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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

August 31, 2017

Patricia Clarey, Chief State Health & Regulatory Relations Officer
Health Net Community Solutions, Inc.
11971 Foundation Place, Bldg. D
Rancho Cordova, CA 95670

RE: Department of Health Care Services Medical Audit

Dear Ms. Clarey:

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 23, 2016 through June 3, 2016. The survey covered the period of May 1, 2015 through April 30, 2016.

On August 28, 2017, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on March 22, 2017.

All items have been reviewed and found to be in compliance. The CAP is hereby closed. 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) 552-8946 or A.J. Martinez at (916) 552-8716.

Sincerely,

Jeanette Fong, 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: 05/01/15 – 04/30/16**

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.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
1.2.1: Patient-specific language on pharmacy prior authorization denials. Prior authorization denials did not contain clear, concise and patient-specific language. The verification study identified several instances where the clinical guidelines were cited to document the reason for denial. The clinical guidelines contained medical jargon and did not exhibit the clear and concise language necessary to meet the requirements for notifying member.	To correct this deficiency, Health Net will make process improvements in the oversight and monitoring process for language used in member denial letters. Health Net will: 1) Conduct re-training of Prior Authorization (PA) staff on using clear and specific language in member denial letters. 2) Implement oversight of the PA department through a quarterly review of 30 PA denials issued for readability, denial language specificity, and required denial elements.	Medi-Cal Internal Audit Desktop.pdf	1. Targeted Completion date: 5/15/2017 2. First review completed on 3/28/2017 3. Annual review completed on 3/28/2017	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: -Updated desktop procedure, "Medi-Cal Internal Audit and Oversight of Medi-Cal Prior Authorization Reviews" (03/28/17) which describes the plan's process for conducting quarterly internal audits of prior authorization files and an annual review of denial language during Q3 of each year to ensure readability. **05/05/17 –** The following documentation supports the MCP's efforts to correct this finding: -Audit Report, "Q1 2017 PA Denial File Review" (05/05/17) as evidence to show oversight of the PA department through a quarterly review of 30 PA denials issued for readability including but not limited

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Recommendation: Document the reasons for the denials in clear and concise language that includes the patient-specific reasons for the denial.	3) Implement annual review of standard language used in member denial letters to ensure readability and clear and concise language with specificity.			to clear and concise language, member-specific denial language, and the presence of medical jargon. For non-compliant files follow-up action is indicated. **05/17/17 –** The following documentation supports the MCP's efforts to correct this finding: - PowerPoint training, "Plain Language 101: Composition" (05/17/17), sign-in sheets, desktop procedures, "Clear and Simple" language tips document, and copy of email communications sent to staff as evidence that Prior Authorization (PA) staff received re-training. The training materials address using clear, concise, and patient-specific reasons in the denial letters. **This finding is closed.**
1.3.1 Tracking and monitoring of open and unused referrals and timely completion. The Plan did not track and monitor open and unused referrals in a timely manner. The Plan uses claims data to follow the referrals but these only measures the closed or used referrals. There are no reports to assess the timeliness of the referrals. Out of network referral reports are tabulated on a quarterly basis to identify shortages but there is no report to demonstrate whether the member was seen within the timeliness standards. These were no in-network reports to	Health Net will be taking the following steps to improve monitoring and tracking of the unused specialty referrals that require prior authorization: 1) Increase member awareness of approved authorization by issuing approval letters. This will trigger the member to reach out to the specialist to set up the appointment. 2) Review random selection of 30 OON specialty referral approvals each month to ascertain the authorization has been used. The Outreach Team will conduct outbound calls to provider/member to validate the date when the authorization was used or find out why an authorization was not used. The Outreach Team will also ask about the wait time to get an appointment. Case Management assistance will be provided if		1) Targeted Implementation dates: Develop Member Approval Notification Letter by 6/1/2017 Obtain DHCS approval of Member Approval notification Letter by 6/15/2017 Begin issuing Member Approval Notification Letters by 6/30/2017 2) Targeted Implementation date: Q3 2017 3) Targeted	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: -Written response (05/01/17) indicating the following milestones for issuing authorization letters to members to increase the likelihood that members follow-up with referrals to make their appointments: • 06/01/17 – Develop notice • 06/15/17 – Obtain DHCS approval • 06/30/17 – Begin use of notice -Written response (05/01/17) indicating that beginning Q3 2017, the plan will conduct monthly audits of 30 OON specialty referral approvals to assess whether the authorization was used and how long it took to get the appointment. -Written response (05/01/17) indicating that on a quarterly basis a reconciliation of claims data against

