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

REPORT ON THE MEDICAL AUDIT OF

HEALTH NET COMMUNITY SOLUTIONS, INC.

2021

Contract Numbers:	03-76812, 07-65847, 09-86157, and 12-89334
Audit Period:	May 1, 2019 Through March 31, 2021
Report Issued:	September 3, 2021

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I. INTRODUCTION

Health Net Community Solutions, Inc. (Plan), a wholly owned subsidiary of Centene Corporation, is a managed care organization that delivers managed health care services through health plans and government-sponsored Managed Care Plans.

The Plan offers behavioral health, substance abuse, employee assistance programs, and managed health care products including prescription drugs. The Plan also offers dental coverage for California State's Healthy Families and Medi-Cal members.

The Plan operates largely as a delegated group network model. Services are delivered to members through the Plan's Participating Provider Groups, Independent Physician Association network, or directly contracted primary care and specialty care practitioners.

The Plan delivers care to Medi-Cal members under the Two-Plan contracts covering Los Angeles, Kern, San Joaquin, Stanislaus, and Tulare counties; and Geographic Managed Care Plan contracts covering Sacramento and San Diego counties.

As of April 2021, the Plan's enrollment totals for the Medi-Cal line of business was 1,445,192. Membership composition by County was 979,069 for Los Angeles; 70,906 for Kern; 21,818 for San Joaquin; 62,732 for Stanislaus; 115,268 for Tulare; 118,329 for Sacramento; and 77,070 for San Diego.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of May 1, 2019 through March 31, 2021. The onsite review was conducted from April 26, 2021 through May 7, 2021. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

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

The prior DHCS medical audit for the period of May 1, 2018 through April 30, 2019, was issued on September 25, 2019. This audit examined the Plan's compliance with its DHCS contract and assessed implementation of its closed prior year's Corrective Action Plan issued on April 20, 2020.

An Exit Conference with the Plan was held on August 11, 2021. 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 August 26, 2021, 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 summary of the findings by category follows:

Category 1 – Utilization Management

No findings were noted for the audit period.

Category 2 – Case Management and Coordination of Care

No findings were noted for the audit period.

Category 3 – Access and Availability of Care

Category 3 includes procedures and requirements for Provider Directory accuracy and Non-Emergency Medical Transportation (NEMT), and Non–Medical Transportation (NMT).

The Plan is required to ensure NMT and NEMT providers are enrolled in the Medi-Cal Program. The Plan did not ensure NMT and NEMT providers were enrolled in the Medi-Cal Program.

Category 4 – Member's Rights

Category 4 includes procedures and requirements for the grievance process.

The Plan is required to capture and process all grievances received, oral or written expressions of dissatisfaction, including any complaint, dispute, or request for reconsideration or appeal made by a member. The Plan did not categorize all expressions of dissatisfactions as grievances.

The Plan's written response to a member's grievance is required to contain a clear and concise explanation of the Plan's decision. The Plan's resolution letters did not include an explanation of the Plan's decision about the grievance as delineated in existing state regulations.

The Plan is required to ensure that resolution letters provided to members are clear, concise, and easy to understand as determined appropriate through the Plan's group needs assessment and approved by DHCS. The Plan's implemented procedures did not ensure letters were clear and concise.

Category 5 – Quality Management

No findings were noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted the audit from April 26, 2021 through May 7, 2021. The audit included a review of the Plan's Contract with DHCS, its policies and procedures 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 conducted interviews with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 25 prior authorization requests (19 medical and six pharmacy) were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to provider and members.

Appeal procedures: 14 prior authorization appeals (seven medical and seven pharmacy) were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Continuity of care: 16 medical records were reviewed for appropriate documentation, timely completion, and fulfillment of all required continuity of care components.

Category 3 – Access and Availability of Care

Provider directory: 20 providers were reviewed for accuracy.

Emergency services and family planning claims: eight emergency service claims and eight family planning claims were reviewed for appropriate and timely adjudication.

NMT and NEMT: 20 records were reviewed to confirm compliance with NMT and NEMT requirements.

Category 4 – Member's Rights

Grievance procedures: 28 grievances including 13 Quality of Care (QOC), 15 quality of service, and eight expedited were reviewed for timely resolution, response to complainant, and appropriate level of review and medical decision-making.

Category 5 – Quality Management

Provider training: Ten newly contracted providers were reviewed for timely Medi-Cal Managed Care Program training.

