DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

July 13, 2023

Deanna Eaves - Director, Compliance
Health Net Community Solutions, Inc.
21281 Burbank Blvd
Woodland Hills, CA 91367

RE: Department of Health Care Services Cal MediConnect Audit

Dear Ms. Eaves:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Cal MediConnect (CMC) Audit of Health Net Community Solutions, Inc., a Medicare-Medicaid Plan (MMP), from April 26, 2021 through May 7, 2021. The audit covered the period of April 1, 2020 through March 31, 2021.

All items have been evaluated and DHCS accepts the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

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

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Oksana Meyer, MPA
Chief, CAP Compliance & FSR Oversight Section
Managed Care Quality & Monitoring Division

Department of Health Care Services
Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Daniel Park, Lead Analyst
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Sonny Tran, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Health Net

Review Period: 04/01/2020 – 03/31/2021

Audit Type: Cal MediConnect

On-site Review: 04/26/2021 – 05/07/2021

MMPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MMPs are required to submit the CAP in word format that will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, the MMP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MMP will be required to include the date when full compliance is expected to be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MMP's Contract Manager for review and approval, as applicable in accordance with existing requirements.**

DHCS will maintain close communication with the MMP throughout the CAP process and provide technical assistance to ensure the MMP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MMP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2. Case Management and Coordination of Care				
2.2.1 The Plan did not ensure PCP participation to conduct outreach to new enrollees for HRA completion.	1. Updated the CMC "Notification to PCP of Incomplete Health Risk Assessment" template to include the following statement "We encourage you to contact the member to schedule a visit and remind them to contact us to complete the HRA."	1. CMC_Letter to PCPs_template	1. 9/27/2021	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - The MMP submitted a revised PCP notification letter template that informs the assigned PCP that the Plan has been unable to reach the member and that they encourage the PCP to contact the member to schedule an office visit and remind them to call the Plan and complete a HRA. **MONITORING & OVERSIGHT** - The MMP submitted a spreadsheet that reflects the monitoring of outreach attempts. - The MMP implemented a monthly tracking system that monitors PCPs who were sent incomplete HRA letters. **The Corrective Action Plan for Finding 2.2.1 is accepted.**
2.2.2 The Plan did not utilize standardized survey health questions in the HRA process.	Health Net is responding to Finding 2.2.2 based on the current requirements in DPL 17-001 only, which superseded DPLs 13-002 and 15-005 and are no longer applicable. 1. Health Net required vendor, Optum Insight, to update the HRA LTSS	1. Optum HRA LTSS Questions 10/01/2021 2. Screenshot of TruCare system updates including COC questions	1. 9/30/2021 2. 1/15/2022 3. 11/15/2021	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - Health Net required vendor, Optum Insight, to update the HRA LTSS questions verbatim per DPL 17-001.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	questions verbatim per DPL 17-001. 2. IT Updates will be made to the Health Net Health Risk Assessment within the TruCare system to include COC questions. 3. In the interim Health Net will utilize the CMC HRA spreadsheet which includes the COC questions and document responses via a manual note in TruCare.	3. CMC Health Risk Assessment with Updated COC Questions 9/27/2021		- IT Updates will be made to the Health Net Health Risk Assessment within the TruCare system to include COC questions. - In the interim Health Net will utilize the CMC HRA spreadsheet which includes the COC questions and document responses via a manual note in TruCare. - Email Response - Health Net has a regulatory change implementation process that serves as the centralized intake and project management function for new regulatory and legislative requirements impacting all products offered in the CA Market. This process ensures that the defined scope of work is completed in compliance with regulatory requirements and due dates. Both the internal Case Management teams and the current business owner of our HRA Vendor are active on the impact assessment committee to ensure visibility to new regulations and participate on the project implementation teams to ensure all changes are implemented. - The internal Case Managers and Vendor representatives completing the HRAs do not have access to change the questions. Survey questions have been verified to ensure they reflect the DPL questions. Our Vendor Oversight Team will add an element to their audit script to verify the accuracy of questions against DPL 17-001. **MONITORING & OVERSIGHT** - MCP email which indicated that the audit tool is still in the process of being updated and that all updates will be complete in time for the 2022 annual audit that begins this summer. The MCP submitted a screenshot of the applicable section of the audit tool that will be

