Medi-Cal member medical appeal process. The Chief Medical Officer continually reviews the operation and reporting of the appeal process to identify any emergent patterns of appeals. The resolution letter contains a clear and concise explanation of the Plan's decision.

Finding: The NARs did not contain relevant information in the explanation of the Plan's decision.

The verification study identified three out of 14 samples that had errors associated with procedure code or tooth number. Two NARs contained procedure codes that were either outdated or misused. One NAR listed a tooth number that was not appealed.

During the interview, the Plan admitted that they did not fully implement a quality review process of all NARs prior to mailing to members.

When the NAR letters contain inaccurate information in the explanation of the Plan's decision, members may be confused regarding the determination results.

Recommendation: Implement procedures to ensure the NAR contains relevant information.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	Initial Health Assessment

2.1.1 Initial Health Screening

The Plan is required to develop and implement an initial health screening policy, and conduct an initial screening of each new member using an Oral Health Information Form (OHIF), in accordance with Code of Federal Regulations (CFR), Title 42, section 438.208(b) and any related APLs issued by DHCS. *(GMC/PHP Contract, Exhibit A, Attachment 13)*

The Plan is required to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. *(GMC/PHP Contracts, Exhibit A, Attachment 13 and D-APL 18-007, Requirements for Oral Health Assessments)*

Finding: The Plan did not ensure that all new members received initial health assessments within 90 days of enrollment.

The Plan did not have an initial health screening policy and procedure to ensure initial health assessments were conducted for new members within the required timeframe.

During the interview, the Plan stated that they utilized the delegated entity's policy and procedures for the initial health assessment for the audit period. The Plan explained that it delegated the responsibility of conducting initial health assessments, but was unable to demonstrate a valid delegation agreement, or how the Plan, or the delegated entity complied.

DHCS requested a sample of new member screenings to verify Plan's compliance. The Plan did not provide a sample file for review. The Plan's written response stated that the delegated entity "conducts an OHIF on all members referred to the Case Management team but has not implemented a process to conduct initial screenings on all new members within 90 days of enrollment." However, the Plan did not ensure all new members received an initial health assessment within 90 days of enrollment.

Without conducting initial health screenings for all members, members' necessary dental services will not be provided appropriately.

Recommendation: Develop and implement policy and procedures to ensure that all new members receive an initial health assessment within 90 days of enrollment.

2.1.2 Initial Health Screening Changes

The Plan is required to submit to DHCS any changes to their initial screening policy within ten calendar days of any changes, and annually no later than 30 days after the first day of every calendar year. *(GMC/PHP Contracts, Exhibit A, Attachment 13 and D-APL 18-007, Requirements for Oral Health Assessments)*

Finding: The Plan did not report changes to their initial screening policy to DHCS within ten calendar days of any changes, and annually no later than 30 days after the first day of every calendar year.

During the interview, the Plan stated that they stopped using previously approved OHIF forms for the assessment of new members since July 26, 2018. In addition, the Plan's delegated entity did not submit their new Oral Health Screenings policy and their Oral Health Risk Assessment forms for DHCS approval until February 28, 2022. The Plan did not inform DHCS when they stopped using the approved forms for the assessment of new members and when they shifted the role of initial health assessment to the delegated entity.

When policy changes are not communicated, DHCS may not be aware if services are provided to members appropriately as required.

Recommendation: Develop and implement a process to ensure reporting of any changes to initial health assessment or screening policies to DHCS within ten calendar days and annually after the first day of every calendar year and monitoring of the delegated entity.

2.2	Case Management

2.2.1 Special Health Care Needs (SHCN) and Children with Special Health Care Needs (CSHCN)

The Plan is required to implement mechanisms to comprehensively assess each member identified as having SHCN, to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *(GMC/PHP Contract, Exhibit A, Attachment 13)*

The Plan is required to implement and maintain services for CSHCN that include but are not limited to the following: Methods for ensuring that each CSHCN receives a comprehensive oral assessment and development of a written dental treatment plan. *(GMC/PHP Contract, Exhibit A, Attachment 13)*

Health Plans are required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with SHCN. *(CFR, Title 42, section 438.208(a)(2))*

Finding: The Plan did not implement mechanisms to identify, assess and treat members with SHCN or CSHCN.

DHCS requested samples of members with special needs from the Plan to verify Plan's compliance. The Plan provided ten cases for DHCS review. The Plan's delegated entity identified, assessed, and treated members with SHCN or CSHCN.

