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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

September 22, 2020

Fabbi Cruz, Compliance Officer
Aetna Better Health of California, Inc.
10260 Meanly Drive
San Diego, CA 92310

RE: Department of Health Care Services Medical Audit

Dear Ms. Cruz:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Aetna Better Health of California, Inc. a Managed Care Plan (MCP), from April 22, 2019 through April 25, 2019. The survey covered the period of April 1, 2018 through March 31, 2019.

On September 16, 2020, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on November 7, 2019.

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

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

If you have any questions, feel free to contact me at (916) 345-7829 or Joshua Hunter at (916) 345-7830.

Sincerely,

Original Signed by

Michael Pank, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Gabriel Pacheco, 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: Aetna Better Health of California, Inc. **Review Period: 4/1/18-3/21/19**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 4/22/19-4/25/19**

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 in word format that 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 short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, 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. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval in accordance with existing requirements.**

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* (*Short-Term, Long-Term)	DHCS Comments
1.1.1 Utilization Management Underutilization The Plan did not have mechanisms to detect underutilization of health care services. There was no evidence to support that the Plan	Current Process: Aetna Better Health of California (ABHCA) currently monitors underutilization through its review of claims and encounter data to create Gaps in Care reports. These reports are distributed to the providers through our HEDIS initiatives. The goal is for the providers to outreach to members and resolve gaps in care.	Practitioner Provider and Member Underutilization of Services policy and UM program description.		**12/9/19** - The following documentation supports the MCP's efforts to correct this finding: - Written response indicating that Delegation Oversight will mine claims and encounter data to create a per-member per-year utilization report. This

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
monitors underutilization.	Enhancement to the Process Delegation Oversight (DO) will begin mining claims and encounter data to create a per-member per-year utilization report. The reporting will stratify membership into different cohorts to monitor utilization patterns related to categories of aid. For example, utilization patterns will be different for a Child when compared to a Seniors and Persons with Disabilities (SPD) member. Such benchmarking will be done on an annual basis with enhancements in the reporting on a monthly basis. This will begin in January 2020. This reporting will be shared with our providers and any underutilization identified will be addressed to be remedied. Additionally, the UM Delegation Assessment Survey (see attached) is used annually as part of the UM Annual audit and serves as a baseline in understanding the UM processes of a delegated entity. All 6 IPA's attested they monitor utilization (over and under). The survey will be completed by the IPA's again in 2020, when the 2019 Annual Audit begins. The enhanced data reviews will be completed by end of January 2020 and the summary will be reported to the next Delegation Oversight Committee meeting which meets quarterly. Medical Management leadership has initiated a process to review and enhance the mechanism to detect both over and underutilization. This is being			will allow the MCP to monitor utilization patterns related to categories of aid. Enhanced data reviews will be summarized and reported to Delegation Oversight Committee which meets quarterly. - Utilization Management Delegation Assessment Survey is used for the UM annual audit and used by the IPAs to serve as a baseline for understanding the UM process of delegated entities. - UM Authorization trend reports for both inpatient and outpatient (11/2018 – 10/2019) are used by the MCP to identify potential indicators of underutilization. Inpatient overview will identify admissions/1000, denial rate and bed days/1000. Trends will be used to monitor underutilization. **6/11/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Gaps in Care Report used measure underutilization through review of claims and encounter data. Reports are

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	done first through the review of and adherence to policy and the UM program description. The team is reviewing and evaluating the effectiveness of several indicators such as quality and UM reports, audits, claims analysis, encounter reporting, complaints and grievance. By the end of January 2020, the team will select the most appropriate mechanism. Furthermore, UM Authorization trend reports, which include Inpatient/ Outpatient utilization, will be used to aid in identifying potential indicators of underutilization. i. The Inpatient Overview identifies Admissions/1000, Denial Rate and Bed Days/1000. Trends in these areas will facilitate monitoring over and underutilization. ii. The Outpatient Overview Report identifies monthly authorizations/1000 and Denial Rates, along with Top 10 service categories and authorization volumes.			shared with IPAs during Joint Operation Meetings. - Emergency Department Utilization Dashboard is used to track high utilizers by analyzing claims data. The data is shared with case management for targeted outreach campaigns. The data is also presented to IPAs as an aggregate during joint operation meetings. - Email communication from 6/11/20 states An enhanced monthly data review process was initiated in January 2020. Due to personnel changes and COVID-19 the process was paused. The data review process has started again in May and will be reported in the June 2020 Delegation Oversight Committee meeting **6/25/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Draft notes from the 6/16/20 Delegated Oversight Meeting state that the MCP has initiated an enhanced claims data analysis as part of a multiphase effort to

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				detect underutilization of health care services. The MCP will review utilization claims data to track trends. This will be done on a quarterly basis. **This finding is closed.**
1.1.2 Delegated Entity Oversight The Plan Delegates prior authorizations. The audit found the delegated entities denied prior authorizations for medically necessary services. Unqualified individuals made a final denial determination without the delegated entity's Medical Director review. The Plan's oversight process was not instituted consistently with all delegated entities.	Current Process Aetna Better Health of California (ABHCA) performed an IPA annual UM audit as part of ensuring compliance with our delegated entities in meeting contract requirements for prior authorizations. The process included notification to the IPAs of upcoming audit, requesting 2018 universes, randomizing a selection of files, reviewing policies/procedures, reviewing the UM Delegation Assessment Survey completed by the IPA, reviewing randomized approval files and reviewing all denial files. Preliminary results were sent to the IPAs over the summer of 2019. Final results were sent to IPAs in September and early October 2019. ABHCA audit findings attached below. From the sample size of the UM annual audit, key findings included: a. Timeliness reports for routine and urgent authorizations were not being submitted by all IPA's b. Two IPAs did not include Threshold Language/Language Assistance in Notice of Action	IPA (individual) audit results and Delegation Oversight policy.		**12/9/19** - The following documentation supports the MCP's efforts to correct this finding: - UM delegation survey results for six IPAs serve as evidence the MCP is monitoring its delegates for compliance with prior authorization contract requirements. -MCP formed a Delegation Oversight Unit that is responsible for monitoring and ensuring adherence to all applicable contract requirements. The Unit will review authorization requests for timeliness/appropriateness and all denials are performed by appropriate medical personnel. Reviews of service authorization files are performed weekly and denials deemed inappropriate will be escalated to the MCP's CMO for review. Reversals will be