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track specialty referral within the network. **Recommendation:** Improve a referral tracking system to track and monitor all referrals and the timeliness of the referrals.	barriers to access of care were identified. 3) Conduct quarterly reconciliation of claims data to open authorizations to identify actionable trends. To address any increases in unused authorizations, targeted interventions will be established. Each quarter 50 unused authorizations will be reviewed for this purpose.		Implementation date: Q3 2017	open authorization will be conducted to identify trends. Each quarter 50 unused authorizations will be reviewed. **This finding is closed.**
1.5.1 Oversight of the Delegated Functions. The Plan did not have a systematic method to detect under and over utilization of services within prior auth denials. Denials were not reviewed to ensure proper denial of services. **Recommendation:** Implement an oversight process of the delegated entities including detection for potential under-utilization of services.	Health Net will develop and implement a Semi Annual Denied Auths Report to review denials by delegated group to detect any patterns. a. Develop work plan and timeline (see embedded targeted dates) b. Hire staff c. Develop spreadsheet with data dictionary/definitions for data gathering; develop data analysis plan d. Develop communication plan to notify PPG of required data submission e. Complete analysis on submitted data f. Produce report g. Report results to Delegation Oversight Committee – include outliers in QI Committee/BOD report h. Improvement activities with PPGs to include focused education on requirements and best practices. **06/16/17 Updated Response:** Heath Net has traditionally reviewed overturn rate volumes at the book of business level and looked for spikes in volume when compared with historical norms as a potential indicator of upstream risk. We recognized based on audit discovery that it was	Work Plan: Workplan for Auth_Denials rev_4.26 Job Requisitions for Manager, Trainer, and Analyst: Manager Delegation Oversight_JD.pdf Provider Trainer_JD.pdf Business Analyst III_JP.pdf Draft Communications for PPGs:		**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: - Draft P&P, "Specialist and % Authorization Denied Reports" (05/01/17) which outlines the process of collecting data from delegated provider groups. The plan will obtain data regarding specialist referrals and denials. These results will be reported to the Delegation Oversight Committee will include outliers in the QI Committee Report. Updated MCP response on 06/16/17 indicates that P&P will be completed by the end of this month. - "Auth Denials 2017-2018" work plan that was created to address this finding. The work plan includes set milestones for activities including but not limited to: hiring of staff, communication with PPGs of required data submissions, analysis of data (denials), reporting to the Delegation Oversight Committee. - Three job descriptions (Manager Delegation Oversight, Provider Trainer, and Business Analyst III) as evidence that the plan is in the process of completing milestones indicated on the work plan and are in the process of hiring new staff to oversee delegated processes. - Draft letter templates to Participant Provider Groups

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	necessary to improve our efforts in this area and have initiated the First Level Appeals Review (FLAR) Committee. The FLAR Committee will evaluate appeal cases and overturn uphold rates, looking at appeal decision making with the goal of increasing Health Net's (and delegated entities) consistency and quality of both initial utilization management decision-making and resulting appeal issue determinations, with the ultimate purpose of assuring benefited and medically necessary services are consistently provided to our enrollees and insured. The Committee is responsible to the Health Net Quality Improvement Committee and chaired by an appointee of the Chief Medical Officer. The Charter has been completed and we will be seeking acceptance in the first committee meeting scheduled for 6/20.	Specialist Referral_Draft Provide Percent Denied Auths Report_Draft Provider Draft P&P "Reporting on Denial Rates and Specialist Referrals for Delegated PPGs: Draft P&P Specialty Referrals and % Auth.		(PPG) as evidence that the plan is on track for completing milestones in the work plan. The letters demonstrate the plan is drafting notices to request information from PPGs regarding specialist referrals and denials. **05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: - Written response (06/16/17) indicating that the plan has initiated the First Level Appeals Review (FLAR) Committee. This committee will evaluate appeal cases and overturn uphold rates, looking at appeal decision making with the goal of increasing Health Net's (and delegated entities) consistency and quality of both initial utilization management decision-making and resulting appeal issue determinations. - Charter document, "First Level Appeals Review Committee" (06/16/17) indicating the scope, functions, report distribution, line authority, and membership of the committee. The plan will be seeking acceptance in the first committee meeting scheduled for 06/20/17. **This finding is closed.**
2. Case Management and Coordination of Care				
2.3.1 Provision and coordination of medically necessary services such as dental anesthesia for Early Start and Developmentally Disabled members. The Plan did not fulfill its responsibility in facilitating provision and coordination of	Ongoing efforts have been undertaken prior to and during the audit period to improve interaction and coordination with providers and Regional Centers, including focus on dental anesthesia services. These efforts include the following: 1) Public Programs coordinated a Regional Center meeting on June 29, 2016 to address greater coordination of dental anesthesia and	**1) L.A. County Regional Centers Quarterly Meeting Agenda**	1) Meeting Agenda: 06/29/2016	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: - Los Angeles County Regional Centers and Health New Quarterly Meeting Agenda (06/29/16) to indicate that dental anesthesia and IV sedation has been discussed. - Regional Center Trackers (2015-2017) as evidence to of ongoing communication between the plan and various local Regional Centers. The tracker documents

