DEPARTMENT OF
Managed
Health Care
Help Center

DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE MEDICAL SURVEY

OF

HEALTH NET OF CALIFORNIA, INC.

A FULL SERVICE HEALTH PLAN

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Final Report of a Routine Medical Survey
Health Net of California, Inc.
A Full Service Health Plan
February 13, 2014

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EXECUTIVE SUMMARY

On February 28, 2013, the California Department of Managed Health Care (the "Department") notified Health Net of California, Inc. (the "Plan") that its Routine Medical Survey had commenced, and requested the Plan to submit information regarding its health care delivery system. The survey team conducted the onsite portion of the survey from May 14, 2013 through May 16, 2013. The Department completed its investigatory phase and closed the survey on November 1, 2013.

The Department assessed the following areas:

Quality Management
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Access to Emergency Services and Payment
Prescription (RX) Drug Coverage
Language Assistance

The Department identified **five** deficiencies during the current Routine Medical Survey. The 2013 Survey Deficiencies table below notes the status of each deficiency.

2013 SURVEY DEFICIENCIES

#	DEFICIENCY STATEMENT	STATUS
GRIEVANCES AND APPEALS		
1	**The Plan failed to demonstrate adequate consideration and rectification of enrollee grievances.** Section 1368(a)(1); Rule 1300.68(a)(4); Section 1368(a)(5); and Rule 1300.68(d)(3).	**Not Corrected**
2	**The Plan does not consistently and correctly display in all its written responses to grievances the Department's telephone number, the CA Relay Service's telephone numbers, the Plan's telephone number, and the Department's Internet address in 12-point boldface type with the statement required by Section 1368.02(b).** Section 1368.02(b).	**Corrected**
3	**The Plan does not consistently follow timeframes indicated in its Evidence of Coverage (EOC) for enrollees to file grievances.** Section 1386(b)(1).	**Corrected**
4	**Upon receipt of an urgent grievance, the Plan does not consistently, immediately inform the complainant of his/her right to contact the Department regarding the urgent grievance.** Rule 1300.68.01(a)(1).	**Corrected**

UTILIZATION MANAGEMENT		
5	**The Plan does not consistently provide the direct telephone number of the professional who made the denial decision in its commercial denial letters sent to requesting/treating providers.** Sections 1367.01(h)(3) and (4).	**Corrected**

SURVEY OVERVIEW

The Department evaluates each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975.[1] At least once every three years, the Department conducts a Routine Medical Survey of a Plan that covers eight major areas of the Plan's health care delivery system. The survey includes a review of the procedures for obtaining health services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the Plan in providing health care benefits and meeting the health needs of the subscribers and enrollees in the following areas:

Quality Management – Each plan is required to assess and improve the quality of care it provides to its enrollees.

Grievances and Appeals – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.

Access and Availability of Services – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

Utilization Management – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

Continuity of Care – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Access to Emergency Services and Payment – Each plan is required to ensure that emergency services are accessible and available, and that timely authorization mechanisms are provided for medically necessary care.

Prescription Drugs – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescriptions and ensure benefit coverage is communicated to enrollees.

Language Assistance – Each plan is required to implement a Language Assistance Program to ensure interpretation and translation services are accessible and available to enrollees.

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

The Preliminary Report was issued to the Plan on November 7, 2013. The Plan had 45 days to file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

This Final Report addresses the most recent Routine Medical Survey of the Plan, which commenced on February 28, 2013 and closed on November 1, 2013.

PLAN BACKGROUND

Health Net of California, Inc. received its Knox-Keene License on March 7, 1991, and is a wholly owned subsidiary of Health Net, Inc. As a federally qualified health maintenance organization (HMO), the Plan operates as a for-profit full service health care service plan that provides services to enrollees for a prepaid monthly fee. Currently, the Plan provides health care services in 30 counties in California, serving 1,653,000 enrollees through its commercial, Medi-Cal, and Healthy Families products.

