

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

**Health Net Community Solutions, Inc.**

Contract Numbers: 12-89334  
03-76182 A14  
07-65847 A06  
09-86157 A03

Audit Period: March 1, 2012  
Through  
February 28, 2013

Report Issued: November 12, 2013

## TABLE OF CONTENTS

I.	INTRODUCTION.....	1
II.	EXECUTIVE SUMMARY .....	2
III.	SCOPE/AUDIT PROCEDURES.....	4
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management .....	6
	Category 2 – Continuity of Care .....	13
	Category 3 – Access & Availability.....	19
	Category 4 – Member’s Rights & Responsibilities.....	21
	Category 5 – Quality Improvement System.....	25
	Category 6 – Organization and Administration of Plan.....	29

## I. INTRODUCTION

The audit report presents the findings of the medical review audit of Health Net Community Solutions, Inc. and their implementation of their managed care contracts with the State of California. Health Net Community Solutions, Inc. has Two-Plan contracts covering Los Angeles, Kern, Stanislaus, San Joaquin, and Tulare Counties; and Geographic Managed Care Plan contracts for Sacramento and San Diego Counties, respectively.

Health Net, Inc. is a publicly traded managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans. Its mission is to help people be healthy, secure and comfortable. Health Net provides and administers health benefits to approximately 5.4 million individuals across the country through group, individual, Medicare (including the Medicare prescription drug benefit commonly referred to as “Part D”), Medicaid, U.S. Department of Defense, including TRICARE, and Veterans Affairs programs. Their website is [www.healthnet.com](http://www.healthnet.com)

Health Net Community Solutions, Inc. is a subsidiary of Health Net of California, Inc. The State of California’s managed care contracts with Health Net of California, Inc. were changed to Health Net Community Solutions, Inc. beginning July 2005. Health Net, Inc. operates in 27 states. Health Net of California, Inc. was licensed in 1991 by the State of California under the Knox-Keene Health Care Service Plan Act of 1975. Health Net, Inc.’s corporate headquarters are located at 21650 Oxnard Street; Woodland Hills, CA.

Health Net of California, Inc. operates largely as a delegated group network model. Services are delivered to members through the Plan’s contracted Participating Provider Groups (PPGs), Independent Physician Association (IPAs) network, as well as with directly contracted primary care and specialty care practitioners. The Plan contracts with multi-specialty Participating Provider Groups (PPGs) based on a fixed capitated amount for each enrollee. In counties where there are no PPGs managing the enrollees, the Plan directly contracts with Providers based on a fee schedule representative of the Medi-Cal fee schedule.

The Plan’s enrollment totals for its Medi-Cal line of business in Los Angeles, Kern, Stanislaus, San Joaquin, Tulare, Sacramento, and San Diego Counties as of June 2013, are as follows:

- Los Angeles: 569,574
- Kern: 51,997
- Stanislaus: 53,161
- San Joaquin: 8,354
- Tulare: 60,512
- Sacramento: 83,435
- San Diego: 43,691

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the audit period of March 1, 2012 through February 28, 2013. The on-site review was conducted from May 14, 2013 through May 24, 2013. The audit consisted of documents review, verification studies, and interviews with Plan personnel.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability, Member's Rights & Responsibilities, Quality Improvement System, and Organization and Administration of Plan.

The summary of the findings by category follows:

### **Category 1 – Utilization Management**

A verification study of the Prior Authorization Appeals process found that the Plan's current Provider Manual and policies allow for an inconsistency between the Plan and the PPGs in the application of utilization review criteria.

A verification study of medical Prior Authorizations found that the Plan's current tracking and/or monitoring procedures failed to ensure that all Notice of Action letters are sent within the required timeframes and with required pending letters when appropriate.

The Plan does not have a policy and procedure which describes their specialty referral system to track out-of-network and other in-network specialty referrals that require prior authorization.

### **Category 2 – Continuity of Care**

In this Category, the verification study includes a review of the medical records from the Plan's provider locations; the findings indicated the following:

- Lack of documentation for coordination of care between PCPs (Primary Care Physicians) and specialists for California Children's Services (CCS) and Early Intervention/Developmental Disabilities (EI/DD) Members.
- Lack of documentation for the completion of Initial Health Assessments (IHA) in the medical records.

### **Category 3 – Access and Availability**

The reviews of the Plan's policies and practices in this Category indicate that the Plan does not have procedures to:

- Monitor waiting times in the providers' offices.
- Ensure that drugs prescribed in emergency circumstances are provided to or received by Members.

#### **Category 4 – Member’s Rights & Responsibilities**

Plan’s procedures do not include routine monitoring of the disposition of quality of care versus quality of service grievances by clinical personnel to ensure appropriate categorization. In addition, the grievance verification study revealed several cases where the Plan’s procedures failed to ensure that grievance cases were not closed and resolution letters not sent to members prior to the completion of a full investigation into the issue.

The Plan did not fulfill its policy in reporting potential security breaches of Patient Health Information (PHI) to all of the Department of Health Care Services (DHCS) contact persons within the timeframes required by the Contract. In addition, the Plan’s “Desktop Procedures” does not indicate that notification or investigation be submitted to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer and the DHCS Information Security Officer as required by the contract. Furthermore, the incorrect DHCS Privacy Officer’s address is indicated in both the 2012 and 2013 Member Services Guide/Notice of Privacy Practices.

#### **Category 5 – Quality Improvement System**

The verification studies of medical records from the Plan’s provider locations indicate that providers did not maintain such records for all Members. Likewise, in a separate verification study of Informed Consent (IC) documentation, the findings include improper completion of consent forms.

#### **Category 6 – Organization and Administration of Plan**

Plan’s Policy does not include procedures to ensure new provider training is received by all new providers as required by Contract.