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medically necessary services for Early Start and Developmentally Disabled Members. This is an ongoing finding. The 2014 CAP states: "Public Programs will establish a liaison for each of the Regional Center in the Health Net counties to be point of contact and facilitate health plan and PPG services required by a Regional Center consumer, for example dental anesthesia.". While the Plan Liaison and Public Programs Administrator are currently making efforts to increase direct interaction with the Regional Center, a review of the documents that were submitted by the Plan to close the prior year's deficiency did not address the specific problem of dental anesthesia. Evidence exists that general anesthesia during dental exams is still being denied. **Recommendation:** Monitor and continually improve systems to increase direct interaction with the local Regional Centers to facilitate care coordination and resolve operational, administrative, and policy issues, specifically as it pertains to dental anesthesia	IV sedation between the plan and Regional Centers in Los Angeles County (agenda attached). 2) Ongoing communication regarding coordination with the Regional Centers is documented via the Regional Center Communication Trackers. Care coordination requests and outcomes are documented by Public Programs Liaisons. To continue improving services for the Regional Center member, an end-to-end process flow in collaboration with relevant departments is being undertaken with the following goals: 1) Audit dental anesthesia reports to understand reasons and appropriateness for denials. 2) Implement monitoring and oversight for denials. 3) Use results of audit process to educate and train providers. As of 4/27/17 documentation of the process flow will be conducted through a series of scheduled meetings with internal departments, including but not limited to, Public Programs, Contracting, Utilization Management, Delegation Oversight and Fee Negotiation.	LA County Regional Centers Quarterly Mee **2) Regional Center Trackers:** 2015 - 2017 Regional Center Trackers.xlsx	2) Ongoing **Process Flow Meetings Schedule**: **04/27/2017** 4:00 PM - 5:00 PM **05/02/2017** 11:00 AM - 12:00 PM **05/02/2017** 1:00 PM - 2:00 PM **05/04/2017** 4:00 PM - 5:00 PM **05/09/2017** 9:00 AM - 10:00 AM **05/09/2017** 1:00 PM - 2:00 PM	issues discussed between the plan and Regional Center representative and includes the outcome of the discussion. - Written response (05/01/17) indicating that the issue of dental anesthesia is additionally being addressed through the auditing of dental anesthesia, analysis of denials, and education and training of providers. The plan also provided a schedule of meetings conducted internally with other departments to go over the audit process. **This finding is closed.**

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3. Access and Availability of Care				
3.4.1 Monitoring and tracking of specialists within the Plan's network. • The Plan did not maintain an adequate number of specialists within its network. • Monitoring and tracking of specialists within the Plan's network was not done. • Member grievances on referral for services and availability of appointments with specialists were among the highest complaints. **Recommendation:** Monitor and track all specialty care accessibility within the Plan's network.	1. The Plan created and reviewed a Geo Access report by county of the network as of Q4 2016 for the following specialties: Dermatology Endocrinology Hematology/Oncology Neurology Orthopedic Surgeon Otolaryngology Rheumatology The report was created based on the access standard of 30 miles or 60 minutes and using 100 data points per zip code in the Plan's 7 Medi-Cal counties. Please see the attached results. • There are no deficiencies in Endocrinologists or Orthopedic Surgeons in any of the counties. • The following counties had no deficiencies for any of the specialties listed above. Los Angeles Sacramento San Diego San Joaquin • Both Stanislaus and Tulare were lacking for Rheumatology. The shortages were felt throughout the counties. Areas of issue are remote areas of the county. • Kern County fell just below 90% in 5 of the specified specialties:	Q4 2016 MediCal Specialty Access Analysis: 4Q 2016 MediCal Specialty Access Analy	1. Q1 2017	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: - Report, "Quarter 4 2016 Medi-Cal Specialty Access Analysis" (05/01/17) indicates the plan tracking access to seven specialties through geo access analysis on a quarterly basis. The report measures compliance with the time and distance standard per county. If any specialties are below 90% access in any county, the results will be shared with the Provider Network Administrators and Regional Directors for those counties to work with the Medical Groups to increase access. If the plan's network of providers is unable to provide necessary medical services covered under the Plan's Medi-Cal contract to a particular member, the plan will cover these services out-of-network for the member. - Written response (05/01/17) indicating that PPGs were issued CAPs during 11/03/16 – 02/09/17 based on PPGs that were identified as non-compliant with the MY 2015 PAAS. The plan issued 55 CAPs, with only 12 remaining that will be monitored for closure. - "PPG Access Grievances Report" (05/01/17) as evidence that the plan is monitoring and tracking member grievances related to access of care. Grievances are broken down by provider and grievance type. Data is analyzed quarterly and reported to the PPGs. PPGs are notified of their grievance volumes and asked to provide feedback on trends. **05/17/17 –** The following documentation supports the MCP's efforts to correct this finding: - Two sample CAPs issued to non-compliant PPGs