The Plan's provider network consists of 186 affiliated medical groups, which share financial risk for enrollee care with the Plan. The affiliated medical groups are reimbursed based on capitation. In addition, the Plan does have some direct contracted providers, which are reimbursed based on a fee-for-service schedule. The Plan contracts with its non-plan affiliate, Managed Health Network (MHN) pursuant to an administrative services agreement for mental health services. Management and administration of prescription drug benefits for Health Net membership is provided by Health Net Pharmaceutical Services (HNPS). Health Net Pharmaceutical Services subcontracts administrative function, including pharmacy claims processing and the retail pharmacy network management to Caremark PCS Health, L.L.C.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On November 7, 2013, the Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to:

(a) Develop and implement a corrective action plan for each deficiency, and
(b) Provide the Department with evidence of the Plan's completion of, or progress toward implementing those corrective actions.

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

DEFICIENCIES

GRIEVANCES AND APPEALS

Deficiency #1: The Plan failed to demonstrate adequate consideration and rectification of enrollee grievances.

Statutory/Regulatory Reference(s): Section 1368(a)(1); Rule 1300.68(a)(4); Section 1368(a)(5); and Rule 1300.68(d)(3).

Assessment: The Department reviewed 60 grievances that the Plan recorded and processed as one-day exempt grievances. The Department found that in 11 of the 60 cases, there was no documented evidence that the Plan addressed or reached resolution of the enrollees' specific grievance(s) or took follow-up actions as necessary to investigate the causes of the grievance(s):

> Case #57: The complainant filed a telephonic grievance stating with regards to the enrollee's "… ankle stiffness and pain … took several months for the primary care provider to refer member to ortho specialist **...** advised that the member has chronic inflammation. Several months went by with member complaining about symptoms … referred to rheumatologist ... wouldn't see patient because he is pediatric …" The case file continued to document the enrollee's difficulties in obtaining timely appointments with referral providers. Documentation showed the Customer Service Representative's two attempts to arrange appointments; and "… called member back to advise info and had to leave voice mail … advised that if she wanted to file a formal grievance or do a PPG transfer … she would have to call back in." The case file further documents the Plan's resolution: "Educate member on PCP change process." There is no documentation showing that the Plan followed up with the complainant to ensure that an appointment had been secured, or that the Customer Service Representative made three attempts to reach the complainant to resolve the grievance, as required by Plan policies and procedures pertaining to one-day grievances. Moreover, there was no evidence that the Plan investigated the enrollee's concerns with regard to delayed access to specialist care, nor is there evidence that the Plan determined whether the delay caused or could have caused a deterioration in the enrollee's medical condition (e.g., by referring the case

to the Quality Management Department for clinical review and, if a problem was confirmed, initiation of corrective action). The case was closed on the same date it was opened.

Case #7: The member called in early August 2011, stating that in February 2011, her primary care provider (PCP) could not fit her in for an appointment. She was scared that she had cancer because of a lump in her breast, so she went out of network to obtain care. And, in July 2011, two weeks prior to her call to the Plan, she could not get a refill for Zoloft because she could not get in for an appointment, and her PCP refused to renew her medication without an appointment. The Plan's resolution was to change the member's PCP, effective August 2011. The Plan closed the case the same date it was opened, (although another place in the file indicates it was closed two days later, which is after the Customer Service Representative was able to make the PCP change.) The case notes also document: "Member is having quality of care issue and may possibly file a grievance … Member is in urgent need of PCP visit ..." There was no documentation in the file indicating that the member had obtained an urgent appointment with a new PCP and received a Zoloft refill. Additionally, there is no documentation that the quality of care issue explicitly identified in the case notes was referred to the Quality Management Department for clinical review and, if a problem was confirmed, implementation of corrective action.

Case #9: An enrollee filed a telephonic grievance stating that the primary care physician (PCP) assigned to him by the Plan would not see him because the physician was temporarily filling in for another provider who was on leave. The case file stated "Member feels that Health Net shouldn't charge for the month of July since member was unable to use his coverage." Although the Plan resolved the case by assisting the enrollee in finding a new PCP, the case file contains no documentation addressing the specific concern that the Plan should not have charged him for the premium paid for that month. Furthermore, there was no evidence that the alleged access concern was investigated and, if a problem was confirmed, and addressed. The case was closed on the same date it was opened.