Potential QOC issues: Six cases were reviewed for reporting, investigation, and remediation.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2019 through March 31, 2021 **DATE OF AUDIT: April 26, 2021 through May 7, 2021**

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

3.8.1 Medi-Cal Enrollment of NEMT and MMT Providers

The Plan is required to comply with all existing final Policy Letters and All Plan Letters (APL) issued by DHCS. All Policy Letters and APLs issued by DHCS subsequent to the effective date and during the term of the Contract shall provide clarification of the Plan's obligations pursuant to the Contract, and may include instructions regarding implementation of mandated obligations pursuant to changes in state or federal statutes, regulations, or pursuant to judicial interpretation.
(Contract, Exhibit E, Attachment 2(1)(D))

Managed Care Plan (MCP) network providers that have a state-level enrollment pathway must enroll in the Medi-Cal Program. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division or another State Department with a recognized enrollment pathway. MCPs have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or MCPs may direct their network providers to enroll through a state-level enrollment pathway. *(APL 19-004, Provider Credentialing and Recredentialing and Screening and Enrollment (06/12/2019))*

According to the Plan's policy, *CA.LTSS.15, Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation for Medi-Cal Members (09/04/2020)*, the Plan is responsible for providing and overseeing the provision of transportation services to its eligible Medi-Cal members. The Plan's transportation services to and from member's residence to provider site(s) include:

(1) NEMT for all medically necessary covered services, and
(2) Effective July 1, 2017, the Plan provides NMT for all members to obtain medically necessary covered services.
(3) Effective October 1, 2017, the Plan provides NMT for all members to receive Medi-Cal services that are not covered under the Plan's Medi-Cal contract.

Finding: The Plan did not ensure that contracted NEMT and NMT providers were enrolled in the Medi-Cal Program. The Plan did not have policies and procedures in place to monitor the transportation provider enrollment and screening process as required by APL 19-004.

In the verification study 20 trips (ten NEMT and ten NMT) were serviced by a total of 17 providers.

- Three NEMT vendors were not enrolled in the Medi-Cal Program.
- Four NMT vendors were not enrolled in the Medi-Cal Program.

Eight trips were serviced by seven vendors not enrolled in the Medi-Cal Program. The Plan's policy does not delineate NEMT and NMT provider enrollment requirements or oversight system to monitor vendor enrollment.

During the interview, the Plan clarified that it does not currently have a system in place to enroll NEMT and NMT providers and instead relies upon vendors to enroll through the DHCS enrollment pathway.

If not enrolled in the Medi-Cal Program, transportation providers may not meet State licensing and safety requirements resulting in members receiving inadequate or unsafe transportation.

Recommendation: Develop policies and implement a process to monitor NEMT and NMT providers in the Plan's network to ensure they are enrolled in the Medi-Cal Program.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2019 through March 31, 2021 **DATE OF AUDIT: April 26, 2021 through May 7, 2021**

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Classification

The Plan is required to maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances.
(Contract, Exhibit A, Attachment 14(3)(A))

Member Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, or request for reconsideration or appeal made by a member.
(Contract, Exhibit E, Attachment 1, (60))

Plan's grievance system shall track and monitor grievances received by the Plan, or any entity with delegated authority to receive or respond to grievances. The system shall monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or Plan; and the number of grievances pending over 30 calendar days. The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the QOC and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.
(*CCR, Title 28, 1300.68(e))*

When a beneficiary expressly declines to file a grievance, the complaint shall still be categorized as a grievance and not an inquiry. While the MCP may protect the identity of the beneficiary, the complaint shall still be aggregated for tracking and trending purposes as with other grievances.
(APL 17-006, Grievance and Appeal Requirements (05/09/2017))

According to the Plan's policy, *GA-201ML: Medi-Cal Grievance Process (01/12/2021),* a member does not need to 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.

The policy also states, the Plan investigates the substance of all grievances, including any clinical aspects. Potential Quality Improvement (PQI) issues are internally investigated using the Plan's grievance investigation protocols.

Finding: The Plan is not categorizing all expressions of dissatisfaction as grievances.

In one example reviewed from the PQI verification study, the summary states a member refused to file a grievance and no grievance case documentation was available for review.

Two PQI cases in the verification study clearly documented member complaints. However, in both cases members did not want to file a formal grievance. The Plan did not record the complaint in either case as a grievance for tracking and trending.

During the interview, the Plan stated when a Plan representative identifies an expression of dissatisfaction involving a QOC issue where the member does not want to file a grievance, a PQI case is opened, rather than a grievance. PQIs are tracked and trended separately from QOC grievances. Further, grievances are member driven whereas PQIs are Plan driven. The Plan did not follow policies and procedures and APL requirements.

The expressions of dissatisfaction for QOC issues where the member does not want to file a grievance are opened as PQI and not as grievances. Since PQI and grievances are tracked and trended separately, the process for capturing QOC grievances does not capture all QOC complaints that are required to be reported to DHCS quarterly.

Recommendation: Implement procedures to ensure all expressions of dissatisfaction are captured and processed as grievances. Follow policy and procedures to open PQI where there is a potential QOC issue without a member complaint.