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	Dermatology, Hematology, Neurology, Otolaryngology and Rheumatology. The zip codes where most deficiencies were located are remote parts of the county and enrollees often must travel for specialty care: Boron - 93516 & 93596 Cantil - 93519 Onyx - 93255 Pine Mountain Club - 93222 Weldon - 93283 Tehachapi – 93581 Health Net will continue the geo access analysis on all required specialties on a quarterly basis. If any specialties are below 90% access in any county, the results will be shared with the Provider Network Administrators and Regional Directors for those counties to work with the Medical Groups to increase access. If Health Net's network of providers is unable to provide necessary medical services covered under the Plan's Medi-Cal contract to a particular member, Health Net will cover these services out-of-network for the member. Based on the MY 2015 Provider Appointment Availability Survey (PAAS) results, HNCS identified a total of 55 out of a total of 84 PPGs that failed to meet one or more timely appointment access or after-hours metrics per internal goals (see attached Excel spreadsheet). PPGs were issued Corrective Action Plans during	Appointment Accessibility for Commercial & SHP (Medi-Cal) – P&P: Appt Accessibility.pdf	2. PPG CAPs: 11/3/2016 – 2/09/2017	(02/09/17) as evidence that the plan is monitoring and tracking specialty care accessibility. The CAPs include the CAP request letter, detailed instructions, guidelines for compliance and monitoring, and the completed CAP submitted by the PPG. -A sample email and corresponding grievance report sent to a PPG (02/16/17) as evidence that the plan provided the PPG with an analysis and breakdown of access related grievances received from the plan and noted trends. **This finding is closed.**

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	11/3/2016 through 2/9/2017 in accordance with "P&P AJ101-103034: Appointment Accessibility for Commercial and SHP (Medi-Cal)". Of the 55 CAPs issued, only 12 remain open and will be monitored to closure. 3. The MY 2015 Provider Appointment Availability Survey (PAAS) included the following high-volume specialty types: Allergy, Cardiology, Dermatology, Gastroenterology, Gynecology, Hematology, Nephrology, Neurology, OB/GYN, Oncology, and ophthalmology. In MY 2016 PAAS the following high-volume and high-impact specialty types were surveyed: Ophthalmology, OB/Gyn, Gastroenterology, Podiatry, Nephrology, Neurology, Hematology, Urology, Otolaryngology (ENT), Physical Medicine Rehab, Rheumatology, Oncology, and Gynecologic Oncology. These specialists were identified by the health plan as practitioners that are most likely to provide services to the largest segment of our membership based on our claims and encounter data. In addition to high-volume specialists identified in 2015 and 2016, Health Net will include orthopedics, endocrinology and endocrine & pain management specialists in the MY 2017 PAAS survey. As outlined in the PPG Access Grievances Report description, member grievances related to access to care Quality of Services (QOS) are analyzed quarterly and reported	Medi-Cal MY 2015 PAAS Results: MY2015 MCal PAAS.xlsx PPG Access Grievances Report Description:	3. MY 2017 PAAS: 8/22/2017 – 11/30/2017 4. PPG Grievance Reports: 4/1/2016	