Case #13: The member called to complain that no return calls had been received from the PCP, that the member was unable to reach office staff for an appointment after several attempts, and that the member was unable to leave a message. The Plan addressed the enrollee's immediate concern by changing the enrollee's PCP. However, the Department did not find any documentation indicating that the Plan followed up with the provider's office to investigate the reported access issues—i.e., to see why no calls were returned, why the member could not reach the office after several attempts, or why the member could not leave a message. There was also no follow-up documentation indicating whether the member obtained an appointment with the new PCP. The case was closed on the same date it was opened.

The Department also reviewed 53 standard grievances and found that the Plan failed to adequately identify, analyze, and resolve all of the issues in 10 cases. The following cases exemplify this:

Case #4: This case involved an enrollee who complained about the difficulties she experienced in accessing urgent, as well as follow-up care in May 2011. The enrollee's statement was noted: "What is the point of having Urgent Care if one cannot get an appointment after 8:30AM. I was forced to go to the ER. Follow-up MD was not a member of group so wouldn't see me. ER Dr. felt important to be seen immediately. Primary won't give referral (for specialist as recommended by ER) until he sees me and that is a week after. In the interim, I still am suffering severe abdominal pain and will have to pay ER charges because I couldn't get into Urgent Care. This is extremely frustrating and no way to treat patients." It appears that the enrollee did not wish to pursue the grievance process. In its resolution letter, the Plan stated "…it is my understanding that you do not wish to file a grievance at this time and we will respect your wishes..." The enrollee's grievance was withdrawn. The Case Coordinator appeared to have considered the potential implications of poor access to urgent care as she appropriately noted the need to identify any potential quality of care issues by documenting "…please run by nurse to see if there is a QOC component…" However, no further entries were found in the file. There is no evidence that the case was reviewed by a nurse reviewer or other qualified personnel to determine whether further investigation was warranted.

Case #49: This case involved an enrollee who contacted the Plan in November 2011 complaining about a number of issues: 1) the provider and the provider group were not returning phone calls; 2) the provider group misplaced the enrollee's medical records/chart for four days; 3) the difficulty to obtain a referral to an orthopedic specialist; and 4) the provider's inability to offer timely appointments which resulted in the enrollee being told to access Urgent Care. The provider group responded to the Plan's inquiries regarding the issues by stating that the provider could not substantiate the loss of medical records for four days or the unreturned phone calls. In its grievance resolution letter, the Plan stated that the provider office had already contacted the enrollee regarding her concerns and that the "referral coordinator advised that they had made a verbal request for additional information to substantiate the referral request." The Plan apologized and noted the change of the enrollee's primary care provider effective January 2012. However, the resolution letter was neither clear nor complete in that it did not indicate what additional information was needed to facilitate the referral, from whom the additional information was requested, and what the enrollee could expect regarding the request for referral to the orthopedic specialist. Furthermore, the resolution letter did not include the phone number and name of the referral coordinator so that the enrollee could follow-up directly with the provider group to determine the status of the referral request.

Case #53: In a letter to the Plan dated December 29, 2011, the enrollee complained about the service she received from a provider (Dr. F). The enrollee requested to see the cardiologist (Dr. B) who had previously put in his pacemaker. The enrollee stated in his letter: "Please review services I am receiving from Dr. F, and requesting services by Dr. B…my doctor who put in my pace maker… My first visit on December 9th was not pleasant…they did not have me fill out a medical report… authorization was not in place…Dr. F spent less than 5 minutes with me as a new patient…again, I am requesting services by Dr. B".