4.1.2 Grievance Resolution

The Contract requires the Plan to implement and maintain a Member Grievance System in accordance with CCR, Title 28, sections 1300.68 and 1300.68.01, CCR, Title 22, section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.12, and 42 CFR 438.420(a)-(c).
(Contract Exhibit A, Attachment 14(1))

A grievance is "resolved" when it has reached a final conclusion with respect to the beneficiary's submitted grievance as delineated in existing state regulations.
(CCR, Title 28, section 1300.68(a)(4))

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

The MCP's written resolution shall contain clear and concise explanation of the MCP's decision. *(APL 17-006, Grievance and Appeal Requirements (05/09/2017)*

The Plan's *Policy GA-201-ML: Medi-Cal Grievance Process (01/12/2021)* defines "resolved" as the grievance has reached a final conclusion with respect to the beneficiary's submitted grievance as delineated in existing state regulations. The Plan's written resolution shall contain a clear and concise explanation of the Plan's decision. Further, Plan's policy states, "Medical Director conducts a peer review assessment of the care provided." Documentation shows the Medical Director along with the nurse, Clinical Specialist II resolve the grievance, rather than a Peer Review Quality Improvement Committee.

Finding: The Plan's resolution letter responses did not contain the required clear and concise explanation of the Plan's decisions about the grievances.

The QOC grievance verification study revealed the Plan's Grievance Resolution letter did not contain a clear and concise explanation of the Plan's decision in 12 of 13 resolution letters. The Plan includes a short summary of the complaint and a template response citing state privacy laws in place of a clear and concise resolution of the Plan's decision.

During the interview, the Plan acknowledged that it did not provide a decision in QOC grievance written resolution letters due to peer review privacy protection. The Plan's QOC resolution letters were incomplete due to a general assumption that all were subject to confidentiality. The Plan's grievance process did not ensure clear explanations about whether the Plan's decisions were provided to members without making references to the peer-reviews. The Plan did not follow regulations and APL 17-006 requirements.

Without receiving a written clear and concise explanation of the Plan's findings and decision, members are not informed if their expression of dissatisfaction have been addressed, investigated, and resolved appropriately. Member's health may be negatively affected if grievances are not addressed and resolved.

Recommendation: Implement grievance policy and procedure to ensure that the contractual and APL requirements of a clear and concise grievance resolution is conveyed in the written notification.

4.1.3 Written Information Material

Plan shall ensure that all written member information is provided to members at a sixth grade reading level or as determined appropriate through the Plan's group needs assessment and approved by DHCS. The written member information shall ensure members' understanding of the health plan processes and ensure the member's ability to make informed health decisions.
(Contract, Exhibit A, Attachment 13(4)(C))

According to Plan's policy *GA-201-ML: Medi-Cal Grievance Process (1/12/2021)*, a final resolution letter is sent to the member that clearly and concisely describes any administrative or service outcome information. Furthermore, *Plan's policy GA-202-ML: Medi-Cal Member Appeal (01/12/2021)*, states that the written issue determination resolution letter to member includes the specific reason for the appeal decision in easily understandable language.

Plan's policy, *CC: MRKT.22, Reading/Literacy Level (02/02/2021),* lists the procedure for ensuring readability for all written informing materials. The policy states to draft the written material in Microsoft Word and utilize the Flesch-Kincaid readability level during the spell check process. The Plan recommends using short, concise sentences, small words, and using bullet points to break up complex sentences.

Finding: The Plan does not have a process in place to ensure that resolution letters to members are written in a clear, concise, and easy to understand language or at the sixth grade reading level.

Notice of Appeals Resolution (NAR) and Grievance Resolutions letters are written with long complex sentences that may be difficult for members to understand.

In the verification study, 14 NAR letters and 16 Grievance Resolution letters for quality of service and QOC grievances contained Flesch-Kincaid reading levels of eighth grade to college level. These letters contained long complex sentences that may be difficult for members to understand and were above the contractual sixth grade reading level.

During the interview, the Appeals and Grievance (A&G) specialist stated that the process is to summarize the original grievance or appeal and then develop a preliminary resolution for the Medical Director to review, revise if necessary, and give approval. The file is sent back to the A&G specialist who drafts the letter which includes the summary of the appeal or grievance and the Plan's resolution response. The Plan's implemented procedures did not ensure letters were clear and concise.

Without the understanding of the outcome of their appeal or grievance, patients are unable to make fully informed choices regarding their healthcare.

Recommendation: Develop and implement a system to ensure that all written informing letters are checked for readability at the sixth grade level.

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

REPORT ON THE CAL MEDICONNECT AUDIT OF

HEALTH NET COMMUNITY SOLUTIONS, INC.

2021

Contract Number:	H3237 Three-Way Contract (Cal MediConnect)
Effective Date:	September 1, 2019
Audit Period:	April 1, 2020 through March 31, 2021
Report Issued:	September 3, 2021

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I. INTRODUCTION

Health Net Community Solutions, Inc. (Plan), is a subsidiary of Centene Corporation. The Plan is a managed care organization that delivers managed health care services through government-sponsored managed care plans.