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	to the PPGs. Outlier PPGs are notified of their grievance volumes. PPGs are asked to review the reports and provide feedback on actions that will be taken to reduce grievance volume. Sample report attached.	PPG Access Grievances Report Sample PPG Report: SHP Access Grievance Q1-Q4_ Heritage Provi		
3.4.2 Develop a specialist directory in written form for members to access specialty care providers. **Recommendations:** Develop a specialist directory in written form for members to access specialty care providers	To maintain a written specialist directory, the Plan added specialists to the Medi-Cal hard copy provider directories to comply with Health and Safety Code section 1367.27(h). a. The Health Net Los Angeles Medi-Cal hard copy provider directory was submitted to DHCS on 8/31/16. b. The Health Net Sacramento Medi-Cal hard copy provider directory was submitted to DHCS on 9/9/16. c. The Health Net San Diego Medi-Cal hard copy provider directory was submitted to DHCS on 10/05/16. d. The Health Net Central Valley (Kern, San Joaquin, Stanislaus, and Tulare) Medi-Cal hard copy provider directories were submitted to DHCS on 4/5/17. e. Revised NPL policy SK416-155828 Medi-Cal Provider Data Verification and Provider Directory Review to include specialists.	a. DHCS Submission Email_Los Angeles DHCS Submission Email_Los Angeles.pdf b. DHCS Submission Email_Sacramento DHCS Submission Email_Sacramento.pdf c. DHCS Submission Email_San Diego DHCS Submission Email_San Diego.pdf d. DHCS Submission Email_Central Valley DHCS Submission Email_Central Valley.p	a. Completed: 8/31/16 b. Completed: 9/9/16 c. Completed: 10/5/16 d. Completed: 4/5/17 e. Completed 12/13/16	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: - Copies of various email submissions to DHCS (08/31/16; 09/09/16; 10/05/16; 04/05/17) as evidence that the plan has added specialists to the Medi-Cal hard copy provider directories. - An email from the Plan Contract Manager (05/16/17) which confirms that the plan has added specialists to the Medi-Cal hardcopy provider directory (Kern, Tulare, Stanislaus, San Joaquin, LA). **This finding is closed.**

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		e. SK416-155828 - Medi-Cal Provider Data Verification and Provider Directory Review		
3.6.1: Availability and accessibility of after-hours nonemergency pharmacy services in all counties. **Recommendations:** Establish and document in the Provider Directory the availability and accessibility of after-hours nonemergency pharmacy services in all contracted counties. Establish the availability of after-hours non-emergency pharmacy services to cover Kern and Stanislaus Counties	During the exit conference, finding 3.6.1 was described in two parts. First, a section of the pharmacy provider directory was described to be published with inaccurate data, and second, the auditor noted a lack of 24-hour pharmacies in Kern County. **Pharmacy Provider Directory** 1. Pharmacy Network Vendor (CVS Health) will conduct an annual review of its California pharmacy directory listing in accordance to the California Health and Safety Code, Section 1367.27. 2. Pharmacy Network Vendor (CVS Health) will remind 24-hour pharmacies that are based in California of their obligation to notify CVS Health immediately of any changes to its listing in the directory (e.g., hours of operation, location, etc.). 3. Pharmacy Network Vendor (CVS Health) will notify Health Net of all directory changes on a monthly basis via a pharmacy network file. This notification will include the pharmacies that will no longer be open 24 hours. The directories will be updated to include these changes. a. Upon receipt of each month's pharmacy network listing, perform quality check of provided pharmacy network listing and log the completion of the 24-hour	CVS Caremark P&P DOC-051625: CVS Caremark P&P DOC-051625.pdf CVS Caremark P&P DOC-051876: CVS Caremark P&P DOC-051876.pdf CVS Caremark Pharmacy Update_FINAL 03 14 2017: CVS Caremark Pharmacy Update_FIN CVS Caremark Pharmacy Update_FINAL 12 21 2016: CVS Caremark Pharmacy Update_FIN		**05/16/17 –** The following documentation supports the MCP's efforts to correct this finding: -Provider Directory (Kern County, Volume 2, 2017) which includes all contracted pharmacies within Kern County. The directory does not display pharmacies outside of Kern County. All pharmacies include posted hours, including those with after hours. **07/28/17 –** The following documentation supports the MCP's efforts to correct this finding: -Written response from MCP clarifying that CVS Caremark sends a monthly pharmacy "274" file that is loaded into their systems. This pharmacy data is used to create the Health Net Community Solutions provider directory, which has been provided to the Department. **This finding is closed.**

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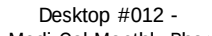
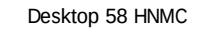
	pharmacy review. b. Upon receipt of each month's pharmacy network listing, audit a selection of pharmacy listings to ensure accuracy of the information provided. 4. The provider directory to include only pharmacies located within the designated county; remove pharmacies that were included because the pharmacy was located within 10-miles of the county line. All required changes will result in an update to the provider directory. **24-Hour Pharmacies** After further review, Health Net would like to request the Department's reconsideration of the second part of this finding asserting that the lack of 24-hour pharmacies is a violation. The DHCS contract language states: "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 including, but not limited to the California State Board of Pharmacy Laws and Regulations, Title 22 CCR Sections 53214 and 53854 and Title 16, Sections 1707.1,1707.2, and 1707.3. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and provider manuals of the Contractor. Health Net complies with the requirement to make arrangements for after-hours nonemergency	Desktop #012 - Medi-Cal Monthly Pharmacy Listing Review 12142016 (sig):  Desktop #012 - Medi-Cal Monthly Phar Desktop 58 HNMC Pharmacy Directory Creation and Review (sig):  Desktop 58 HNMC Pharmacy Directory Cr		

