State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

July 23, 2019

Deanna Eaves, Director, Compliance
Health Net Community Solutions, Inc.
11971 Foundation Place, Bldg. D
Rancho Cordova, CA 95670

RE: Department of Health Care Services Medical Audit

Dear Ms. Eaves:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Health Net Community Solutions, Inc., a Managed Care Plan (MCP), from May 21, 2018 through June 1, 2018. The survey covered the period of May 1, 2017 through April 30, 2018.

On July 18, 2019, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on November 6, 2018.

All items have been reviewed and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Full implementation of the CAP will be monitored on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

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

If you have any questions, feel free to contact me at (916) 345-7829 or Anthony Martinez at (916) 345-7828.

Sincerely,

Michael Pank, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Mary Cobb, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Health Net Community Solutions, Inc.

Audit Type: Medical Audit and State Supported Services **Review Period: 05/01/17 – 04/30/18**

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

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

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

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2. Case Management and Coordination of Care				
2.3.1 Timely Access During the interview, the Plan's staff stated that if the Primary Care Physician (PCP) identifies the need for further evaluation then PCP would advise beneficiary to	A Provider Update was sent out to Primary Care Providers (PCPs) to educate them on the referral process of EPSDT-eligible members to Managed Health	Provider Update 18-360_BHT Services for EPSDT Members	Provider Update: 6/1/2018	**12/17/18** – The following documentation supports the MCP's efforts to correct this finding: - Provider update from 6/1/18 informs PCPs of the referral process of EPSDT eligible members identified

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contact customer service for further assistance. However, according to the APL the Plan's PCP is required to coordinate the care for the beneficiary. Therefore, the Plan's process is not compliant with the APL section of a COE requirements to ensure that access to a comprehensive diagnostic evaluation is provided in accordance with timely access standards. The verification study further revealed when CDEs were completed through the Plan, there were at times delays up to two and a half months because the Plan's provider manual and policy and procedures did not include the APL requirements. RECOMMENDATION: Develop a process to provide a COE for qualified beneficiaries within the	Network (MHN) for assessment and referral to a mental health provider. The Plan has updated the MHN policy "EPSDT Services inclusive of BHT" to meet the contractual requirements of timely access to Non-Emergency Health Care. The policy has been updated to include direction that the PCP is responsible for the coordination and referral for EPSDT-eligible members to MHN for assessment. The referrals section of the Plan's Provider Manual has been updated to instruct the PCP to direct all referrals for EPSDT services to MHN for assessment and referral to a mental health provider. The Plan	EPSDT Services inclusive of BHT Provider Manual_Referrals Excerpt	Policy and Provider Manual: 12/6/2018	as needing BHT services to MHN for assessment and referral to a mental health provider. - EPSDT Services inclusive of BHT policy was updated to include that the PCP is responsible for the coordination and referral of EPSDT – eligible members to MHN for assessment. - Provider Manual Referrals Excerpt now states that PCPs are responsible for referring EPSDT –eligible members identified as needing BHT services to MHN for assessment and referral to a mental health provider. **This finding is closed.**

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timely access standard requirements.	coordinates with MHN to manage the behavioral health benefits of Medi-Cal members.			
2.3.2 Eligibility Criteria for BHT Services During the interview, the Plan stated that in their procedure a prescription is a required criterion to initiate BHT services. According to the APL, completion of a COE is a required criteria. Therefore, based on the Plan's procedure the Plan's policy is not compliant with the APL requirements. The verification study confirmed that for the newly identified beneficiaries during the audit period, the Plan utilized a prescription instead of completing a COE. The Plan did not monitor the department responsible for BHT services to ensure that CDEs were completed prior to providing BHT services	The Plan and Managed Health Network (MHN) agree that some files did not contain a CDE as required by APL 15-025. Per APL 18-006, which supersedes APL 15-025, Managed Care Plans must provide access to medically necessary diagnostic and treatment services, including BHT services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist. MHN policies and processes have been updated to adhere to the requirements of APL 18-006. Clinical communications	Admin of ABA Benefit P&P-FINAL MCAL BH Responsibility_ MHN and CA SMHS P&P MHN Medi-Cal ABA Referral Form	Policies: 4/24/2018	**12/17/18** - The following documentation supports the MCP's efforts to correct this finding: - Admin of ABA Benefit P&P's criteria for BHT services has been updated to be compliant with APL 18-006. - Medi-Cal Behavioral Health Responsibility: MHN and California County Specialty Mental Health Plans P&P was updated to state that the completion of the CDE is no longer required, consistent with APL 18-006. - CCP Communication Medi-Cal ABA/BHT Process Update, CCP Communication Regional Center Behavioral Health Transition to MHN_Clinical Communication and Clinical Leadership Committee BHT Transition_Clinical Communication were distributed to to all service

