MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Aetna Better Health of California, Inc.

2021

Contract Numbers:	17-94600 Sacramento 17-94602 San Diego
Audit Period:	April 1, 2019 Through March 31, 2021
Report Issued:	September 16, 2021

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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 2021, the Plan served 14,181 members in Sacramento and 19,699 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 audit period of April 1, 2019 through March 31, 2021. DHCS conducted an audit of the Plan from April 19, 2021 through April 30, 2021. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on August 19, 2021. 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 November 7, 2019, for the audit period of April 1, 2018 through March 31, 2019, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP closeout letter dated September 22, 2020, documented that DHCS closed all previous findings.

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 delegation of UM, prior authorization review, and the appeal process.

Prior Authorization Appeal Process: The Plan is required to provide a notice of resolution that contains a clear and concise explanation of the reason for the decision. The audit found the Plan's notices of appeal resolution excluded the reason the Plan used to overturn the decision.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements for Early Intervention/Developmental Disabilities, Initial Health Assessment (IHA), Behavioral Health Treatment (BHT), and continuity of care.

Early Intervention/Developmental Disabilities: 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.

IHA: The Plan is required to make repeated attempts to contact members and schedule an IHA. The Plan shall make at least three documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA. The audit found the Plan did not document its attempts to contact members to schedule and complete an IHA.

BHT: 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 have a system to ensure BHT treatment plans are reviewed no less than once every six months and contained transition, crisis, and exit plans.

Continuity of Care: The Plan is required to provide continuity of care at the request of members with pre-existing relationships with a terminated or out-of-network provider and members who are transitioning from Medi-Cal fee-for-service into a Medi-Cal Managed Care Plan (MCP). The Plan did not have a system in place to ensure the provision of continuity of care in accordance with Contract requirements.

Continuity of Care: The Plan is required to notify members 30-calendar-days before the end of the continuity of care period. The Plan shall engage with members and providers before the end of the continuity of care period to ensure continuity of services through the transition to a new provider. The Plan did not have a mechanism in place to notify and engage with members and providers before the end of the continuity of care period to ensure transition to a new provider.

Category 3 – Access and Availability of Care

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

Appointment Procedures and Monitoring Wait Times: The Plan is required to develop, implement, and maintain a procedure to monitor appointment availability and provider office wait times. The Plan did not fully implement and maintain its policy and procedure to monitor appointment availability and provider office wait times. The Plan did not consistently document survey results and its intervention activities against non-compliant providers.

Access to Pharmaceutical Services: The Plan is required to ensure access to at least a 72-hour supply of a medically necessary, covered outpatient drug in an emergency situation. The Plan shall have written policies and procedures to describe how the Plan

and/or Plan's network hospitals will monitor compliance with requirements. The Plan did not have a monitoring system to ensure that the emergency room medication dispensing requirements are met.

NEMT and NMT: The Plan is required to cover NEMT and NMT services to ensure members have access to medically necessary services. The Plan did not maintain documentation to ensure the provision of medically necessary NEMT and NMT services.

NEMT and NMT: The Plan is required to arrange transportation for a minor who is unaccompanied by a parent or a guardian with written consent. The Plan is also responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor. The audit found the Plan did not collect written consent forms for unaccompanied minors requiring NEMT and NMT services.

NEMT and NMT: The Plan must ensure that all network providers are enrolled in the Medi-Cal program. The Plan contracted with transportation vendors not enrolled in the Medi-Cal program.

NEMT and NMT: The Plan is required to cover NEMT and NMT services and provide transportation for a parent or a guardian when the member is a minor. The Plan did not inform members that transportation costs are covered for parents or guardians of minors receiving NEMT and NMT services.

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.

Grievance System: The Plan is required to develop, implement, and maintain a Member Grievance System. The Plan shall also establish and maintain written procedures for submittal, processing, and resolution of all grievances. "Resolved" means that the grievance has reached a final conclusion with respect to the member's grievance. The audit found the Plan concluded members' complaints without conducting a thorough investigation. As a result, the Plan closed the grievances without completely addressing the members' complaints.

Grievance System: Grievances are exempt from the requirement to send a written acknowledgement and response when they are received over the telephone and are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and resolved by the close of the next business day. The audit found the Plan did not properly process all exempt grievances and incorrectly categorized standard grievances as exempt grievances.

Grievance System: If the Plan is unable to distinguish between a grievance and an inquiry, the Plan is required to consider the grievance or inquiry as a grievance. 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.

Grievance System: The Plan is required to implement and maintain a procedure to ensure every grievance submitted is reported to an appropriate level. Grievances related to medical quality of care issues are required to be referred to the Plan's Medical Director. The audit found the Plan did not ensure all quality of care issues are referred to the Medical Director.

Grievance System: The Plan is required to have a grievance system that tracks and monitors grievances received, and indicates the total number of grievances received, pending, and resolved in favor of the member. The Plan did not track and monitor exempt grievances.

Grievance System: The Plan is required to maintain a written record for each grievance received, which shall be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer of the Plan or designee. In addition, the review shall be thoroughly documented. The Plan's governing body, public policy body, and Plan official did not review the written grievance log periodically and did not thoroughly document the review.

Grievance System: The Plan is required to maintain a grievance system that addresses the linguistic and cultural needs of its members. Member information, which includes any notices related to grievances, shall be translated into the identified threshold and concentration languages. The audit found the Plan did not provide translated acknowledgement and resolution letters in the member's preferred language.

Confidentiality Rights: 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.

Confidentiality Rights: The Plan is required to immediately investigate and submit an updated DHCS Privacy Incident Report within 72 hours of discovery of 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.

Confidentiality Rights: 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 5 – Quality Management

Category 5 includes requirements to deliver adequate quality of care to members and take effective action to address quality of care improvements needed within the provider network.

Quality Improvement System: The Plan is required to implement an effective quality improvement system and to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The audit found the Plan did not have a mechanism in place to monitor, evaluate, and take effective action to address quality improvements related to the Potential Quality Issue (PQI) processes.

Provider Qualifications: The Plan is required to ensure that all providers receive training regarding the Medi-Cal Managed Care program and to conduct training for all providers within ten-working-days after the Plan places a newly contracted provider on active status. The audit found the Plan did not ensure all providers received training within ten-working-days after the Plan placed a newly contracted provider on active status.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to implement and maintain a health education system and compliance program.

