

CONTRACT & ENROLLMENT REVIEW
DIVISION – SOUTH SAN DIEGO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Aetna Better Health of California, Inc.

2022

Contract Numbers: 17-94600 Sacramento
17-94602 San Diego

Audit Period: April 1, 2021
Through
March 31, 2022

Dates of Audit: May 16, 2022
Through
May 25, 2022

Report Issued: December 21, 2022

TABLE OF CONTENTS

I.	INTRODUCTION.....	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES.....	6
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management	8
	Category 2 – Case Management and Coordination of Care.....	15
	Category 3 – Access and Availability of Care.....	21
	Category 4 – Member’s Rights.....	28
	Category 6 – Administrative and Organizational Capacity.....	34

I. INTRODUCTION

Aetna Better Health of California, Inc. (Plan) is a subsidiary of Aetna, Inc., which is headquartered in Hartford, Connecticut and is one of the largest health care companies in the United States. Together with its national partners, the Plan supports 2.7 million Medicaid members in 16 states.

In November 2017, the Plan obtained its Knox-Keene license from the California Department of Managed Health Care. The Plan provides members full medical benefits, including vision coverage and obstetrical care.

The Department of Health Care Services (DHCS) implemented the Plan as a new Geographic Managed Care health plan in Sacramento and San Diego counties beginning January 1, 2018.

As of April 2022, the Plan serves 19,164 members in Sacramento and 25,480 members in San Diego through the Medi-Cal line of business.

II. EXECUTIVE SUMMARY

This report presents the results of the medical audit for the period of April 1, 2021 through March 31, 2022. DHCS conducted an audit of the Plan from May 16, 2022 through May 25, 2022. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on October 13, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in this report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management (QM), and Administrative and Organizational Capacity.

The prior DHCS medical audit issued on September 16, 2021, for the audit period of April 1, 2019 through March 31, 2021, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). As of August 2, 2022, the CAP remains open.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 covers requirements and procedures for the UM program, including Prior Authorization (PA) review, Medical Director and medical decisions, and delegation of UM.

The Plan is required to ensure that its PA review, concurrent review, and retrospective review procedures involve consultation with the requesting provider when appropriate. The audit found the Plan rendered a decision for PA requests without receipt of all information necessary to render medical PA determinations and prematurely denied requests.

The Plan is required to comply with all current and applicable provisions of the Medi-Cal Provider Manual. The audit found the Plan did not provide medically necessary services covered by the Medi-Cal Provider Manual, which resulted in a delay in treatment for its members.

The Plan is required to maintain a Medical Director who actively participates in the functioning of the Plan's Grievance and Appeal (G&A) procedures. The audit found the Medical Director did not actively participate in the Plan's grievance process.

The Plan is required to report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions to their Managed Care Operations Division (MCO) Contract Managers within three business days of discovery or imposition. The Plan did not have procedures to report instances of subcontractors' non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the Contract with DHCS to their MCO Contract Manager within three business days of discovery or imposition.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements for California Children's Services (CCS), Early Intervention/Developmental Disabilities (EI/DD), and Behavioral Health Treatment (BHT).

The Plan is required to develop and implement written policies and procedures to identify and refer children with CCS-eligible conditions to the local CCS program. The audit found the Plan did not have a system to ensure members with CCS-eligible conditions were identified and referred to the local CCS program.

The Plan is required to develop and implement systems to identify children under three years of age who may be eligible to receive services from the Early Start Program. The Plan did not have mechanisms to identify children under three years of age who may be eligible to receive services from the Early Start Program.

The Plan is required to cover medically necessary BHT services. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by the provider of BHT services. The audit found the Plan did not ensure BHT treatment plans are reviewed no less than once every six months and contained transition, crisis, and exit plans.

Category 3 – Access and Availability of Care

Category 3 includes the requirements regarding members' access to care, including emergency and family planning services, and the provision of Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services.

The Plan is required to reimburse out-of-network family planning providers for services, such as contraceptive pills, devices, and supplies. The Plan incorrectly denied family planning claims.

The Plan is required to maintain sufficient claims processing/tracking/payment systems capability to determine the status of received claims and calculate the estimate for incurred and unreported claims. The Plan shall either send the claimant a notice of denial with instructions to bill the capitated provider, or forward the claim to the appropriate capitated provider within ten working days of the receipt of the claim. The audit found the Plan did not have a system to identify and process misdirected claims within the required timeframes.

The Plan and transportation brokers are required to use a DHCS-approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The Plan did not maintain a process to ensure utilization of the PCS forms to determine the appropriate level of service.

The Plan is required to ensure that all network providers are enrolled in the Medi-Cal program. The Plan did not ensure contracted NMT providers were enrolled in the Medi-Cal program.

The Plan is required to ensure that all network providers are enrolled in the Medi-Cal program. The Plan did not ensure contracted NEMT providers were enrolled in the Medi-Cal program.

Category 4 – Member’s Rights

Category 4 includes the requirements and procedures to establish and maintain a grievance system, and to protect members’ rights by properly reporting suspected or actual breaches or security incidents.

Grievances are defined as written or verbal expressions of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint or dispute. Inquiries are requests for information that do not include expressions of dissatisfaction. The audit found the Plan did not appropriately classify and process call inquiries as member grievances.

The Plan is required to notify the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of Protected Health Information (PHI) or Personal Information (PI), or potential loss of confidential data. The audit found the Plan did not notify the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 24 hours by email or fax of the discovery of a breach of PHI.

The Plan is required to immediately investigate and submit an updated DHCS Privacy Incident Report within 72 hours of discovering the security incident, breach, or unauthorized access, use or disclosure of PHI or PI to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer. The audit found the Plan did not provide an updated DHCS Privacy Incident Report to the DHCS

Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 72 hours of discovery.

The Plan is required to provide a complete report of the investigation to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within ten working days of the discovery of the breach or unauthorized use or disclosure. The audit found the Plan did not provide a completed Privacy Incident Report to all required DHCS entities within ten working days of discovery.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to conduct, complete, and report fraud and abuse cases to DHCS.

The Plan is required to notify DHCS when the Plan receives information about changes in a member's circumstance that may affect the member's eligibility, such as changes in the member's residence, changes in the member's income, and the death of a member. The Plan did not have a method to notify DHCS of information the Plan received regarding changes in a member's circumstance.

The Plan is required to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members, and the application of these verification processes on a regular basis. The Plan did not regularly verify if services were received by members.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS, Contract & Enrollment Review Division (formerly Medical Review Branch) to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the state Contracts.