In collaboration with the Centers for Medicare and Medicaid Services (CMS), the State of California Department of Health Care Services (DHCS) operates a program to integrate care for beneficiaries who are eligible for both Medicare and Medi-Cal, also called Cal MediConnect (CMC). The program is an alternative effort under the Coordinated Care Initiative. The goal of CMC program to provide enrolled beneficiaries with a more coordinated, person-centered care experience, along with access to new services.

The Cal MediConnect contract is a three-way contract between CMS, DHCS, and Medicare-Medicaid plans to coordinate the delivery of care for covered Medicare and Medicaid services for CMC enrollees. The covered services include medical, behavioral health, long-term institutional and home-and-community based services.

The Plan is a commercial plan serving Medi-Cal beneficiaries in counties under the Two-Plan model and the Geographic Managed Care (GMC) contracts. Plan's county service areas for CMC enrollees are Los Angeles and San Diego.

As of April 2021, the total number of CMC-enrolled dual eligible beneficiaries in the two counties was 8,014. The Plan's membership was composed of 6,723 in Los Angeles (Two-Plan) and 1,291 in San Diego (GMC).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS Cal MediConnect audit for the review period of April 1, 2020 through March 31, 2021. The audit was conducted from April 26, 2021 through May 7, 2021. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on August 11, 2021. 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 August 26, 2021, 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 five categories of performance: Utilization Management, Continuity of Care, Access and Availability of Care, Enrollee Rights, and Quality Management.

The prior DHCS medical audit for the period of May 1, 2017 through April 30, 2018, was issued on November 6, 2018. This audit examined the Plan's compliance with its DHCS contract and assessed implementation of its closed prior year's Corrective Action Plan.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

No findings were noted for the review period.

Category 2 – Continuity of Care

The Plan is required to notify Primary Care Providers (PCPs) of enrollment of any new enrollee who has not completed a Health Risk Assessment (HRA) within the required time period. The Plan is required to encourage PCPs to conduct outreach to enrollees and schedule visits. The Plan did not implement the procedure to ensure PCPs participated in the Plan's outreach effort for new enrollees with an incomplete HRA.

The Plan is required to utilize survey questions that meet the standardized criteria in the HRA process. The Plan subcontracted its HRA function to a vendor and in-network care coordinators. Each utilized non-standardized survey questions in assessing enrollees' health status and needs in Long Term Services and Supports (LTSS).

Category 3 – Access and Availability of Care

The Plan is required to ensure its Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) providers are enrolled in the Medi-Cal Program. The Plan did not ensure its NEMT and NMT providers were enrolled in the Medi-Cal Program.

Category 4 – Enrollee Rights

The Plan is required to consider all expressions of dissatisfaction and complaints as grievances, regardless of whether remedial action is requested. The Plan did not aggregate all expressions of

dissatisfaction as grievance for tracking and trending purposes. The Plan did not categorize expressions of dissatisfaction as grievances when an enrollee was not interested in participating in the Plan's grievance process.

The Plan is required to provide enrollees with an outcome or an explanation of the Plan's Quality of Care (QOC) grievance review in the resolution letters. The Plan's written response to the resolved QOC grievances omitted the Plan's review outcome or explanation of the Plan's decision in resolution letters to enrollees.

The Plan is required to write grievance resolution letters and notice of resolution to enrollee appeals using easily understood language and format. The written responses in the letters to enrollees contained long and complex sentences that may be difficult for enrollees to understand the outcome of grievances and the reasons for determination of appeals.

Category 5 – Quality Management

The Plan did not comply with the requirement to ensure provider training was conducted for newly contracted providers. The Plan's effort in providing initial training was by mailing the training material package to the new in-network providers and recorded mailing dates as the training completion dates. However, the Plan did not have documentation or any evidence substantiating the providers completed the training.

III. AUDIT SCOPE / PROCEDURES

SCOPE:

This audit was conducted by the DHCS – Medical Review Branch to ascertain that Medicaid-based medical services provided to Cal MediConnect enrollees complied with the Three-Way Contract, the federal and state laws and regulations, applicable guidelines, and accordingly to State's Medi-Cal Managed Care Program under the Two-Plan model and GMC Contracts.

PROCEDURES:

DHCS conducted an audit of the Plan from April 26, 2021 through May 7, 2021. The audit included a review of the Plan's contracts 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 administration and staff. The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 14 prior authorization (ten medical and four pharmacy) requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Prior authorization appeals procedure: Eight appeals were reviewed for appropriateness and timeliness of decision making.

Category 2 – Continuity of Care

HRA and Interdisciplinary Care Plan: 15 files were reviewed for care coordination, completeness, and compliance within the required timeframes.

Category 3 – Access and Availability of Care

NEMT and NMT: 22 transportation vendors were verified to confirm compliance with NEMT and NMT requirements.

Category 4 – Enrollee Rights

Grievance procedures: 20 grievances including five QOC, ten Quality of Service (QOS), and five exempt QOS were reviewed for timely resolution, response to complainant, and appropriate medical decision-making.

