DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SANTA ANA – SECTION

# REPORT ON THE MEDICAL AUDIT OF HEALTH NET COMMUNITY SOLUTIONS, INC. FISCAL YEAR 2023-24

Contract Number(s): 03-76182, 07-65847, 09-86157, and 12-89334

Audit Period: April 1, 2022 — May 31, 2024

Dates of Audit: March 6, 2023 — March 22, 2023
and June 17, 2024 — June 28, 2024

Report Issued: February 14, 2025

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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 (MCP).

The Plan delivers care to members under the Two-Plan contracts covering Amador, Calaveras, Inyo, Mono, Los Angeles, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties and Geographic MCP contracts covering Sacramento and San Diego Counties.

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

As of June 2024, the Plan's enrollment total for the Medi-Cal line of business was 1,480,555. Membership composition by county was 1,915 for Amador, 6,015 for Calaveras; 2,047 for Inyo; 1,053 for Mono; 1,175,795 for Los Angeles; 34,242 for San Joaquin; 68,813 for Stanislaus; 138,233 for Tulare; 6,506 for Tuolumne; and 45,936 for Sacramento.

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of April 1, 2022 through May 31, 2024. The audit was conducted from March 6, 2023 through March 22, 2023 and June 17, 2024 through June 28, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on January 24, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On February 10, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

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

The prior DHCS medical audit for the period of April 1, 2021, through March 31, 2022, was issued on October 31, 2022. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2022, Corrective Action Plan.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

## Category 1 – Utilization Management

There were no findings noted for this category during the audit period.

## Category 2 – Case Management and Coordination of Care

The Plan is required to ensure that the behavioral health treatment plan be reviewed, revised, or modified no less than once every six months by the provider of Behavioral Health Treatment (BHT) services. The Plan did not ensure members' behavioral health treatment plans were reviewed every six months by the qualified autism service provider of the BHT services.

The Plan is required to ensure that Continuity of Care (COC) requests that are approved include the following information in the notice: A statement of the MCP's decision, the duration of the COC arrangement, the process that will occur to transition the member's care at the end of the COC period, and the member's right to choose a different network provider. The Plan did not include the member's right to choose a different network provider and/or the transition plan in the member notification letter of approval for COC requests.

## Category 3 – Access and Availability of Care

The Plan is required to communicate, enforce, and monitor providers' compliance with access standards. In addition, the Plan is required to have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. The Plan did not ensure that corrective actions were implemented for primary and specialty providers who did not comply with appointment wait time standards.

The Plan shall develop, implement, and maintain a procedure to monitor waiting times for telephone calls (to answer and return). The Plan did not monitor the providers' return calls to members.

The Plan shall develop, implement, and maintain a procedure to monitor waiting times in network providers' offices. The Plan did not monitor providers' compliance with office wait times.

## Category 4 – Member's Rights

The Plan is required to comply with the State's established timeframe of 30 calendar days for grievance resolution. The Plan did not send resolution letters for Quality of Service (QOS) grievances within the required 30 calendar days.

## Category 5 – Quality Management

There were no findings noted for this category during the audit period.

## Category 6 – Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

# III. SCOPE/AUDIT PROCEDURES

## SCOPE

The DHCS, Contract and Enrollment Review Division 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 an audit of the Plan from March 6, 2023 through March 22, 2023 and June 17, 2024, through June 28, 2024 for the audit period of April 1, 2022 through May 31, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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 verification studies were conducted:

### Category 1 – Utilization Management

Prior Authorization (PA) Requests: 53 medical PA records were reviewed for timely decision making, consistent application of criteria, and appropriate review.

Appeals: 38 medical appeal records were reviewed for appropriateness and timely adjudication.

Delegated PA Requests: 20 medical PA records were reviewed for appropriate and timely adjudication.

### Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): Ten medical records were reviewed for appropriate CCS identification, referral to the CCS program, and care coordination for non-eligible CCS conditions.

Behavioral Health Treatment: 25 medical records were reviewed for care coordination, completeness, and compliance with BHT service requirements.

Continuity of Care (COC): 15 medical records were reviewed to evaluate the timeliness and appropriateness of COC request determination.

## Category 3 – Access and Availability of Care

Non-Compliant Providers from 2021 and 2022 Provider Appointment Availability Surveys (PAAS): 23 non-compliant provider documents were reviewed to determine the implementation of corrective actions.

Non-Emergency Medical Transportation (NEMT): 35 records were reviewed for timeliness and compliance with NEMT requirements.

Non-Medical Transportation (NMT): 37 records were reviewed for timeliness and compliance with NMT requirements.

## Category 4 – Member's Rights

Call-Inquiry: 25 call-inquiry cases were reviewed to verify the grievance classification and investigation process.