Health Education Program: The Plan is required to implement and maintain a health education system, and to monitor the performance of subcontractors that deliver health education programs and services to members. The Plan did not have a system to monitor the performance and effectiveness of subcontractors that deliver health education programs to members.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS, 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 April 19, 2021 through April 30, 2021. 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

Prior Authorization Requests: 40 medical, 60 pharmacy, and 50 delegated prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 34 appeals of denied medical and pharmacy prior authorizations were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

IHA: 25 medical records were reviewed for timeliness and completeness of the IHA requirements.

Category 3 – Access and Availability of Care

NEMT and NMT: 80 records (40 NEMT and 40 NMT) were reviewed to confirm compliance with the NEMT and NMT requirements for timeliness and appropriate adjudication.

Category 4 – Member's Rights

Grievance Procedures: 76 standard grievances (36 quality of care and 40 quality of service), 28 exempt grievances, and 20 call inquiries were reviewed for timely resolution, response to complainant, submission to the appropriate level for review, and translation in member's preferred language (if applicable).

Confidentiality Rights: 12 security incidents were reviewed for processing and reporting requirements.

Category 5 – Quality Management

Quality Improvement System: Ten PQI were reviewed for evaluation and effective action taken to address needed improvement.

Provider Qualifications: 22 new provider training records were reviewed for timeliness.

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, 2019 through March 31, 2021 **DATE OF AUDIT:** April 19, 2021 through April 30, 2021

CATEGORY 1 – UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Notice of Appeal Resolution

The Plan is required to provide a notice of resolution to the member as quickly as the member's health condition requires within 30-calendar-days from the date the Plan receives the request for an appeal. *(Contract, Exhibit A, Attachment 14(1)(B))*

For appeals resolved in favor of the member, the Plan shall ensure that the written response contains the date it was completed and a clear and concise explanation of the reason, including the reason for why the decision was overturned. *(All Plan Letter (APL) 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments)*

The Plan's policy 3100.70, *Member Appeals* (revised April 2020), states that the Plan's notice of appeal resolution will include the results of the resolution process, the date it was completed, and the specific reasons for the decision in easily understandable language.

Finding: The Plan did not adhere to APL requirements and its policy. The Plan's notice of appeal resolution excluded the reason the Plan used to overturn the prior authorization decision.

During the audit period, the Plan received 201 prior authorization appeals. There were 34 prior authorization appeals reviewed to determine if the Plan has an appeals procedure and adhered to the required timeframes for acknowledging and resolving the appeals. The audit found that of the 34 appeals reviewed, 11 appeals did not include the reason or criteria used to overturn the initially denied prior authorization.

The Plan's oversight process was insufficient to detect non-compliance with the notice of appeal resolution format. The Plan reviewed the appeals and acknowledged the lack of criteria in the notice of appeal resolution letters during the interview. The Plan stated that certain information was not extracted from the Plan's system onto the notice of appeal resolution letters. Therefore, the notice of appeal resolution letters did not include the reason or criteria the Plan used to overturn the initial denial.

The omission of the reason or criteria that the Plan uses to overturn the decision does not give providers and members the opportunity to understand why the request for

services are ultimately approved. If the reason or criteria is omitted, members may not understand the rationale behind the Plan's decision.

Recommendation: Adhere to APL requirements and implement policies to ensure that notice of appeal resolution letters include the reason the Plan uses to overturn denied prior authorizations.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1.1	EARLY INTERVENTION / DEVELOPMENTAL DISABILITIES

2.1.1 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 7000.43, *Coordination of Member Care* (revised September 2020), describes the coordination of care for vulnerable members that move between care settings. Member identification is conducted through claim reports, referral and authorization processes, member and/or care team communications, and provider referrals/notifications.

The policy 7000.43 states the Plan's clinical staff 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 Early Start Program.

Additionally, the Plan's policy 7500.05, *Integrated Care Management* (revised June 2020), describes the care management services available to special populations with complex medical, behavioral, and/or social needs such as Early Intervention Services/Early Start Program.

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.

The audit found that the Plan's policies and procedures delineated the identification of children who may be eligible for receiving Early Start services. However, the Plan did not have documentation to show it identified children eligible for Early Intervention services. The Plan provided a tracking log, *California Care Management Tenure/Referral*, for the period of March 1, 2020 through January 1, 2021, which identified one member (age 11) as part of the Early Intervention Program subgroup. The log identified the member as receiving integrated care management; a grievance was the referral source. No other documentation was received to show a mechanism to identify children under three years old.

The audit was unable to determine coordination efforts between the Plan, Early Start Program, and a Primary Care Physician (PCP) based on the lack of referrals for eligible children.

The Plan's Medical Management Department is responsible for the Early Start Program. A review of the QM/UM Committee meeting minutes showed agenda topics for special needs; however, there were no discussions related to early intervention.

During the interview, Plan staff acknowledged and demonstrated limited knowledge in its policies and procedures due to a recent hire. The policies the Plan subsequently provided were related to *Coordination of Member Care* and *Integrated Care Management*, which did not delineate procedures for early intervention services. The Plan's lack of policies and procedures specific to early intervention services resulted in no members identified on the Plan's tracking log.

The Plan's *2019 Quality Assessment Performance Improvement (QAPI)/UM Work Plan* identified objectives to monitor and assess quality and appropriateness of care for children with special needs. The Plan recognized potential risks in identifying and reporting for these members. The Plan's 2020 and 2021 *QAPI/UM Work Plan* excluded objectives related to children with special needs.

The Early Start Program is California's Early Intervention program for families with infants and toddlers with disabilities. Based on the child's assessed developmental needs and the families' concerns, Early Intervention Services may include, but are not limited to nutrition services, occupational therapy, and physical therapy.

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

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.

2.1.2	INITIAL HEALTH ASSESSMENT

2.1.2 Contacting Members for IHA Completion

Pursuant to APL 20-004 (revised March 9, 2021), IHAs for all members newly enrolled in the Plan between December 1, 2019, and the end of the Public Health Emergency (PHE), DHCS temporarily suspended the requirement to complete an IHA within the timeframes outlined in the Contract. The Plan may defer the completion of the IHA for these members until the COVID-19 emergency declaration is rescinded; however, DHCS will require the completion of the IHA for these members once the PHE is over. The findings in the section below pertains to the audit period April 1, 2019 to November 30, 2019.