Plan’s policies do not ensure that preliminary investigation of fraud and abuse by the Plan or its subcontractors are reported to DHCS within the required time frame. A referral for such investigation was not reported to DHCS until several weeks have elapsed after it was first received by the Plan’s Special Investigation Unit (SIU). The contract requires that “the preliminary investigation of suspected fraud case be reported within 10 working days from the date Contractor first becomes aware of, or is on notice of, such activity.”

### III. SCOPE/AUDIT PROCEDURES

#### **SCOPE**

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that the medical services provided to Plan Members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan and Geographic Managed Care Contracts.

#### **PROCEDURE**

The on-site audit of Health Net Community Solutions, Inc. (Health Net) was conducted from May 14 through 24, 2013. 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. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following reviews were conducted:

#### **Category 1 – Utilization Management**

For Prior Authorization Requests, 39 medical and 21 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

For Notification of Prior Authorization Denial, Approved, or Modification, 49 denials, 9 approvals, and 2 modified and modification letters were reviewed for written notification requirements.

For Appeal Procedures, 39 prior authorization appeals were reviewed for appropriate and timely adjudication.

#### **Category 2 – Continuity of Care**

For CCS Members, 34 of the 44 records requested were received and reviewed to determine if coordination of care occurs between the Plan and the CCS providers.

For EI/DD Services, 20 of 26 records requested were received and reviewed to determine if coordination of care occurs between the Plan and the Regional Centers.

For IHA, 157 of 233 records requested were received and reviewed to determine if IHAs were provided within the contractual timeframe.

### **Category 3 – Access and Availability**

Emergency Service Claims: 60 of the 60 emergency service claims were received and reviewed for appropriate and timely adjudication. The review indicated that the claims were paid appropriately and within the required timeframe.

Family Planning Claims: 60 of the 60 family planning claims were received and reviewed for appropriate and timely adjudication. The review indicated that the claims were paid appropriately and within the required timeframe.

### **Category 4 – Member’s Rights & Responsibilities**

For Grievance Procedures, 89 grievances were received and reviewed. Forty (40) quality of care grievances, forty-four (44) non-quality of care grievances, and five (5) exempt grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

### **Category 5 – Quality Improvement System**

For Medical Records, 233 medical records were requested. One hundred fifty-seven (157) records were received and reviewed for compliance with contract requirements.

For Informed Consent, 43 of the 43 paid claims were received and reviewed for the completion of the Informed Consent form number PM330.

### **Category 6 – Organization and Administration of Plan**

New Provider Training: 40 of the 40 provider training records were received and reviewed for completion of new provider training within the required timeframe.

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: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**CATEGORY 1 - UTILIZATION MANAGEMENT**

**1.1**

**UTILIZATION MANAGEMENT PROGRAM**

**Utilization Management (UM) Program Requirements:**

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. ... (as required by Contract)

GMC/Two-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

GMC/Two-Plan Contract A.5.2.C

**Under and Over-Utilization:**

Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.

GMC/Two-Plan Contract A.5.4

**Appeal Procedures:**

There shall be a well-publicized appeals procedure for both providers and Members.

GMC Contract A.5.2.E

There shall be a well-publicized appeals procedure for both providers and patients.

Two-Plan Contract A.5.2.E

**SUMMARY OF FINDINGS:**

Health Net has developed, implemented and maintains an extensive Utilization Management (UM) program, which is updated annually, and supported by qualified clinical staff. All of the required elements of UM are present, including a prior authorization process, monitoring of over and under-utilization, and integration of UM into the quality improvement process.

The UM Program is under the clinical oversight of the Vice President of Clinical Services, Health Net, and the Chief Medical Director of the State Health Program (SHP); the SHP serves the Medi-Cal members within Health Net. Regional Medical Directors are responsible for assuring appropriate clinical relevance and focus of the UM Program. The health plan has numerous policies and procedures which directly relate to UM and review, including a detailed description of the prior authorization review process, a list of services and procedures which require prior authorization, and a list of those that do not. Review of the minutes from the SHP UM/QI Committee and of the Health Net Quality Improvement Committee, reveals oversight of and follow-up on UM topics and issues.

Though the Plan has an extensive UM Program, a Verification Study conducted for Section 1.4 Appeals, found an inconsistency between the Plan and its PPGs in the application of utilization review criteria, which is relevant to the current section. Of the 39 appeals reviewed, 4 (approximately 10%) were appeals of an original PPG denial that Health Net overturned. The appeals were rightfully overturned as the original requests involved PCP directed specialty consultations, which Health Net allows without prior authorization. However, Health Net also allows for "Referrals to participating and non-participating specialists for members assigned to a delegated PPG" to be "subject to any additional rules imposed by the PPG", which results in an inconsistency in the manner in which utilization review criteria are imposed between Health Net and its PPGs. In other words, a Member seen by a PPG may not get a needed specialty consult that a member who sees a directly contracted Provider would receive. This is in violation of the Contract which states, "Plan shall have a set of written criteria or guidelines for Utilization Review



**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

that is based on sound medical evidence, *is consistently applied*, regularly reviewed, and updated“ (Exhibit A.5.2.C). Note, the appeals process was reviewed and found to be in compliance with the Contract, so there are no findings specific to Section 1.4.

**RECOMMENDATION:**

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**1.2**

**PRIOR AUTHORIZATION REVIEW REQUIREMENTS**

**Prior Authorization and Review Procedures:**

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements...(as required by Contract)

H. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Attachment 2, Provision 19 & 20.

GMC/Two-Plan Contract A.5.2.A, B, D, F, H, and I.

**Exceptions to Prior Authorization:**

Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

GMC Contract A.5.2.G

Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

GMC/Two-Plan Contract A.5.2.G.