A review of all ten cases provided by the Plan's delegated entity revealed that members had medical conditions and needed providers with hospital setting privileges. Members' medical status of the ten cases indicated a potential of complex and/or special health conditions. However, the Plan did not ensure case management and care coordination initiated to address members' needs.

During the interview, the Plan and the delegated entity stated that the identification of SHCN and/or CSHCN was depended on self-reporting of members or reporting by primary care dentists for the audit period.

When the Plan does not ensure SHCN and CSHCN members are identified, case management and care coordination cannot be initiated to address members' needs.

Recommendation: Develop and implement policy and procedures to identify, assess, and treat members with SHCN and CSHCN.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1. Grievance Resolution Decision

The Plan is required to have in place a Member Grievance and Appeal System in accordance with California Code of Regulations (CCR), Title 28, sections 1300.68 and 1368.01; CCR, Title 22, section 53858; CFR, Title 42, sections 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.416, and 438.424, and APL 17-003 and any future APLs related to compliance with the Member Grievance and Appeal System. *(GMC/PHP Contracts, Exhibit A, Attachment 15)*

The Plan's resolution is required to contain a written response to the grievance and be sent to the complainant within 30 calendar days of receipt. The written response is required to contain a clear and concise explanation of the Plan's decision. *(CCR, Title 28, section 1300.68(d)(3))*

The Plan is required to provide subscribers and enrollees with written response to the grievance, with a clear and concise explanation of the reasons for the Plan's response. For grievances involving the delay, denial, or modification of health care services, the Plan's response is required to describe the criterial used and the clinical reasons for its decision, including all criterial and clinical reasons related to medical necessity. *(Health and Safety Code, Section 1368(a)(5))*

The DMC Plan's written resolution is required to contain a clear and concise explanation of the MCP's decision. *(D-APL 20-003, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)*

The Plan's policy and procedure, *GA-201ML: Medi-Cal Grievance Process* (Reviewed 10/18/2021), stated that the Plan's written resolution is required to contain a clear and concise explanation of Plan's decision.

Finding: The Plan's QOC resolution letters did not contain a clear and concise explanation of the Plan's decision.

A verification study revealed that in 12 of 13 QOC grievance files, the resolution letters did not say what steps the Plan had taken to address member's grievances or the outcome of the Plan's investigation. The grievance resolution letter did not tell the member whether or not the Plan's review was completed.

The Plan was incorrectly applying the Knox Keene Act as a reason why explanations were not included in the resolution letter. The Knox Keene Act protects Peer Review Committee decisions. Decision on QOC issues were not made by the Peer Review Committee.

Without receiving a clear and concise written explanation of the Plan's findings and decisions on QOC resolution letters, members are not aware if their issues have been investigated or resolved appropriately.

This is a repeat finding from prior audit finding 4.1.1 – Grievance Resolution.

Recommendation: Revise and implement policy and procedures to ensure that QOC resolution letters contain a clear and concise explanation of decisions.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022
DATES OF AUDIT: March 21, 2022 through April 1, 2022

CATEGORY 5 – QUALITY MANAGEMENT

5.3	PROVIDER QUALIFICATIONS

5.3.1 Provider Training Time Frame

The Plan is required to conduct training for all providers within ten business days after the Plan places a newly contracted provider on active status. *(GMC/PHP Contracts, Exhibit A, Attachment 9(E))*

The Plan is required to conduct training for all providers within ten business days after the Plan places a newly contracted provider on active status. Training shall include methods for sharing information between the Plan, provider, member and/or other healthcare professionals. *(D-APL 13-014, Clarification on Exhibit A, Attachment 9; Provision E- Provider Training)*

Finding: The Plan did not ensure newly contracted providers received training within ten business days of being placed on active status.

The delegated entity provided the training for new providers. However, the Plan did not properly document and track the new provider training date. As a result, the Plan couldn't provide proper documents that indicated new providers received training within ten business days.

A verification study revealed that 15 out of 15 samples failed to indicate the Plan promptly and properly conducted the new provider training within ten business days. The Plan either failed to provide a valid training record or failed to document the training dates in attestation forms. The Plan did not perform follow-up procedures with the providers who did not attend the provider training.

During the interview, the Plan acknowledged that they did not request providers to sign training dates in attestation forms and incorrectly used new provider credentialing dates as the dates the providers completed the new provider training program.

Without ensuring the timely new provider training, new providers will be unaware of the covered services and requirements of the Medi-Cal Dental program.

Recommendation: Develop and implement policy and procedures to ensure training for all new providers within ten business days.