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	pharmacy services by making available by telephone information regarding the availability, location and hours of operation of after-hours pharmacies." Additionally, title 22 CCR § 53854 states the following: "(a) Each plan in a designated region shall at a minimum, make available to members during the hours of operation of each member's primary care service site, either directly or through subcontracts, the services of pharmacies and pharmacists in accordance with title 22, CCR, section 53214. (1) Pharmaceutical services shall, at a minimum, be available to members during established service site hours. (2) When the course of treatment provided to a member by a contracting provider under emergency circumstances requires the use of drugs, a sufficient quantity of such drugs will be provided to the member to last until the member can reasonably be expected to have a prescription filled. (3) Plans shall establish and document the availability of after-hours non-emergency pharmacy services. Plans shall make available by telephone information regarding the availability, location and hours of operation of pharmacies providing such services." And finally, title 22 CCR § 53214 states: "… (a) Each plan shall provide, either directly or through subcontracts, the services of pharmacies and pharmacists. Such pharmaceutical services shall be available to members during reasonable hours as specified in the contract."			

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	The regulations above indicate that pharmaceutical services shall, at a minimum, be available to members during established service site hours defined as the “hours of operation of each member's primary care service site”, with which the Plan complies. Additionally, the Plan also complies and publishes a directory of pharmacies available after hours for nonemergency services (i.e, pharmacies open from 8am to 9pm). Health Net complies with the requirement to make arrangements for after hours nonemergency pharmacy services by making available by telephone information regarding the availability, location and hours of operation of after hours pharmacies Due to the existence of the above processes believed to be in compliance with relevant state requirements, evidenced by the provided documentation attached, the Plan requests reconsideration of this deficiency.			

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4. Members' Rights				
4.1.1 Medical Director's oversight on quality of care grievances. Implement a process to have the Medical Director review all quality of care grievances.	1. To improve the Plan's appropriate identification and evaluation of quality related cases, the following changes have or will be made by internal Plan departments and the Peer Review Committee ("PRC"): a. To ensure all quality of care ("QOC") and PQI cases are properly leveled and reviewed by a medical director, 100% of cases are sent to the Health Net A&G medical director for review and leveling. This process was implemented on July 7, 2016. b. The Plan developed an escalation process for the clinical A&G staff to use when medical records have not been received timely for case completion from rendering providers. Targeted implementation date was on February 14, 2017. Additionally, Clinical A&G Staff and Medical Directors will be instructed that cases with insufficient clinical information cannot be defaulted to "Level 0". If failure to provide information persists, the case must be assessed with the information available and leveled appropriately.		a. Completed on 7/7/16 b. Completed 2/14/17	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: - Written response (05/01/17) indicating that 100% of cases are sent to the Health Net A&G medical director for review and leveling. - Written response (05/01/17) indicating the Plan Quality Department will conduct remedial and ongoing training for the Plan Appeals & Grievances ("A&G") clinical staff and medical directors which commenced in March 2017. This is to ensure that there is an appropriate understanding of grievance leveling criteria **05/25/17 –** The following additional documentation supports the MCP's efforts to correct this finding: - PowerPoint Training, "Clinical Appeals & Grievance and Peer Review Response to DMHC/DHCS CAP" (May 2017) and corresponding rosters (04/11/17; 04/19/17) as evidence that clinical staff were trained on this finding. The PowerPoint indicates that the root cause for this finding was staffing and attempts to improve TATs. However, effective July 7, 2016, all cases are reviewed by an A&G MD. In addition, 4 out of 5 Clinical Staff open positions have been filled (slide 3). **This finding is closed.**