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	(NOAs) letters. The updated NOA letters were provided to remedy as soon as possible over the summer, when this was identified. One IPA had variability in authorizations with a significant amount of voided or withdrawing of authorizations that needed to be explained and understood. c. Five IPA's not having the appropriate decision maker for authorizations, e.g. LVN performing inpatient reviews which can only be done by an RN. There was 1 IPA that identified LVN's and RNs could supervise denials when only the medical director can make the designation. Currently, the Chief Medical Officer (CMO) as the Chair of the Delegation Oversight Committee, and the Compliance Officer are in the process of reviewing the final responses received by four of the IPA's to determine next steps, i.e. formal corrective action plans. For any deficiencies identified, delegates will be placed on a Corrective Action Plan by the end of January 2020 if immediate resolution is unsatisfactory. Enhanced Process ABHCA has a newly formed Delegation Oversight (DO) unit comprising of a DO RN Manager, a senior data analyst and a senior claims analyst. This unit is responsible for monitoring and ensuring adherence with all applicable contract requirements; laws and regulations; contract and reporting requirements as			communicated to delegated entities for correction. - Policy 8000.60 describes the oversight responsibilities the MCP has over its delegates. **6/22/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Examples of the review of weekly service authorization files of the IPAs from February 2020 through May 2020 serve as evidence the MCP's weekly review process in operational. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	per Delegation Oversight Responsibilities policy and per the plan's delegation agreement. The DO RN Manager is responsible for ensuring members are receiving timely and appropriate medical care by reviewing authorizations for timeliness and appropriateness; specifically, meeting timelines for urgent and routine authorizations, and any denials are performed by the appropriate medical personnel. As part of the plan's oversight, the DO RN Manager will review the weekly service authorization files received from the IPAs. This review is performed on a weekly basis. Any denials deemed inappropriate, will be escalated to the plan's CMO for review, verification, and uphold or reversal. For any reversal (s) by the plan's CMO for determinations initially made by an IPA, will be communicated to the IPA for correction.			
1.3.1 Prior Authorization Appeal Process The denial of inpatient post stabilization services occurred during the audit period. These prior authorization decisions were not made by qualified individuals.	Aetna Better Health's (ABHCA) claims system will be modified to identify and pay emergency in-patient (IP) post stabilization claims, without requiring a prior authorization to meet contractual requirements. A system change request (SCR) will be submitted to update the system to allow for automatic processing of in-patient hospital facility claims when a 450-revenue code is billed on the IP claim. Other standard edits will apply i.e., eligibility, claims over dollar threshold for internal review. The system change will take 90 day to be operational.	N/A	12/03/19	**3/16/20** - The following documentation supports the MCP's efforts to correct this finding: - Email communication dated 3/16/20 from MCP confirms that system edit made to claim system to ensure emergency in-patient post stabilization claims are identified and paid is now operational.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
The audit found the decisions were overturned on appeal.	In the interim, the plan will implement the following methodologies to ensure post stabilization claims are not inappropriately denied: a. The plan will run a claims report to identify any current claims that may have been denied for no authorization. b. These claims will be reprocessed within 30 days. c. An additional process that is called a pre-check run query will be put in place within 2 weeks to stop any claims that fall into the above criteria. The claims department will manually work those claims on a weekly basis until the claims system has been updated to the new requirement, tested, approved and built. Once completed, we will run an additional claims report to ensure we capture all claims that fall into this category. Ongoing monitoring of denied inpatient claims will be conducted on a monthly basis to ensure claim denials are appropriate.			**6/8/20** - The following additional documentation supports the MCP's efforts to correct this finding: - CAP narrative from 6/8/20 and Code 450 Review and Reprocessed spreadsheet demonstrates that all impacted claims were secured and reprocessed. The MCP secured a SQL query that is run on a weekly basis to ensure systems are functioning properly. The Manager of Business Informatics reports to the COO to ensure no other claims are impacted. **7/21/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Desktop Procedure for Ensuring system enhancements are in place to prevent the incorrect denial of inpatient claims for post stabilization services. The procedure includes the weekly running of a query. In the event there are denied claims the Manager of Business Informatics will notify the Chief Operating officer who will work with Configuration and Claims to identify the root cause and reprocess the denied

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				claims. The Compliance Officer will report the non-compliance issue with a root cause analysis and resolutions to the Compliance Committee. No additional incorrect denials of inpatient claims have been discovered since the implementation of corrective action. **This finding is closed.**
2.1.1 Initial Health Assessment The Plan did not ensure the provision of an Initial Health Assessment (IHA) to new members within 120-calendar days of enrollment. The Plan lacked oversight to monitor the provision of IHAs.	New Process: Identification and Outreach Aetna Better Health (ABHCA) is implementing new processes for oversight, monitoring, tracking, and compliance of the IHA per contractual requirements. • New members in the eligibility file are identified by using the enrollment date on a monthly basis • The plan conducts outreach campaigns for new members every month, through an automated call system (automated software), that informs members to establish care with their Primary Care Provider • Member welcome packet that includes EOC and information regarding an IHA • Second mailing IHA specific, after 60 days of enrollment if an IHA has not been completed by this time frame Monitoring and Tracking • ABHCA is initiating an additional provider outreach	Provider Memo-IHA Guidance SAMPLE.		**12/9/19** – The following documentation supports the MCP's efforts to correct this finding: - Provider memo, "Initial Health Assessment Billing Codes and Requirements", as evidence that MCP is providing information regarding appropriate billing codes, requirements for completing an IHA and procedures for ensuring provisions of IHA (medical record-keeping of scheduling, rescheduling, well-visits, refusal for IHA's, etc.) - Written narrative 2.1.1- states Aetna's implementing new processes for oversight, monitoring, tracking and compliance of the IHA. This will

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	campaign, additionally to the Provider Onboarding Training, which includes a reminder to complete IHAs within 120 days of new member enrollment, claim cpt codes that may be used as a guideline to identify new member visits and health assessments, reminders on the IHA elements necessary to complete the assessments. The provider fax blast campaign will be completed by January 2020 • ABHCA will be data mining claim and encounter files on a monthly basis to identify completion of IHAs based on claim cpt codes submitted by providers • ABHCA will perform audits bi-annually to validate the completion and appropriateness of the IHAs • ABHCA will be reporting the outcomes of the monthly data mining and bi-annual audits to the QMUM Committee			include the MCP conducting a calling campaign to reach out to new members on a monthly bases, through a calling system known as Eliza, this will notify members to make an appointment with their PCP. New members will also be receiving EOC with necessary information regarding an IHA and a second mailing will go out specific to IHA 60 days after the member has enrolled if an IHA has not been completed. **5/27/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding. - IHA Policy 7000.33 provides the provider and MCP requirements and responsibilities for ensuring the provisions of IHA, SHA and IHEBA. This includes IHA requirements to be utilized by the MCP to ensure that members are receiving an IHA within the 120 calendar days following enrollment in addition to at least three documented attempts being made to the member being inclusive of one