The Plan contacted the provider group regarding the enrollee's concerns and inquired whether there was an authorization requested on behalf of the enrollee to see Dr. B. The

provider group responded in writing on January 24, 2012, and provided office notes from the enrollee's office visit with Dr. F, past notes from Dr. B, and a copy of the authorization issued, dated November 7, 2011, in which the provider group redirected the enrollee to see Dr. F instead of authorizing the referral to Dr. B. The authorization to see Dr. B was requested by the enrollee's primary care physician. The provider group's reason for redirecting the enrollee to Dr. F was that Dr. B was not a contracted provider and reasoned that other cardiologists were available in the provider group's network. Hence, the enrollee was referred to Dr. F. The January 24th letter also stated that the enrollee needed to contact his PCP to submit a referral for any services needed.

The Plan's resolution letter explained that the Plan had reached out to the provider group and confirmed that Dr. F conducted an examination. However, it did not address the enrollee's concern regarding the short duration of the visit with Dr. F. Additionally, the Plan stated "In regards to the authorization request to Dr. B…they (the provider group) have no record of receiving a referral request for a consultation with Dr. B. Please contact your Primary Care Physician…"

Here, the Plan was in possession of the original authorization request (to see Dr. B) made by the enrollee's primary care physician on November 7th, but inaccurately informed him that the provider group never received one. Additionally, the Plan appeared to instruct the enrollee to contact his PCP for a referral to consult with Dr. B. The Plan did not correctly inform the enrollee that the request for referral to Dr. B had been received and reviewed by the provider group in November, and that its determination was to modify the request by redirecting the enrollee to another cardiologist, one who was a contracted provider in the medical group. The Plan failed to inform the enrollee of the provider group's reason for its determination—the follow-up referral to Dr. B was not considered medically necessary because the service was available within the network.

Case # 59: The enrollee in this case called the Plan regarding son's activation code for enrolling into Debix services. The initial code expired after 120 days. The enrollee wanted a new code and is concerned about privacy, identity theft, and threatened to sue if there was a breach. Plan contacted Debix to assist this enrollee with a new enrollment code. The Plan's resolution letter informed the enrollee that the Plan has provided Debix with the information needed to offer this service to affected enrollees. "To receive the identity protection service you must have registered within 120 days from the date of the notification letter sent to you from Health Net regarding this matter using the activation code listed at the top of the letter." The resolution failed to address the enrollee's request for a new code.

Section 1368(a)(1) requires each plan to establish and maintain a grievance system to provide reasonable procedures ensuring adequate consideration of enrollee grievances and rectification when appropriate. Rule 1300.68(a)(4) defines "resolved" as reaching a final conclusion with respect to the enrollee's submitted grievance. Because the Plan does not consistently and adequately consider and investigate all issues raised through enrollee grievances, the Department finds that the Plan is in violation of Section 1368(a)(1). As a result of its failure to consider all issues raised in grievances, the Plan could not demonstrate that it had reached a final conclusion with respect to all aspects of the enrollee's submitted grievance; therefore, the Department finds the Plan in violation of Rule 1300.68(a)(4).

In addition, Section 1368(a)(5) and Rule 1300.68(d)(3) requires the Plan's resolution letter to enrollees to contain a clear and concise explanation of the Plan's decision. With regards to the written resolution of standard grievances, without adequate consideration and rectification of all issues in the grievance as discussed above, the Plan, in turn, could not consistently send written resolution letters with a clear and concise explanation of the Plan's decision(s).

Relevant Case Summaries: See examples above.

TABLE 1
Resolution of One-Day (Exempt) and Standard Grievances

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
One-Day (Exempt) Grievances	60	Grievance adequately considered and rectified when appropriate	49	11
Standard Grievances	53		43	10

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort:

One-Day Grievances: The Plan conducted refresher training for all Customer Service Associates. The training was conducted from October 28, through November 8, 2013. A copy of the training materials and sign in sheets were provided by the Plan for both the Commercial and Behavioral Health Departments. This training will be included in new hire training and will be provided to current associates annually.

In addition, health plan associates will receive refresher training on how to identify quality of care complaints, and on the procedure for opening a quality of care case. The training materials are in the last stages of review, so the Plan was not able to provide copies. All other provider related issues tracked as one-day grievances will be reported monthly to the Quality Improvement team. This training will be completed by January 31, 2014.