The Plan is required to make repeated attempts, if necessary, to contact a member and schedule an IHA. The Plan shall make at least three documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA. Contact methods must include at least one telephone and one mail notification. The Plan must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed. *(Contract, Exhibit A, Attachment 10(3)(E))*

The Plan's policy 7000.33, *Initial Health Assessment* (revised September 2019), states the Plan will make at least three documented attempts to contact a member, which must include one telephone call and one mail notification.

Finding: The Plan did not document its attempts to contact members to schedule and complete an IHA.

According to the Plan's IHA log, the Plan enrolled 8,288 new members from April 1, 2019 to November 30, 2019. The audit identified 14.95 percent in Sacramento and 21.75 percent in San Diego of new members that completed an IHA. A verification study of 25 medical records showed that all records did not have documented outreach attempts.

The Plan included new processes for member outreach to address the prior audit's finding. This consisted of the Plan stating it will conduct automated calls every month to members and send a letter to members after 60 days of enrollment if an IHA was not completed. The Plan submitted an IHA Completion Tracker; however, it only tracked the status of IHA completion and did not contain elements of outreach.

The Plan did not provide documented evidence of these outreach attempts to show it contacted newly enrolled members in need of a completed IHA.

If the Plan does not conduct outreach, members may miss opportunities to schedule an IHA for completion. This may lead to members not receiving necessary medical care due to delays or a lack of identification of health risks, medical treatment, or referrals for coordination of care.

Recommendation: Implement policies and procedures to document attempts to contact members through telephone and mail notification to schedule and complete an IHA.

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. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by the provider of BHT services. *(Contract, Exhibit A, Attachment 10(5)(G) and APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21)*

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)*

The Plan's policy 7000.91, *Behavioral Treatment* (revised April 2020), states that medical necessity determination of BHT services must be based on the member's treatment plan and/or continuation of BHT services under continuity of care. BHT treatment plans are reviewed no less than once every six months by a qualified autism service provider and must contain the following required elements: transition, crisis, and exit plans.

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

While the Plan's policy 7000.91 and desktop procedure, *Applied Behavioral Analysis and Behavioral Health Treatment Medical Necessity for Members Under the Age of 21*, stated that the Plan will review treatment plans to contain the required transition, crisis, and exit plans, 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 according to requirements.

Twenty medical records were requested for the audit period. After multiple requests, nine medical records related to February to June 2020 were not received. Eleven medical records related to April to December 2019 were received and reviewed. The audit found the following deficiencies related to the 2019 medical records:

- Two medical records did not have treatment plans.

- One medical record had a treatment plan but did not include transition, crisis, and exit plans.

Based on the medical records reviewed, the Plan was unable to ensure treatment plans contained the required elements such as transition, crisis, and exit plans. The Plan did not have a process to monitor and ensure the completeness or compliance of its treatment plans.

If BHT plans do not have the required elements of transition, crisis, and exit plans, members may miss program goals and desired health care outcomes.

Recommendation: Establish a system to monitor BHT services to ensure treatment plans are reviewed, revised, and modified no less than once every six months and contain transition, crisis, and exit plans.

2.5	CONTINUITY OF CARE

2.5.1 Continuity of Care Provision

The Plan is required to provide for the completion of covered services by a terminated or out-of-network provider at the request of a member in accordance with the continuity of care requirements in Health and Safety Code section 1373.96. The Plan shall also comply with APLs issued by DHCS. *(Contract, Exhibit A, Attachment 9(17)(B) and Exhibit E, Attachment 2(1)(D))*

Members transitioning from Medi-Cal fee-for-service into a Medi-Cal MCP have the right to request continuity of care in accordance with state law and Plan Contracts. All members with pre-existing provider relationships who make a continuity of care request to a Plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider.

The Plan must begin to process the request within five-working-days following the receipt of the request. The request must be completed within 30 days of receipt. However, the request must be completed in 15-calendar-days if the member's medical condition requires more immediate attention or three-calendar-days if there is risk of harm to the member. Upon approval of a continuity of care request, the Plan must notify the member within seven-calendar-days. *(APL 18-008, Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care)*

The Plan's policy 7000.40, *Member Transition/Continuity of Care* (revised September 2020), states the Plan will meet contractual and APL 18-008 timeframes for member coordination of care.

Finding: The Plan did not have a system in place to ensure the provision of continuity of care in accordance with Contract requirements.

This was a prior audit finding. The CAP indicated the Plan updated its policy 7000.40 to incorporate APL 18-008, timeframes, and retroactive requests. The Plan also updated its *Transition of Care/Continuity of Care* workflow diagram to include completion timeframes, member notification, and retroactive request processes. In addition, the Plan will provide staff and member education, as well as evaluate their reporting requirements.

A Medical Exemption Request (MER) is a report of continuity of care requests. According to MER reports, dated April 2019 to January 2021, the Plan identified five of 13 members

met criteria for continuity of care. However, the audit found no evidence of the Plan's decision-making process regarding members' eligibility for continuity of care as well as member/provider engagement. Instead, the Plan provided resolution comments in lieu of documents for review.

Additionally, during the interview, the Plan stated all members with continuity of care are referred to Case Management. However, the audit found that none of the five members from the MER reports, who were identified meeting criteria for continuity of care, were captured on the Plan's *Case Management Monitoring and Tracking Log*.

Accordingly, the audit found two instances in which the Plan did not ensure continuity of care as follows:

- The Plan denied a member's request to continue the member's pre-existing relationship with an out-of-network neurologist. The member appealed the denied prior authorization. The Plan overturned its decision and determined the member's condition and current treatment with the provider met the criteria for continuity of care. Due to the Plan's initial denial, the member's access to care was delayed beyond 53 days.

- A new member, with a history of breast cancer, contacted the Plan to request continued care with her current doctors. The Plan informed the member that her case would be forwarded to Case Management. However, review of the *Case Management Referral Monitoring and Tracking Log* showed no evidence that the member received continued care.

The Plan's policy 7000.40, *Member Transition/Continuity of Care* (revised September 2020), did not contain procedures to track and monitor continuity of care services. The Plan provided a narrative statement indicating there was no formal tracking of MERs from 2019 to 2020.

