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

REPORT ON THE FOCUSED COMPLIANCE AUDIT OF

Health Net Community Solutions, Inc.

2021

Contract Number: 03-76182

Audit Period: January 1, 2019
Through
December 31, 2020

Report Issued: September 14, 2021

TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 3

IV. COMPLIANCE AUDIT FINDINGS 5

I. INTRODUCTION

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

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

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.

The Plan entered into a delegation agreement with Los Angeles County, Department of Health Services (formerly LA DHS) in January 2014. As of January 2021, the total number of members assigned to LA DHCS is 74,530. As of January 2021, LA DHCS has the following number of providers: 281 primary care physicians, 622 specialists, and 4 hospitals.

The Los Angeles Times published an article specifically alleging that LA DHCS' quality of care deficiencies resulted in patient harm. Starting September 30, 2020, the Los Angeles Times' investigation reported an average wait time of three months for LA DHCS patients who needed to see a specialist. The reporters analyzed LA County data from 2016 to 2019, tracking when specialty care was requested to when an appointment occurred. Subsequently, reporters found cases from where patients died of diseases that should have been treated earlier.

On November 12, 2020, the DHCS Managed Care Quality and Monitoring Division (MCQMD) requested a special focused review of the Plan's oversight process of LA DHCS. MCQMD's review of submitted Corrective Action Plans (CAP) and improvement plans indicated the Plan's oversight was insufficient and the delegates' documentation did not reflect the needed remediation.

DHCS conducted a focused review of the Plan's delegation oversight of LA DHCS and their collective compliance with applicable federal and state laws, Medi-Cal regulations and guidelines, and the State contract related to Utilization Management, Access and Availability to Care, Members Rights, and Quality Management.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS focused audit for the period of January 1, 2019 through December 31, 2020. The audit was conducted from February 1, 2021 through February 5, 2021. The audit consisted of document review, verification studies, and interviews with Plan and LA DHCS personnel.

An Exit Conference with the Plan was held on July 29, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the audit report findings.

The audit evaluated four categories of performance: Utilization Management, Access and Availability of Care, Member's Rights, and Quality Management.

The summary of the findings follows:

Access and Availability of Care

The Plan did not effectively communicate and enforce providers' compliance with access standards. The Plan did not ensure CAPs were communicated down to the provider level.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Medical Review Branch conducted this focused audit to ascertain that medical services provided to Plan members through LA DHCS comply with federal and state laws, Medi-Cal regulations and guidelines, and the State contract related to appointment access requirements.

PROCEDURE

DHCS conducted a focused audit of the Plan from February 1, 2021 through February 5, 2021. The audit included a review of the Plan's Medi-Cal contract, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan and LA DHCS administrators and staff.

Samples selected were exclusively from LA DHCS' network. The following verification studies were conducted:

2018 Access Surveys: Eight providers, consisting of four primary care providers and four specialty care providers, were selected from the 2018 Access Standards Noncompliant Provider List to review the Plan's corrective action oversight of LA DHCS.

2019 Access Surveys: 17 providers, consisting of ten primary care providers and seven specialty care providers, were selected from the 2019 Access Standards Noncompliant Provider List to review the Plan's corrective action oversight of LA DHCS.

Provider Directory: Information of ten primary care physicians and ten specialists were reviewed with the Plan's printed and online Provider Directories to verify accuracy.

Call Inquiries: Ten call inquiries related to access and availability were reviewed to verify the classification and investigation process.

Quality of Service Grievances: 15 access-related quality of service grievances were reviewed for investigation, resolution, tracking, and trending access of care issues.

Quality of Care Grievances: Nine access-related quality of care grievances were reviewed for investigation, resolution, tracking and trending access of care issues, and submission to the appropriate level for further review.

Exempt Grievances: 13 exempt grievances were reviewed to verify classification, investigation, and how the cases were used for tracking and trending access of care issues.

The results of the review are outlined in this report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: HEALTH NET COMMUNITY SOLUTIONS, INC.

AUDIT PERIOD: January 1, 2019 through December 31, 2020
DATE OF AUDIT: February 1, 2021 through February 5, 2021

ACCESS AND AVAILABILITY OF CARE

1. Communication and Enforcement of Provider Compliance with Access Standards

The Plan shall 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. *(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. *(CCR, Title 28, section 1300.67.2.1)*

The Plan is ultimately responsible for ensuring their subcontractors comply with all applicable state and federal laws and regulations, contract requirements, reporting requirements, and other DHCS guidance. The Plan must also have policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of noncompliance. *(Managed Care All Plan Letter 17-004, Subcontractual Relationships and Delegation)*

Finding: The Plan did not effectively communicate and enforce providers' compliance with access standards. The Plan did not ensure CAPs were communicated down to the provider level.

DHCS conducted verification studies from a sample of eight noncompliant LA DHCS providers for the 2018 access surveys and 17 noncompliant LA DHCS providers for the 2019 access surveys.

DHCS' verification study of the 2018 access surveys determined no corrective actions were requested for the eight noncompliant providers.

DHCS' verification study of the 2019 access surveys found the Plan investigated and requested corrective actions from their PPG when timely access to care standards were not met. The review identified ten providers where the Plan submitted corrective action requests to the PPG, but Plan could not substantiate that they were communicated to the noncompliant individual providers.

Without implementing effective corrective action, the Plan will continue to have noncompliant providers that results in the delay of necessary medical services to its members.

Recommendation: Ensure communication, enforcement, and monitoring of provider's compliance with timely access standards by ensuring that effective corrective actions are communicated down to all levels of noncompliant providers.