**Notification of Prior Authorization Denial, Deferral, or Modification:**

Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

GMC Contract A.13.8.A

Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

GMC/Two-Plan Contract A.13.8.A

**Appeal Procedures:**

There shall be a well-publicized appeals procedure for both providers and Members.

GMC Contract A.5.2.E

There shall be a well-publicized appeals procedure for both providers and patients.

GMC/Two-Plan Contract A.5.2.E

**Delegation of Quality Improvement Activities:**

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

- 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
- 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
- 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

GMC/Two-Plan Contract A.4.6

**SUMMARY OF FINDINGS:**

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

Health Net has policies which address the prior authorization procedure and which are in compliance with statute and the Contract. Medical necessity is determined utilizing nationally recognized criteria, such as InterQual, and applicable Federal or State regulations. All prior authorization (PA) requests are reviewed by utilization management personnel (non-clinical personnel and RNs) who may approve the request if it meets Health Net standardized guidelines. Only a physician, or in the case of a pharmacy PA, a qualified pharmacist, may deny a PA request based on lack of medical necessity. The Plan monitors the application of medical necessity criteria of its Participating Provider Groups (PPGs), to whom it has delegated Utilization Management via annual audits, including a review of denied files and inter-rater reliability results, and the review of all appeals which are not delegated.

A total of sixty (60) prior authorizations, which includes thirty-nine (39) medical and twenty-one (21) pharmacy prior authorizations, were received and reviewed for this verification study. Five (5) of 39 (or 13%) medical prior authorizations reviewed had Notice of Action letters sent outside of time frames and/or without the required pending notification letter. This is a repeat finding from 2008.

Also relevant to this section, a Verification Study conducted for Section 1.4 Appeals, found an inconsistency between the Plan and its PPGs in the application of utilization review criteria. Of the 39 appeals reviewed, 4 (approximately 10%) were appeals of an original PPG denial that Health Net overturned. The appeals were rightfully overturned as the original requests involved PCP directed specialty consultations, which Health Net allows without prior authorization. However, Health Net also allows for "Referrals to participating and non-participating specialists for members assigned to a delegated PPG" to be "subject to any additional rules imposed by the PPG", which results in an inconsistency in the manner in which utilization review criteria are applied between Health Net and its PPGs. In other words, a Member seen by a PPG may not get a needed specialty consult that a member who sees a directly contracted Provider would receive. This is in violation of the Contract which states, "Plan shall have a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, *is consistently applied*, regularly reviewed, and updated" (Exhibit A.5.2.C). Note, the appeals process was reviewed and found to be in compliance with the Contract, so there are no findings specific to Section 1.4.

Furthermore, a Verification Study conducted for Section 5.6 Informed Consent, revealed an issue of Contract non-compliance also pertinent to the current section. It was found that some of the reviewed PPGs required prior authorization for sterilization procedures, and in some cases, denied those services. This is in violation of the Contract and Health Net's own policies. Staff at one of the surveyed PPGs reported that prior authorization is required for many family planning services, and that neither Essure nor the IUD are covered services. Family planning services, including sterilization procedures, do not require prior authorization; this includes the Essure procedure, which is a covered benefit for Medi-Cal recipients, per the Medi-Cal Provider Manual. As part of its delegation oversight, Health Net receives quarterly denial reports (for referred services) from the PPGs. To reduce risks of non-compliance with contractual requirements and the inappropriate denial of medically necessary covered services, the Plan's monitoring systems should track inappropriate prior authorization denials by its PPGs, and when necessary, take corrective action to remedy the problem.

### **RECOMMENDATION:**

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**1.3**

**REFERRAL TRACKING SYSTEM**

**Referral Tracking System:**

Contractor is responsible to ensure that the UM program includes: ... An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

GMC/Two-Plan Contract A.5.1.F

**SUMMARY OF FINDINGS:**

The Plan has an established referral tracking system for prior authorizations and the decisions to approve deny or modify the requests. The Plan has policies that address prior authorization procedures; however, the Plan has not implemented a specific policy which describes the referrals tracking system.

The Authorization Tracking Report was developed by Health Net to track and monitor prior authorization requests submitted directly by contracted providers. This system includes authorized, denied, deferred or modified referrals and the timeliness of referrals. This report is updated and shared at the State Health Programs UM/QI Committee meetings four times per year.

The Plan's *UM/CM Program Description* states that Health Net has established a referral tracking process to track and monitor referrals that do require prior authorization.

**RECOMMENDATION:**

Develop a policy which describes the referral tracking system.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**1.5**

**DELEGATION OF UTILIZATION MANAGEMENT**

**Delegated Utilization Management (UM) Activities:**

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.  
GMC/Two-Plan Contract A.5.5

**Delegation of Quality Improvement Activities:**

- B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
  - 4) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
  - 5) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
  - 6) Includes the continuous monitoring, evaluation and approval of the delegated functions.

GMC/Two-Plan Contract A.4.6

**SUMMARY OF FINDINGS:**

All of the delegated entities undergo a pre-delegation review or audit to determine their ability to perform the functions intended for delegation. Subsequently, each entity undergoes an annual Utilization Management (UM) audit to ensure consistency with Health Net's policies and with Health Net's contractual obligations to the Department of Health Care Services (DHCS). Health Net's Provider Oversight department conducts the annual UM audits of the delegated entities and reports the results of the audits to the Delegation Oversight Workgroup (DOW), which in turn reports to the Delegation Oversight Committee (DOC). The UM department utilizes an audit tool based on National Committee on Quality Assurance (NCQA) material. If standards are not met, a corrective action plan (CAP) must be submitted by the delegated entity; the CAP is then followed by the DOW.

Minutes from the State Health Program (SHP) UM/QI Committee verify that delegation oversight is occurring and being reported to the SHP on a routine basis. The Regional Medical Directors are directly involved in oversight of the Participating Provider Groups (PPGs), including UM functions.