In addition, the Plan confirmed during the interview that turnaround times of continuity of care request completion are negatively impacted by the Single Case Agreement process and obtaining clinical information. A Single Case Agreement is a contract between the Plan and an out-of-network provider to render services. The Plan's QM/UM Committee meeting minutes showed ongoing discussion of this topic.

Provider satisfaction survey results during the audit period showed all provider types had low satisfaction rates related to continuity of care.

Without procedures to track and monitor continuity of care processes, members may not receive medically necessary services in a timely manner.

This is a repeat of 2019 audit finding 2.5.1 – Continuity of Care.

Recommendation: Develop and implement a system to track and monitor continuity of care requests to ensure the timely provision of continuity of care in accordance with Contract requirements.

2.5.2 End of Continuity of Care Notification

The Plan is required to provide for the completion of covered services by a terminated or out-of-network provider at the request of a member in accordance with the continuity of care requirements in Health and Safety Code section 1373.96. The Plan shall also comply with APLs issued by DHCS. *(Contract, Exhibit A, Attachment 9(17)(B) and Exhibit E, Attachment 2(1)(D))*

The Plan must notify the member 30-calendar-days before the end of the continuity of care period. The notification must include the process that will occur to transition the member's care to an in-network provider at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider. *(APL 18-008, Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care)*

The Plan's policy 7000.40, *Member Transition/Continuity of Care* (revised September 2020), states the Plan will meet contractual and APL 18-008 timeframes and member coordination of care. The policy indicates the Plan will communicate and work with applicable departments and staff to identify transitioning members and notify providers of services to be monitored during the transition. The Chief Medical Officer (CMO) directs transition operations and designates a transition Coordinator/Case Manager, who oversees all transition activities, issues, and responsibilities.

Finding: The Plan did not have a mechanism in place to notify and engage with members and providers before the end of the continuity of care period to ensure transition to a new provider.

According to the Plan's policy and APL 18-008, the Plan has the responsibility to notify the member and provide outreach at the end of the continuity of care period. However, the Plan did not follow its policy and APL. The audit found the Notice of Action letter instructed members to contact the Plan to choose an in-network provider.

The Plan did not have procedures in place to notify members at the end of the continuity of care period. A Plan interview revealed it was at the Case Manager's discretion when

to contact the member.

Without procedures to track and monitor continuity of care processes, members may not receive medically necessary services in a timely manner.

Recommendation: Develop and implement processes to notify members and coordinate care at the end of the continuity period to ensure continuity of services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Aetna Better Health of California, Inc.
AUDIT PERIOD: April 1, 2019 through March 31, 2021 **DATE OF AUDIT:** April 19, 2021 through April 30, 2021

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAIT TIMES

3.1.1 Monitoring of Appointment Availability and Office Wait Times

The Plan is required to develop, implement, and maintain a procedure to monitor appointment availability and provider office wait times. *(Contract, Exhibit A, Attachment 9(3)(C))*

The Plan's policy 6100.60, *Provider Appointment Availability Study (*effective January 2018), states that the Plan's Provider Services Department coordinates a survey of its contracted providers to evaluate compliance with appointment availability and providers' office wait times.

The Plan's desktop procedure, *Provider Appointment Accessibility*, details the process of conducting the survey using the Appointment Accessibility Study Tool. The tool captures responses, scores the provider, and notates intervention activities. A monthly provider survey of its contracted providers is conducted to evaluate compliance with appointment availability.

Finding: The Plan did not fully implement and maintain its policy and procedure to monitor appointment availability and provider office wait times. The Plan did not consistently document survey results and its intervention activities against non-compliant providers.

According to its policy, the Plan conducts surveys using the Appointment Accessibility Study Tool to review provider compliance with appointment availability and office wait times. If a provider fails to meet mandatory Contract requirements, the Plan contacts the provider to re-survey and re-educate up to three times. If a provider continues to remain out of compliance, the Plan contacts the UM Manager and the Compliance Manager to determine a resolution through the CAP process.

The audit found the Plan conducted surveys and documented its results in the Appointment Accessibility Study Tool. However, the Plan did not fully implement its policy. While the tool showed non-compliant providers, there was no evidence that the Plan re-surveyed non-compliant providers or issued a CAP.

During the interview, the Plan explained that survey results are generated through a manual spreadsheet, and acknowledged challenges in completing the Appointment

Accessibility Study Tool. This resulted in a lack of review, documentation, and corrective actions with non-compliant providers.

Without proper monitoring of appointment availability and office wait times, network capacity may not be sufficient to meet access and availability standards. If so, members may not receive the necessary care, which may be detrimental to their health.

Recommendation: Implement and maintain policy and procedures to monitor appointment availability and provider office wait times. When deficiencies are identified, implement CAPs.

3.4 ACCESS TO PHARMACEUTICAL SERVICES

3.4.1 Monitoring of Emergency Room Medication Requirement

The Plan is required to cover and ensure the provision of all prescribed drugs and medically necessary pharmaceutical services. The Plan shall provide pharmaceutical services and prescription drugs in accordance with all federal and state laws and regulations. *(Contract, Exhibit A, Attachment 10(8)(G)(1))*

The Plan shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours and ensure access to at least a 72-hour supply of a medically necessary, covered outpatient drug in an emergency situation. Written policies and procedures must describe how the Plan and/or Plan's network hospitals will monitor compliance with the requirements. *(Contract, Exhibit A, Attachment 10(8)(G)(2))*

The Plan's policy 7000.64, *Emergency Services* (revised January 2020), states the Plan will monitor the compliance of its network hospitals and contracted providers to ensure members have access to at least a 72-hour supply of covered outpatient drugs.

Finding: The Plan lacks a monitoring system to ensure that the emergency room medication dispensing requirements are met.

This was a prior audit finding. As part of the CAP, the Plan revised its policy 7000.64, the Provider Manual, and developed a desktop procedure. The Plan also asked contracted emergency facilities to submit a patient face sheet for verification of the 72-hour supply of medication, but the Plan did not receive the requested face sheets. Therefore, the Plan's corrective actions were ineffective and did not address the deficiencies. Review of the Plan's narrative statement confirmed it did not monitor Emergency Department's dispensing of prescribed medication.

The Plan did not have procedures in place to effectively monitor compliance and ensure members have access to at least a 72-hour supply of outpatient medication. The Plan acknowledged a gap in this area, which continued in this audit period. During the interview, the Plan expressed challenges in implementing its current procedures.