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	3. To ensure that there is an appropriate understanding of leveling criteria, tools, and documentation standards, the following activities will be conducted: a. The Plan Quality Department will conduct remedial and ongoing training for the Plan Appeals & Grievances ("A&G") clinical staff and medical directors which commenced in March 2017.		a. Completed 3/2017	
4.1.2 Documentation of additional investigations or referrals in the member's grievance files. The plan did not document in the grievance files to show that further investigations or referrals were completed. There was no documentation in the grievance file to show that a follow-up referral was completed or that further investigation or action was performed. The Plan did not have a mechanism in place to document that referrals and/or investigations were completed and documented in the grievance files. Plan's processes did not include controls to ensure follow-up referrals were close. **Recommendation:**	Follow-up referral requests for clinical and non- clinical from A&G Medical Directors are captured in the case file. The Clinical Staff will be accountable for sending all clinical and non-clinical A&G Medical Director's request for further action to the Clinical A&G manager. The requests will be documented on the Clinical A&G's "Peer Review Tracking" tool and forwarded to the peer review team for action. The peer review team receives all referral requests for clinical and non-clinical in order to have a central department that is responsible for tracking and monitoring actions and closure. The peer review team logs requests from A&G MDs in the Peer Review "Advisement & Further Action" tool. The requests are triaged to the appropriate department for referrals or for further investigation (action) and captured on the log. Once the case is ready to be closed, the Clinical A&G team will track in the Peer Review "Advisement & Further Action" log that the referrals or investigations have been	Clinical A&G and Peer Review Training Final April 2017: Clinical A&G and Peer Review Training Final Clinical A&G_Peer Review Team Tracking Desktop 4_13_17: Clinical A&G_Peer Review Team Tracking Peer Review Tracking Tool (without PHI): Peer Review Tracking Tool (without PHI).xls› Peer Review's	Implementation Dates: Training was conducted on 4/11/17 & 4/19/17	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: - PowerPoint Training, "Clinical Appeals & Grievance and Peer Review Training" (April 2017) as evidence that clinical staff received training. The PowerPoint indicates that the root cause for this finding was that RNs were not consistently reviewing the follow-up requests of the A&G MD. When follow-up did occur, it was not being documented in the case to show closure. The clinical A&G manager developed and is managing a tracking document that captures all A&G MD requests to ensure documentation in full (slide 5). - Desktop procedure, "A&G Clinical and Peer Review Team Follow Through Desktop" (undated) indicating that the plan will ensure requests for further action on grievances cases will be tracked by the A&G Clinical team and forwarded to the Peer Review team for tracking, action, follow-up and closure in case file. - "Advisement & Further Action log" (02/17/17-03/27/17) and "Peer Review Tracking Tool" (2017) as evidence that the plan will ensure that referrals or investigations have been documented in the grievance case files as completed and closed.

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Implement documentation in the grievance files to show that referrals or investigations have been completed.	documented in the grievance case files as completed and closed.	Advisement & Further Action Tracking documents 2017: ADVSMNT LTTR and FRTHR ACTN LOG 201		**This finding is closed.**
5. Quality Management				
5.1.1 Reporting of quality improvement activities to the Board of Directors Implement a process for written reports to communicate the identification of quality improvement activities from the respective committees: Credentialing, Peer Review, Delegation Oversight, Compliance and Utilization to the Board of Directors.	Actions of the Quality Improvement/Utilization Management committee are regularly presented to the Board of Directors. Steps will be taken to more clearly identify the report as QI/UM Activities from the QI Committee. Quarterly reports presented by the HNCS UMQI subcommittees to the UMQI Committee will also be provided to the Board. This standing report will be called Quality Improvement Activities update and include key activities from the quarter that demonstrate quality monitoring and outcomes. Input will come from VP, Delegation Oversight and the Director of Clinical support Services for Credentialing and Peer Review. The Q4 2016 and Q1 2017 Delegation Oversight reports (including Credentialing) to the UMQI committee and Board are provided as examples.	Q4 2016 Delegation Oversight Report: Q4 2016 Delegation Oversight report to QI Q1 Delegation Oversight Report: Q1 2017 Delegation Oversight report to QI	Implementation Date: Q2 2017	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: - Reports, "Quarter 4 2016 Delegation Oversight Report to QI" and "Quarter 1 2017 Delegation Oversight Report to QI" (05/01/17) as evidence that the plan's QI committee is demonstrating regular reporting of delegation oversight and credentialing to the Board of Directors. - Board of Directors Meeting Minutes (09/13/16; 12/12/16; 03/21/17) which include documented review and discussion of QI reports and activities. MCP's written response further indicates as of 2017, the BOD reviews a Compliance report at each quarterly Board meeting. Compliance reports were also attached (Q4 2016; Q1 2017). - Medical Management Quarterly Reports (2016) to the Board of Directors as evidence of reporting to the BOD in regards to quality improvement, credentialing, compliance, utilization, delegation oversight, and peer review. **This finding is closed.**