Exempt Grievances: 25 exempt grievance cases were reviewed to verify the classification, reporting timeframes, investigation process, and appropriate resolution.

QOS Grievances: 27 QOS grievance cases were reviewed for timely investigation process and appropriate resolution.

QOC Grievances: 45 QOC grievance cases were reviewed for timely processing, clear response to members, and appropriate level of review.

## Category 5 – Quality Management

Potential Quality Issues: 35 cases were reviewed for timely evaluation and effective action taken to address needed improvements.

## Category 6 – Administrative and Organizational Capacity

Fraud, Waste and Abuse: Ten cases were reviewed for investigation process and timely reporting to DHCS.

Overpayment Reporting: Ten overpayment recovery cases were reviewed for timely reporting to DHCS and annual reporting of total overpayment recoveries to DHCS.

Encounter Data: Five encounter data cases were reviewed for the accuracy of the information.

# COMPLIANCE AUDIT FINDINGS

## Category 2 – Case Management and Coordination of Care

### 2.3 BEHAVIORAL HEALTH TREATMENT

#### 2.3.1 Behavioral Health Treatment

The Plan is responsible for covering and ensuring the provision of medically necessary BHT services to eligible members under 21 years of age as required by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate. The Plan must inform its providers and members how to access these covered services. *(Contract, Exhibit A,* Attachment 10(5)(F)(G))

The Plan is required to provide, observe, and direct BHT services under a Plan-approved behavioral health treatment plan. The behavioral health treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific member being treated. The behavioral health treatment plan must be reviewed, revised, or modified no less than once every six months by the provider of BHT services. The behavioral health treatment plan may be modified or discontinued only if it is determined that the services are no longer medically necessary under the EPSDT medical necessity standard. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary. *(APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21)*

The Plan's policy, *MHN.UM.01 Administration of Applied ABA Behavioral Analysis (ABA) Benefit (revised 12/08/2021),* states that ABA services must be based upon a treatment plan that is reviewed no less than every six months by a qualified autism service provider and prior authorized by MHN for a time period not to exceed 180 days.

**Finding:** The Plan did not ensure members' behavioral health treatment plans were reviewed every six months by the qualified autism service provider of the BHT services.

In the verification study of BHT services revealed that two of 25 members did not have the required six-month review of the behavioral health treatment plans by the qualified autism service provider of the BHT services. The members were authorized or did not have authorization for the continuation of services. For reauthorization for six months, the case manager advises the member about the diagnostic evaluation/assessment

requirement must be completed by a physician or licensed clinical psychologist if it has not been completed within the past 12 month and the written recommendation from evaluator must be either emailed or faxed to MHN Autism Center. If the member has a copy of it within the past 12 months, case manager must provide the above documents to either be emailed or faxed to MHN Autism Center.

During the interview, the Plan explained that it generated an ABA Care Report that tracked service hours and reauthorization of BHT services. However, an analysis of this report did not show that the Plan tracked the six-month review of the behavioral health treatment plan by a qualified autism service provider as required by APL 19-014.

When the Plan does not track for timely review of six-month behavioral health treatment plans, this can delay the member's medically necessary treatment, which can lead to poor health outcomes.

**Recommendation**: Revise and implement policies and procedures to ensure BHT treatment plans are reviewed no less than every six months by the qualified autism service provider of the BHT services.

### 2.3.2 Continuity of Care

For continuity of care (COC) requests that are approved, the MCP must include the following information in the notice:

- A statement of the MCP's decision.
- The duration of the COC arrangement.
- The process that will occur to transition the member's care at the end of the COC period.
- The member's right to choose a different network provider.

*(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, On or After January 1, 2023; APL 18-008 (Revised), APL 22-032 (Superseding APL 18-008 as of 1/1/2023), Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care).*

The Plan's policy, *CA.UM.20 V17 Continuity of Care (revised 03/14/2024),* states that notification of approval to member and the member's care manager includes: (1) a notification that the member may continue with his or her provider, (2) notify the member of the length of time that they can stay with their provider, (3) the process for transitioning the member's care at the end of the COC period, and (4) the member's right to choose a different network provider.

**Finding:** The Plan did not contain the member's right to choose a different network provider and/or the transition plan in the member notification letter of approval for COC requests to comply with APLs.

In the verification study, 11 of 15 member records did not include the member's right to choose a different network provider and/or the transition plan in the member notification letter of approval for COC requests.

In the Corrective Action Plan (CAP) to the 2022 audit finding 2.4.2, the Plan updated its policy with the notification requirements in accordance with APL 18-008 (Continuity of Care for Medi-Cal members who transition into Medi-Cal Managed Care): to include a COC notification letter template and an audit tool to review both the transition plan and the member's right to choose a different network provider. The Plan revised the notification letter template that included the required information. The template has not been implemented since the Compliance Department team was still reviewing it. Therefore, for the 2023 audit, the Plan continued to send the COC notification letters to members that did not include the member's right to choose a different network provider and/or the process that will occur to transition the member's care at the end of the COC period.