Members that visit the emergency room are susceptible to readmission or serious health consequences when medically necessary medications are not provided.

This is a repeat of 2019 audit finding 3.4.1 – Access to Pharmaceutical Services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2019 through March 31, 2021
DATE OF AUDIT: April 19, 2021 through April 30, 2021

Recommendation: Develop and implement a process to monitor and ensure compliance in the provision of emergency medication requirements.

3.8 NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION

3.8.1 NEMT/NMT Services

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))*

The Plan will maintain such records and documents necessary to disclose how the Plan discharged its obligations under this Contract. These records and documents will disclose the quantity of covered services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive covered services, the manner in which the Plan administered its daily business, and the cost thereof. *(Contract, Exhibit E, Attachment 2(18))*

The Plan's policy 4500.95, *Emergent and Non-Emergent Transportation* (revised June 2019), documents the Plan's protocols related to NEMT and NMT transportation services.

Finding: The Plan did not maintain documentation to ensure the provision of medically necessary NEMT/NMT services.

In a verification study of 80 NEMT/NMT services, 20 records were not received and only claims data was submitted for the remaining 60 records. The Plan did not maintain documents to show its provision of transportation services or compliance with related requirements.

When the Plan does not maintain documentation to disclose services provided, the Plan cannot effectively track that members receive medically necessary NEMT and NMT services.

Recommendation: Implement procedures to ensure collection and maintenance of documentation to substantiate the provision of NEMT and NMT transportation services.

3.8.2 Written Consent for Unaccompanied Minors

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))*

The Plan may arrange transportation for a minor who is unaccompanied by a parent or a guardian with written consent. Additionally, the Plan is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor. *(APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services)*

The Plan's policy 4500.95, *Emergent and Non Emergent Transportation* (revised June 2019), states that the Plan may arrange for NMT for a minor who is unaccompanied with the written consent of a parent or guardian.

Finding: The Plan did not collect written consent forms for unaccompanied minors requiring NEMT and NMT services.

While policy 4500.95 stated transportation services will be covered and written consent would be obtained for unaccompanied minors receiving NMT services, the policy did not state the same requirement for NEMT services.

A verification study included two NEMT and two NMT services rendered to minors. No documentation was received to support written consent was obtained for minors in these five services sampled.

Without unaccompanied minor consent forms, the Plan cannot document parent or guardian authorization for transportation of minor children. Parents or guardians may be unaware of potential risks to minor children.

Recommendations: For NEMT services, develop and implement policies and procedures to ensure written consent forms are received prior to arranging transportation services for unaccompanied minors. For NMT services, implement policies and procedures to ensure written consent forms are received prior to arranging transportation services for unaccompanied minors.

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 MCP network providers must enroll in the Medi-Cal program. MCPs 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 January 2020), 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 Open Data Portal.

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

The Plan utilizes an outside vendor to provide transportation for its members. The vendor delegates the NEMT services to their subcontractors. The audit reviewed the vendor's list of NEMT providers to ensure the providers were enrolled in the Medi-Cal program. The audit found eight of the 13 NEMT transportation providers were not enrolled in the Medi-Cal program.

The Plan did not have procedures to ensure its NEMT network providers are enrolled in the Medi-Cal program.

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.

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

3.8.4 Transportation Coverage for a Parent or a Guardian

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))*

The Plan must provide transportation for a parent or a guardian when the member is a minor. *(APL 17-010)*

The Plan's policy 4500.95, *Emergent and Non Emergent Transportation* (revised June 2019), states that the Plan will cover transportation costs for parents or guardians of minors receiving NMT transportation services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2019 through March 31, 2021
DATE OF AUDIT: April 19, 2021 through April 30, 2021

Finding: The Plan did not inform members that transportation costs are covered for parents or guardians of minors receiving NEMT and NMT services.

While policy 4500.95 stated transportation costs will be covered for parents or guardians of minors receiving NMT services, the policy did not state the same requirement for NEMT services. The Plan's member newsletters also did not contain information on transportation coverage for parents or guardians of minors receiving NEMT and NMT services.

Without information that transportation is covered for parents and guardians, parents or guardians may not send their children to medically necessary appointments due to fear of incurring transportation costs.

Recommendations: For NEMT services, develop and implement policies and procedures to ensure members are informed that transportation costs are covered for parents or guardians of minors. For NMT services, implement policies and procedures to ensure members are informed that transportation costs are covered for parents or guardians of minors.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Resolution

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

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances. *(CCR, Title 22, section 53858(a))*

"Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance, and there are no pending member appeals within the Plan's grievance system, including entities with delegated authority. *(CCR, Title 22, section 1300.68(a)(4))*

The Plan's policy 3100.90, *Member Compliant/Grievance* (revised November 2020), states all grievances are documented and submitted to the Grievance and Appeal (G&A) Manager to process, review, and determine a resolution. If further research is needed, the G&A Department will coordinate and collect all pertinent facts, and the Grievance Committee will consider additional information for resolution.

Finding: The Plan concluded members' complaints without conducting a thorough investigation and sent resolution letters without completely addressing the members' complaints.

A verification study found 15 of 40 quality of service grievances were not thoroughly investigated and complaints remained unresolved. Examples of unresolved complaints were related to access to care, delay in medications and referrals, provider attitude, and out-of-pocket expenses.

In addition, a review of the call transcriptions, grievance log, and supporting documentation found that after repeated attempts to resolve the complaints with the Plan, two members filed complaints with the Department of Managed Health Care related to similar issues unresolved by the Plan.

According to the Plan's policy 3100.97, *Grievance and Appeal Real Time Quality Assurance Program* (revised August 2020), the G&A Manager is accountable for the

completion of a daily quality review. The audit found that the manager did not have sufficient time to review letters to ensure all issues were resolved, as 15 of 40 grievances sampled were not thoroughly investigated and resolved. During the audit period, the Plan received 1,363 standard grievances and employed one manager to supervise G&As.

The Plan utilized a spreadsheet to document internal and external grievance requirements. These requirements include, but are not limited to receipt of grievance and turnaround times. Review of the spreadsheet found no evidence that the Plan confirmed each grievance issue was fully addressed and resolved.

Incomplete resolution of member grievances may result in missed opportunities for improved health care delivery and poor health outcomes for members.

Recommendation: Develop and implement policies and procedures to ensure all complaints are thoroughly investigated, addressed, and resolved.