PROCEDURE

The review was conducted from May 16, 2022 through May 25, 2022. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: 41 medical, 35 pharmacy, and 32 delegated PA requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 35 appeals of denied medical and pharmacy PAs were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

CCS: Six medical records were reviewed for completeness, timeliness, and evidence of coordination of care between the Plan and providers.

Initial Health Assessment (IHA): Nine medical records were reviewed for timeliness and completeness of IHA requirements.

Complex Case Management: Ten medical records were reviewed for evidence of coordination of care between the Plan and providers.

BHT: 15 medical records were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Category 3 – Access and Availability of Care

Emergency Services and Family Planning Claims: 16 emergency and 11 family planning claims were reviewed for appropriate and timely adjudication.

NEMT and NMT: 24 records (12 NEMT and 12 NMT) were reviewed to confirm compliance with transportation requirements for timeliness and appropriate adjudication.

Category 4 – Member’s Rights

Grievance Procedures: 60 standard grievances (35 quality of care and 25 quality of service), ten exempt grievances, and 30 call inquiries were reviewed for timely resolution, response to the complainant, submission to the appropriate level for review, and translation in member’s preferred language (if applicable).

Confidentiality Rights: The sole security incident during the audit period was reviewed for processing and reporting requirements.

Category 5 – Quality Management

Twenty-one potential quality issue files were reviewed for evaluation and effective action taken to address needed improvement.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 16 fraud and abuse cases were reviewed for processing and reporting requirements.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

CATEGORY 1 – UTILIZATION MANAGEMENT

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Receipt of Information Necessary to Determine Treatment Requests

The Plan shall ensure that its PA review, concurrent review, and retrospective review procedures involve consultation with the requesting provider when appropriate. *(Contract, Exhibit A, Attachment 5 (2)(A))*

Timeframes for medical authorizations are within 30 calendar days for retrospective review; five working days from receipt of information reasonably necessary to render a decision, but no longer than 14 calendar days from receipt of a request for routine authorization; and expedited decision no later than 72 hours for requests that a provider indicates following the standard timeframe could seriously jeopardize the member's life or health. *(Contract, Exhibit A, Attachment 5 (3)(E, H, and I))*

If the Plan cannot make a decision because the Plan is not in receipt of all of the information reasonably necessary, or because the Plan requires consultation by an expert reviewer, or because the Plan has asked that an additional examination or test be performed, the Plan shall immediately upon the expiration of the timeframe or as soon as the Plan becomes aware that it will not meet the timeframe, notify the provider and the enrollee, in writing, that the Plan cannot make a decision and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. Upon receipt of all information reasonably necessary and requested, the Plan shall approve, modify, or deny the request. *(Health and Safety Code section 1367.01(h)(5))*

The Plan's policy 7100.05, *Prior Authorization* (revised July 2021), states that if a request lacks clinical information, the Plan may extend the non-urgent pre-service timeframe up to 14 calendar days. The Plan will ask the member or the member's representative for the specific information necessary to make the decision within the timeframe, or give the member or the member's representative at least 30 calendar days to provide the information.

Finding: The Plan rendered a decision for PA requests without receipt of all information necessary to render medical PA determinations and prematurely denied requests.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

The Plan's desktop procedure, *Utilization Management Clinical Request for Additional Information and Extension Desktop* (updated October 2021), outlined the steps if additional information is required. The procedure is to make three attempts of outreach to contact the provider. It is recommended that initial outreach take place within two business days of receipt of the request, unless expedited then within hours. If the clinical information is not received, then an extension should be requested. The procedure acknowledges that California regulations allow up to 14 calendar days from the date of extension notification. It clarifies that information may be received over the phone.

A medical PA verification study found that the Plan denied PAs for nine of forty-one patients. The Plan made at least two outreach attempts to obtain necessary clinical information and rendered a decision within 72 hours for expedited requests and five working days for routine requests. The examples below show the Plan's lack of an extension request to obtain necessary clinical information.

- An expedited request for an implantable cardioverter defibrillator, a device used to continuously monitor and help regulate potentially life-threatening problems with the heart, was denied because the note did not specify that the patient was a good candidate for placement. Three outreach attempts were not made and one fax outreach attempt was sent to the wrong provider. Turnaround time (TAT) was four days. The reviewer noted an extension was needed but the process was not initiated. An implantable cardioverter defibrillator was approved five months later after a repeated PA request.
- Two separate requests for a continuous positive airway pressure machine to keep the airways open to breathe during sleep were denied because the notes did not include a face-to-face re-evaluation. Neither had an outreach attempt. TAT was three and five days. The machine was approved for both patients two weeks later after repeated PA requests.
- A request for treatment of a child with autism was denied because there were no medical records to review. There were two outreach attempts. A third attempt was not made. TAT was eight days with only two days between the initial attempt and denial. Treatment was approved two months later after a repeated PA request.

The Plan rendered a decision without utilizing the 14 calendar day limit to obtain the necessary clinical information from providers. As a result, PA requests were denied prior to the 14 calendar day limit without the information reasonably necessary to render a decision.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

If PA requests are not properly evaluated, it can lead to inappropriate denials and unnecessary delays in treatment resulting in suboptimal care and adverse patient outcomes.

Recommendation: Ensure receipt of necessary clinical information to determine medical necessity before rendering PA decisions within 72 hours from receipt of expedited PA requests, or within five working days but no longer than 14 calendar days from receipt of routine PA requests.

1.2.2 Review Criteria for Medically Necessary Covered Services

The Plan shall provide all medically necessary covered services required in the Contract and ensure that the covered services are provided in an amount no less than what is offered to beneficiaries under the Medi-Cal Fee-For-Service program. (*Contract, Exhibit A, Attachment 10(1)(A)*)

The Plan shall comply with all current and applicable provisions of the Medi-Cal Provider Manual. (*Contract, Exhibit E, Attachment 2(1)(E)*)

The Plan's *2021 UM Program Description* (revised March 2021) states that the Plan uses medical review criteria for medical necessity decisions consulted in the following order: (1) criteria required by applicable state or federal regulatory agency, (2) Milliman Care Guidelines (MCG), and (3) Aetna Clinical Policy Bulletins.

Finding: The Plan did not provide medically necessary services covered by the Medi-Cal Provider Manual, which resulted in a delay in treatment for its members.

A PA verification study found two patients were denied treatment, which resulted in a delay of care because the Plan used a criteria more restrictive than the Medi-Cal Provider Manual.