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				used to verify the accuracy of the questions against DPL 17-001. **The Corrective Action Plan for Finding 2.2.2 is accepted.**
3. Access and Availability of Care				
3.2.1 The Plan did not ensure all transportation providers met the screening and enrollment requirements.	1. Revise/create policies and procedures. a. Update Health Net's "Non-Medical Transportation and Non-Emergency Medical Transportation for Medi-Cal Members" transportation policy to add Medi-Cal enrollment requirements per APL 19-004. b. Require vendor, ModivCare, to create a Medi-Cal Provider Enrollment Policy to meet the requirements of APL 19-004. 2. Request vendor, ModivCare, to develop a remediation plan and process to identify and address non-enrolled providers and potential network adequacy issues. a. Termination of non-enrolled providers from the vendor network. 3. Improved reporting	1a. CA.LTSS.15 Non-Medical Transportation and Non-Emergency Medical Transportation for Medi-Cal Members 1b. ModivCare policy 2. Health plan-approved remediation plan 2a. Monthly Report titled "Medi-Cal Registered and Unregistered CA TP" 3a. Updated monthly transportation reports	1a. 12/31/2021 1b. 12/31/2021 2. 11/8/2021 2a. 12/31/2021 3a. 11/15/2021 3b. 11/15/2021 4. 12/31/2021 5. 11/30/2021	**This finding has been addressed under the Two-Plan Contracts 03-76182, 07-65847, 09-86157, 12-89334, and 2022 CAP.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	a. Revise vendor monthly report to include aging of provider enrollments, follow-up dates and actions taken for pending applications, terminations for non-approved enrollments & expiration of enrollment timeframe. b. Add “Medi-Cal Enrollment” as a standing VOC agenda topic to discuss status of provider enrollments. 4. Amend vendor subcontract to include APL 19-004 provider enrollment requirements. 5. Add provider enrollment compliance as an element for the annual vendor audit.	3b. 3.2.1-3.b MODIVCARE VOC Agenda Template 4. ModivCare contract amendment 5. Revised audit plan and tool		
4. Member Rights				
4.1.1 The Plan did not consider all expressions of dissatisfaction as grievances.	1. Revise Call Center Procedure to categorize 100% of expressions of dissatisfaction concerning a quality of care issue as a grievance. 2. Staff Training on QOC Process flow to understand how to categorize the expression of dissatisfaction as a grievance	1. QOC Process Flow CCC to A&G. 2. Agenda, Attendance and training material.	1. 10/31/2021 2. 10/31/2021	The following additional documentation supports the MCP’s efforts to correct this finding: **POLICIES & PROCEDURES** - Flow Chart, “QOC Process Flow CCC to A&G” (10/21) which details the sequence of events required to create a grievance once a member declines to file a formal grievance. - Revised P&P, GA-201ML: Medi-Cal Grievance Process