4.1.2 Grievance Classification and Processing

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

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances. *(CCR, Title 22, section 53858(a))*

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgement and response. *(CCR, Title 28, section 1300.68(d)(8))*

The Plan's policy 3100.90, *Member Grievance System and Oversight* (revised November 2020), states grievances are primarily categorized as either quality of service or care issues. If further research is needed, the G&A Department will coordinate and collect all pertinent facts, and the Grievance Committee will consider additional information for resolution.

The Plan's Member Services desktop procedures, *Job Aid: Grievance Processing*, defines an exempt grievance as a grievance received over the telephone that is not related to an appeal, a coverage dispute, disputed health care service involving medical necessity or experimental or investigational treatment, and that is resolved by the close

of the next business day.

Finding: The Plan did not properly process all exempt grievances and inconsistently processed grievances as exempt grievances instead of standard.

A verification study of 29 exempt grievances found:

- Two complaints contained elements related to quality of care that was classified as an exempt, instead of a standard quality of care grievance.

- Ten complaints were closed without fully addressing the members' complaints.

According to the Plan's desktop procedure, Member Services Representatives (MSRs) are instructed to obtain a member's permission to use their name to file a provider grievance. The audit found that the Plan closed grievances if members decline to use their name. Since the Plan closed the complaint before the next business day, the Plan classified the complaint as an exempt grievance instead of standard grievance for track and trend purposes only. This resulted in the Plan not fully investigating and resolving the member's complaint.

A review of the call transcriptions found that in three cases, the MSR did not request permission to use the member's name; however, the MSR indicated that the member declined permission to use his or her name. Subsequently, the grievances were closed without an investigation and resolution. In one instance, a dissatisfied member who contacted the Plan on multiple occasions, attempted to resolve issues related to out-of-pocket expenses incurred. Since the MSR did not ask permission to use the member's name, the MSR closed the grievance and the complaint remained unresolved.

The Plan did not have policies and procedures regarding the processing of exempt grievances. In the Plan's Member Services desktop procedures, *Job Aid: Grievance Processing*, it mentioned that a complaint "cannot be resolved by the MSR during the call." However, the Plan stated MSRs resolve exempt grievances and solely forward data to the G&A Department to track and trend. There was no evidence that the G&A staff reviewed exempt grievances to ensure the member's complaint was properly addressed and resolved.

If grievances are not properly classified, investigated, and resolved, then members may miss opportunities for improved health care delivery, which may lead to poor health outcomes.

Recommendation: Develop and implement policies and procedures to ensure exempt grievances are appropriately classified, processed, and resolved.

4.1.3 Grievances Classified as Call Inquiries

The Plan shall develop, implement, and maintain a Member Grievance System in accordance with CCR, Title 22, section 53858 and Title 28, sections 1300.68 and 1300.68.01. *(Contract, Exhibit A, Attachment 14(1))*

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)*

The Plan's policy 3100.90, *Member Grievance System and Oversight* (revised November 2020), 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.

Additionally, 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.

A verification study found 15 of 20 call inquires had an expression of dissatisfaction documented in the member service call center notes. Out of the 15, nine of these inquiries were not classified and processed as grievances. The Plan acknowledged the nine inquiries were not forwarded to G&A Department for review; it was closed by Member Services as resolved.

The Plan did not follow its policy and procedures regarding the processing of grievances

and call inquiries. In the Plan's Member Services desktop procedures, *Job Aid: Grievance Processing*, it mentioned that a complaint "cannot be resolved by the MSR during the call."

However, other desktop procedures and verification study documentation showed that the MSRs took steps to address and resolve the complaint during the call. In those instances, the complaint bypassed G&A Department's grievance review. In one example, the MSR resolved the complaint by forwarding it to the Case Manager.

The Plan's desktop procedure, *Medicaid Quality Review,* stated the Plan conducts a quality review of the MSR calls to check for a complete and accurate explanation of the member's complaint and if the call was forwarded to the respective department. However, a review of the Plan's call inquiry logs found the MSRs averaged 200 calls per month and less than two percent of the calls are reviewed for quality.

Misclassification of grievances may lead to inadequate investigations, in which members' complaints remain unresolved and result in missed opportunities for healthcare quality improvement.

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

4.1.4 Quality of Care Grievance Identification

The Plan shall develop, implement, and maintain a Member Grievance System in accordance with CCR, Title 22, section 53858 and Title 28, sections 1300.68 and 1300.68.01. *(Contract, Exhibit A, Attachment 14(1))*

The Plan is required to implement and maintain a procedure to ensure every grievance submitted is reported to an appropriate level, i.e. quality of care versus quality of service. Grievances related to medical quality of care issues are required to be referred to the Plan's Medical Director. *(Contract, Exhibit A, Attachment 14(2)(C and D))*

The Plan's policy 3100.90, *Member Grievance System and Oversight* (revised November 2020), states grievances are primarily categorized as either quality of service or care issues. If the grievance requires research or input by another department, the G&A Department will coordinate with those departments to thoroughly research and collect pertinent facts including any clinical care involved. The Grievance Committee will consider the additional information and will resolve the grievance.

Finding: The Plan did not ensure all quality of care issues are referred to the Medical

Director.

A verification study found three exempt grievances, two standard quality of service grievances, 36 standard quality of care grievances, and one call inquiry were not elevated to the appropriate level of review. None of the documentation received showed these grievances were reviewed for quality of care issues by the Medical Director.

The Plan's policy 3100.90 did not contain policies and procedures of the Medical Director's involvement in the review of the quality of care grievances.

The Plan acknowledged that the Medical Director did not review quality of care grievances. In addition, the Plan's non-clinical staff identified and determined the grievance classification based on their judgment.

When quality of care issues are not referred to the Medical Director, there may be the potential for health care delivery problems, including access to appropriate high-quality care. The Plan may miss quality improvement opportunities and as a result, the Plan may not fully address member's health care concerns.

Recommendation: Develop and implement policies and procedures to ensure all quality of care grievances are referred to the Medical Director for review.

4.1.5 Exempt Grievance Oversight

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

The Plan's grievance system shall track and monitor grievances received by the Plan, or any entity with delegated authority to receive or respond to grievances. *(CCR, Title 28, section 1300.68(e))*

The system shall be able to indicate the total number of grievances received, pending, and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances. *(CCR, Title 28, section 1300.68(e)(2))*

The Plan's policy 3100.90, *Member Grievance System and Oversight* (revised November 2020), 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.
The Plan's policy 3100.96, *Grievance and Appeal Assessments* (revised June 2020),

establishes guidelines for the Plan's review of grievance policies, procedures, case resolution timeliness and documentation accuracy, completion, clarity, and appropriateness.