- One patient had a three week delay of treatment for multiple myeloma, a cancer of the blood. The Plan denied the initial PA request through MCG that would have been approved through the Medi-Cal Provider Manual. The provider submitted a second PA request that was denied using the same MCG criteria by a different Plan reviewer. Treatment was ultimately approved because the provider simultaneously requested an alternate medication.
- One patient had a three week delay of treatment for Crohn's disease, a systemic inflammatory disorder of the gastrointestinal tract. The Plan denied the initial PA request through a Plan internal Aetna Clinical Policy Bulletins. Otherwise, the request would have been approved through the Medi-Cal Provider Manual.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

If medical review criteria for medical necessity decisions are not used uniformly, it can lead to inappropriate denials and unnecessary delays in treatment, resulting in suboptimal care and potential adverse patient outcomes.

Recommendation: Ensure that all medically necessary covered services included in the Medi-Cal Provider Manual are provided to its members.

1.4

MEDICAL DIRECTOR AND MEDICAL DECISIONS

1.4.1 Medical Director Involvement in the Grievance Process

The Plan is required to maintain a Medical Director who actively participates in the functioning of the Plan's G&A procedures. (*Contract, Exhibit A, Attachment 1(6)(G)*)

Finding: The Plan's grievance system is not overseen by the Plan's Chief Medical Officer or the designated Medical Director.

The Plan's policy 3100.90, *Member Grievance* (revised May 2021), does not include procedures for a Medical Director's involvement in the grievance process. The policy states that the G&A Department assumes primary responsibility for coordinating, managing, and resolving member grievances. If the grievance requires research or input from another department, the G&A Department will forward the information to the affected department, and in coordination, thoroughly research each grievance. The Grievance Committee will consider the additional information and resolve the grievance. Additionally, the Grievance Committee is responsible for reviewing grievance trends.

A review of the Grievance Committee meeting minutes did not demonstrate attendance or involvement of a Medical Director. Additionally, the audit found the Plan's job description for its Medical Director was limited to UM and did not delineate any responsibilities in grievances.

The Plan indicated that Medical Director participation in the G&A procedure is primarily through appeals review. A review of the Plan's documents showed a lack of policies and procedures to specify a Medical Director's responsibilities, participation, or involvement within the grievance system. As a result, a Medical Director did not provide input into the Plan's grievance processes.

Grievances are an integral component of improving health care quality by potentially exposing systemic issues and deficiencies in Plan processes. Without a Medical Director's active participation in the grievance process, the Plan cannot ensure that

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

quality care is provided to its members.

Recommendation: Develop and implement policies and procedures to ensure that a Medical Director actively participates in the grievance system.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

1.5

DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Reporting Non-Compliance of Delegated Entities

The Plan may delegate UM activities. If the Plan delegates UM activities, the Plan shall comply with Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities, of the Contract. (*Contract, Exhibit A, Attachment 5(5)*)

The Plan shall ensure that subcontractors fully comply with all terms and conditions of the Contract. When doing so, the Plan shall oversee and remain responsible and accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in All Plan Letter (APL) 17-004, Subcontractual Relationships and Delegation. (*Contract, Exhibit A, Attachment 6(14)*)

The Plan must also have in place policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of non-compliance with the subcontract or other Medi-Cal requirements. The Plan shall report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the Contract with DHCS to their MCO Contract Managers within three business days of discovery or imposition. (*APL 17-004*)

The Plan's policy 8000.60, *Delegation Oversight Responsibilities* (revised March 2021), states the Plan will impose corrective action and financial sanctions on subcontractors upon discovery of non-compliance, and report instances of non-compliance, imposition of corrective actions, or financial sanctions within three business days of discovery or imposition.

Finding: The Plan did not report instances of subcontractors' non-compliance, imposition of corrective actions, or financial sanctions to MCO Contract Managers within three business days of discovery or imposition.

While the Plan's policy 8000.60 and desktop procedure, *Delegation Oversight End To End Desktop Procedures* (effective February 2018), outlined the Plan's ongoing monitoring and CAP process, the audit found that the desktop procedure did not have steps included to report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions to the Plan's MCO Contract Managers within three business days of discovery or imposition.

The following two examples showed how the Plan's subcontractors were non-compliant but the Plan did not report both instances to its MCO Contract Manager.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

- During the Plan's routine monthly review of reporting requirements, a subcontractor did not submit the Notice of Action packets to the Plan from January 2021 through June 2022. The Plan and subcontractor met to discuss the contractual requirement of submitting requested reports. The Plan continues to communicate with the subcontractor, and stated it will issue a CAP in June 2022.
- Another subcontractor informed the Plan in August 2021 that it will be using an off-shore vendor to process claims effective February 2021. The Plan issued a Cease and Desist Letter in September 2021 to the subcontractor, which discontinued the use of an off-shore vendor. The Plan did not confirm from February 2021 through September 2021 that no activity pertaining to the Plan's obligations under the DHCS Contract was conducted using an off-shore account.

The Plan confirmed that instances of non-compliance were not reported to MCO within the required timeframe.

Without procedures in place to report non-compliance to DHCS, the Plan cannot ensure its subcontractors comply with all applicable state and federal laws and regulations and Contract requirements. The risk of prolonged non-compliance can lead to poor quality of care and potential member harm.

Recommendation: Develop and implement procedures to report subcontractors' non-compliance or imposition of corrective actions to MCO Contract Managers within three business days of discovery or imposition.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	CALIFORNIA CHILDREN’S SERVICES
------------	---------------------------------------

2.1.1 Identification and Referral of CCS-Eligible Children

The Plan is required to develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. For members with CCS-eligible conditions, initial referrals are to be made to the local CCS program by telephone, same-day mail or fax, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program. (*Contract, Exhibit A, Attachment 11(9)*)

The Plan’s policy 7000.43, *Coordination of Member Care* (revised September 2021), states the Plan will perform and obtain baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion that a member has a medical condition and qualifies for CCS. Coordination and transition of member care services include making referrals for services the member may be eligible through Plan partner programs or community resources and organizations.

Additionally, the Plan’s desktop procedure, *California Children’s Services Referral Process* (revised December 2021), states the Plan identifies members through data systems and screening tools. Independent Physician Associations (IPA) will send a referral to the Plan for members eligible for CCS or in CCS. The Plan’s Health Homes Program staff will ensure qualified children are referred to CCS. Primary Care Physicians (PCP) are responsible for performing appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish or raise a reasonable suspicion, that a member has a CCS-eligible medical condition. The PCP is responsible for initiating referrals of members with CCS-eligible conditions to their local CCS program. Furthermore, the Plan’s case management staff is also responsible for the identification and referral of members with CCS-eligible conditions to the local CCS program.