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				telephone and one mail notification. If a member refuses the IHA this also needs to be notated in the medical file. - IHA Completion Tracker as evidence that MCP is monitoring due date and completion date of member's IHAs by PCPs. **7/21/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding. - New Member Welcome Letter (approval Q3 2020 and implementation Q4 of 2020, provides IHA language addressing the importance of scheduling an appointment immediately with the member's PCP to start their care and complete an IHA. It also outlines how an IHA will benefit their PCP with better understanding the member's health care history and to ensure they are receiving the care they need in addition to getting up to date vaccinations and prescriptions and necessary referrals.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- Sample document, ‘Provider Memo” is evidence of the fax blast campaign to update the providers on the IHA requirements as well as the necessary timeline for completion. In addition to the intended follow up if an IHA does not occur with 120 days of the member becoming active. - Meeting minutes of the Quality Management/Utilization Management Committee (QM/UM) (07/08/2020) which provides evidence of the documented review and discussion of the bi-annual audit and reporting the outcomes of the monthly data mining. The MCP will be data mining claim and encounter data files, this will occur monthly, allowing the MCP to focus on necessary completion of IHA’s based on claim codes from providers. **This finding is closed**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2.1.2 The Plan does not have a method to validate the completion of the IHA comprehensive health assessment components for preventative services, primarily children services.	Monitoring and Tracking • ABHCA is initiating an additional provider outreach campaign, additionally to the Provider Onboarding Training, which includes a reminder to complete IHAs within 120 days of new member enrollment, claim cpt codes that may be used as a guideline to identify new member visits and health assessments, reminders on the IHA elements necessary to complete the assessments. The provider fax blast campaign will be completed by January 2020 • ABHCA will be data mining claim and encounter files on a monthly basis to identify completion of IHAs based on claim cpt codes submitted by providers • ABHCA will perform audits bi-annually to validate the completion and appropriateness of the IHAs • ABHCA will be reporting the outcomes of the monthly data mining and bi-annual audits to the QMUM Committee	N/A		**12/9/19** – The following documentation supports the MCP's efforts to correct this finding: - Written narrative 2.1.2 states Aetna's implementing new processes for oversight, monitoring, tracking and compliance of the IHA. This will include the MCP conducting a calling campaign to reach out to new members on a monthly bases, through a calling system known as Eliza, this will notify members to make an appointment with their PCP. New members will also be receiving EOC with necessary information regarding an IHA and a second mailing will go out specific to IHA 60 days after the member has enrolled if an IHA has not been completed. **5/27/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding. - IHA Completion Tracker serves as evidence that MCP is monitoring due date and completion dates of member's IHAs by PCPs.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				7/21/20 – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding. - Desktop Procedure, "IHA Oversight and Biannual Audit" (07/07/2020) has been created to validate the completion of the IHA process and continued monitoring to be overseen by the MCP. - Meeting minutes of the Quality Management/Utilization Management Committee (QM/UM) (07/08/2020) which provides evidence of the documented review and discussion of the bi-annual audit and reporting the outcomes of the monthly data mining. - Sample document, "60-day member mailer" is evidence of the MCP providing follow-up to members who do not have a well visit after the 60 days of enrollment. The MCP is monitoring the IHA's in an ongoing tracker and will be following up with those members who have not completed an IHA

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- Sample document, 'Provider Memo" is evidence of the fax blast campaign to update the providers on the IHA requirements as well as the necessary timeline for completion. In addition to the intended follow up if an IHA does not occur with 120 days of the member becoming active. **This finding is closed**
2.3.1 Behavioral Health Treatment The Plan does not systematically track and report the number of authorized Behavioral Health Treatment (BHT) services. The audit identified incomplete information in the Plan's system to track and report the actual number of authorized BHT services. This lead to inaccurate identification of	Aetna Better Health of California (ABHCA) is currently producing a Quarterly BHT Report and Monthly BHT Comprehensive Diagnostic Exam Report based on claims paid for BHT services as a method to identify and report authorized BHT services to DHCS. Enhanced Process ABHCA will ensure of the following contractual requirements are met per GMC contract section A.5.G and APL 18.006: a. Modify and update job aid/desk stop to ensure ABHCA adheres to contract requirements by end of December 2019 b. ABHCA will construct a tracking tool to track and trend BHT authorizations by January 2020 as an	N/A		**05/05/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Sample Excel Spreadsheets, "BHT Report" (4/1/19 – 1/31/20 and 2/1/20 – 3/31/20) as evidence that the plan has a system to track and report BHT services. The plan will be utilizing these reports based on claims paid for BHT services as a method to identify and report authorized BHT services to DHCS. - Updated Job Aid, "Applied Behavior Analysis (ABA) and Behavioral Health Treatment (BHT) Medical Necessity"

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
members that receive BHT services	early indicator of BHT services, in addition to the current claims-based reporting process c. ABHCA's Behavioral Health liaison will monitor the members receiving BHT services identified in the monthly BHT tracking report and ensure all contractual requirement provisions are met as follows: i. BH Liaison will lead ABHCA efforts to ensure we provide members access to comprehensive screening and prevention services as per Bright Future periodicity schedule ii. Provide access to comprehensive diagnostic evaluation based on recommendation by license physician or psychologist for treatment of Autism Spectrum Disorder (ASD) iii. Ensure appropriate and timely EPSDT services are initiated iv. Ensure coverage criteria for BHT is met v. Ensure BHT services are medically necessary to correct or ameliorate condition and ensure BHT plan is reviewed every 6 months vi. Ensure BHT services are delivered in accordance to the MCP approved treatment plan and developed by a BHT credentialed provider; including measurable goals and that includes transition, crisis and exit plans vii. Ensure Continuity of Care (CoC) per APL 18.006 d. BH liaison will report monthly monitoring to			(12/27/19) as evidence that the MCP's BHT treatment plans contains all of the required elements. The criteria for BHT services includes the following required elements: transition plan, crisis plan, and exit plan (page 3). - Meeting Minutes, "Quality Management / Utilization Management Committee" (4/8/20) as evidence that the MCP will track and trend BHT authorizations and provide monitoring report to QM/UM committee, as part of state requirement (page 10). **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	ABHCA's UMQM committee on a quarterly basis			
2.4.1 Non-Emergency Medical Transportation The Plan does not have a mechanism to capture and submit data to Non-Emergency Medical Transportation (NEMT) services. The Plan's policy does not reference a mechanism to capture and submit data for NEMT services to DHCS.	The plan has updated Emergent and Non-Emergent Transportation policy which now includes the process for capturing and submitting data for NEMT services. This data is captured in the Provider Certification Statement (PCS) form. PCS forms will be scanned and retained by the transportation vendor. The plan will audit completed PCS forms on a quarterly basis and provide findings back to the transportation vendor. The plan will capture PCS data and report to regulatory agencies accordingly. The current form includes the information as required by APL-17-010 and has been in use since 01/01/2018. The plan will begin the first quarterly audit in January 2020.	Updated policy, draft PCS Form.		**12/09/19** - The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "4500.95: Emergent and Non-Emergent Transportation" which now states that PCS forms will be scanned and retained by the transportation vendor. The MCP will audit completed PCS forms on a quarterly basis and provide findings back to the transportation vendor. The MCP will capture PCS data and report to regulatory agencies accordingly. In addition, the P&P also states that the MCP may use prior authorization processes for approving NMT services and reauthorize services every 12 months when necessary. However, the MCP does not require prior authorization for NMT services to ensure there are no restrictions on these services. NEMT services subject to prior authorization and a written prescription from a physician.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- Physician Certification Statement (PCS) Form, “Aetna Non Emergent Medical Transportation Physician Certification Form” as evidence that the MCP is utilizing an approved PCS form. DHCS approved the form on 1/27/2020. **05/20/20** - The following additional documentation supports the MCP’s efforts to correct this finding: - New Desktop Procedure, “Non-emergency Medical Transportation – Physician Certification Statement Form Audit Process” as evidence that the MCP has developed a process to review and audit Aetna Better Health of California’s transportation vendor adherence to Non-Emergency Medical Transportation and use of Physician Certification Statement (PCS) Form. Access2Care (A2C) will run daily reports that identify members who have a Para Transit Vehicle (PAR) level of service and higher. Those reports will be sent monthly to the MCP’s Delegation Oversight, and they will review the report to identify members who do not have a valid or expiring