Category 5 – Quality Management

Potential QOC issues: Four cases were reviewed for reporting, investigation, and remediation.

Provider qualifications: Four newly contracted providers were reviewed for timely Cal MediConnect Program training.

CATEGORY 2 – CONTINUITY OF CARE

2.2 Health Risk Assessment / Individualized Care Plan

2.2.1 Outreach to New Enrollees

The Plan is required to notify PCPs of enrollment of any new enrollee who has not completed a HRA within the time period set forth above and whom the Plan has been unable to contact. The Plan is required to encourage PCPs to conduct outreach to their enrollees and to schedule visits for HRA completion. *(Three-Way Contract § 2.8.2.5)*

The Plan's policy and procedure, *CA.CM.39: Health Risk Assessment – Cal MediConnect (06/30/2020),* states in the event an enrollee does not complete an initial HRA, either because they decline or are unable to reach after the required attempts, the Plan will inform the enrollee's assigned PCP and will encourage the PCP to conduct outreach/schedule office visits within 30 days of the HRA required deadline for completion of outreach activities.

Finding: The Plan did not ensure PCP participation to conduct outreach to new enrollees for HRA completion.

In a verification study, four HRAs remained incomplete beyond the required timeframe due to the Plan's inability to reach enrollees. During the interview, the Plan's effort to reach out for enrollees with overdue HRAs was by directly contacting enrollees via telephonic, mailing or other electronic means. However, the letters did not include a statement encouraging PCPs to contact the enrollee to schedule visits.

The responsibility to conduct outreach to the enrollees for HRA completion was delegated to the subcontracted vendor and in-network case managers. PCP participation was not documented in the outreach efforts.

Without PCPs participation, the Plan's outreach effort to new enrollees may potentially delay HRAs completion.

Recommendation: Implement the procedure to ensure PCPs participation in the Plan's outreach effort to new enrollees HRA incompletion.

2.2.2 Standardized HRA Survey

Assessment of each enrollee's risk level and health needs shall be conducted through a standardized risk assessment survey. (*Welfare and Institutions Code, Section 14182(c)(14)(A))*

The Plan is required to develop a HRA to assess an enrollee's current health risk utilizing survey questions. The questions are required to contain minimum assessment components to enable comparability and standardization of elements among all other Medicare-Medicaid Plans. The Plan is also required to include specific LTSS referral and contributory risk factors questions in HRA tools. The LTSS referral and contributory risk factors questions must be used verbatim; however, they may be incorporated into the existing HRA and can replace similar existing HRA questions. (*Duals Plan Letter (DPL) 17-001 – Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect (07/21/2017))*

The Plan must ask the enrollee if there are any upcoming health care appointments or treatments scheduled and assist the enrollee at that time in initiating the continuity of care process if the enrollee chooses to do so. (*DPL 15-005 – Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect (08/17/2015))*

The Plan is required to provide enrollees with an assessment incorporating standard survey questions, such as VR-12 (Veterans Rand 12-Item Health Survey), as specified by the State. (*DPL 13-002 – Health Risk Assessment and Risk Stratification Requirements for Dual Demonstration Plans under the Coordinated Care Initiative (06/24/2013))*

The Plan's policy and procedure, *CA.CM.39: Health Risk Assessment – Cal MediConnect (06/30/2020),* states that the Plan will complete the HRA process in accordance with DHCS requirements for higher risk and lower risk enrollees, including utilization of the LTSS Referral Questions. Each of these standardized questions seeks to identify whether a beneficiary is experiencing risk factors that make them a candidate for LTSS services that will keep them in their home and community.

Finding: The Plan did not utilize standardized survey health questions in the HRA process.

In the verification study, the Plan utilized survey questions that were neither meeting minimum requirement nor standardized. The review of survey questions identified differences and inadequacies between those utilized by a subcontracted vendor and those by in-network case managers or coordinators, which were, but not limited to, as follows:

- The Plan's survey did not include questions on enrollee's upcoming health care appointments or treatments scheduled as delineated in DPL 15-005.
- Both surveys did not include self-perceived comparison of a yearlong progression of emotional status of VR-12 questions as required in DPL 13-002.

- Both surveys did not include the LTSS referral and contributory risk factors questions verbatim as outlined in DPL 17-001's Attachment of LTSS Referral Questions.

During the interview, the Plan indicated the HRA process was conducted either by the subcontracted vendor or in-network case managers utilizing tools consisting of the same survey questions. However, the questions were inconsistent with the applicable standards and DPLs requirement.

Without complete required information, the Plan cannot make proper enrollee's referral to LTSS.