Finding: The Plan did not have a system to ensure members with CCS-eligible conditions were identified and referred to the local CCS program.

While the Plan’s desktop procedure had mechanisms to identify members eligible for CCS and refer them to their local CCS program, the audit found that the Plan did not

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

have methods to track and monitor its process as the Plan did not have documentation to show those procedures were implemented. A review of the Plan's *CCS Member List* showed 160 members receiving CCS during the audit period. However, only one member had a CCS-eligible condition indicated and the list did not contain a field for the PCP assignment date.

A verification study found all six medical records reviewed had deficiencies. The records did not indicate when and how the members were identified for CCS. Additionally, for five members, there was no documentation of a CCS-eligible condition, coordination of care with the local CCS agency, and coordination of care with the PCP and other community entities.

The Plan stated that the Case Management Department is responsible for tracking and monitoring members with CCS through the electronic system, Dynamo, under tracking activity. However, the Plan staff also stated that the Case Management Department would not have documentation of all the steps of the CCS process. The Plan staff explained that they would not document in depth unless the member was enrolled into the Plan's case management program.

If the Plan does not have a system to identify and monitor members in need of CCS, members may not receive necessary health services, which can lead to potential harm.

Recommendation: Develop and implement mechanisms to ensure members are identified for CCS and referred to the local CCS program.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

2.1

EARLY INTERVENTION/DEVELOPMENTAL DISABILITIES

2.1.2 Early Start Program Eligibility Identification

The Plan is required to develop and implement systems to identify children under three years of age who may be eligible to receive services from the Early Start Program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. (*Contract, Exhibit A, Attachment 11(11)*)

The Plan's policy 7000.90, *Children with Special Health Care Needs* (revised January 2022), indicates the Plan aims to facilitate the provision of safe, effective, member-centric, timely, efficient and equitable care and services to its members. Member identification is conducted through diagnosis driven predictive modeling, welcome calls, self-referral, provider referral, or from a community agency or partner. The Plan monitors children with special health care needs through those enrolled in the Plan's case management program, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) rates, and immunization rates.

The Plan's policy 7000.43, *Coordination of Member Care* (revised September 2021), states the Plan will perform and obtain baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion that a member has a medical condition and qualifies for EI services or Early Start Program. The Plan will monitor and provide oversight through the collection of data, analyzing the data, identifying areas of improvement, and measuring the effectiveness of improvement actions annually. Coordination of activities are reported to the Plan's QM/UM Committee, Quality Management Oversight Committee (QMOC), and Board of Directors.

Finding: The Plan did not have mechanisms to identify children under three years of age who may be eligible to receive services from the Early Start Program.

This was a prior audit finding. As part of the corrective actions, the Plan implemented its desktop procedure, *Early Start Program Referral*, on April 28, 2021, which outlined the EPSDT benefit, eligibility requirements, available services, local Early Start Program contact information, referral process, and manager oversight responsibilities. The Plan collaborated with the QM Department to identify members that are EPSDT eligible by age and potential gaps in care. The Plan distributed gaps in care reports to providers that include EPSDT related Healthcare Effectiveness Data and Information Set measures, such as well child visits, child and adolescent immunizations, and blood lead screening. Additionally, the Plan sent out EPSDT mailers to eligible members. The Plan

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

shared that the Chief Medical Officer regularly reports to the QMOC on the EPSDT/Prevention and Wellness activities.

While the Plan's policies and procedures delineated the identification of children who may be eligible for receiving Early Start services, the audit found that the Plan did not have documentation to show it identified children eligible for EI services. The Plan provided a log, *Final DD ID Referrals*, for the period of April 2021 through March 2022, which identified three members (ages two, three, and four), of which two were referred to the Early Start Program. However, the Plan did not provide the date the referrals were made.

The Plan provided a monitoring activity report, *Community Resource Referrals Case Events*. The report summarized resource types and the number of referrals during January 1, 2021 to March 25, 2022. However, the report had no specific indication related to EI/DD services or the Early Start Program.

Additionally, a review of the QM/UM Committee, QMOC, and Board of Directors meeting minutes showed agenda topics for EPSDT outreach activities. However, there were no discussions specific to members identified for EI or referrals made to the Early Start Program.

The Plan stated that the electronic system, Dynamo, is used to monitor EI/DD. To generate a report, Plan staff would have to go to specific cases and flag the subcategory. The report would show all referrals, both complete and incomplete, so Plan staff would have to manually search and extract the necessary information. However, the report does not specify which referrals are related to EI/DD.

In a narrative statement, the Plan specified that the care management team does not have the reporting capability to isolate a subcategory referral for a specific population.

When children in need of a referral to the Early Start Program are not identified, access to support and EI can lead to further developmental delay and potential long-term disability.

This is a repeat of the 2021 audit finding 2.1.1 – Early Start Program Eligibility Identification.

Recommendation: Develop and implement mechanisms to identify children under the age of three who may be eligible to receive services from the Early Start Program.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

2.3 BEHAVIORAL HEALTH TREATMENT

2.3.1 Behavioral Treatment Plans

The Plan is required to cover medically necessary BHT services for members under 21 years of age diagnosed with Autism Spectrum Disorder, or for members under three years of age with a rule out or provisional diagnosis. (*Contract, Exhibit A, Attachment 10(5)(G)*)

The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by the provider of BHT services. The approved behavioral treatment plan must include measurable goals and objectives. In addition, it must contain the member's progress and a transition, crisis, and exit plan. (*APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21*)

The Plan's policy 7000.91, *Behavioral Treatment* (revised April 2021), states the Plan ensures the provision of EPSDT services for members under 21 years of age, which includes medically necessary BHT services for members that meet eligibility criteria. BHT services are provided under a behavioral treatment plan that must be reviewed, revised, and/or modified no less than once every six months by a BHT Services Provider and must include transition, crisis, and exit plans. The Plan is responsible for ensuring that all delegates comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including applicable APLs, Policy Letters, and Dual Plan Letters.

Finding: The Plan did not ensure BHT treatment plans are reviewed no less than once every six months and contained transition, crisis, and exit plans.

This was a prior audit finding. The CAP indicated that the Plan updated their desktop procedure, *Applied Behavior Analysis and Behavioral Health Treatment Medical Necessity for Members Under the Age of 21*, in October 2021. The Plan included responsibilities for monitoring services to ensure treatment plans are reviewed, revised, and modified no less than once every six months. Additionally, treatment plans are to include all required elements, including a transition, crisis, and exit plan.