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				PCS. If the report shows a member is missing a valid PCS form, the MCP's Delegation Oversight will communicate to A2C and request submission of a new updated report by the 2nd Friday of the month. In addition, the MCP will facilitate a random selection of 40 records and their PCS forms from the report provided by A2C. The MCP will review for accuracy or missing information on Functional Limitation Justification, Dates of Service Needed, Mode of Transportation Needed, and Certification Statement. A summary of audit findings will be sent to A2C within 30 calendar days, and a report will be submitted to the Delegation Oversight Committee for review and/or feedback. - Report Template, "A2C PCS NEMT NMT Report" which includes columns to track for elements such as member name, date of service and time, service type, drop off address, requesting provider, level of services, etc. This report includes results for NEMT and NMT.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				This finding is closed.
2.5.1 Continuity of Care The audit identified factors that contributed to members not receiving the provision of continuity of care, including dissemination of information to educate members and a system to track, monitor, and ensure the provision of continuity of care in accordance with all contract requirements. The Plan's policies do not contain all requirements that describe the continuity of care request workflow. The policy excluded contractually required timeframes, retroactive requests process,	The plan updated policy Member Transition/Continuity of Care to incorporate the requirements in APL 18-008. ABHCA will be submitting this policy for approval as part of the CAP process to ABHCA's Contract Manager for review and approval in accordance with existing requirements. a. Timeframes are in the attached policy b. Retroactive requests are also included in the policy Enhanced Process 1. ABHCA will update the Transition of Care (ToC)/Continuity of Care (CoC) workflow diagram to include timeframes in APL, and retroactive request process by 1/31/20. 2. Incorporate workflow diagram into an internal procedure document by 2/29/20. 3. Education on updated process to internal departments: Member Services, Utilization Management, and Care Management staff will be completed by 2/29/20. 4. Member education to ensure members are properly informed regarding CoC provisions will be	Updated policy.	03/01/20	**06/15/20** - The following documentation supports the MCP's efforts to correct this finding: - Updated Workflow Diagram, "Transition of Care (ToC)/Continuity of Care (CoC)" which now includes timeframes from APL 18-008, and retroactive request process. In addition, the updated Workflow diagram is included in the MCP's library as a Job Aid. Timeframes CoC – Completion: Routine – 30 days of Receipt Immediate – 15 days if medical condition requires Urgent – 3 days if risk of harm (imminent and serious threat) Member Notification within 7 days of decision Retroactive process:

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
telephone intake procedures, and member notification of approved requests.	provided through a member newsletter, ABHCA website (member facing page), and the Member Advisory Committee (MAC) by March 2020. 5. Evaluate reporting requirements to ensure CoC provisions are implemented in accordance with the plan's contractual state requirements by 2/29/20. 6. Ensure CoC notification letters to members, from the plan and the plan's delegated IPAs, are sent timely and include all CoC provisions by January 2020.			When Member Services is verifying a member for TOC/COC, determine whether it is a retroactive request. Make a dated note that it is a retroactive request and proceed with following the process. Retroactive continuity of care reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies. - PowerPoint training, "Continuity of Care (CoC) ABHCA Staff" (02/28/20) as evidence that MCP Member Services, Utilization Management, and Care Management staff received training. The training materials address APL 18-008, Conditions Covered for CoC, Completion of CoC Requests, CoC with an Out of Network Provider, Notification to Member, Updated Workflow Diagram, CoC Care Management and Utilization Management. - "AETNA Member Newsletter," (Summer 2020) which includes member education to ensure members are properly informed regarding Continuity of Care provisions. The Member Newsletter includes information

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				regarding a provider who leaves Aetna Better Health of California. If the provider stops working with Aetna Better Health of California, the member may be able to keep getting services from that provider (page 3). In addition, Continuity of Care information from the Member Handbook was also placed on the ABHCA website and was live as of May, 5, 2020. https://www.aetnabetterhealth.com/california/medicaid-continuity-care.html - PowerPoint presentation, “Continuity of Care (CoC) Member Advisory Committee” (06/10/20) in which the MCP prepared for the Member Advisory Committee (MAC) in order to review Continuity of Care and solicit feedback from the MCP’s members. - Program Screenshots, “Member Services (MS) and Utilization Management (UM) System” in which the MCP implemented additional codes and selection options to the system to improve tracking and reporting for CoC. - Fax Blast, “Aetna Better Health of California IPA Broadcast” (February