Recommendation: Revise and implement procedures to ensure in-network providers and subcontracted vendors utilize survey questions that are standardized to meet the requirements in assessing enrollee's current health status.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.2 Non-Emergency Medical and Non-Medical Transportation

3.2.1 Enrollment of Transportation Providers

Pursuant to 42 Code of Federal Regulations (CFR) § 438.602(b), the Plan is required to ensure that all network providers are enrolled with DHCS as Medicaid providers consistent with the provider screening, disclosure, and enrollment requirements of 42 CFR 455, subparts B and E. *(Three-Way Contract § 2.9.5)*

The contract requires the Plan to provide beneficiaries with transportation services for Medically Necessary Services, and for transportation services pursuant to this Contract, applicable law including but not limited to Welfare & Institutions Code 14132(ad) and the requirements in applicable current and future DPLs. *(Three-Way Contract Appendix A.3.2)*

Per the Contract, without limitation, all applicable law, including federal and state law, and the regulations, policies, procedures, and instructions of CMS and DHCS, are incorporated into the Contract, all as existing now or during the term of the Contract; thereby, making them applicable to Plans. *(DPL 18-001, Non-Emergency Medical and Non-Medical Transportation Services (April 26, 2018))*

The State-level enrollment pathways that are available either through the DHCS' Provider Enrollment Division (PED) or another State department with a recognized enrollment pathway. In addition, the Plan has the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or the Plan may direct their network providers to enroll through a state-level enrollment pathway. (*All Plan Letter (APL) 19-004, Provider Credentialing and Recredentialing and Screening and Enrollment (06/12/2019)*)

Finding: The Plan did not ensure all transportation providers met the screening and enrollment requirements.

Review of the Plan's 22 sampled subcontracted transportation providers revealed six vendors not enrolled in accordance with requirements. During the interview, the Plan stated that state-level enrollment was the Plan's only pathway in verifying enrollment of providers.

The Plan's policy and procedure, *CA.LTSS.14 Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) for Cal MediConnect Members (02/22/2021*), did not describe any monitoring process in place to ensure all entities providing transportation were properly enrolled. The Plan's annual audit of transportation vendor did not indicate any verification of the required providers' program participation was conducted.

Improper screening of transportation providers may potentially result in enrollees receiving transportation service by unqualified providers, which could result in substandard services to members.

Recommendation: Develop procedures to implement a process to verify transportation service providers are properly enrolled.

CATEGORY 4 – ENROLLEE RIGHTS

4.1 Grievance and Appeal System

4.1.1 Grievance Classification

The Contract defines the term 'grievance' as "any complaint or dispute, other than one that constitutes an organization determination under 42 CFR § 422.566 or other than an Adverse Benefit Determination under 42 CFR § 438.400, expressing dissatisfaction with any aspect of the Plan's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 CFR § 422.561. A grievance is filed and decided at the Contractor level." *(Three-Way Contract § 1.49)*

The Plan is required to track and report to DHCS the number and types of inquiries, complaints, grievances, appeals, and resolutions related to Cal MediConnect. (*Three-Way Contract § 2.14.2.1)*

The Plan's policies and procedures, CA.AG.33, *Cal MediConnect – Member Grievances and Expedited Grievances (Medical Services Tier 3 Drugs – Non Part D) (01/12/2021)* and CA.AG.02, *Cal MediConnect – Member Appeals & Expedited Appeals (Medical Services Tier 3 Drugs – Non Part D) (12/13/2020)* defines the term 'grievance' similarly to that in the Contract.

Finding: The Plan did not consider all expressions of dissatisfaction as grievances.

A quality of care related expression of dissatisfaction by an enrollee, who declined the Plan's member services' (Customer Contact Center) offers to file a grievance, was referred to the Plan's Potential Quality Improvement (PQI) system. The complaint was not aggregated for tracking and trending purposes as with other grievances pursuant to the Contract requirement.

The Plan's policies and procedures did not provide any specific procedure in categorizing enrollee's complaint when an enrollee declines to file a grievance. During the interview, the Plan stated that when an enrollee's call is regarding a QOC concern but the enrollee has no interest in participating in the Plan's grievance process, concerns determined to have potential of QOC issue are referred to PQI.

Exclusion of any expression of dissatisfaction from grievance data results in incomplete grievance information that the Plan could use to improve quality of care to enrollees.

Recommendation: Revise the procedures to ensure all grievances are properly captured and recorded in the Plan's grievance records.

4.1.2 Grievance Resolution Letters

The Plan is required to establish and maintain a grievance process consistent with 42 CFR Part 438 Subpart F. *(Three-Way Contract § 2.14.2.1.1)*

The State must establish the method that an Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), and Prepaid Ambulatory Health Plan (PAHP) will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at §438.10. (*CFR, Title 42, section 438.408(d)(1))*

The definition of "Resolved" grievance is when the grievance has reached a final conclusion with respect to the beneficiary's submitted grievance. (California Code of Regulations (*CCR), Title 28, section 1300.68(a)(4))*

The Plan, at a minimum, is required to provide "the immediate submittal of all medical QOC grievances to the Medical Director for action." (*CCR, Title 22, section 53858 (e)(2))*

The Plan's written response shall contain a clear and concise explanation of the Plan's decision. Nothing in this regulation requires a Plan to disclose information to the grievant that is otherwise confidential or privileged by law. (*CCR, Title 28, section 1300.68(d)(3))*

Grievance system shall track and monitor grievances received by the Plan. *(CCR, Title 28, section 1300.68(e))*

The Plan's *2020 Utilization Management Program Description (05/21/2020)* explains continuous efforts for improving care and service to the Plan's members. Investigations are initiated when the outcome of clinical review and severity outcome level coding of complaints, grievances, and reported potential QOC issues determined to represent questionable or substandard QOC.