While the Plan's policy 7000.91 and desktop procedure stated that the Plan is responsible for ensuring compliance with BHT requirements, the audit found that the Plan did not implement its policy. A verification study showed the Plan approved treatment plans that did not meet criteria requirements. The audit found six of fifteen medical records reviewed either did not have treatment plans reviewed no less than

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

once every six months, had a treatment plan but did not include a crisis plan, had a treatment plan but did not include an exit plan, had a treatment plan but did not include a transition plan, or did not have a treatment plan at all.

The Plan did not ensure the completeness or compliance of its treatment plans. If BHT plans are not reviewed timely and do not have the required elements of transition, crisis, and exit plans, members may miss program goals and desired health care outcomes.

This is a repeat of the 2021 audit finding 2.3.1 – Behavioral Treatment Plans.

Recommendation: Revise and implement policies and procedures to ensure BHT treatment plans are reviewed, revised, and modified no less than once every six months and contain transition, crisis, and exit plans.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.6

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

3.6.1 Family Planning Claims Processing

The Plan is required to reimburse non-contracting family planning providers for services. *(Contract, Exhibit A, Attachment 8(9))*

Members of childbearing age have the right to access services, such as contraceptive pills, devices, and supplies, from out-of-network family planning providers without PA. *(Contract, Exhibit A, Attachment 9 (9) (A) (2) and California Code of Regulations (CCR), Title 28, sections 1300.67(g) and 53216))*

The Plan's policy 6300.11, *Out-of-Network Provider Payments* (revised August 2021), states members have the right to access family planning services through any family planning provider without PA. Members of childbearing age may access services, as outlined in the Contract, from out-of-plan family planning providers to temporarily or permanently prevent or delay pregnancy.

Finding: The Plan incorrectly denied family planning claims.

A verification study found that three of eleven family planning claims reviewed were inappropriately denied for missing precertification/authorization. Denied claims included contraceptive drug implants (CPT codes J7298 and J7307).

In the interview, the Plan acknowledged that due to an incorrect reconfiguration of its claims system, the system was set up incorrectly to automatically deny out-of-network family planning claims. The Plan also stated it has not reprocessed denied family planning claims due to the incorrect system configuration.

Inappropriate denials and reimbursements of family planning claims may limit members' access to care and discourage providers from participating with the Plan if not properly reimbursed.

Recommendation: Revise and implement policies and procedures to ensure appropriate reimbursement of family planning claims.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

3.6.2 Processing of Misdirected Claims

The Plan shall maintain sufficient claims processing/tracking/payment systems capability and comply with applicable state and federal law, regulations, and Contract requirements to determine the status of received claims and calculate the estimate for incurred and unreported claims. (*Contract, Exhibit A, Attachment 8(5)(D)*)

The Plan is responsible for meeting claim filing deadlines, including claims incorrectly sent to the Plan. For provider claims that do not involve emergency service or care, if the provider that filed the claim is contracted with the Plan's capitated provider that is responsible for adjudicating the claim, the Plan shall either (1) send the claimant a notice of denial with instructions to bill the capitated provider, or (2) forward the claim to the appropriate capitated provider, within ten working days of the receipt of the claim. (*CCR, Title 28, section 1300.71(b)(2)(B)*)

The Plan's policy 6300.11, *Out-of-Network Provider Payments* (revised August 2021), describes the Plan's systems to identify out-of-network provider claims, authorization requirements, and claim review procedures to identify and confirm prompt payment for out-of-network services.

Finding: The Plan did not have a system to identify and process misdirected claims within the required timeframes.

According to the Plan's misdirected claims report for March 2022, 499 out of 3,633 (approximately 13.7 percent) of the misdirect claims had a turnaround time beyond ten days from the receipt date.

The Plan's policy 6300.11, *Out-of-Network Provider Payments* (revised August 2021), lacks procedures for processing misdirected claims within the required timeframes. In written statement, the Plan acknowledged that it does not have a documented process regarding misdirect claims.

The Plan stated in an interview that, from April 2021 to December 2021, the procedures to identify, process, and track misdirected claims was not effective. Upon recognizing this issue in January 2022, the Plan's staff manually reviewed claims and send back misdirected claims to the IPAs. However, the manual review results showed that for misdirected claims received by the Plan, the Plan did not meet the ten-day deadline to either send the claimant a notice of denial, with instructions to bill the capitated provider or forward the claim to the appropriate capitated provider.

When the Plan does not forward misdirected claims, providers may not be reimbursed for services rendered, which may lead to members being erroneously billed for covered

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

Medi-Cal services.

Recommendation: Revise and implement policies and procedures to identify and process misdirected claims.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

3.8

NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION

3.8.1 Physician Certification Statement

The Plan is required to cover transportation services as required in the Contract and directed in APL 17-010, *Non-Emergency Medical and Non-Medical Transportation Services*, to ensure members have access to medically necessary services. The Plan shall cover NEMT services and NMT services. (*Contract, Exhibit A, Attachment 10(8)(H)*)

NEMT means ambulance, litter van, and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, rendered by licensed providers. (*Contract, Exhibit E, Attachment 1*)

All NEMT services require a physician's prescription and PA. (*CCR, Title 22, section 51323*)

The Plan and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. (*APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services.*)

The Plan's policy 4500.95, *Emergent and Non-Emergent Transportation* (revised April 2021), documents the Plan's protocols related to NEMT and NMT transportation services. The Plan will use a DHCS approved PCS form to determine the appropriate level of service for members.

Finding: The Plan did not maintain a process to ensure utilization of the PCS forms to determine the appropriate level of service.

A verification study found that in seven out of twelve NEMT services, the PCS forms were not received prior to the Plan rendering such services.

The Plan conducts a monthly audit of its transportation broker to verify that PCS forms are obtained prior to the provision of NEMT and that CAPs are issued for non-compliance with this protocol. The Plan noted that, for three consecutive months, its transportation broker did not obtain PCS forms prior to rendering NEMT services. However, the Plan did not implement its policy to issue a CAP to its transportation broker.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

Without completed PCS forms, the Plan cannot assign the best method of transportation to fit the members' needs.

Recommendation: Implement policies and procedures to ensure utilization of the PCS forms to determine the appropriate level of services.