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and the Plan's policy was not compliant with the BHT section of the APL. RECOMMENDATION: Revise and implement policy and procedures for a COE completion in accordance with criteria for BHT services to ensure that eligibility criteria are met for qualified beneficiaries prior to authorization of BHT services.	were distributed to all service center, Clinical Staff and the Clinical Leadership Committee regarding the BHT services outlined in APL 18-006. The Manager of the MHN Autism Center audits at minimum one case per month of each Autism Center Case Manager (CM). Results are reviewed with the CM and the Manager. If cases do not pass audit, CMs are coached and errors corrected. If a CM demonstrates a persistent pattern of failing audits, disciplinary action is taken, up to and including termination.	CCP Medi-Cal ABA Process Updates_ Clinical Communication CCP Regional Center Behavioral Health Transition to MHN_Clinical Communication Clinical Leadership Committee BHT Transition_Clinical Communication	Clinical Communications 7/1/2018 Clinical Leadership Committee: 5/24/2018 Audit Process: 4/1/2018	center, Clinical Staff and the Clinical Leadership Committee to inform them of the BHT services outlined in APL 18-006 **02/19/19** - The following additional documentation supports the MCP's efforts to correct this finding: - MHN ABA Treatment Plan Audit Case Review Tool, MHN ABA Approval Audit Case Review Tool, MHN Denial Authorization Audit Tool lists the criteria used for the auditing of ABA Approvals, ABA Denials and ABA Treatment Plans. - BH MHN Audit results for Approvals, Denials and Treatment Plans from 2018 serve as evidence that MHN cases are being monitored. **This finding is closed.**

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2.3.3 Behavioral Treatment Plan Criteria The verification study medical record review included dates of service after January 2018, which demonstrated the Plan's authorization request form was still missing the required transition plan from the procedure. The Plan did not document all of the required elements and a few of the medical records were missing the required transition plan in their procedure. RECOMMENDATION: Modify the system for the treatment plan authorization process and update the Plan's Authorization Request form to ensure that the behavioral treatment plan meets the requirements of BHT services.	To ensure the treatment plans are complete prior to authorizing services, the Plan and Managed Health Network (MHN) revised the authorization request form used by providers to request BHT services. Upon contacting MHN to initiate treatment, providers will receive the revised form. MHN will not authorize services if the member's treatment plan does not include all of the required criteria, including criteria for discharge, and a transition plan. Care Managers were trained on the revised authorization request form and the desk reference.	Desk Reference MHN AC ABA Treatment Plan Criteria MHN Auth Request Form	11/13/2018	**12/17/18** - The following documentation supports the MCP's efforts to correct this finding: - Desk Reference Autism Center Treatment Plan Review lists the guidelines for reviewing clinical treatment plans from ABA providers requesting ABA services for members. The transition plan is listed as a required element. - Updated MHN ABA Request for Service Authorization form includes check boxes for all elements of a treatment plan including the transition plan. All elements of the treatment plan must be present or MHN will not authorize services. **This finding is closed.**