However, as described in Sections 1.1 and 1.2, four appeal cases were found to show inconsistencies with regards to the application of prior authorization or utilization review criteria between Health Net and provider groups who perform their own utilization management. The cases involved requests for specialty consultation, which were denied by the PPGs, and then overturned by Health Net on appeal. The Provider Operations Guide and policies state that the referral process, as a utilization management function, has been delegated to some PPGs. Despite the fact that the Plan does not require prior authorization to see in network specialists if directed by the Primary Care Physician (PCP), the Provider Operations Guide states that "Referrals to participating and non-participating specialists for members assigned to a delegated PPG are subject to any additional rules imposed by the PPG". This has created a barrier to Members within PPGs. The process of allowing PPGs "additional rules" has resulted in the inconsistent application of utilization review criteria or guidelines between the Plan and the PPGs, and a potential inconsistency in Member care between the Plan and the PPGs.

Furthermore, a Verification Study conducted for Section 5.6 Informed Consent, revealed an issue of Contract non-compliance also relevant to the current section. It was found that some of the reviewed PPGs required prior authorization for sterilization procedures, and in some cases, denied those services. This is in violation of the Contract and Health Net's own policies. Staff at one of the surveyed PPGs reported that prior authorization is required for many family planning services, and that neither Essure nor the IUD are covered services. Family planning services, including sterilization procedures, do not require prior authorization; this includes the Essure procedure, which is a covered benefit for Medi-Cal recipients, per the Medi-Cal Provider Manual. As part of its

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

delegation oversight, Health Net receives quarterly denial reports (for referred services) from the PPGs. To reduce risks of non-compliance with contractual requirements and the inappropriate denial of medically necessary covered services, the Plan's monitoring systems should track inappropriate prior authorization denials by its PPGs, and when necessary, take corrective action to remedy the problem.

**RECOMMENDATION:**

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**CATEGORY 2 - CONTINUITY OF CARE**

**2.1**

**COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN**

**Case Management and Coordination of Services:**

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network.  
GMC/Two-Plan Contract A.11.1

**Out-of-Plan Case Management and Coordination of Services:**

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services...

GMC/Two-Plan Contract A.11.5

**SUMMARY OF FINDINGS:**

Health Net has policies for the coordination and continuity of care for its Members. They have a policy that provides for a systematic approach to the identification of members with serious or complex medical condition that may benefit from Case Management. There is also a policy that identifies the various avenues in which case management referrals may be received. In addition, the Plan's policy indicates that Health Net provides information about case management services to its associates and contracted providers to facilitate timely, accessible and appropriate referrals for case management services. Furthermore, the Plan's policy specifically describes the case management process which includes a multidisciplinary team in educating, supporting and empowering the member in achieving optimal health status, enhancing quality of life, increasing appropriate access to services, and yielding cost-effective outcomes.

The Provider Manual states that the Plan encourages referrals from members and their family members.

Although the Facility Site Review (FSR) determines if there is documentation for coordination of care for Members, the Plan could not provide any documentation of case management or monitoring for five (5) selected complex CCS-eligible and EI/DD Members. However, in the sampled medical records reviewed for other sections of this report, there were some notations found for case management.

Although Health Net has written policies for the provision of case management and coordination of care both within and outside the network, the Plan did not provide documentation and/or demonstrate any actual performance of monitoring and tracking of Members who receive these services.

**RECOMMENDATION:**

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**2.2**

**CALIFORNIA CHILDREN'S SERVICES (CCS)**

**California Children's Services (CCS):**

Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program....(as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program...for the coordination of CCS services to Members.

GMC/Two-Plan Contract A.11.9.A, B

**SUMMARY OF FINDINGS:**

Health Net (Plan) has policies for identifying and referring members with CCS-eligible conditions to the local CCS program. Health Net participating providers (PCP) are responsible for providing a complete baseline health assessment and diagnostic evaluations sufficient to ascertain the evidence or suspicion of a CCS-eligible condition. Potential CCS-eligible members are then referred to local CCS programs for eligibility determination. The PCP remains responsible for the complete health care of the member until CCS program eligibility is determined.

Case management records were requested for five (5) complex CCS-eligible Members to evaluate the effectiveness of the Plan's case management function. However, the Plan could not provide the documentation.

A total of forty-four (44) medical records for Health Net Members from Los Angeles, Kern, Sacramento, and San Diego counties were requested for this verification study. Thirty-four (34) out of 44 (77%) medical records were received and reviewed. Medical Records for Health Net Members with CCS-eligible conditions lacked documentation of:

- Medically necessary covered services, preventive services, specialty and/or ancillary services not authorized by the CCS program.
- Coordination of care with CCS specialty providers and the CCS program
- The compliance rate for 34 of the 44 medical records reviewed for the items described in the above bullets was 77%.

The Plan has the responsibility to ensure that CCS-eligible conditions are referred in a timely manner to the CCS program, to continue to provide medically necessary covered services not authorized by CCS, and to coordinate care and case management between the members' PCP, CCS specialty providers and the local/county CCS program.

**RECOMMENDATION:**

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



**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**2.3**

**EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES**

**Services for Persons with Developmental Disabilities:**

Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers...for the coordination of services for Members with developmental disabilities.

GMC/Two-Plan Contract A.11.10.A, E

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services with Regional Center staff, which includes identification of all appropriate services, which need to be provided to the Member.

GMC Contract A.11.10.C

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

Two-Plan Contract A.11.10.C

**Early Intervention Services:**

Contractor shall develop and implement systems to identify children under 3 years of age who may be eligible to receive services from the Early Start program and refer them to the local Early Start program....Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program.

Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

GMC Contract A.11.11

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program....Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

Two-Plan Contract A.11.11

**SUMMARY OF FINDINGS:**

The Plan has policies for identifying and referring those Members, who are newborn to age three years, who may be eligible for the Early Start Program. Policies state Primary Care Providers (PCPs) will identify infants and toddlers who are at risk or suspected of having a developmental disability or delay through appropriate screening or assessment measures.

Memoranda of Understanding (MOU) between Health Net and Los Angeles Regional Center, Alta California Regional Center (Sacramento), San Diego Regional Center (SDRC), and Kern Regional Center delineate the

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

responsibilities in coordinating services for members with developmental disabilities. The Plan and Regional Centers facilitate coordination of comprehensive services and medical care for the Regional Center and Early Start eligible Members.

Case management notes/records were requested for five (5) eligible members to evaluate the effectiveness of the Plan's case management function. However, these notes/records were not submitted by the Plan. Health Net does not appear to be coordinating care for EI/DD (Early Intervention/Developmentally Disabled) Members as evidenced by lack of case management notes for these five Members.

A total of twenty-six (26) medical records of Health Net Members with EI/DD-eligible conditions from Los Angeles, Sacramento, Kern, and San Diego counties were requested for this verification study. Twenty (20) out of 26 medical records were received and reviewed. This gives a compliance rate of 76% for the availability of the medical records. Medical records were lacking documentation of coordination of care with local programs to provide continuity of the medically necessary covered diagnostic, preventive and treatment services identified for its members. The compliance rate for the medical record review was approximately 59%.

### **RECOMMENDATION:**

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

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**2.4**

### **INITIAL HEALTH ASSESSMENT**

#### **Provision of Initial Health Assessment:**

Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR 53910.5(a)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

GMC Contract A.10.3.A

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

Two-Plan Contract A.10.3.A

#### Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

GMC/Two-Plan Contract A.10.5

#### IHAs for Adults, Age 21 and older

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes...(as required by Contract)

GMC Contract A.10.6

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes...(as required by Contract)

Two-Plan Contract A.10.6

Contractor shall repeated attempts, if necessary, to contact a Member and schedule an IHA.

Contractor shall make at least three documented attempts...Contact methods must include at least one telephone and one mail notification....

GMC Contract A.10.3.E

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

Two-Plan Contract A.10.3.D

### **SUMMARY OF FINDINGS:**

The Plan has policies to address the completion of the Initial Health Assessment (IHA). These policies address both the content and the timeframe for the IHA completion requirements.

The 2012 Statewide Operations Guide states that Health Net's Medi-Cal member relations representative contact the new Medi-Cal members by telephone at 30, 60 and 90-day intervals after enrollment to discuss the importance

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

of scheduling an IHA and to share other information on using the health plan. Member relations representatives help members schedule an appointment by conference calling the member's PCP office, providing translation services if needed, or exiting the call if the member prefers. Health Net reviews PM 160 INF form claim and encounter data monthly and checks IHA encounters against member enrollment data. Some providers both denied and provided declarations that some of the Members assigned to them were not their patients even if they were named as PCP by the Plan.

The 2012 Operations Guide also states that "The PCP's staff should send another letter or attempt to make telephone contact with the member or a child member's parent or guardian to schedule an appointment. All contacts or attempted contacts with members must be documented in the member's medical record. Prior to the initial visit and creation of an individual medical record, this documentation may be kept on a multi-patient tracking log used specifically for these contacts." There was no evidence of a tracking log in some of the PCP offices reviewed.

In a verification study for this section, a total of two hundred thirty-three (233) Members' medical records from Los Angeles, Kern, Sacramento, and San Diego counties requiring IHA were requested. One hundred fifty-seven (157) of 233 (67%) requested medical records were received and reviewed for compliance with the IHA requirements.

- Policy # LR1129-14550- Initial Health Assessment, states that all new Plan members must have a complete Initial Health Assessment (IHA) within 120 days of enrollment. A new member may visit their PCP initially for episodic care. Regardless of the reason for the initial visit, the PCP conducts the IHA at the first health care contact whenever possible, and documents the assessment in the medical record. Members under 18 months of age require a health assessment within 60 days of enrollment or within periodicity timeliness for ages two and younger, whichever is less.
- Ninety-four (94) of 233 (40%) of IHAs were documented. However, 13 of the 94 IHAs were completed after the required timeframe making the overall IHA compliance rate 35%.

### **RECOMMENDATION:**

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE**

**3.1**

**APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES**

**Appointment Procedures:**

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children’s preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

GMC/Two-Plan Contract A.9.3.A

**Prenatal Care:**

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

GMC/Two-Plan Contract A.9.3.B

**Monitoring of Waiting Times:**

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers’ offices, telephone calls (to answer and return), and time to obtain various types of appointments...

GMC/Two-Plan Contract A.9.3.C

**SUMMARY OF FINDINGS:**

The Provider Manual informs providers about the Plan’s accessibility standards for routine, urgent, specialty and emergency care appointments and services. The Member Services Guide reiterates these standards to inform Members about such services and appointments.

The Plan has policies to ensure that such standards are being monitored through the Plan’s access and availability studies. The Plan’s annual oversight audit of Health Net reviews Health Net’s policies, access and availability studies, and other provider network reviews to ensure compliance with the Plan’s availability and accessibility standards. In addition, the Plan’s Quality Improvement/Utilization Management Committee discusses the results and areas of improvements from these studies.

However, the Plan does not have procedures to monitor waiting times in the provider’s offices.

**RECOMMENDATION:**

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

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**3.7**

### **ACCESS TO PHARMACEUTICAL SERVICES**

#### **Pharmaceutical Services and Prescribed Drugs:**

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours.... Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation.

GMC Contract A.10.8.G.1

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.