One-Day Grievance Trend Reports will be generated and distributed to the Adverse Action Unit monthly for trending, and as appropriate, for follow-up with respective providers (a copy of the 2013 trend report was provided by the Plan).

Additionally, in March 2013, a one-day grievance daily review and audit process was implemented. The purpose of the review and audit is to ensure accurate, complete and timely resolution; this will be an ongoing process. A copy of the Plan's policy was provided. The policy states that the Plan reviews exempt grievances with staff informally, on a case-by-case basis for the appropriateness of classification, as well as for trending purposes. The supervisors

are responsible to ensure that associate feedback/coaching are done. The primary officer responsible for compliance oversight of the grievance process, including evaluation and assessment of issues, reporting of trends, and implementation and evaluation of corrective actions is the Director of Appeals and Grievances.

The Quality Auditing and Training Department monitors adherence to the exempt grievance process during the course of the call and reports "misses and opportunities" to the associate and direct supervisor immediately. Any trends identified are reviewed during the monthly root cause and preventable meetings. The purpose of these meetings is to review operational issues with other business areas to determine if any changes can be made. The Appeals and Grievances Director and Contact Center Director attend the Utilization Management and Quality Improvement Committee meetings and present trends for exempt and formal grievances.

Standard Grievances: Corrective actions for standard grievances include retraining all appeals and grievances coordinators by January 31, 2014 on effective written communication and focusing on strategies for addressing all members concerns in the final response letters.

The Plan will initiate a quarterly letter review workshop to identify trends and training opportunities in the letter creation process by the end of the first quarter in 2014.

Also, the Plan's Appeals and Grievances Department will continue to provide monthly reports of all closed grievances involving providers, provider staff, and facilities to the Health Net Credentialing Teams Adverse Action Unit. The report lists the region, provider number, total number of grievances identified within the previous six months, and the date the last case was closed. If the total count of member complaints in a six-month period for a single provider is three or greater, the provider's file is reviewed at the Peer Review/Credentialing Committee. These reports are trended and reviewed as part of Health Net's Overall Quality Strategy. The Plan provided a copy of this report from July 2013 through November 2013.

The Plan provided copies of its Peer Review Committee meeting minutes for July 2013 and August 2013. The meeting minutes included detailed discussions of individual cases including the Peer Review Committee's actions.

Additional Actions for Potential Quality Issues Identified: The Adverse Action Unit, under the leadership of the Plan's Credentialing Department, is responsible for submitting to the Peer Review Committee any identified quality of care issues where providers have been identified through member complaints and/or through the potential quality issue process, which is identified through various avenues.

Cases reviewed and identified by a Plan Medical Director as a potential quality of care issue are forwarded to the Adverse Action Unit. The Adverse Action Unit opens a case, conducts an investigation through gathering further data as needed, and prepares the case for the Peer Review Committee. After reviewing and discussing the case, the Peer Review Committee may take one or more of the following actions: close the case, and track and trend the provider, send a letter of education, request a corrective action plan, conduct a focused site visit by a Plan nurse, or initiate the termination process for the provider. Termination may result in a formal appeal and reporting to the medical boards and the National Practitioners Data Base (NPDB).

The Adverse Action Unit generates a monthly report of all member complaints and potential quality issues identified. Any provider with three or more issues in a six-month period is reviewed by the Peer Review Committee regardless of the severity of the cases. The Peer Review Committee follows the same review process as above for making decisions and taking action.

Below are some of the upcoming changes the Plan will be implementing regarding its current potential quality issue process.

- Develop an improved process and standardize criteria for potential quality issue identification and reporting by February 28, 2014.
- Conduct Plan associate training to ensure cases are being identified and closed appropriately by February 28, 2014, and conduct annually thereafter.
- Identify reporting capabilities to include One-Day Grievances and develop any required reporting modifications/improvements by March 15, 2014, to be included in the data received by the Adverse Action Unit for review.
- Generate sample report including all additional data according to developed criteria for presentation to the Western Region Credentialing/Peer Review Committee by April 15, 2014.
- Standardize and implement final process by May 31, 2014.