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				(01/12/2021), a member need not use the term “Grievance” for a complaint to be captured as an expression of dissatisfaction, and therefore, a grievance. If a member expressly declines to file a grievance, the complaint shall still be categorized as a grievance and aggregated for tracking and trending purposes. If member declines to file a grievance, Plan policy is to still categorize it as a grievance for tracking and trending purposes. - Procedures, “Health Net Customer Contact Center (CCC) Work Process/Standard Appeals and Grievances Quality Review Process”, (12/07/21) which implemented a CCC quality review of Appeals and Grievances from the CCC to the A&G Department and to monitor quality and process adherence. The Plan has removed PQI quality review process as it’s no longer applicable for CCC and updated QOC reviewer process steps. **TRAINING** - Training Module, “Member Appeals and Grievances” (Revision date 11/12/21 and document controlled until 03/29/22) as evidence that A&G staff received training. This training module addresses on how to identify a grievance. - PowerPoint training, “QOC vs QOS, Appeals and Grievance”, and a list of attendees (11/5/21) as evidence that the MCP is providing to G&A staff a clearer understanding of grievances, when needed, and grievance categorization, and the importance of accurate categorization. **MONITORING & OVERSIGHT**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- An oversight review is occurring within 1 hour for standard and expedited grievances and 1 business day for exempt grievances to ensure compliance with contractual requirements. These reviews are completed by a Quality Reviewer with the Plan. - Sample Log, “Exempt Grievances Universe” (10/2021) which is shared at a monthly meeting with the Plan’s A&G team for review. The purpose of these meetings is to review operational issues with other business areas to determine if any changes can be made internally to prevent the issue from reoccurring. **SUPPORTING DOCUMENTATION** - An email, “Discontinue asking “Would You Like to File a Grievance” (08/04/20) as evidence the MCP is providing Customer Care Contact staff documentation from the MCP’s Knowledgebase Management Database in regard to ensuring that every member’s expression of dissatisfaction is classified as a grievance, including those grievances that meet the regulatory guidelines for exemption, or grievances requiring written acknowledgement. **The Corrective Action Plan for Finding 4.1.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.2 The Plan did not provide enrollees with any outcome explanation of Plan's QOC grievance review in the resolution letters.	1. Update QOC letter template to reflect consistent language related to the review of QOC grievances.	1. Grievance Quality of Care QOC No. 904 template	1. Dependent on DHCS MCOD approval	**This finding has been addressed under the Two-Plan Contracts 03-76182, 07-65847, 09-86157, 12-89334, and 2022 CAP.**
4.1.3 The Plan did not write decisions or actions in resolution letters in a manner that could be easily understood.	1. Training on letter writing to ensure written letters are easily understood. 2. Implemented a pilot process to provide a reading level tool for use by Medical Directors to assist in reducing the reading level. Full implementation of the pilot process is underway. 3. Enhanced existing monthly workshops to evaluate denial letter language reading levels including utilizing the readability tools for medical decisions to better identify the readability score of a prudent layperson review. The workshop was also expanded to include all A&G Medical Directors.	1. Attendance and training materials. 2. Readability Tool screenshot 3. Monthly Clinical Appeal Review Minutes	1. 10/31/2021 2. 12/31/2021 3. 9/22/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - Case Review Desktop Procedure outlines the process for the internal auditing G&A cases, including auditing for understandability of denial language. **MONITORING & OVERSIGHT** - Readability tool screenshot. The tools is used to assist medical directors with the readability of their letters - Clear and concise language focused audit was conducted January 12, 2022 to confirm its letter's language are easily understandable. - Email communication from 3/2/22 explains that monthly audits are performed on resolution letter in which clear and concise language is a key element. In addition to the monthly audits, a random selection of files is reviewed on a routine basis with the medical

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				directors to review clear and concise language in the letters **TRAINING** - Training materials and attendance sheet from 11/17/21 demonstrate the MMP has trained its staff on using clear and concise language on their resolution letters. - Minutes from monthly Clinical Appeal meeting. Monthly meetings include the evaluation of reading level of denial letter language **The Corrective Action Plan for Finding 4.1.3 is accepted.**
5.2.1 The Plan did not document and monitor provider training to ensure newly contracted providers completed the initial training within 30 working days.	1. Revise the current "New Cal MediConnect Provider Training" process to include a certified mail/return receipt tracking mechanism for receipt of training materials by newly contracted providers. 2. Revise the current system logic to include only newly contracted providers for the Cal MediConnect line of business.	1. CA.NM.12 Provider Orientation Process P&P. 2. Testing results and workflow documentation evidencing completion of system update.	1. 10/29/2021 2. 10/31/2021	**On January 1, 2023, Cal MediConnect plans transitioned to Medicare Medi-Cal plans, any ongoing corrective action procedures through this CAP have no further impact.**

Submitted by: Christy K. Bosse **Date: 10/7/2021**
Title: VP & CA Compliance Officer