Two-Plan Contract A.10.8.G.1

#### **SUMMARY OF FINDINGS:**

The Plan contracts with CVS Caremark, Inc., a Pharmacy Benefits Manager (PBM) based in San Diego. The PBM is responsible for account management, claims processing, general support, and consulting services. Pharmacy audits are conducted by CVS Caremark internal auditors once every other year. The PBM sends a copy of the audit report to the Plan. The PBM provides pharmacy claims and network services. The network includes the name and address of primary care physicians (PCPs) and hospitals from different areas for members to access the various pharmacies.

The Plan has a Pharmacy and Therapeutics (P&T) Committee consisting of regional and national members. During 2012, the P&T Committee met four times. In January 2012, the P&T Committee made changes to the Rx-101 Recommend Drug List (RDL).

Health Net Pharmaceutical Services (HNPS) provides oversight of the pharmacy claims processing vendor through a variety of regularly scheduled meetings, reporting requirements, audits and document review. The Health Net UM/QI Committee monitors pharmacy operation metrics including prior authorization, turn-around-time compliance, provider service metrics, and Inter-Rater Reliability study results.

Monitoring of member grievances revealed that there were two grievances. One grievance was related to a delay in obtaining a prescription because prior authorization was sent to the wrong person. The other grievance was due to a member not being able to receive a certain drug. Both grievances were resolved within one month.

The Plan has a hospital contract with Fee-for-Service Facilities providers. However, there are no stipulations in the contracts that require the hospital and emergency room contractors to provide a 72-hour emergency supply of needed drugs as required by contract.

#### **RECOMMENDATION:**

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

### **CATEGORY 4 – MEMBER'S RIGHTS**

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**4.1**

**GRIEVANCE SYSTEM**

**Member Grievance System and Oversight:**

Contractor shall implement and maintain a Member Grievance System in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).

GMC Contract A.14.1

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).

Two-Plan Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract)

D. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus

health care delivery issues.

GMC/Two-Plan Contract A.14.2

Contractor shall 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. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

GMC/Two-Plan Contract A.14.3.A

**Provider Participation:**

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and a valid National Provider Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

GMC/Two-Plan Contract A.4.12.A

**SUMMARY OF FINDINGS:**

The Plan has a Member complaint/grievance system that is in accordance with the Contract and regulations. Meeting minutes of the Board of Directors and State Health Plan UM/QI Committee were reviewed, revealing regular Grievance monitoring and oversight. Health Net's Chief Medical Officer is responsible for oversight of the administration of the Medi-Cal Member grievance process.

The Plan has a policy which addresses the procedures for both administrative (quality of service) and clinical (quality of care) grievances in detail. Grievances are categorized as either quality of service or quality of care; numerous subcategories exist, as well. All quality of care grievances are investigated by clinical personnel (nurses), with provider response solicited, and then reviewed by a Health Net Medical Director. Quality of Service grievances is handled by non-clinical personnel.

Non-clinical personnel receive and log all grievances, and categorize the grievances as quality of service or quality of care based on criteria developed by Health Net. The non-clinical grievance staffs are able to consult with clinical staff (nurses) if there are any questions regarding the disposition of a particular grievance. If there is any issue about a grievance being expedited or urgent, it is automatically reviewed by a nurse. There is no overall clinical

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

oversight of the disposition of grievances, however. The grievance log is not periodically reviewed by clinical personnel to ensure that grievances are appropriately categorized, that clinical grievances are not overlooked and that criteria are being appropriately applied.

A total of 89 grievances, which includes forty (40) quality of care, forty four (44) non-quality of care, and five (5) exempt were received and reviewed with the following results:

- Four (4) of the 40 quality of care grievances did not have evidence of a full investigation of the complaint documented in the records available for review.
- Two (2) of the 44 quality of care grievances involved issues that were not fully investigated prior to closing the case.
- Five (5) of the 44 non-quality of care grievances reviewed should have been classified as quality of care grievances in order to receive physician review.
- One (1) of the 44 quality of care grievances involved a provider who has been on Medi-Cal's Suspended & Ineligible list since 2010.

### **RECOMMENDATION:**

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



**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**4.3**

**CONFIDENTIALITY RIGHTS**

**Members' Right to Confidentiality**

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

- 1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
- 2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

Two-Plan Contract A.13.1.B

**Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:**

Contractor agrees:

- B. Safeguards—To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract.....
- H. Notification of Breach—During the term of this Agreement:
  - 1). Discovery of Breach. To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract...
  - 2). Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer...
- I. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit...

GMC/Two-Plan Contract G.3.B, H, and I

**SUMMARY OF FINDINGS:**

The Plan's Privacy Program provides the general guidelines for Health Net and its associates to safeguard the confidentiality of Member's Patient Health Information (PHI). The Privacy Officer is designated by Health Net's Chief Compliance Officer and is responsible for the development, monitoring, and implementation of the Privacy Program. The Privacy Officer reports to the Plan's Chief Compliance Officer who in turn reports to Health Net's CEO. During the audit period, the Privacy Officer presided over the Privacy and Security Committee and reported to Health Net's Privacy Office regarding the privacy incidents investigation and reporting as well as other privacy protection efforts by the Plan.

During the audit interview Plan personnel stated that the Plan's HIPAA training is conducted online during (1) initial hire and (2) annually for employees. The Plan's Notice of Privacy Practice (NPP) in the Member Services Guide informs Members of how their health information may be used, how to access it, how it may be shared, when Member's written approval is needed for other uses, what is meant by Member's privacy rights, etc. The Member Services Guide indicates the contact information of the DHCS Privacy Officer for Members to contact as an alternate means to file PHI privacy complaints. The incorrect DHCS Privacy Officer's address is still indicated in both in 2012 and 2013 Member Services Guide/Notice of Privacy Practices. This is a repeat finding from the 2008 audit.