3.8.2 Unenrolled NMT Transportation Providers

The Plan must ensure that all network providers are enrolled in the Medi-Cal program. (*Code of Federal Regulations, Title 24, section 438.608(b)*)

All Managed Care plan network providers must enroll in the Medi-Cal program. Managed Care plans have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through DHCS. (*APL 19-004, Provider Credentialing / Recredentialing and Screening / Enrollment*)

The Plan's policy 8100.45, *Provider Credentialing, Recredentialing and Screening/Enrollment* (revised October 2021), states that before requiring the applicant to enroll with DHCS, credentialing associate or contracting staff will request the applicant to include Medi-Cal enrollment information in their application, or will validate provider enrollment via the State California Health and Human Services (CHHS) Open Data Portal.

Finding: The Plan did not ensure contracted NMT providers were enrolled in the Medi-Cal program.

The Plan utilizes an outside broker to provide transportation for its members. The broker delegates the NMT services to transportation providers. Both the Plan and the broker monitor the Medi-Cal enrollment status. The broker reports to the Plan monthly on various performance measures, including the enrollment status of the NMT providers. Additionally, to ensure enrollment of transportation providers in the Medi-Cal program, the Plan developed a CAP for this prior audit finding.

A review of providers rendering NMT services showed that the broker's monthly enrollment status reports contained incorrect and missing information as noted in the following:

- The Plan's log contained claims paid to 11 NMT providers, however, these NMT providers were not included in the transportation broker's monthly enrollment status report. The Plan did not verify the enrollment of the 11 NMT providers in the Medi-Cal program before paying NMT service claims.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

The CAP developed by the Plan effective May 24, 2021, included the following actions: assisting the broker's new or existing transportation providers in enrolling with Medi-Cal and generating monthly reporting and monitoring of transportation providers' Medi-Cal enrollment status. Review of the Plan's monthly enrollment status report revealed that it included all network providers and the Plan's transportation broker but not any NMT providers. In a written statement, the Plan explained that its monthly report to monitor for provider enrollment in Medi-Cal does not include transportation providers. The Plan did not implement its CAP to generate monthly reports to monitor enrollment status of NMT providers.

If the Plan contracts with NMT providers that are not enrolled in the Medi-Cal program, it cannot ensure that providers meet Medi-Cal requirements.

Recommendation: Revise and implement policies and procedures to ensure NMT providers are enrolled in the Medi-Cal program.

3.8.3 Unenrolled NEMT Transportation Providers

The Plan must ensure that all network providers are enrolled in the Medi-Cal program. (*Code of Federal Regulations, Title 24, section 438.608(b)*)

All Managed Care plan network providers must enroll in the Medi-Cal program. Managed Care plans have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through DHCS. (*APL 19-004, Provider Credentialing / Recredentialing and Screening / Enrollment*)

The Plan's policy 8100.45, *Provider Credentialing, Recredentialing and Screening/Enrollment* (revised October 2021), states that before requiring the applicant to enroll with DHCS, credentialing associate or contracting staff will request the applicant to include Medi-Cal enrollment information in their application, or will validate provider enrollment via the State California Health and Human Services (CHHS) Open Data Portal.

Finding: The Plan did not ensure contracted NEMT providers were enrolled in the Medi-Cal program.

The Plan utilizes an outside broker to provide transportation for its members. The broker delegates the NEMT services to transportation providers. Both the Plan and the broker monitor the Medi-Cal enrollment status. The broker reports to the Plan monthly on various performance measures, including the enrollment status of the NEMT providers. Additionally, to ensure enrollment of transportation providers in the Medi-Cal program,

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

the Plan developed a CAP for this prior audit finding.

A review of providers rendering NEMT services showed that the broker's monthly enrollment status reports contained incorrect and missing information as noted in the following:

- One NEMT provider was misidentified as a participant enrolled in the Medi-Cal program. Although, the Plan stated that it uses the CHHS website to verify for provider enrollment, there was no CHHS record of this provider. Additionally, there was no documentation of the Plan's verification that the broker's monthly enrollment status reports were accurate and complete.

The Plan submitted a log containing claims paid to transportation providers who rendered either NEMT, NMT, or both NEMT/NMT services. Fourteen providers from this log were reviewed for enrollment, whether with DHCS or through the Plan. Enrollment was verified by cross-referencing against the broker's monthly enrollment status reports to the Plan, the Plan's own monthly enrollment status report that was developed for the CAP, DHCS' ACSNET database, and the Provider Application and Validation for Enrollment (PAVE) portal. The CHHS website was also cross-referenced since the Plan stated in an interview that it checks the CHHS website to verify for provider enrollment. The review of paid transportation providers showed that four of fourteen NEMT providers were not enrolled in the Medi-Cal program. Of the four NEMT providers that were not enrolled in Medi-Cal, three providers rendered both NEMT and NMT services.

The CAP developed by the Plan effective May 24, 2021, included the following actions: assisting the broker's new or existing transportation providers in enrolling with Medi-Cal and generating monthly reporting and monitoring of transportation providers' Medi-Cal enrollment status. Review of the Plan's monthly enrollment status report revealed that it included all network providers and the Plan's transportation broker but not any NEMT providers. In a written statement, the Plan explained that its monthly report to monitor for provider enrollment in Medi-Cal does not include transportation providers. The Plan did not implement its CAP to generate monthly reports to monitor enrollment status of NEMT providers.

If the Plan contracts with NEMT providers that are not enrolled in the Medi-Cal program, it cannot ensure that providers meet Medi-Cal requirements.

This is a repeat of the 2021 audit finding 3.8.3 – Unenrolled NEMT Transportation Providers.

Recommendation: Revise and implement policies and procedures to ensure NEMT providers are enrolled in the Medi-Cal program.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

CATEGORY 4 – MEMBER’S RIGHTS

4.1 GRIEVANCE SYSTEM

4.1.1 Grievances Classified as Call Inquiries

The Plan is required to implement and maintain a Member Grievance System in accordance with CCR, Title 22, section 53858 and Title 28, sections 1300.68. (*Contract, Exhibit A, Attachment 14(2)*)

A grievance is defined as a written or verbal expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint or dispute. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. (*CCR, Title 28, section 1300.68(a)(1)*)

An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Plan processes. (*APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments*)

The Plan’s policy 3100.90, *Member Compliant/Grievance* (revised May 2021), defines a member grievance as any written or verbal expression of dissatisfaction by a member or member representative, including complaints about any matter other than an adverse benefit determination. In addition, the policy defines an inquiry as a request from a member for information that would clarify health plan policy, benefits, procedures, or any aspect of health plan function but does not express dissatisfaction. Furthermore, the policy states that upon receipt of a verbal or written grievance, Member Services Department will document the grievance in the call system and assign it to the G&A Department. The G&A Department will either conduct the investigation or assign it to the appropriate department to conduct an investigation and document the actions taken.