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				2020) in which the MCP sent Continuity of Care (CoC) information to their providers. The information includes providing CoC with an out of network provider and CoC request timeframes, along with an attachment of APL 18-008. - Updated Notice of Action letters, "CoC Approval Letter and CoC Denial Letter" that are now specific to Continuity of Care that have been developed based off the Continuity of Care guideline. - Desktop Procedure, "Continuity of Care (CoC) Review Process based on CoC Guidelines" in which the MCP has created a general process review for UM staff. This is to ensure that UM staff follow CoC guidelines and incorporate key aspects in the standard Notice of Action letters. The review process includes identifying that the request is a CoC review, identifying if there is an established relationship with the provider, determining the length of approval, and to send to the CMO for review and decision. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.1.1 Appointment Procedures and Monitoring Wait Times The Plan did not meet the members' specialty appointments within the contractual timeframes.	Aetna Better Health of California (ABHCA) strives to ensure that our network providers understand and comply with timely access to care regulatory requirements. We have improved and enhanced several of our current processes to aid in meeting those requirements. ABHCA has revised our Provider Orientation curriculum to include a separate module explaining the timely access services requirements. Additionally, it will include a handout that can be posted within with provider's office that outlines access to care standards. The updated Provider Orientation packet will be distributed beginning 12/16/19. This will also include guidance to ensure routine specialty care appointments are available within 15 business days of request. Please see Attachment A and Attachment B. Additionally, ABHCA will begin issuing semi-annual reminders to all existing network providers via fax blast on 12/16/19. This will provide consistent reminders as well as education of the requirements for any new or existing provider office staff. Please see Attachment C. In addition to the annual DMHC Access and Availability surveys. ABHCA will implement monthly Appointment and Accessibility survey that will	Provider Handout, Provider Orientation Curriculum, Provider Fax Blast, Internal Desktop.	04/01/20	**12/09/19** – The following documentation supports the MCP's efforts to correct this finding: - A revised Provider Orientation curriculum "Attachment A, Appointment Availability Standards" and an excerpt from 2019 Aetna's "New Provider Orientation Agenda" page 33 (Attachment B) which explains the timely access services requirements and commits the MCP to routine monitoring. Provider Relations will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. - The MCP's CAP response "3.1.1 Appointment Procedures and Monitoring Wait Times VF" commits the MCP to the following milestones: • The updated Provider Orientation packet will be distributed beginning 12/16/19, which will also include guidance to ensure routine specialty care appointments are available within 15 business days of the request. (3.1.1 Attachment B)

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	include 15 randomly selected high-volume and high-impact specialist types and ten (10) primary care providers beginning as of 2/1/20. This will allow us to immediately provide re-education of any provider that is out of compliance and monitor their corrections. Survey results will be shared with the delegated IPAs at quarterly Joint Operations Meetings (JOMs). Please see Attachment D. ABHCA monitors access to care issues via grievances and appeals. The access to care issues are presented to our delegated IPAs at quarterly Joint Operations Meetings (JOMs). In conjunction with the remediations noted above, ABHCA is actively working to finalize agreements with several specialty care providers in San Diego County to increase the size of its provider panel and enhance accessibility/availability. This will increase our network by approximately 200 providers. This increased capacity will aid in minimizing the wait times for our members to access specialists; additionally, ABHCA will issue reminders to these new provider panels to ensure members are receiving timely access to care and ABHCA is meeting members' specialty appointments within the contractual timeframes. In the interim, ABHCA and its delegated IPAs, will fulfill Timely Access regulatory standards by arranging care through Single Case Agreements (SCA).			• The MCP will begin issuing semi-annual reminders to all existing network providers via fax blast on 12/16/19, which will provide consistent reminders as well as education of the requirements for any new or existing provider office staff. (3.1.1 Attachment C) • The MCP will implement a monthly Appointment and Accessibility survey that will include 15 randomly selected high-volume and high-impact specialist types and ten (10) primary care providers beginning as of 2/1/20. This will allow us to immediately provide re-education of any provider that is out of compliance and monitor their corrections. (3.1.1 Attachment D, Provider Appointment Accessibility Study) • The MCP commits to oversite efforts by reporting survey results with the delegated IPAs at quarterly Joint Operations Meetings (JOMs). • The MCP commits to oversite efforts by monitoring access to care issues via grievances and appeals. Furthermore, the Access to Care issues presented to the delegated

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				IPAs at quarterly Joint Operations Meetings (JOMs). • In conjunction with the remediations noted above, ABHCA is actively working to finalize agreements with several specialty care providers in San Diego County (approximately 200 providers) to increase the size of its provider panel and enhance accessibility/availability. In the interim, ABHCA and its delegated IPAs, will fulfill Timely Access regulatory standards by arranging care through Single Case Agreements (SCA). - Attachment A: Revised module "Appointment Availability Standards" included in the Provider Orientation curriculum explains the requirement for Specialty appointments and the MCP's monitoring efforts through Corrective Action Plans. "Provider Relations will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards."

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- Attachment B: “New Provider Orientation Agenda” (2019) demonstrates the Timely Access Standards section. - Attachment C: A fax blast “Appointment Availability Standards Annual Notification” demonstrates MCP’s commitment to semi-annual reminders to all existing network providers via fax blast on 12/16/19. This will provide consistent reminders as well as education of the requirements for any new or existing provider office staff. (MCP’s response to CAP 12/09/19) - Attachment D: A Draft Desktop Procedure, “Provider Appointment Accessibility Study. (Rev. 11/30/2019) The Appointment Accessibility Study Tool is used to conduct the survey, capture responses, score the provider, and notate intervention activities. • The Provider Relations Manager will request a Provider Report for each active county. The report must include 15 randomly selected providers from three (3) high-volume specialist types and

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				three (3) high-impact specialist types in addition to the ten providers from the following provider types (Internal Medicine, Family Practice, Pediatrics, Oncologist, OB/GYN, Specialist, and Behavioral Health Specialists). • The Provider Relations Manager works with the Quality Management department and other health plan leaders as needed to identify providers that meet the high-volume and high-impact specialist types. • In addition to the Provider type criteria, the Provider report criteria must include call tracking codes. Appointment Accessibility surveys are documented in QNXT using the Accessibility Audit] Call Code. For passing surveys, the call is closed using the PSAA – Pass call resolution code. For failing surveys, the Call Code is left open until resurvey results indicate the Provider is compliant with Appointment Availability standards.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• If a Provider fails a survey, the Provider Experience Representative conducts a resurvey in the next 30 calendar days. If the Provider fails the resurvey, the Provider Liaison will conduct a retraining to educate the Provider on appointment requirements. The Provider Experience Representative will conduct a second resurvey in 30 calendar days from the first resurvey. If the provider fails the second resurvey, the results are sent to the Quality Management department and the Medical Director for review. **07/20/20** – The MCP submitted additional documentation to support its efforts to correct this deficiency. P&P 3100.76 "Appeal and Grievance Oversight Team Bi-Weekly Quality Assurance (QA) Program" (01/20/20) commits the MCP to an evaluation of the health plan's Appeal and Grievance files in real-time. The AMA Appeal and Grievance oversight team will perform a bi-weekly quality assurance review and