The Provider Manual defines Patient Health Information (PHI) as a Member's confidential health care information and that providers have to ensure protection of such information. Plan personnel indicated during audit interview that

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

a Security Addendum schedule is attached on every business associate agreement. A review of the Security Addendum schedule indicates that it requires the Plan's business associate to establish confidentiality policies and that "a documented process must exist to report privacy issues affecting Health PHI and e-PHI to the Health Net's Privacy Officer."

The Plan's delegated Utilization Management (UM) oversight audit has a section entitled "Provisions for Protected Health Information" that serves as criteria to determine whether the delegation of such services include the protection of Patient Health Information (PHI). The Facility Site Review (FSR) also determines whether a provider follows procedures to maintain the confidentiality of personal patient information.

In addition to the Plan's national policies for PHI protection, the Plan's "Desktop Procedures" include procedures to report the discovery of privacy breach immediately and submit an investigation report within 72 hours. However, it indicates that such notifications be submitted only to the DHCS Privacy Officer. It does not indicate that such notification or investigation be submitted to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer and the DHCS Information Security Officer as required by the contract.

In a review of five (5) HIPAA breach cases, one (1) of 5 HIPAA breach cases was not initially reported to DHCS Privacy Officer within the required time frame of 24-hours. Likewise, for 2 of 5 HIPAA breach cases, the notification of Investigation were submitted more than 72-hours after breach was discovered.

### **RECOMMENDATION:**

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**CATEGORY 5 – QUALITY MANAGEMENT**

**5.5**

**MEDICAL RECORDS**

**Medical Records**

- A. General Requirement  
Contractor shall ensure that appropriate Medical Records for Members, pursuant to 28 CCR 1300.80(b)(4) and 42 USC 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each Encounter in accordance with 28 CCR 1300.67.1(c).
- B. Medical Records  
Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records...
- C. On-Site Medical Records  
Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.
- D. Member Medical Record  
Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services...(as required by Contract)

GMC Contract A.4.13.A, B, C, D

- A. General Requirement  
Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861 and MMCD Policy Letter 02-02.
- B. Medical Records  
Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records...
- C. On-Site Medical Records  
Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.
- D. Member Medical Record  
Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services...(as required by Contract)

Two-Plan Contract A.4.13.A, B, C, D

**SUMMARY OF FINDINGS:**

The Plan's Policy KK47-121230 Medical Record Documentation Standards, lists the requirements for medical record documentation, storage and access as required by contract. The Plan has established standards for the administration and maintenance of medical records by individual practitioners to facilitate communication, coordination and continuity of care and to promote efficient and effective treatment.

Facilities visited had properly secured medical records and had a designated person responsible for securing medical records.

Facility Site Reviews (FSRs) consist of site, medical record and physical accessibility reviews. The reviews seek to ascertain quality of care, quality of service and the quality of the facility. In a verification study, a total of 233 Members medical records from Los Angeles, Kern, Sacramento, and San Diego counties were requested and 157 (67%) records were received. 157 out of 233 medical records were reviewed

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

according to contract requirements for documentation of medical services and coordination of care. The overall compliance rate for the 157 collected medical records was 63%. Examples of the discrepancies found:

- 145 of 157 (92%) medical records did not meet all three criteria for immunizations.
- 113 of 157 (72%) medical records had no documentation of Tuberculosis screening.
- 79 of 157 (50%) medical records were missing the Member ID on every page.

### **RECOMMENDATION:**

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**5.6**

**INFORMED CONSENT**

**Informed Consent**

Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services, and at a minimum includes: ...All informed consent documentation, including the human sterilization consent procedures required by 22 CCR Sections 51305.1 through 51305.6, if applicable.

GMC Contract A.4.13.D.7

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes: ...All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.

Two-Plan Contract A.4.13.D.6

Contractor shall ensure that Members are informed of the full array of covered contraceptive methods and that informed consent is obtained Members for sterilization, consistent with requirements of 22 CCR 51305.1 and 51305.3.

GMC Contract A.9.9.A.1

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.

Two-Plan Contract A.9.9.A.1

**Exceptions to Prior Authorization:**

Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

GMC Contract A.5.2.G

Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

Two-Plan Contract A.5.2.G

**SUMMARY OF FINDINGS:**

Policies inform providers that family planning services are available to Members without prior authorization. The sterilization services of tubal ligations and vasectomies are listed in the policy. The policy informs providers that the PM330 form is required to document Informed Consent and it must accompany the claim submission.

The Provider Library "Overview" specifies that Member education regarding sterilization must occur and that the Member must be provided with the DHCS published brochure on sterilization. The Provider Library in the "Informed Consent Process Requirements" section has requirements for medical record documentation. The medical record must note that the booklet and a copy of the consent form were given to the member. The provider is instructed to retain a copy of the signed consent form in the medical record.

While the Provider Library's "Certification of Informed Consent for Reproductive Sterilization" section informs the providers of the need to utilize the PM330 form for Informed Consent, it does not go into details about the specific requirements for proper completion of the PM330.

The Member Handbook informs Members that they can go to any provider for family planning services without prior authorization. However, sterilization services are not mentioned in the Member Handbook.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

In a verification study, forty three (43) paid sterilization claims, eleven (11) denied claims, and the corresponding forty-one (41) medical records from Los Angeles, Kern, Sacramento, and San Diego counties were reviewed for compliance with standards and the findings are as follows:

- 2 of 43 paid claims lacked the Informed Consent form PM330,
- 18 of 43 PPM 330 forms were completed incorrectly,
- 42 of 43 paid claims lacked adequate education documentation (including not providing DHCS sterilization booklet),
- 32 of 43 paid claims were submitted without a copy of the PPM 330,
- One (1) out of 11 denied claims had a denial code of no PPG (Participating Provider Groups) authorization. The claim was resubmitted with the proof of Prior Authorization and paid,
- Evidence of Prior Authorization for sterilization procedures was found in eleven (11) instances – two (2) in the claims documentation and nine (9) in the medical records.