Final Report Deficiency Status: Not Corrected

The Department finds that the Plan has made significant changes to its exempt and standard grievances process and reporting activities and has conducted and will continue to conduct training sessions regarding the handling of exempt grievances. However, many of the changes and trainings will not be fully implemented or completed until the first and second quarter of 2014. The Department will need to follow-up on the revised grievance process to ensure full and sustained implementation of all proposed corrective actions, and will need to verify that the Plan adequately considers and rectifies enrollee grievances on a consistent basis through file review.

Because more time is required for the Plan to demonstrate complete implementation of the corrective actions, the Department has determined that this deficiency has not been fully corrected.

Deficiency #2: The Plan does not consistently and correctly display in all its written responses to grievances the Department's telephone number, the CA Relay Service's telephone numbers, the Plan's telephone number, and the Department's Internet address in 12-point boldface type with the statement required by Section 1368.02(b).

Statutory/Regulatory Reference(s): Section 1368.02(b).

Assessment: The Department reviewed 43 cases of commercial standard grievances and found that written responses in 12 of the 43 cases did not correctly contain the statement required under Section 1368.02(b) pertaining to the Department's grievance process.

In the response letters to enrollees' grievances, the Plan provides information regarding enrollees' right to appeal in an attachment. Plan staff stated that in recent years, it has used several versions of the attachments addressing appeals. Plan staff submitted two of its "most current versions" of the attachment for Grievance and Appeals, Independent Medical Review, and Arbitration. The Department found that in the two current versions, the Plan failed to include the statutory statement in its entirety. Instead, the Plan paraphrased and displayed the required statement in separate places in the documents and failed to include the Department's telephone number and the TDD line, as well as the Department's Internet address. Although the three archived versions of the documents displayed the statutory required statement in its entirety, the Plan no longer uses these versions.

The Department also reviewed 29 cases of commercial expedited appeals and found that in 11 of these 29 cases, the Plan's resolution letters failed to include, in its entirety, the statutory statement required under Section 1368.02(b).

Section 1368.02(b) requires that every health care service plan publish the Department's toll-free telephone number, its TDD line for the hearing and speech impaired, and its Internet address, as well as the Plan's telephone number, on all written notices to enrollees involving the Plan's grievance process. It also specifies that the Department's telephone number, its TDD line, the Plan's telephone number, and the Department's Internet address be displayed in 12-point boldface type using a statement specified in the section. The Department's review of template documents that the Plan uses to respond to grievances, as well as its review of individual case files, demonstrates that the Plan does not consistently or correctly include the required statement pertaining to the Department's grievance process in the specified format; therefore, the Department finds the Plan in violation of Section 1368.02(b).

TABLE 2
Review of Standard Grievances and Expedited Appeals

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Commercial Standard Grievances	43	Resolution letter includes Section 1368.02(b) required statement in appropriate format	31	12
Commercial Expedited Appeals	29		18	11

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan's letter enclosures were updated, and communication of the updates were sent to the entire Appeals and Grievances team on June 11, 2013. The Plan provided a copy of the communication that was sent out to the Appeals and Grievances team. In order to prevent the issue from occurring again, any changes to the required enclosures going

forward will be clearly highlighted in redlined format for future review and approval so that any information removed or modified can be clearly identified. In addition, the Plan provided an update of its Grievance and Appeal Process, which indicates on page four the Section 1368.02(b) requirement for all written communication.

To validate that the Plan corrected its enclosures, the Department reviewed a random sampling of grievance response letters. The Department reviewed nine standard and ten expedited grievance response letters and all letters had the corrected Section 1368.02(b) language.

Final Report Deficiency Status: Corrected

The Department finds that the Plan has corrected its grievance response enclosure to be in compliance with Section 1368.02(b). The Plan has updated its grievance policy to include the required language in all of its grievance response letters.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been fully corrected.

Deficiency #3: The Plan does not consistently follow timeframes indicated in its Evidence of Coverage (EOC) for enrollees to file grievances.