Finding: The Plan did not appropriately classify and process call inquiries as member grievances.

This was a prior audit finding. The Plan implemented corrective action on September 2, 2021, and re-educated and trained its Member Service Representatives (MSR). The Plan also audited calls to ensure compliance with the Plan’s policy 3100.90 that if a grievance is identified, it will be forwarded to the grievance team to be documented and resolved.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

A verification study revealed that 7 of 30 call inquiries, dated after September 2, 2021, had an expression of dissatisfaction documented in the call notes by the MSR. However, the call inquiries were not forwarded to the G&A Department to be appropriately logged and investigated as a grievance. One case involved a paraplegic member whose wound bandages should be changed daily and it had not been changed in a week. Another case involved a member who was denied services and conferenced called the MSR and IPA. The cases were closed at the Member Service Department.

The Plan did not follow its policy and procedures regarding the processing of grievances and call inquiries. Documentation showed the MSRs did not identify calls with an expression of dissatisfaction as grievances, and those calls were not forwarded to the G&A Department to be documented and resolved.

Misclassification of grievances may lead to inadequate investigations that result in unresolved member complaints and missed opportunities for quality of care improvement.

This is a repeat of the 2021 audit finding 4.1.3 – Grievances Classified as Call Inquiries.

Recommendation: Develop and implement policies and procedures to ensure proper classification of call inquiries as grievances.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

4.3

CONFIDENTIALITY RIGHTS

4.3.1 Privacy Breach and Notifying Required Entities within 24 Hours

The Plan is required to notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, or potential loss of confidential data. Notice shall be provided to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer. (*Contract, Exhibit G (III)(J)(1)*)

The Plan's policy, *CVS Health and/or Aetna Privacy Policies* (revised December 2020), states that the Plan will notify DHCS immediately by telephone call plus email or fax upon the discovery of a breach of unsecured PHI or in electronic media or in any other media if the PHI or was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. The Plan will also notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, or potential loss of confidential data.

Finding: The Plan did not notify the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 24 hours by email or fax of the discovery of a breach of PHI.

In a CAP to address this prior audit finding, the Plan updated its policy and desktop procedure, and trained Plan staff to ensure that breaches are reported within the required timeframe.

A verification study found the Plan reported one case of a PHI breach during the audit period. A review of the case showed the Plan did not notify all required three DHCS entities within the 24-hour timeframe.

During an interview, the Plan identified the lack of reporting was due to the inadequate auto-generated notification of potential cases or incidents. The Plan's Compliance Officer is the only individual who receives a notification. However, the Compliance Officer was on leave at the time of the incident. Therefore, it was not reported to DHCS due to a lack of internal communication, monitoring, and succession planning.

Prompt investigation and reporting of any breach or suspected security incident is important in order to prevent and mitigate the access, use, or disclosure of confidential information by an unauthorized person. Failure to report in a timely manner indicates that

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

the Plan's procedures in investigating and rectifying the breach or suspected security incident is insufficient to protect member's PHI and PI.

This is a repeat of the 2019 audit finding 4.3.1 – Breaches and Security Incidents and 2021 audit finding 4.3.1 – Privacy Breach and Notifying Required Entities within 24 Hours.

Recommendation: Implement policies and desktop procedures to ensure breaches or suspected security incidents are reported to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 24 hours by email or fax.

4.3.2 Privacy Breach and Filing an Incident Report within 72 Hours

The Plan is required to immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, the Plan must submit an updated DHCS Privacy Incident Report containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer. (*Contract, Exhibit G (III)(J)(2)*)

The Plan's policy, *CVS Health and/or Aetna Privacy Policies* (revised December 2020), states that the Plan will immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI, and submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 72 hours of discovery.

Finding: The Plan did not provide an updated DHCS Privacy Incident Report to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 72 hours of discovery.

In a CAP to address this prior audit finding, the Plan updated its policy and desktop procedure, and trained Plan staff to ensure that breaches are reported within the required timeframe.

A verification study found the Plan reported one case of a PHI breach during the audit period. A review of the case showed the Plan did not submit the DHCS Privacy Incident Report within the 72-hour reporting timeframe at all.

During an interview, the Plan identified the lack of reporting was due to the inadequate

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

auto-generated notification of potential cases or incidents. The Plan's Compliance Officer is the only individual who receives a notification. However, the Compliance Officer was on leave at the time of the incident. Therefore, it was not reported to DHCS due to a lack of internal communication, monitoring, and succession planning.

Prompt investigation and reporting of any breach or suspected security incident is important in order to prevent and mitigate the access, use, or disclosure of confidential information by an unauthorized person. Failure to report in a timely manner indicates that the Plan's procedures in investigating and rectifying the breach or suspected security incident is insufficient to protect the member's PHI and PI.

This is a repeat of the 2019 audit finding 4.3.1 – Breaches and Security Incidents and 2021 audit finding 4.3.2 – Privacy Breach and Filing an Incident Report within 72 Hours.

Recommendation: Implement policies and desktop procedures to submit an updated DHCS Privacy Incident Report to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within the 72-hour timeframe.

4.3.3 Privacy Breach and Filing a Complete Incident Report within Ten Days

The Plan is required to provide a complete report of the investigation to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within ten working days of the discovery of the breach or unauthorized use or disclosure. (*Contract, Exhibit G (III)(J)(3)*)

The Plan's policy, *CVS Health and/or Aetna Privacy Policies* (revised December 2020), states that the Plan will provide a complete report of the investigation within ten working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and/or state law. The report shall also include a full, detailed CAP, including information on measures that were taken to halt and/or contain the improper use or disclosure.

Finding: The Plan did not provide a completed Privacy Incident Report to all required DHCS entities within ten working days of discovery.

In a CAP to address this prior audit finding, the Plan updated its policy and desktop procedure, and trained Plan staff to ensure that breaches are reported within the required timeframe.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

A verification study found the Plan reported one case of a PHI breach during the audit period. A review of the case showed that a completed Privacy Incident Report was not submitted within ten working days of discovery to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.

During an interview, the Plan identified the lack of reporting was due to the inadequate auto-generated notification of potential cases or incidents. The Plan's Compliance Officer is the only individual who receives a notification. However, the Compliance Officer was on leave at the time of the incident. Therefore, it was not reported to DHCS due to a lack of internal communication, monitoring, and succession planning.