Thus, based on the verification study the overall compliance rate for complete sterilization service documentation is 56%.

### **RECOMMENDATION:**

1. Update both the Operations Guide and the Provider Library “Conditions Under Which Sterilization May Be Performed” and “Informed Consent Process Requirements, Documentation and Noncompliance” to specify the “booklet on sterilization published by the Department of Health Services”. In addition, update the Member Handbook to include sterilization procedures under family planning services.
2. Educate providers and the claims department on the proper completion of the PM330 and develop a system to monitor compliance with the training.
3. Educate providers and Members about the documentation requirements for the discussion regarding sterilization contained in the Operations Guide, Provider Library, and Member Handbook.
4. Ensure that the PM 330 Sterilization Consent forms are completed appropriately for claim submission.
5. Ensure each Member has access to sterilization procedures including Essure and the required hysterosalpingogram without Prior Authorization.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY**

**6.4**

**PROVIDER TRAINING**

**Medi-Cal Managed Care Provider Training:**

Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status....

GMC/Two-Plan Contract A.7.5

**SUMMARY OF FINDINGS:**

Plan's policy COMM-102 HNCA Provider Orientation Program – Medi-Cal Managed Care states that all newly contracting Medi-Cal providers in counties where Health Net is the primary contractor with DHCS and who have completed the credentialing process must receive orientation material within 10 days of being placed on active status. The provider orientation program includes Welcome-Orientation Packets developed and distributed by the National Provider Communications Department and onsite-office trainings (on request) are conducted by the Plan staff.

The Plan personnel confirmed that the Plan submits a welcome package and other brochures to the new providers within (10) working days and once the new provider packet is sent to newly contracted provider, it provides instruction for the provider to create a username and password to access the training materials. However, the Plan does not track whether the provider obtained the training within (10) working days as required by contract requirements.

In addition, sign-in sheets were provided, but no agendas were provided for in-service trainings to the new providers. The Plan staff indicated that they do not keep those documents on file and are provided only upon request.

**RECOMMENDATION:**

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

**6.5**

**FRAUD AND ABUSE**

**Fraud and Abuse Reporting**

Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse....

- 1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
- 2) Contractor shall provide effective training and education for the compliance officer and all employees.
- 3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
- 4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity.
- 5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs.

GMC/Two-Plan Contract E.2.26.B

**SUMMARY OF FINDINGS:**

The Plan's Fraud & Abuse Program is administered by the Special Investigation Unit's (SIU) director. The SIU director reports to the Plan's Senior Vice-President/Corporate Controller, who then reports to the Executive Vice-President/Corporate Financial Officer.

Plan policies indicate that the SIU management develops a Work Plan on an annual basis. The Work Plan lists the activities for SIU on the prevention, detection, correction, and reporting of fraud. During the onsite interview, the SIU director stated that the SIU prepares/submits a report to the Health Net Audit Committee. On a quarterly basis, SIU provides information regarding fraud case referrals and turnaround time metrics to the Medicaid Compliance Committee.

Both the Provider Manual and Member Services Guide provide the Health Net's Fraud and Abuse Hotline number, so any suspicion of health care fraud can be reported to the Plan. The Provider Manual provides information regarding the Plan's fraud prevention program. Plan's policies require that new employees are to complete a course called "The Painful Price of Pharmaceutical Fraud" within 60 days after being hired. "Integral," or employees who form part of the claim payment or denial functions, receive annual fraud prevention training.

Plan policies state that that the SIU will generally submit a referral to DHCS at the same time the case is opened, but no later than 10 days thereafter. Policy PW323-123443, SIU Oversight and Monitoring, states that both the "preliminary investigation and SIU management's decision to determine whether a referral becomes a case or closed must be completed within fourteen (14) calendar days from when the referral is received by the SIU." Due to this policy, a preliminary investigation may not be reported to DHCS until after a total of 24 days has elapsed from when the referral is initially received by the Plan.



**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Health Net Community Solutions, Inc.**

AUDIT PERIOD: **March 1, 2012 through February 28, 2013**

DATE OF AUDIT: **May 14 through 24, 2013**

Policy PW323-123443, SIU Oversight and Monitoring, also states that “as of June 2012 Health Net outsourced SIU functions such as “case investigation and recovery, and the performance of data mining.” According to this policy, “Optum has set a 60 day timeframe for completing case investigations. This starts when either Health Net refers the case or when Health Net asks Optum to start an investigation such as through data mining or other methods. This 60 day timeframe “excludes time spent waiting for medical records, and time spent waiting for information or approvals from Health Net.” In addition, this policy also indicates that the SIU has a bi-weekly meeting with Caremark, the contracted Pharmacy Benefit Manager, to review open “tasks owned by CVS Caremark...” The Plan’s subcontract with its PBM requires it to submit fraud, waste, and abuse reports as well conduct onsite/offsite audits of participating network pharmacies to verify their compliance with contractual requirements and whether they “are taking adequate actions to address fraud, waste, abuse.”

In both scenarios for the respective subcontractors, the policy does not indicate the procedures to ensure that potential fraud cases investigated by either Optum or CVS Caremark are reported to DHCS within 10 working days after the date such activity was first noticed as required by contract.

In addition, a referral for investigation, which the Plan’s SIU investigator indicated as having been received from the SIU director, was reported to DHCS several weeks after it was first received by the SIU investigator. The case was eventually assigned to OptumInsight by the Plan one month after the SIU investigator noted it as a referral and it was reported to DHCS about another month thereafter.

**RECOMMENDATION:**

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