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Assessment: The Plan's Evidence of Coverage (EOC) for both its HMO and POS plans, which serves as a contractual agreement with enrollees, states, "You must file your grievance or appeal with Health Net within 365 calendar days following the date of the incident or action that caused your grievance."

In its review of the Plan's denial letters, the Department noted that in 16 of the 53 cases, the Plan allowed only 180 days for enrollees to dispute the denial determinations, stating in the denial letters that, "Your health plan requests that you submit your grievance within 180 days from the postmark date of this notice." This statement is inconsistent with the 365 days allowed by the EOCs. Section 1386(b)(1) provides for penalties should a plan fail to operate in compliance with basic organizational documents filed with the Department (e.g., policies and procedures, annual reports, application for licensure). Because the Plan failed to operate in accordance with the provisions stated in its evidence of coverage, the Department finds it in violation of section 1386(b)(1).

TABLE 3
Review of Utilization Management Denials

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Commercial Utilization Management Denials	53	Plan adhered to timeframes specified in its Evidence of Coverage	37	16

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: To be consistent with the Plan's Evidence of Coverage, the Plan changed the number of days the member has to dispute a denial from 180 to 365 in its utilization management denial letter template. The revised denial letter template went into production for use on June 26, 2013.

To validate that the Plan had changed the appeal timeframe on utilization denials, the Department reviewed a random sampling of nine utilization denial letters. In all of the nine denial letters reviewed, the letter indicated that a member has 365 days to appeal, which is consistent with the Plan's Evidence of Coverage.

Final Report Deficiency Status: Corrected

The Department finds that the Plan has changed its utilization denial letter template to indicate that members have up to 365 days to file an appeal, as indicated in the Plan's Evidence of Coverage. A review of utilization denial letters indicates that the change has been implemented.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been fully corrected.

Deficiency #4: Upon receipt of an urgent grievance, the Plan does not consistently, immediately inform the complainant of his/her right to contact the Department regarding the urgent grievance.

Statutory/Regulatory Reference(s): Rule 1300.68.01(a)(1)

Assessment: Of 29 expedited appeals reviewed, 11 cases did not contain documented evidence that the Plan immediately informed the complainant of his/her right to contact the Department regarding the urgent grievance, although the Plan's policy and procedures guiding expedited appeals state that "…member will be immediately verbally provided the right to contact the Department regarding the appeal documenting the telephone call within the on-line system."

Upon receipt of an urgent grievance, Rule 1300.68.01(a)(1) requires the Plan to immediate notify the complainant of his/her right to contact the Department regarding the grievance. Notice need not be in writing, but may be accomplished by a *documented* (emphasis added) telephone call. Because the Plan does not consistently document that it informed enrollees who submit expedited appeals of their right to contact the Department regarding the grievances, the Department finds the Plan in violation of Rule 1300.68.01(a)(1).

TABLE 4
Review of Expedited Appeals

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Commercial Expedited Appeals	29	Immediately inform the enrollee in writing or by documented phone call of the right to notify the Department	18	11

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: On June 29, 2013, the Plan updated its Expedited Appeal Member Notification Desktop Procedure to reflect the requirement to call members and make them aware of their rights to contact the Department and to provide the Department contact information on all expedited cases. The Plan provided a copy of the Desktop Procedures. The Procedure includes a script which states… *"Additionally, you have the right to contact the Department of Managed HealthCare (DMHC) for any case that meets the expedited appeal criteria. You are not required to participate in Health Net's appeal process prior to contacting the DMHC for review of your expedited appeal. You can go directly to the DMHC for further assistance by…"* This will be clearly documented in the Plan's data system for each member's case. The Plan provided retraining to Appeals and Grievances coordinators on this requirement on December 17, 2013. A copy of the training sign in sheet was provided.

To validate that the Plan is documenting that it is informing enrollees of their right to contact the Department, the Department reviewed a random sampling of five expedited grievance files. Each of the five expedited grievance files contained documentation indicting that the enrollee was informed of his or her right to contact the Department regarding an urgent grievance.