In an interview for the 2024 audit, the Plan stated that that the Compliance Department team reviews the COC notification letters and sends the letter requirements to the Regulatory Legislative Implementation team to review and identify all the processes and policies that must be updated prior to submitting the notification letter template to DHCS for publication. The Plan submitted the updated COC notification letter template that had been approved by DHCS on June 2024. However, the notification letters that were sent to members prior to June 2024 did not include the required information to meet APL requirements.

If the Plan's notification letters do not include the transition plan and the member's right to choose a different network provider, this may delay the continuity of services and access to medically necessary care, which could lead to poor health outcomes.

**Recommendation:** Implement policies and procedures to comply with APL requirements to include all the required information in its member notification letter of approval for COC requests.

# COMPLIANCE AUDIT FINDINGS

## Category 3 – Access and Availability of Care

## 3.1 APPOINTMENT PROCEDURES AND MONITORING OF WAIT TIMES

### 3.1.1. Corrective Actions for Timely Access Deficiencies

The Plan is required to establish acceptable accessibility standards in accordance with California Code of Regulations *(CCR), Title 28, section 1300.67.2*. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan is required to develop, implement, and maintain a procedure to monitor the time to obtain various types of appointments. (Contract, Exhibit A, Attachment 9, (3)(C))

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access, which includes but is not limited to taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies and to bring its network into compliance. *(28 CCR section 1300.67.2.2 (d)(3))*

The Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. (28 CCR section 1300.67.2 (f))

The Plan's policy, CA.NM.05 Appointment Accessibility for all LOBs (revised May 2024), stated that it identifies providers and PPGs that are non-compliant with one or more of the Appointment Access metrics. A CAP is issued to PPGs that fail to meet the Plan's compliance goal and meet criteria for issuance of a CAP. The Plan investigates and requests corrective actions when timely access to care, monitored by the PAAS are not met.

**Finding:** The Plan did not ensure that corrective actions were implemented for primary and specialty providers who did not comply with appointment wait time standards.

The verification study selected 23 non-compliant providers with appointment wait times access standards from the 2021 and 2022 PAAS surveys. The Plan provided documentation to inform provider of their deficiencies as follows:

- For 15 non-compliant providers found in the 2021 PAAS survey, the Plan provided PPG correspondence informing these providers that they were found non-compliant with access standards. However, the correspondence did not

specify which access time standards were not met.
- For eight non-compliant providers found in the 2022 PAAS survey, the Plan provided Plan's PPG correspondence which included improvement plan, notification of timely access results attestation, and completion certificate for timely access to care provider training. However, the PPG correspondence could not demonstrate the CAP was requested at the provider level.

In addition, the Plan could not provide any documentation that corrective actions were requested for the non-compliant providers for both 2021 and 2022 PAAS Surveys.

In an interview, the Plan stated that a CAP is issued to PPGs that are non-compliant with one or more of the appointment access metrics and meet criteria for issuance of a CAP. However, the Plan did not follow up with the PPG to ensure that corrective actions were requested from non-compliant providers.

Without an effective process to ensure CAP implementation to meet access standards, the Plan will continue to experience non-compliance with appointment wait times that could result in members not receiving timely care access.

**Recommendation:** Ensure communication and enforcement of corrective actions for providers who did not comply with appointment wait time standards.

### 3.1.2 Telephone Wait Times

The Plan shall establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times for telephone calls (to answer and return). *(Contract, Exhibit A, Attachment 9(3)(C))*

The Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. *(28 CCR section 1300.67.2 (f))*

The Plan's Policy, *CA.NM.05 Provider Network Management (revised date 6/2022)* indicated that the wait time for providers to return calls to members is within one business day. The Plan monitors wait times to answer and return telephone calls in the PCP's offices through a provider survey.
**Finding:** The Plan did not monitor the providers' return calls to members.

In the verification study of seven samples from the 2021 PAAS survey indicated that the providers self-reported the telephone return call wait times data. The Plan did not have

documentation to substantiate how it determined the actual providers' return calls.

In the interview, the Plan stated that it monitors telephone wait times through a PAAS survey that simply asked the provider's office how soon the office returns a member's call.

The PAAS survey identified the wait times to answer telephone calls as it indicated when the provider actually answered the calls. However, the providers' self-reported data from the PAAS survey cannot accurately determine or verify if the providers' return calls to members.

**Recommendation:** Develop and implement procedures to monitor wait times to return telephone calls in the providers' offices.