The Plan's policy and procedure, *HN.PR.02: Peer Review Committee Policy (10/2020)*, describes any case that is severity-leveled 0, I, or II requiring advisement letter, a corrective action, or further review by a Medical Director will be referred to the investigation team for investigation and submitted to the Peer Review Committee for review, determination, and/or action. The document's definition of QOC grievance states that written grievance responses to enrollees do not include reference to the peer-review protected information or outcome severity code levels.

Finding: The Plan did not provide enrollees with any outcome explanation of Plan's QOC grievance review in the resolution letters.

In the verification study, the Plan's written response to the four sampled QOC grievances were resolved. However, the resolution letters omitted the Plan's review outcome or

explanation of the Plan's decision. The Plan is required to provide written response to grievance containing a clear and concise explanation of the Plan's decision.

During the interview, the Plan acknowledged the omission of the Plan's decision in QOC grievance written resolution letters to enrollees due to peer review privacy protection. The resolution letters in verification study explained the results are confidential in accordance with federal regulations and applicable state law.

The Plan's policy and procedure, *CA.AG.33: Cal MediConnect – Member Grievances and Expedited Grievances (Medical Services Tier 3 Drugs – Non Part D) (01/12/2021),* briefly describes that any grievances involving clinical issues are reviewed by professionals with proper clinical expertise. When grievances are determined to have potential QOC issues and are approved for investigation by clinical experts, the Appeals and Grievances (A&G) associate will send the approved QOC closure letter to the member within the timeframe.

Based on the Plan's policies and procedures, review of all four files in the verification study demonstrated that the Plan's clinical review and severity outcome level did not determine any representation of questionable or substandard QOC. All reviewed cases were severity-leveled 0, I, and II with no further action by Medical Director, such as referral to further investigation, Peer Review Committee, or any other Departments for quality improvement purposes. A review of the cases communication log did not indicate any cases were approved for investigation either. The Plan's QOC resolution letters were incomplete due to a general assumption that all were subject to confidentiality. The Plan's grievance process did not ensure clear explanations about whether the Plan's decisions were provided to enrollees without making references to the peer-reviews or outcome severity code levels.

Without written notification of the Plan's findings and decisions, enrollees are not informed if their expressions of dissatisfaction have been addressed, investigated, and resolved appropriately. Enrollee's health may be negatively affected if grievances are not addressed and resolved.

Recommendation: Revise and implement policies and procedures to ensure that written grievance responses include appropriate explanations of the issues in the resolution letter to enrollees.

4.1.3 Resolution Notices

Notice to the enrollee of the disposition of the grievance. The notice must meet the requirements of 42 CFR § 438.408(d)(1), and must: Be produced in a manner, format, and language that can be easily understood. *(Three-Way Contract §§ 2.14.2.1.3.5 and 2.14.2.1.3.5.1)*

The Plan is required to write notice of resolution to enrollee appeals using easily understood language and format. (*Three-Way Contract § 2.17.1.4)*

The Plan's policy and procedure, *CA.AG.33 Cal MediConnect – Member Grievances & Expedited Grievances (Medical Services Tier 3 Drugs – Non Part D) (12/13/2020)*, states disposition of grievance notice to member must be produced in a manner, format, and language that can be easily understood.

Finding: The Plan did not write decisions or actions in resolution letters in a manner that could be easily understood.

In the verification study, eight Notice of Appeal Resolution letters and 12 grievance letters contained long complex sentences that may be difficult for members to understand. The letters were written at above tenth grade reading level.

The Plan's grievance procedure describes a current disposition of grievances procedure requiring the Plan's A&G associate to review the closure letter for spelling, grammar, and content ensuring each grievance concern is addressed and resolved. The same procedure applies to A&G associate when disposing appeals as described in the Plan's policy and procedure number: CA.AG.02, *Cal MediConnect – Member Appeals & Expedited Appeals (Medical Services Tier 3 Drugs – Non Part D) (12/13/2020)*.

The Plan does not have a specific process in place to endure the production of resolution letters which are written in a manner and format which is easily understood. The Plan, during interviews, postulated potential future approaches which might lead to compliant resolution letters for enrollees.

Without understanding of the grievance or appeal outcomes, enrollees are not fully informed to make health care decisions.

Recommendation: Develop and implement procedures to ensure that resolution letters comply with all regulatory requirements.