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				report results to the health plan responsible staff and leaders. **08/12/20** - The MCP submitted survey results from Feb-June of 2020. The MCP is tracking incorrect timeframes. (MCP's response 08/21/20) Areas of opportunity include: - Staff auditors to be re-trained on how to enter provider responses as pass/fail. In the month of June, auditors recorded N\A instead of pass/fail, which had a direct impact on summary results. Training scheduled for 8.31.2020 to include process of data collection and consistency regarding the use of Pass, Fail and N\A. **08/21/20** – 08/21/20 – The MCP submitted an updated "Provider Survey Sheet," which demonstrates correct timeframes for Appointment Availability Standards. - A written response from the MCP (08/21/20) confirmed that since January 1, 2020, Aetna had added a total of 652 PCP's and Specialists in the San Diego Area.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				08/27/20 - The MCP submitted the revised Provider Survey Sheet (Rev. 08/27/20). The MCP's written response commits the MCP to begin the implementation on September 1, 2020. (E-mail 08/26/20) **09/16/20** –The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - MCP's written response (09/16/20) demonstrates the Short-Term Corrective Plan to continue to monitor access to care during COVID-19. On March 27th, 2020 Provider Relations team reached out to 81 Providers to survey Access to Care during the start of the Pandemic to gauge readiness. - Access to Care survey: "ABHCA: COVID Update/Survey" (03/27/20) and Summary Sheet to demonstrate monitoring efforts during Pandemic. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.4.1 Access to Pharmaceutical Services The Plan did not have a mechanism to monitor Emergency Department's compliance with the provision of outpatient prescription drugs in emergency situations.	1. Updated policy Emergency Services is attached that now includes the contractual requirements a. Upon DHCS approval, ABHCA will provide all contracted emergency room facilities with a copy of the updated policy b. Upon policy approval, ABHCA will also update the Provider Manual to reflect the changes c. Provider Relations will provide any follow-up education to the related changes 2. Contracted Emergency facilities will be required to submit Face Sheets to the plan for all members serviced in the emergency room a. Upon receipt of the Face Sheet, the ABHCA will perform member outreach calls (in conjunction with IPAs for delegated members) to verify members are being provided a 72-hour medication supply if warranted b. During outreach, members will also be encouraged to contact their Primary Care Provider for post-ED care follow-up ABHCA is implementing this new process effective January 2020. Full compliance with this deficiency will be met by July 2020.	Updated policy.	03/01/20	**12/09/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated policy A-CA 7000.64 "Emergency Services" includes the contractual requirements to access to at least a 72 hour supply of a covered outpatient drug in an emergency situation, along with a process to monitor this occurs in the Emergency Department visit. (pp. 3, 4) - Policy & Procedure A-CA 7100.05 "Prior Authorization", also includes the requirement for 72-hour emergency medication supply. "Monthly the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data, identifying areas of concern in the plan's performance, and identifying recommendations for action. At a minimum, the CMO or designee presents quarterly summaries of this information to the Quality Management/Utilization Management Committee (QM/UM)."

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- The MCP implemented a new Desktop Procedure (effective 03/31/20) "Monitoring Provision of Medications in Members Discharged from the Emergency Department (ED)" to evaluate access to prescribed medications pursuant to an ED visit and to identify and address any barriers to follow up care that may exist. - A sample of Fax Blast "ABHCA: Guidance for Emergency Treatment Notification." Contracted Emergency facilities are required to submit Face Sheets to the plan for all members serviced in the emergency room. Upon receipt of the Face Sheet, the MCP will perform member outreach calls (in conjunction with IPAs for delegated members) to verify members are being provided a 72-hour medication supply. During outreach, members will also be encouraged to contact their Primary Care Provider for post-ED care follow-up. - "DHCS CAP Claim Report Template" will be used to identify those members who have visited the Emergency Department through claims data. This

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				will occur starting in July 2020 with the previous month data. Data refreshes after the 15th of the month for the previous month. - A sample report "Emergency Fill Report Pharmacy" to be used to identify 72-hour fills related to an ER visit on a quarterly basis. The first report ran on 4/9/2020 for dates of service 1/1/2018 – 4/8/2020. The subscription for this report has been scheduled to be received quarterly on the 5th (i.e., Jan, Apr, Jul, Oct) A report received in July for the 2nd quarter showed no 72 hour emergency fills related to an ER visit. These reports will be further submitted to the QMUM Committee for oversight. **This finding is closed.**
4.1.1 Grievance System The Plan exceeded Grievance Acknowledgement and Grievance Resolution timeframes.	Aetna Better Health of California's Appeal and Grievance department hired additional staff on June 10, 2019 to help ensure that all contractual timeframes are met. As of May 3, 2019, the ABHCA's Appeals and Grievance department, with assistance from the Aetna Better Health corporate team, began auditing cases weekly and providing feedback to Leadership	Updated organizational charts.	05/03/19	**12/09/19** – The following documentation supports the MCP's efforts to correct this finding: - The MCP's CAP response (12/09/19) states: "Aetna Better Health of California's Appeal and Grievance department hired additional staff on June 10, 2019 to help ensure that all

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	and the Appeals and Grievance Supervisor. In addition, ABHCA has implemented a quality review process in which the Appeal and Grievance Supervisor monitors and reviews the appeal and grievance cases daily, this two-tier process ensures that all grievances and appeals are processed and completed timely. As of July 12, 2019, ABHCA and the corporate Appeals and Grievance team now meet bi-weekly to review and discuss any concerns or issues with cases. The Appeal and Grievance department has consistently met timeframe standards as of July 1, 2019.			contractual timeframes are met. (ABHC Org. chart, November 2019) - The audit tool "CA Bi-Weekly GSheet1 Review 04-24 to 05-07-20" demonstrates several areas related to monitoring for the completeness of Grievance and Appeal files, including timeliness. "As of May 3, 2019, the ABHCA's Appeals and Grievance department, with assistance from the Aetna Better Health corporate team, began auditing cases weekly and providing feedback to Leadership and the Appeals and Grievance Supervisor." - A sample of a bi-weekly meetings agenda: "05-25-20 California Partnership Meeting Agenda". ABHCA opted to pursue an outside quality review program. This program audits cases using the G&A data and outcomes are shared with the G&A team. This review is conducted on a bi-weekly basis using a sample of cases. The results are communicated with the supervisor for review and correction. Following the communication, the supervisor meets with the corporate team bi-weekly in a partnership meeting