Prompt investigation and reporting of any breach or suspected security incident is important in order to prevent and mitigate the access, use, or disclosure of confidential information by an unauthorized person. Failure to report in a timely manner indicates that the Plan's procedures in investigating and rectifying the breach or suspected security incident is insufficient to protect the member's PHI and PI.

This is a repeat of the 2019 audit finding 4.3.1 – Breaches and Security Incidents and 2021 audit finding 4.3.3 – Privacy Breach and Filing a Complete Incident Report within Ten Days.

Recommendation: Implement policies and desktop procedures to submit an updated DHCS Privacy Incident Report to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within ten working days of discovery.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2

FRAUD AND ABUSE

6.2.1 Notification Regarding Changes in Member's Circumstances

The Plan must notify DHCS when the Plan receives information about changes in member's circumstances that may affect the member's eligibility, such as changes in the member's residence, changes in the member's income, and the death of a member. (*Contract, Exhibit E, Attachment 2 (25)(B)(3)*)

Finding: The Plan did not have a method to notify DHCS of information the Plan received regarding changes in a member's circumstance.

The Plan maintains a desktop procedure 4500.05D, *Processing Demographic Change Requests*, to document member's change requests and make the change in the Plan's core processing system, QXNT. However, the Plan does not have a policy and the desktop procedure does not delineate steps to notify DHCS of changes in a member's circumstance.

In a narrative statement, the Plan expressed that if the MSR or Plan staff believe that a member continues to receive benefits while residing in another state, an internal referral can be made to the Plan's Special Investigations Unit. Additionally, the Plan provided documentation showing the Plan's email correspondence with DHCS. The correspondence stated that the Plan shall report changes regarding member circumstances to DHCS in addition to reporting changes to the county. However, the Plan did not provide policies and procedures nor documentation of communicating changes in member circumstances to DHCS. The Plan is working on a redetermination to utilize different sources to track member addresses and phone numbers.

It is the Plan's responsibility to guard against fraud and abuse by reporting changes in member circumstances. Failure to report to DHCS may compromise the integrity of the Plan and the Medi-Cal program.

Recommendation: Develop and implement policies and procedures to ensure DHCS is notified of changes in a member's circumstance.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

6.2.2 Verification of Services Delivered By Network Providers

The Plan must have a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members, and the application of this verification processes on a regular basis. *(Contract, Exhibit E, Attachment 2 (25)(B)(5))*

Finding: The Plan did not verify if services delivered by network providers were received by members.

The Plan does not have policies and procedures to verify services. The Plan's Chief Operations Officer stated that the process is currently being developed with procedures and templates still being drafted.

Furthermore, the Plan did not have any other method for verification during the audit period. The Plan stated that members may call the MSRs to inform them that represented services were not received or to file a grievance. There were no grievances related to this issue.

Verification of services ensure that services are delivered to people needing those services and that providers only bill for services rendered. Failure to verify services may compromise the Plan and Medi-Cal's program integrity.

Recommendation: Develop and implement policies and procedures to verify if services delivered by network providers were received by members.

CONTRACT & ENROLLMENT REVIEW
DIVISION – SOUTH SAN DIEGO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Aetna Better Health of California, Inc.

2022

Contract Numbers: 17-94601 Sacramento
17-94603 San Diego
State Supported Services

Audit Period: April 1, 2021
Through
March 31, 2022

Dates of Audit: May 16, 2022
Through
May 25, 2022

Report Issued: December 21, 2022

TABLE OF CONTENTS

I.	INTRODUCTION.....	1
II.	COMPLIANCE AUDIT FINDINGS.....	2

I. INTRODUCTION

This report presents the audit findings of Aetna Better Health of California, Inc. (Plan) State Supported Services Contract Nos. 17-94601 and 17-94603. The State Supported Services Contracts cover contracted abortion services with the Plan.

The audit period is from April 1, 2021 through March 31, 2022. The review was conducted from May 16, 2022 through May 25, 2022, which consisted of a document review of materials provided by the Plan and interviews with the Plan's administration and staff.

An Exit Conference with the Plan was held on October 13, 2022.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

STATE SUPPORTED SERVICES

The Plan and Department of Health Care Services (DHCS) agree to be bound by all applicable terms and conditions of the Primary Contract. (*Hyde Contract, Exhibit E, Section 1(A)*)

The Plan shall pay all claims submitted by contracting providers in accordance with Section 1932(f), Title XIX, Social Security Act (42 United States Code Section 1396-2(f)), and Health and Safety Code Sections 1371 through 1371.36. (*Primary Contract, Exhibit A, Attachment 8, Section 5*)

The Plan is required to reimburse complete claims within 45 working days after the date of receipt, unless the complete claim or portion thereof is contested or denied. (*California Code of Regulations, Title 28, section 1300.71(g)*)

Abortion services are covered by the Medi-Cal program. Medical justification and/or prior authorization for outpatient abortion services is not required. (*All Plan Letter 15-020, Abortion Services*)

The Plan's policy 8300.20, *Family Planning and Reproductive Health* (revised December 2020), states payments must be made in compliance with the clean claims requirements and timeframes outlined in the Plan's Contract, and these requirements apply to both the Plan and their contracted and delegated providers. If a member chooses to see an out-of-network provider for abortion services, the reimbursement rate must not be lower, and is not required to be higher than the Medi-Cal fee-for-service rate unless the out-of-network provider and the Plan mutually agree to a different reimbursement rate. The policy further states abortion services are covered by the Medi-Cal program, and medical justification and/or prior authorization of services are not required.

Finding: The Plan denied payment of claims related to State Supported Services.

The verification study found three of ten in-network and out-of-network State Supported Services claims reviewed were denied, which resulted in untimely reimbursement.

The Plan's policy 8300.20 states abortion services do not require prior authorization and claims will be reimbursed within the required timeframes outlined in the Contract. The Plan uses the system called QNXT to process claims, and procedure codes can be configured by the Plan for auto adjudication.

In 2020, the Plan re-configured State Supported Service procedure codes to auto adjudicate. However, the Plan reconfigured the auto adjudication for participating

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2021 through March 31, 2022

DATES OF AUDIT: May 16, 2022 through May 25, 2022

providers only and excluded non-participating providers. The re-configuration caused denied State Supported Service claims related to non-participating providers in 2021. The Plan discovered the incomplete code reconfiguration as a result of the DHCS annual audit.

Untimely reimbursement of claims may discourage providers from participating with the Plan and impact members' access to abortion services.

Recommendation: Ensure abortion service claims are reimbursed within 45 working days.