CATEGORY 5 – QUALITY MANAGEMENT

5.2 Provider Training

5.2.1 Newly Contracted Provider Training

The Plan is required to ensure that all network providers receive training regarding the Cal MediConnect Program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. In addition, the Plan is required to conduct training for all network providers within 30 working days after the Plan places a newly contracted provider on active status. *(Three-Way Contract § 2.9.11.2)*

The Plan's policy and procedure, *CA.NM.12: Provider Orientation Process (08/2020)*, states that the training methodology will include orientation sessions conducted through in-person meetings, webinars, or the distribution of information through the provider communications (e.g., provider updates, guides), and the provider operations manuals. All attendees will be documented. Completed sign in sheets will be sent to Provider Network Management Operations (PNM Ops) for record retention and tracking. Provider Network Management (PNM) will provide orientation training to existing and newly contracting providers within 30 working days of being active for the Cal MediConnect line of business. Each PNM regional team is responsible to conduct this training for their contracting providers.

Finding: The Plan did not document and monitor provider training to ensure newly contracted providers completed the initial training within 30 working days.

The Plan did not maintain and was unable to provide proof of records demonstrating that newly contracted providers received the initial training. In the verification study, the Plan submitted an identical orientation material package as the only proof of initial provider training completion of all sampled new providers. The Plan was unable to provide any completed sign-in sheets, as mentioned in the Plan's procedure, or its equivalent document type to substantiate the training completion.

The Plan did not follow the current training procedure in documenting initial provider training completions. The Plan's PNM Department, is responsible for providing initial training or orientation to newly contracting providers. During the interview, the Plan stated that in-person meetings or webinars were not conducted during the audit period. Instead, the Plan mailed out the orientation package material directly to new providers.

The PNM was assisted by the Plan's Integrated Communications Services in preparing and mailing out the orientation materials to new providers per PNM's instruction. The mailing utilized standard, non-certified, mailing service without tracking nor return receipt. PNM recorded the mailed dates as the training completion dates recorded in PNM. The Plan

stated when mailing the materials, the Plan did not collect any attestations from each new provider confirming the receipt for record retention and tracking.

Without the Plan's effective record retention and tracking of mailed initial training materials, newly contracted providers may not receive the initial training as required.

Recommendation: Revise and implement the Plan's procedure to include and maintain supporting evidence of newly contracted providers' training completion.

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

Health Net Community Solutions, Inc.

2021

Contract Number: 03-76208, 07-65848, 09-86158, and 12-89335
State Supported Services

Audit Period: May 1, 2019
Through
March 31, 2021

Report Issued: September 3, 2021

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INTRODUCTION

This report presents the review of Health Net Community Solutions, Inc. (Plan) compliance and implementation of the State Supported Services contracts with the State of California. The Contracts cover abortion services contracted with the Plan.

The onsite audit was conducted from April 26, 2021 through May 7, 2021. The audit covered the review period from May 1, 2019 through March 31, 2021. It consisted of document reviews and interviews with the Plan's staff.

An Exit Conference with the Plan was held on August 11, 2021. There were no deficiencies found for the review period on the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2019 through March 31, 2021 **DATE OF AUDIT: April 26, 2021 through May 7, 2021**

STATE SUPPORTED SERVICES

The Plan agrees to provide, or arrange to provide, to eligible members the following State Supported Services based on the following codes:

- Current Procedural Terminology (CPT) Coding System: 59840 through 59857
- Health Care Financing Administration Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and Z0336

(State Supported Services Contracts, Exhibit A.1)

All Plan Letter (APL) 15-020, Abortion Services (09/15/2015), states that the Plan maintain procedures ensuring confidentiality and access to sensitive services, such as abortion services. Plans that provide physician services must not require medical justification and/or prior authorization. Members may access the services through any provider of their choice regardless of provider network affiliation.

The Plan's Policy and Procedure, *CA.LTSS.18: Pregnancy Termination (03/04/2021)* ensures members timely access to abortion services, including follow-up care, from any qualified in- or out-of-network provider without prior authorization. Access to sensitive services such as termination of pregnancy is available for members, including those under the age of 18 obtaining minor consent services. The Plan ensures processing payments of all submitted clean claims at Medi-Cal rates from both in- and out-of-network providers within the required timeframe and reimbursement at the rates. The Plan participating providers are required to comply with this policy and procedure as described in *Provider Operations Manual (03/31/2020)* and monitor for compliance.

Member Handbook (2020), Combined Evidence of Coverage and Disclosure Form, informs members of their rights to pregnancy termination services at any qualified provider without requiring any referral or prior authorization or parental consent for members under the age of 18.

The Plan maintains a list of CPT Codes for procedures and services which are exempt from prior authorization for the Plan's Claims Department to use in auto payment of claims submitted. The Plan's claims system configuration ensures no prior authorization is needed. The billing codes for sensitive services which are exempt from prior authorization include the CPT Codes 59840 through 59857.

Based on the review of the Plan's policy, member and provider information materials, and staff interviews, no deficiencies were noted for the audit period.

Recommendation: None.