Finding: The Plan did not track and monitor exempt grievances.

While the Plan had policies related to grievances, the policies excluded procedures to track and monitor exempt grievances to ensure completion and proper resolution.

The Plan conducted bi-weekly reviews of standard member grievances to ensure completeness and timeliness. However, the audit found the bi-weekly review spreadsheet did not sample exempt member grievances.

Without proper tracking and monitoring of exempt grievances, the Plan may miss opportunities to address member's health care issues and complaints.

Recommendation: Develop and implement policies and procedures to ensure tracking and monitoring of exempt grievances.

4.1.6 Grievance System Oversight

The Plan shall develop, implement, and maintain a Member Grievance System in accordance with CCR, Title 28, sections 1300.68 and 1300.68.01. The Plan is required to follow grievance requirements and use all notice templates included in APL 17-006. *(Contract, Exhibit A, Attachment 14(1))*

The Plan is required to maintain a written record for each grievance received. The written record must include the following information: date and time of grievance receipt, member's name, name of representative recording the grievance, description of the grievance, action taken to investigate and resolve the grievance; proposed resolution, name of Plan staff resolving the grievance, and notification date to the member of the resolution. *(CCR, Title 28, section 1300.68(b)(5))*

The written record of grievances and appeals shall be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer of the Plan or designee. The review shall be thoroughly documented. *(APL 17-006)*

The Plan's policy 3100.90, *Member Grievance System and Oversight (*revised November 2020*)*, states the Plan will track, trend, and report all data to the Service Improvement Committee and Quality Management Oversight Committee at least quarterly, summarizing the frequency and resolution of all grievances.

Finding: The Plan's governing body, public policy body, and Plan official did not review the written grievance log periodically and did not thoroughly document the review.

The Plan's policy 3100.90 did not contain procedures to review the written record of grievances within its governing body, public policy body, or by a Plan officer.

According to the Board of Directors' meeting minutes, the Plan discussed quarterly grievance trends and statistics. There was no indication or documentation that the Plan reviewed the written record of grievances.

If key Plan entities do not periodically review the written grievance log, the Plan may miss significant issues not captured by aggregated data in grievance reports.

Recommendation: Develop and implement policies and procedures to ensure the Plan's governing body, public policy body, and Plan official review the written record of grievances periodically and thoroughly document the review.

4.1.7 Grievance Letter Translations

The Plan shall develop, implement, and maintain a Member Grievance System in accordance with CCR, Title 28, sections 1300.68 and 1300.68.01. *(Contract, Exhibit A, Attachment 14(1))*

The Plan's grievance system must address the linguistic and cultural needs of its members. *(CCR, Title 28, section 1300.68(b)(3))*

Member information, which includes any notices related to grievances, shall be translated into the identified threshold and concentration languages. *(Contract, Exhibit A, Attachment 13(4)(D) and APL 17-006)*

The Plan's policy 3100.90, *Member Grievance System and Oversight* (revised November 2020), states the Plan complies with applicable state requirement policies on translation of all information related to members' grievance rights.

Finding: The Plan did not provide translated acknowledgement and resolution letters in the member's preferred language.

The audit found five of 40 standard quality of service grievances sampled in the verification study required acknowledgement and resolution letters to be translated. However, the Plan did not translate any of the letters in the member's preferred

language.

In addition, in 14 of the 40 grievances sampled, member's preferred language were blank or listed as "unknown." Therefore, the audit was unable to determine whether these letters required translation services.

The Plan's policy 3100.90 did not contain policies and procedures to identify members who required translated letters in languages other than English. The policy stated that all written documents from the Plan relating to a grievance will be written in English and if requested the prevalent non-English language.

The Plan's grievance system did not have a field to identify the member's preferred language. The Member Service call center system was the only system that contains the member's preferred language. However, that information was not linked to the grievance system.

The Plan acknowledged that there was a deficiency with the translation of the grievance letters and began a process to correct this deficiency in the beginning of 2021.

The Plan also acknowledged that it assigned English by default, or the last known non-English language based on communication with the member. However, no evidence was received on how the Plan verifies the accuracy of this assignment procedure.

Without proper identification of the member's preferred language, members who require these translation services may not know how to access the proper care nor how to resolve issues when they arise. Members may not be able to understand the criteria used by the Plan in response to the member's grievance.

Recommendation: Develop and implement policies and procedures to identify the member's preferred language and ensure the grievance letters are translated in the member's preferred language.

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 CPM 11-100, *Privacy Breach Reporting* (approved January 2020), states that in the event of a privacy event related to the Plan, the Plan shall notify the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer immediately upon discovery of a breach or suspected breach involving a member's PHI or PI. Notification shall be by telephone, with a follow up fax or email, within 24 hours upon the discovery of a breach.

The Plan's desktop procedure, *Medicaid Compliance*, details steps taken by the Plan when notified by a provider of a potential breach or suspected security incident. The Plan will notify appropriate DHCS officials within 24 hours by telephone or email.

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.

The verification study sampled all 12 cases that occurred during the audit period to determine compliance with contractual timeframes of reporting any breach or suspected security incident to DHCS. Three of the 12 cases reviewed showed the Plan did not notify all required three DHCS entities within the 24-hour timeframe.

In addition, the Plan did not provide all required documentation to review two of the 12 cases included in the verification study.

This was a prior audit finding. As part of the CAP, the Plan revised the policy and developed a desktop procedure to ensure breaches are reported within the required timeframe. During the interview with the Plan's Compliance Officer, the Plan acknowledged it experienced challenges in implementing its policies and desktop procedures to report breaches due to a lack of internal communication and limited staff resources.

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 member's PHI and PI.

This is a repeat of 2019 audit finding 4.3.1 – Breaches and Security Incidents.

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 CPM 11-100, *Privacy Breach Reporting* (approved January 2020), states that in the event of a privacy event related to the Plan, the Plan shall submit an updated DHCS Privacy Incident Report to DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 72 hours of the discovery of the event providing additional information and corrective actions taken since the initial report.