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4. Members' Rights				
4.1.1 Grievance Process, Appeals and State Hearing Timeframes The Medi-Cal Member Handbook, the Provider Manual, the website related to grievance, and "Your Rights" attachment were not updated to reflect the federal and state requirements in accordance with APL 17-006 for the grievance process, appeals and state hearing timeframes. RECOMMENDATION: Update the grievance process filing timeframes in the Member Handbook, Provider Operation Manual and the Plan's Website. Update the appeals and state hearing filing timeframes in the Member Handbook, Provider Operation Manual and "Your Rights" attachment to comply	The grievance process filing timeframes have been updated in the Member Handbook, Provider Operations Manual and the Plan's Website. In addition, the appeals and state hearing filing timeframes were updated in the Member Handbook and Provider Operations Manual. The Plan continues to use the "Your Rights" attachment that was included in APL 17-006 which states the appeals process filing timeframe is 60 days, and the State Hearing filing timeframe is 120 days.	Your Rights Attachment - DHCS template Provider Operations Manual Excerpt HN Member Handbook Website Screen Shot	Member Handbook and Provider Operations Manual: 6/1/2018 Website: 12/13/2018	**01/14/19** – The following documentation supports the MCP's efforts to correct this deficiency: -Updated Provider Manual reflects current timeframes for filing grievances, appeals and requesting state hearings as required by the updated federal regulations effective 07/01/17. -Updated MCP website that reflects the updated timeframe for filing grievances as required by the new federal regulations effective 07/01/17. -Updated Member Handbook to reflect current timeframes for filing grievances, appeals and requesting state hearings per the updated federal regulations effective 07/01/17. **05/08/19** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency:

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with the federal regulations.				-Revised Member Handbook that updates State Hearing timeframe to 120 calendar days per the Final Rule. **05/20/19** - The following additional documentation submitted supports the MCP's efforts to correct this deficiency: DHCS Technical Assistance: MCP previously submitted Your Rights attachments that appear on the DHCS website, which do not reflect "calendar days" as required by APL 17-006. Directed MCP to update Your Rights attachments to reflect timeframes with "calendar days" as required by the body of the APL. **This finding is closed.**
4.1.2 - Grievance Status Notification Letter The verification study for this audit period identified that the Plan did not always send a notification letter to	The Plan updated the Appeals & Grievances Desktop Procedure "A&G Cases in Excess of Regulated Turn-Around-Times (Interim Letter	Desktop Procedure A&G Cases in Excess of Regulated Turn-Around-Times	11/21/2018	**01/14/19** – The following documentation supports the MCP's efforts to correct this deficiency: -Written response from MCP Desktop Procedure, "A&G Cases in Excess of

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members when a resolution was not reached within 30 days. A review of quality of service grievance files indicated that some grievances were processed beyond the thirty (30) calendar day timeframe from the receipt of the grievance letter. The Plan did not send a notification letter to members with the status of the grievance and the estimated completion date of resolution. RECOMMENDATION: Develop a process to ensure that notification letters are sent on a timely basis to members based on the state regulations and update the policy related to Medi-Cal Member Grievance Appeal Process section related to CCR, Title 22, Section 53858(9).	Process)". An oversight process was implemented for all cases that exceed the 30 calendar day regulatory timeframe. Cases will be audited by a Supervisor or Lead to ensure that the notification letter has been saved to the case file and sent to the member prior to exhausting the regulatory timeframe.			Regulated Turnaround Time Interim Letter Process" in which the supervisor/lead utilizes the live system and the daily summary reports to monitor inventory of all open cases. Cases are physically reviewed to ensure the appropriate notification letters are in the file. If letter is missing, it is immediately addressed with the individual case coordinator. Currently there are no reports or tracking tools document this effort. DHCS provided technical assistance to the MCP recommending they create a tracking log in order to document internal monitoring efforts are being made the ensure the appropriate notifications are being sent. **05/22/19** – The following additional documentation submitted supports the MCP's effort to correct this deficiency: -Updated P&P, "GA 202ML Medi-Cal

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				Member Appeal Process" removed portion of policy referencing members will receive status letters every 14 calendar days until the case is closed. Policy now reflects only the requirements outlined in Title 22 53858. **This finding is closed.**
5. Quality Management				
5.2.1 - Provider Orientation Program Policy and Procedure Provider Orientation Program policy does not specifically state that new provider training will be provided within ten (10) working days after the Plan places a newly contracted provider on active status. RECOMMENDATION: Update Provider Orientation Policy No. COMM-102-HNCA to meet the contract	The Plan has updated "Provider Relations Policy: Medi-Cal Network Provider Training" to ensure all newly contracted providers have completed the new provider training within ten working days of being placed on active status. Training of appropriate staff was completed and the updated policy was submitted to DHCS and is pending approval.	Provider Relations Policy Medi-Cal Network Provider Training	Policy Submitted to DHCS: 10/15/2018 Training: 6/1/2018	**12/17/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "Provider Relations Policy: Medi-Cal Network Provider Training" (09/05/18) which has been amended to include that all New Providers in counties where Health Net is the primary contractor with DHCS, must receive training within 10 business day of being placed on active status (page 1). Also, a Provider Relations Representative will be responsible to document all activities in the New Provider