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				to discuss any issues or errors that have been identified and the status of their correction. (MCP's submission 07/20/20) **07/20/20** – MCP's written response (07/20/20) confirmed, the Appeal and Grievance department has consistently met timeframe standards as of July 1, 2019. **This finding is closed.**
4.3.1 Confidentiality Rights The Plan failed to report breaches and suspected security incidents to all required DHCS officers.	The plan has taken steps to ensure the Compliance Officer of the plan has a guideline on how to submit this type of reports to DHCS. Guidance document was created and published to the Compliance shared drive (internal ABHCA folder) for all Compliance staff to access at any point in time.	N/A	10/29/19	**12/9/19** - The following documentation supports the MCP's efforts to correct this finding: - Written document, MCP process, which ensures the MCP has taken steps to ensure the Compliance Officer of the MCP has a guideline/desktop procedure on how to submit these reports to DHCS. Guidance/Desktop procedure document was created and published to the Compliance shared drive (internal ABHCA folder) for all Compliance staff to access at any point in time.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- Revised Desktop Procedure, "Desktop Medicaid Compliance", (06/17/20) as evidence that the compliance officer and compliance staff receives guidance on how to immediately upon discovery of the potential breach or suspected security incident, the Compliance officer will notify the appropriate DHCS officers using two steps: 1. Notification to the DHCS Contract Manager by telephone; and, 2. By emailing the DHCS Contract Manager and carbon coping: DHCS Privacy Officer [PrivacyOfficer@dhcs.ca.gov] and DHCS Information Security Officer [iso@dhcs.ca.gov] - An email dated 01/13/20, provides evidence that the MCP properly contacted all three required DHCS officers to report the potential privacy breach. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
5.2.1 Network Provider Training The Plan did not conduct provider training for all of its newly contract providers. In addition, when training was provided, it occurred outside contractual timeframes.	Aetna Better Health of California (ABHCA) has revised its policy A-CA 8100.45 Provider Credentialing, Recredentialing Screening Enrollment to include provider orientation requirements and timeframes. See Attachment A, revised/redlined policy A-CA 8100.45 Provider Credentialing, Recredentialing Screening Enrollment pending committee and DHCS Approval. ABHCA identified and acknowledges that the QuickBase application, a database that is used to house key information about our network providers including, but not limited to, provider demographics, contract status and provider orientation date did not include the date on which a provider is placed into an active status by ABHCA. The core system contains the date a provider is placed into an active status. A ticket has been submitted to the IT dept to add an additional field to the database to house the provider's contract effective date with ABHCA. The additional field should be available in the QuickBase application by December 15, 2019. This will sync information on the two systems. The addition of the contract effective date field will facilitate the ability to identify newly credentialed providers in need of new Provider Orientations and help with the monitoring of the orientation status and track the timeliness. Provider Relations will run the validation report from QuickBase daily to identify	Updated policy, updated internal job aid, updated New Provider Orientation table of contents, New Provider Orientation Attestation.	01/01/20	**12/9/19** - The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, 'A-CA 8100.45: Provider Credentialing, Recredentialing Screening Enrollment" (11/25/19) which has been amended to include the requirement to train network providers within ten business days after the Plan places a newly contracted network provider on active status. In addition, the MCP will provide, track and monitor new provider orientations to occur within ten working days after a provider is placed in an active status. - An email (12/19/19) clarifying that the QuickBase database was added with a field to include the date on which a provider is placed into an active status. This will sync information on the two systems. The addition of the contract effective date field will facilitate the ability to identify newly credentialed providers in need of new Provider Orientations and help with the monitoring of the orientation status and track the timeliness.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	providers who are placed in an approved credentialing status. See Attachment B Draft Job aid for New Provider Orientation process and documentation. ABHCA is expanding the available options for providers to receive New Provider Orientations to include a Self-Guided Training to be available beginning January 1, 2020 and weekly Webinars which began November 1, 2019 in addition to in-person trainings currently offered. See Attachment C sample cover page, contents and attestation pages of the self-guided training. Attestation of New Provider Orientation has been revised to capture and identify the method of training a provider received. See Attachment D, revised Attestation of New Provider Orientation, defining the delivery method of the orientation plus additional options of fax and email options for returning the completed forms. Completed Attestation forms are scanned in the appropriate provider contracts folders and orientation dates are documented in the CA Contracting and End to End Tracker. Effective January 1, 2020 Provider Relations will begin to run weekly reports to monitor and track the timeframes between of new providers that have completed credentialing and receipt of a new			Effective January 1, 2020 Provider Relations will begin to run weekly reports to monitor and track the timeframes between of new providers that have completed credentialing and receipt of a new provider orientation. This will also include guidance to ensure the Plan conducts training for all network providers within ten-working days after the Plan places a newly contracted network provider on active status. **07/21/20** – The following additional documentation supports the MCP's efforts to correct this deficiency: - Weekly Monitoring Report, "Sample Orientation Reports" (04/23/20, 05/22/20, 06/16/20) as evidence the MCP is monitoring new provider orientations to occur within ten working days after a provider is placed in an active status. - DHCS Technical Assistance: Recommended changing provider create date to active status date and

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	provider orientation. This will also include guidance to ensure the Plan conducts training for all network providers within ten-working days after the Plan places a newly contracted network provider on active status.			changing attestation date to orientation date on weekly monitoring reports. **This finding is closed.**
6.1.1 Health Education Maintain a system to monitor the performance of the Plan and its subcontractors that deliver health education programs and implement strategies to improve performance and effectiveness.	Oversight and Monitoring Aetna Better Health of California (ABHCA) has a Health Education Program Description that details our health education oversight and monitoring process. Attached is the program description (following on page 3). Oversight and Monitoring process starts on page 5 of the attached program description. Strategies to Improve Performance and Effectiveness A number of implementation strategies will be a part of ABHCA's health education program. Member newsletters and health education handouts are field tested at Member Advisory Committee (MAC) meetings and member feedback is used to revise existing materials and create new materials. The review of materials and results of the field-testing exercises are a standing agenda item at the MAC meetings. Once health education classes begin in February 2020, the Health Educator will collect feedback and revise the class format and topics, as needed. The provider manual, orientation and website are being updated in Q1 2020 and will	Updated policies, Health Education Program Description.	06/30/20	**12/09/19-** The following documentation supports the MCP's efforts to correct this finding: - Aetna's Better Health of California system is evidence of the MCP having a platform to monitor effectives of health education. This includes a multitude of oversight including: Community Advisory Communities, Health Education Classes and surveys, Population Health Assessment, and Delegation Oversight. . **3/31/20-**The following documentation supports the MCP's efforts to correct this finding: - Updated P & P, Policy Number 8300.05, Prevention and Wellness Program (09/01/19) outlines the MCP's dedication to health education. The MCP utilizes an operating system,

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	include more information for members regarding health education topics that are available at no-charge to members. ABHCA's Provider Experience team is currently revising their provider site visit checklist (to be completed by January 30, 2020) to include education for providers regarding member health education and health education materials that are directly available to members. A Population Needs Assessment action plan will be completed and submitted to DHCS by June 30, 2020.			"Aetna Better Health Business Application, which is also aligned with the health plans database which will seek out specific groups of focus, including areas with high health issues or disease, in addition to other necessary areas of focus where tracking may be an asset and possible intervention may be needed. The system also integrates services to support screening to manage health risk by utilizing, EPSDT, USPSTF, and all mandatory vaccinations and immunizations. As well as HEDIS Reporting software to better manage outcomes. - P & P, Policy Number 7000.38, Self-Management Tools (09/01/2019) outlines the MCP's focus continued health education with self-management tools, allowing members to focus on areas of improvement to stay healthy and minimize risk. The MCP will monitored the success of the tools through semi-annual reports. (Page 4) **03/31/20-** The following additional documentation supports the MCP's efforts to correct this finding:

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				-Health Education Management - The MCP manages their Health Education through an online portal, Aetna Health and Wellness which allows members to view an array of heath resources based on their current and future needs. Health topics range from basic account management such as how to select a PCP to more advanced health education needs, such as Chronic Care management with areas of focus on certain conditions and assistance with how to best manage the member's situation. The site offers resources based on the members sex or age to quickly navigate to portals to find the information that is best suited for that audience. If a member is looking for other topics related to healthy living, the website features an array of options including: Meal planning and recipes,, managing BMI, resources for quitting smoking, and podcast to assist members with their healthy education journey. The website is also linked to other community sites that may be beneficial to members including CalFresh and Covered CA.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				04/02/20- The following additional documentation supports the MCP's efforts to correct this finding: - Sample Education Documents: Aetna Spring Member Newsletter, (Spring 2020) and Aetna Provider Manual serve as evidence that the MCP is providing detailed communication regarding health education to its members. This includes topics include areas such as: eating right, staying healthy, and obtaining services that members may be unfamiliar with such as free flu shots. This also goes into other services that are provided to educate Medi-Cal Members such as transportation benefits and how the process works, as well as resource and assistance for different management of health issues that may affect members or their families - Health Education classes, Community Resource list and follow up evaluations are evidence of the MCP providing health education to their beneficiaries. The MCP is providing an array of health education classes including: Smoking Cessation Counseling, Diabetes Care

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				and Prevention, Healthy Eating, Living with Chronic Diseases, Yoga, Zumba, Stress Management and more. In addition the MCP provides a Community Resource List to the beneficiaries that includes a multitude of resources: Foster Youth programs, Health Management, Housing (homelessness), Nutrition & Food access, Resources for personal hygiene and household goods, and more. The MCP will be utilizing the class evaluations as tools to review, evaluate and record discussions after the health education classes have taken place. The MCP will also be using field testing to use new and current health education materials and member newsletters which will take place at the Member Advisory Committee Meetings (MAC). **04/22/20-** The following additional documentation supports the MCP's efforts to correct this finding: - MyActiveHealth online, serves as evidence of the MCP utilizing their Health Education tools to monitor effectiveness and member satisfaction

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				though their vendor Active Health management. The survey is provided to users in January and results will be delivered on an annual basis to the MCP. **05/12/20-** The following additional documentation supports the MCP's efforts to correct this finding: - The MCP is holding regular meetings- MAC/CAC Meeting Minutes (4/23/20) which provides evidence of the continued health education focus, including MyActiveHealth and how to improve the system for its members. The MCP Is trying to make the website more user-friendly, while keeping users updated with changes. The MCP has also implemented new methods for evaluating the effectiveness of the health education materials which include calls and mailers that will be monitored through National Aetna's Better Health QM Team. - MAC/CAC Meeting Minutes (6/12/19), (9/11/19), and (4/23/20) which provide evidence of the continued health education focus, including

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				MyActiveHealth and how to improve the system for its members. The MCP Is trying to make the website more user-friendly, while keeping users updated with changes. The MCP has also implemented new methods for evaluating the effectiveness of the health education materials which include calls and mailers that will be monitored through National Aetna's Better Health QM Team. - MAC Meeting 6/12/19- provides evidence of the continued health education focus including discussion of the recent diabetes booklet and field testing review Eating Healthy on the Go. The Eating Healthy on the Go made additions in some of the following areas including: WIC approved stickers to notate items that are approved, details about diet restrictions, health education podcast, percentages being included in health benefits slides, and additional education about restrictions in diets. The diabetes booklet also made recommendations: Health education Facebook groups, how to differentiate

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				between the two types of diabetes, and nutrition recommendations. - MAC Meeting 9/11/19- provides evidence of the continued health education focus including field testing of recipe cards and text message program. During the MAC meeting the team recommended varies areas of focus to the Field testing which focused a recipe card that highlights a single vegetable, some of the recommendations include: rotation of vegetables with the season, member participation with recipe submission, a list of available area farmers markets, and a star/ footnote to remind members that this can prevent cancer and heart disease. It is also been recommended to include this information in member newsletters and distribute the new recipes at the upcoming feeding America events. The committee continue discussion focusing on the text messaging program, which the MCP is trying to implement. The committee is working on various suggestions to send their members and healthcare including: Diabetes-examples of sugary drinks,

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Diabetes information which will align with the diabetes prevention program, and cervical cancer messages to go to all genders. In addition, the committee will work with providers and case management to make sure they are aware of the text messaging program, **06/04/20-** The following additional documentation supports the MCP's efforts to correct this finding: - An email (06/04/20) which includes web links to the MCP's new website, as well as the Community Resource Link serve as evidence of the MCP providing a Health Education System and Resources to its members in a multitude of areas. This includes support in areas such as; Education, Employment, Foster, Youth Programs, Health Management, Housing/Homelessness, Nutrition/ Food Access, Primary Care, and more. Each section includes supporting links to assist the members with a variety of topics.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				07/01/20- The following additional documentation supports the MCP's efforts to correct this finding: - Sample report "Population Needs Assessment" (2019) is evidence that the MCP is effectively monitoring it's beneficiaries by conducting a yearly assessment to identify needs of the population allowing the MCP to provide high quality health care. In the analysis, the MCP's goal is to review the data to provide MCP a strategy to improve health outcomes of members while at the same time gauging health risk and pinpointing health needs and focusing on health programs and resources that will effectively improve health outcomes. The audit is also focused on a variety of demographics and populations that may be vulnerable to ensure the MCP has a full view of their health and health education necessary to support. Upon completion of the audit the MCP has created the Population Health Management Strategy (PHMS) this is a tool to outline specific prevention and wellness programs, as well as interventions for beneficiaries. Moving forward, the assessment will be

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				managed on an annual basis and items that have a high level of focus will be brought forward for quarterly review to DHCS. Upon conclusion of this report, data will be trended year to year to focus on any areas with necessary focus for the MCP. **This finding is closed**
7.1.a Revise the Plan's policy to state that it is the Plan's responsibility to provide, or arrange to provide, abortion services	Changes made to the policy.	Updated policy.	10/29/19	**12/9/19** - The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, Policy Number 8300 20: Policy Name: Family Planning/Reproductive Health (10/14/2019) which has been amended to include a section on Access to Abortion care based on the APL15-020 and states the MCP is responsible to provide, or arrange to provide abortion services. **This finding is closed**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
7.1.c Revise the Plan's Provider Manual to remove the verbiage regarding abortion to clarify that it is a covered benefit.	Changes made to the Provider Manual.	Updated Provider Manual.	10/29/19	**12/9/19 -** The following documentation supports the MCP's efforts to correct this finding: MCP Provider Manual, (p. 47) has been amended to remove the non-covered services related to abortion- "Election Abortions- not performed as a physician service," this line has now been deleted from the Manual. **This finding is closed**

Submitted by: Chet Uma **Date: 12/09/19**
Title: CEO