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5.1.2 Documentation of quality improvement activities in Member Appeals and Grievances. The Plan generates monthly Appeals and Grievance reports and has performs aggregation and analysis of the causes for the appeals and grievances. There is no documentation to demonstrate the implementation of quality improvement activities on member appeals or grievances. Further, there was no evidence to demonstrate corrective actions. **Recommendation**: Document the interventions following aggregation and analysis for Member Appeals and Grievances.	The Plan acknowledges that while tracking and trending of member appeals and grievance data has been in place, the follow-up on such data has not been clearly documented. When trends are identified, the trended data is communicated to business areas to address. Owners quality improvement projects that target resolution of this trended data will now be invited to present their ongoing work at the Health Net Community Solutions QI Committee. The activities conducted by business areas to improve results will be captured. For PPG related trends, the Provider Engagement Team (PEPM) team meets quarterly with the each region's Medical Directors and representatives from various business areas. These meetings are held to discuss actions to improve PPGs performance. The Committee will request that an update be given at the HNCS UMQI Committee regarding actions taken so that these activities can be captured in the minutes. Of particular importance is the oversight of trended data related to Quality of Care Grievances. The Peer Review team works with practitioners and providers to collect and review any quality improvement activity initiated by the Peer Review Committee. Results of CAP implementation are presented again to the Peer Review Committee for final approval and closure. CAPS that are approved for final closure by the Peer Review Committee are entered into the "Advisement	5.1.2 TAB 000 - HN Community Solutions UMQI Agenda 05.11.17 5.1.2 TAB 000 - HN Community Solutions I Clinical A&G and Peer Review Training Power Point: 5.1.2 Clinical A&G and Peer Review Trair 5.1.2 Peer Review Agenda - Provider	May 2017 Implementation Dates: Training was conducted on 4/11/17 & 4/19/17	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: -UM/QI Committee Agenda (05/11/17) as evidence that the Appeals & Grievance report is reviewed by the committee as a standing agenda item. - Peer Review Committee Agenda (04/28/17) indicating that the plan reviews quality of care grievances and CAP implementation for specific providers are presented. **08/28/17 –** The following documentation supports the MCP's efforts to correct this finding: - UM/QI Committee meeting minutes (02/09/17; 05/11/17) as evidence that MCP reviews and discusses the Appeals & Grievances Report. The minutes included documented discussion of topics such as compliance turnaround times, overall appeal volume, appeal overturned rates, top grievances observed, quality of service grievance trends, etc. **This finding is closed.**

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	& Further Action log and forwarded to the Clinical A&G department for entry into the grievance case file. CAPS that fail to meet Peer Review Committee approval will be acted upon based on the situation and final outcomes will be entered into the "Advisement & Further Action" log and forwarded to the Clinical A&G team for entry into the grievance case file.	Compliant Report 5.1.2 Peer Review Agenda - Provider Cor		
5.2.1 Training of newly contracted providers and tracking of online training participation. Develop and implement procedures to ensure that providers receive training within ten working days of being placed on *active* status and track provider's participation in online trainings.	Health Net developed a Policy, (GR 106-135753), which was approved by DHCS on June 22, 2016, and implemented the process of contacting newly contracted physicians within 10 days of being placed on active status. The Policy states "Provider Relations is *required to follow-up with newly contracted Medi-Cal providers* within 10 days..." Health Net follows the process as set forth in this policy. To address this finding, Health Net's systems will be programmed to track the completion of on-line provider training no later than Q1 2018. Until such time as the website is updated, Health Net will add a "Successfully Completed" certificate to the end of the training for the provider to print and return either via fax to Provider Relations or hand delivery to the assigned Sr. Provider Relations Representative. This process will be implemented by August 2017.	Policy GR 106-135753: Provider Relations Policy_New Provider T	Implementation Dates: Printable Certificate – August 2017 Programming - End of Q1 2018	**05/01/17 –** The following documentation supports the MCP's efforts to correct this finding: -Existing Policy #GR 106-135753, "Provider Relations Policy: New Provider Training – Medi-Cal" (10/09/14) which gives providers the option of completing in-person or online training. - Written response (05/01/17) that the plan's systems will have the capability of tracking on-line provider training no later than Q1 2018. In the meantime, a certificate of completion is required for the providers to print and return to verify training completion. This process will be implemented by August 2017 - Written response (07/25/17) indicating that the plan is requiring the submission of the certificate from every provider who has completed the training online, and is tracking the completion in the plan's database. The Plan is currently working with the Web team to generate a report listing of any provider who opted for online training but subsequently did not complete it. The Plan will then follow up with these providers. This report is estimated to be completed by 12/31/17. In order to address providers who don't do online training, the plan's outreach to new providers includes an opportunity to schedule an in-person training. If the provider declines, the provider is referred to the

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				online training module, and follow-up will occur within 5 days to ensure they actually took the training. For those providers who did not complete the training, the plan will schedule an in office training. - Sample report, "Tracking Report" (07/25/17) as evidence that the plan has implemented an oversight process to track new providers who have completed in-person training. This tracking sheet includes the providers who were contacted, trained, dates of active status, dates of sent and received welcome packets, and completion date of training. **This finding is closed.** **DHCS will continue to monitor status on implementation and progress during the next medical audit.**

Submitted by: **Christy Bosse** **Date: May 1, 2017**
Title: **Director & Medi-Cal Compliance Officer**