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requirements.				Database and to store signed Attestation Forms and in-person training sign-in sheets on the Provider Relations SharePoint site (page 4). In addition, the Provider Relations Department will generate weekly reports to ensure training and proof of training are completed within the 10 business day requirement. The Communication and Channel Services Department will generate monthly fulfillment reports, and submit to Provider Relations Department as requested for program metric monitoring (page 4). **This finding is closed.**
5.2.2 - New Provider Training Certificate of Completion The verification study for the current audit period indicated that fourteen (14) new providers declined the new provider training after being placed on active status. The verification study further	In order to ensure training completion is documented for newly contracted providers, the Provider Relations Representative (PRR) will manually input the receipt date of the attestation form and type of training received into the Provider Database.	New Provider Training Attestation Form Provider Relations Policy Medi-Cal Network Provider Training	Process & Form: 6/1/2018 Policy Submitted to DHCS: 10/15/2018	**12/17/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "Provider Relations Policy: Medi-Cal Network Provider Training" (09/05/18) which has been amended to include that the Provider Relations Representative (PRR) will contact the New Provider to confirm

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revealed that the Plan could not provide documentation to demonstrate that new providers were trained within the required timeframe based on the prior year findings. RECOMMENDATION: Continue to develop and implement corrective action plan process to ensure that new providers receive required training per contract requirements.	The updated "Provider Relations Policy: Medi-Cal Network Provider Training" policy was submitted to the DHCS and is pending approval.			receipt of the Welcome-Orientation Packet and conduct training. The PRR is responsible to document all activities in the New Provider Database and to store signed Attestation Forms and in-person training sign-in sheets on the Provider Relations SharePoint site (page 4). - Updated New Provider Training Attestation Form, Confirmation of New Provider Training, as evidence that the plan has documentation to demonstrate that new providers were being trained. **This finding is closed.**
5.2.3 New Providers declining the training The Plan was not compliant with provider training requirement as the Plan did not mandate their new providers to complete the training. Also, the Plan did not have a system or process in place to ensure	The Plan's Provider Relations Department generates weekly reports from the Provider Database to ensure the provider has received training materials and that a signed attestation form has been received from the provider within ten	New Provider Training Attestation Form	Process & Form: 6/1/2018	**12/17/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated New Provider Training Attestation Form, Confirmation of New Provider Training, as evidence that the plan has removed the option for providers to "decline" training.

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new providers received required training as stated in the 2-Plan and GMC Contracts. The verification study disclosed that fourteen (14) new providers declined the new provider training from the sample of sixteen (16) new providers. RECOMMENDATION: Develop, implement and monitor a process to mandate new providers to complete the required training per contract requirements.	working days of being placed on active status. The Plan has modified the New Provider Training Attestation Form to remove the option for providers to "decline" training. In addition, the Plan will document the following in the Provider Database: 1. The date the provider was contacted by the Provider Relations Representative (PRR). 2. Type of training completed (online, in-person, self-study). 3. Attestation receipt date. 4. Any additional provider feedback. If the PRR identifies that the provider did not complete the required training within ten working			- Updated P&P, "Provider Relations Policy: Medi-Cal Network Provider Training" (09/05/18) which has been amended to include that the plan's Provider Relations Department will generate weekly reports to ensure training and proof of training are completed within the 10 business day requirement (page 4). In addition, the Plan will document the following in the Provider Database: • New Provider Active Date • Welcome-Orientation Packet Mailing Date • Dates New Provider was contacted by PRR • Type of Training Completed (Online, in-person, self-study) • Attestation receipt date • Additional New Provider feedback - Written response from the plan (12/17/18) that if the PRR identifies that the provider did not complete the required training within ten working days, the PRR will continue to coach

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	days, the PRR will continue to coach and follow-up with the provider until a signed attestation form has been received.			and follow-up with the provider until a signed attestation form has been received. **This finding is closed.**

Submitted by: Christy Bosse **Date: 12/17/2018**
Title: Vice President and Medi-Cal Compliance Officer