### 3.1.3 Office Wait Times

The Plan shall establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2.1. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times in network providers' offices. *(Contract, Exhibit A, Attachment 9(3)(C))*

The Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. *(28 CCR section 1300.67.2 (f))*

The Plan's Policy, *CA.NM.05 Provider Network Management (revised date 6/2022)* indicated that in-office wait time for scheduled appointments should not exceed 30 minutes. The Plan conducts an annual audit using PAAS or Consumer Assessment of Healthcare Providers and Systems (CAHPS) to monitor in-office wait time for scheduled appointments.

**Finding:** The Plan did not monitor providers' compliance with office wait times.

In the interview, the Plan stated that it conducted a CAHPS survey to monitor in-office wait times. The CAHPS survey results could not identify which individual provider completes the survey. The Plan acknowledged that the CAHPS survey could not identify non-compliant providers who did not comply with office wait time requirements.

If the Plan is unable to identify providers who did not comply with in-office wait time requirements, it cannot ensure their compliance with this requirement. This may result in delayed access to medically necessary services.

**Recommendation:** Develop and implement procedures to ensure providers comply with in-office wait time requirements.

# COMPLIANCE AUDIT FINDINGS

## Category 4 – Member's Rights

### 4.1 GRIEVANCE SYSTEM

#### 4.1.1 Quality of Service (QOS) Grievance Resolution Letters

Timeframes for resolving grievances and sending written resolution to the members are defined in federal and state law. The State's established timeframe is 30 calendar days. MCPs must comply with the State's established timeframe of 30 calendar days for grievance resolution. *(APL 21-011, Grievance and Appeal Requirements)*

The Plan's policy, *CA.AG 35 Medi-Cal Grievance Process (revised 01/16/2024),* stated that the final resolution letter is sent to the member that clearly and concisely describes any administrative or service outcome information (Health & Safety Code, section 1368(a)(5)). Additionally, the letter describes the member's options if the member is not satisfied with the grievance outcome. The resolution letter is sent within 30 calendar days from receipt of the grievance (*Health & Safety Code, section 1368.01(a); CCR, Title* 28, sections 1300.68(a) and (d)(3)).

**Finding:** The Plan did not send resolution letters for QOS within the required 30 calendar days.

In the verification study of 27 QOS grievance cases from March 1, 2023, through May 31, 2024, the resolution letters for 4 of 27 cases were not sent within the required 30 calendar days timeframe.

For example:

- A member filed a grievance on October 5, 2023. The Plan completed the investigation and sent the resolution letter to the member on November 17, 2023, 42 days after the grievance was originally received by the Plan.
- A member filed a grievance on March 7, 2024. The Plan completed the investigation and sent the resolution letter to the member on April 18, 2024, 41 days after the grievance was originally received by the Plan.

In an interview, the Plan stated that it monitors the timeliness of the grievance cases daily and monthly. However, delays can occur due to the misdirection of a grievance to a different department.

Untimely grievance resolution letters may lead to delayed patient care and may have an impact on clinical outcomes for the members.

**Recommendation:** Develop and implement a process to ensure QOS grievance resolution letters are sent to members within required timeframes.

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# REPORT ON THE MEDICAL AUDIT OF HEALTH NET COMMUNITY SOLUTIONS, INC. FISCAL YEAR 2023-24

Contract Number(s): 22-20472, 22-20473, 22-20478, 22-20484, 23-30253, 23-30254, and 23-30255

Contract Type: State Supported Services

Audit Period: April 1, 2022 — May 31, 2024

Dates of Audit: March 6, 2023 — March 22, 2023 and June 17, 2024 — June 28, 2024

Report Issued: February 14, 2025

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# I. INTRODUCTION

This report presents the results of the audit of Health Net Community Solutions, Inc.'s (Plan) compliance and implementation of the State Supported Services contract numbers 03-76182, 07-65847, 09-86157, and 12-89334 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of April 1, 2022, through May 31, 2024. The audit was conducted from March 6, 2023 through March 22, 2023 and June 17, 2024 through June 28, 2024, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on January 24, 2025. No deficiencies were noted during the review of the State Supported Services Contracts.

# COMPLIANCE AUDIT FINDINGS

## State Supported Services

The Plan's policies and procedures, Provider Manual, and Member Handbook indicate that Medi-Cal members may obtain an abortion from any qualified provider without obtaining a referral or prior authorization. A qualified provider of abortion services is the member's primary care physician, an obstetrician/gynecologist, certified nurse midwife, nurse practitioner, physician assistant, family planning clinic, or a Federally Qualified Health Center.

A verification study of 12 State Supported Services claims was conducted to determine appropriate process and timely adjudication of claims. There were no material findings noted during the audit period.

**RECOMMENDATION:** None