Final Report Deficiency Status: Corrected

The Department finds that the Plan has updated its Desktop Procedure to include the requirement to call members and document that the Plan has informed them of their right to contact the Department regarding an urgent grievance. The Department reviewed five expedited grievance files and validated that the Plan is notifying enrollees and including documentation of such verbal notifications.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been fully corrected

UTILIZATION MANAGEMENT

Deficiency #5: The Plan does not consistently provide the direct telephone number of the professional who made the denial decision in its commercial denial letters sent to requesting/treating providers.

Statutory/Regulatory Reference(s): Sections 1367.01(h)(3) and (4).

Assessment: The Department noted that the Plan did not initially include in the case files copies of the denial letters sent to the requesting provider for 44 of the cases, which were medical service denials. The remaining nine denial files were processed by Managed Health Network (MHN), the behavioral health plan that the Plan uses to administer its mental health benefits. The MHN-generated denial notices did include the name of the reviewing physician along with the telephone and extension numbers.

On July 29, 2013, after the Medical Survey Team's onsite survey, and upon the Department's request, the Plan submitted copies of the 44 written notices sent to the medical providers. Upon review of the notices, the Department found that the Plan did include a telephone number to call, (818) 676-7371. The letter stated:

> If the treating practitioner would like to discuss the case with the Health Net physician reviewer or obtain a copy of the criteria used to make this decision, the treating practitioner can call Health Net's Medical Management Department at (818) 676-7371 8:00am – 5:00pm.

The Department called the telephone number twice—once on July 29, 2013, at 2:25 p.m. and again on July 30, 2013, at 1:48 p.m. Both times, an automated message indicated that the number belonged to the Executive Assistant in the Medical Management Department and instructed the caller to leave a message. No further instructions were given on how to contact the Medical Director or physician reviewer. This is in contrast with the telephone and extension number indicated in the MHN-generated denial notices: (800) 287-0383, ext. 5549. Upon calling this number, an individual who identified herself as a care manager immediately answered the telephone and readily recognized the name of the physician reviewer's name (indicated in the denial notice) given by the caller.

Sections 1367.01(h)(3) and (4) require that any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider to easily contact the professional responsible for the denial, delay, or modification. Because the Plan failed to provide the name and direct telephone number of the reviewing medical provider responsible for the denial decision, the Plan is found in violation of Sections 1367.01(h)(3) and (4).

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: As of December 9, 2013, the voicemail for the direct phone number provided on utilization management denial letters for Peer Review discussion regarding an authorization decision has been modified. The voicemail now states:

"You've reached the executive assistant for Drs. Reis, Blumberg, Zaher, and Fine of the Medical Management Department. If this is a provider calling to speak to one of the Medical Directors, please state your name and phone number, the Medical Director with whom you wish to speak, and a detailed message regarding your request and I will arrange for the Medical Director to return your call."

The direct phone number provided on the utilization management denial letters is answered live Monday through Friday from 8:30 a.m. to 5:00 p.m. If calls are sent to an answering machine after hours, messages are checked each business day, and calls are promptly returned the same day they are checked.

Final Report Deficiency Status: Corrected

The Department finds that the Plan's utilization management denial letter does have the direct phone number for providers to contact. The Department validated that the voice mail message was modified to include the names of the Medical Directors and instructions to the caller for leaving a message for one of the four Medical Directors involved in decision-making, should the call be sent to voice mail. The Department validated that the phone number is answered live daily, and for calls that come in after-hours, the provider can leave a message.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been fully corrected.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Medical Survey. The Department will conduct a Follow-Up Review of the remaining outstanding deficiency and issue a Report within 14-16 months of the date of this Final Report.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, **DMHC Web Portal**

Once logged in, follow the steps shown below to submit the Plan's response to the Final Report:

- Click the "eFiling" link.
- Click the "Online Forms" link
- Under Existing Online Forms, click the "Details" link for the **DPS Routine Survey Document Request** titled**, 2013 Routine Full Service Survey - Document Request.**
- Submit the response to the Final Report via the "DMHC Communication" tab.