The Plan's desktop procedure, *Medicaid Compliance*, details steps taken by the Plan when notified by a provider of a potential breach of suspected security incident. The Plan will submit a DHCS Privacy Incident Report to appropriate DHCS officials containing applicable information within 72 hours of the 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.

The verification study sampled all 12 cases that occurred during the audit period to determine compliance with contractual timeframes of reporting any breach or suspected security incident to DHCS. One of the 12 cases reviewed showed the Plan did not submit the DHCS Privacy Incident Report within the 72-hour reporting timeframe at all.

In addition, the Plan did not provide all required documentation to review two of the 12 cases included in the verification study.

This was a prior audit finding. As part of the CAP, the Plan revised the policy and developed a desktop procedure to ensure breaches are reported within the timeframe. During the interview with the Plan's Compliance Officer, the Plan acknowledged it experienced challenges in implementing its policies and desktop procedures to report breaches due to a lack of internal communication and limited staff resources.

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 member's PHI and PI.

This is a repeat of 2019 audit finding 4.3.1 – Breaches and Security Incidents.

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 CPM 11-100, *Privacy Breach Reporting* (approved January 2020), states that a completed Privacy Incident Report shall be submitted to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within ten-working-days after discovery of the incident. This report shall include an assessment of all known factors relevant to the determination of whether a breach occurred, as well as a full, detailed CAP, including measures that were taken to halt and/or contain the improper use or disclosure.

The Plan's desktop procedure, *Medicaid Compliance*, details steps taken by the Plan when notified by a provider of a potential breach of suspected security incident. The Plan will submit a complete report to appropriate DHCS officials within ten-working-days of the discovery.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2019 through March 31, 2021
DATE OF AUDIT: April 19, 2021 through April 30, 2021

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

The verification study sampled all 12 cases that occurred during the audit period to determine compliance with contractual timeframes of reporting any breach or suspected security incident to DHCS. Three of the 12 cases were not submitted within ten-working-days of discovery, and two of the three were not submitted to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer. In addition, the Plan did not provide all required documentation to review two of the 12 cases included in the verification study.

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 member's PHI and PI.

This is a repeat of 2019 audit finding 4.3.1 – Breaches and Security Incidents.

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, 2019 through March 31, 2021 **DATE OF AUDIT:** April 19, 2021 through April 30, 2021

CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

5.1.1 Quality Improvement Monitoring

The Plan is required to implement an effective Quality Improvement System (QIS) in accordance with the standards in CCR, Title 28, section 1300.70. The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The Plan shall be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between the Plan and the provider. *(Contract, Exhibit A, Attachment 4)*

The Plan shall ensure that the person making the final decision for the proposed resolution of G&As has clinical expertise in treating a member's condition or disease if deciding on any G&A involving clinical issues.
(Contract, Exhibit A, Attachment 14(1)(D))

The Plan's policy 8000.70, *Quality Management Oversight* (revised September 2020), states the Plan has a QAPI program to track, trend, evaluate, and improve the continuity, quality, safety, accessibility, and availability of health care and services provided to members. The Plan's Chief Executive Officer in conjunction with the CMO is responsible for directing and overseeing the QAPI program.

The Plan's policy 8000.20, *Review of Potential Quality of Care Concerns* (effective December 2019), stated the CMO oversees PQI processes. The Plan refers PQIs to Aetna's National Quality Management Department (NQMD) who conducts an investigation and tracks and trends concerns. The NQMD Registered Nurse renders a determination and decides when a case is referred to the CMO for review.

Finding: The Plan did not have a mechanism in place to monitor, evaluate, and take effective action to address quality improvement related to the PQI processes.

According to the Plan's PQI log submitted for the verification study, the Plan identified 30 PQIs from April 1, 2019 through February 18, 2021. Ten PQI cases were selected for review. The audit noted that all ten cases originated from member grievances. Three of ten PQI cases lacked an investigation, evaluation, and effective action to address the issues before they were closed. In two cases, the members were not contacted for more information per recommendations from the Plan's NQMD to aid in the investigation. In

the third case, the audit found the Plan incorrectly categorized a quality of care issue as a misdiagnosis instead of a delay in access to care. Subsequent to the interview, the Plan acknowledged the case was a delay in care.

Although the policy stated the CMO oversees PQI processes, the audit found only one of ten cases was reviewed by the CMO. The CMO did not routinely review the referrals and only reviewed PQIs that the NQMD nurse brought to the CMO's attention.

In addition, the audit found the Plan's Member Service Department and G&A staff did not properly identify members' issues to be elevated to a health professional for PQI determination. While the Plan's policy 8000.20 stated that all Plan staff are responsible for the identification of PQIs and use a list of examples as a guide to identify PQI concerns, the policy did not specify that medically related complaints are reviewed by an individual with clinical expertise.

The following four grievances showed how the MSRs responded to delays in medication but did not elevate the issue for a PQI.

- A member reported difficulty in obtaining assistance with prior authorization for diabetes and pain medications. The issue was documented as resolved during the call by providing the member information based on inquiries and filing a complaint. The Plan assigned the member a new Case Manager.

- A member reported not receiving prior authorization for depression and blood pressure medications, and requested to change PCP due to a lack of care. The complaint was documented as resolved through the Member Services Department by contacting the PCP and the member receiving the blood pressure medication. However, there was no evidence of the member receiving medication for depression or changing to a new PCP.

- A member reported not receiving prior authorization for a breathing medication. The complaint was documented as resolved by reaching out to the PCP and receiving and processing the authorization.

- A member called the Plan crying in pain due to a broken foot and in need of pain medication. The member reported not knowing what to do after the PCP was told to submit prior authorization for medication. The Plan noted the medication authorization was received by the pharmacy team five days prior to the call. The Plan informed the member that the issue was escalated as urgent and the PCP was instructed to submit a prescription and authorization for an orthopedic specialist. The Plan documented it would reach out to the member after the authorization is completed.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2019 through March 31, 2021
DATE OF AUDIT: April 19, 2021 through April 30, 2021

The Plan utilized non-clinical staff and limited criteria to determine whether reports of quality of care concerns are PQIs and should be referred to NQMD for investigation. Additionally, the Plan's policy 8000.20, *Review of Potential Quality of Care Concerns* (effective December 2019), did not have procedures on how PQI investigations are monitored. The CMO did not ensure the oversight of PQI processes.

The Plan did not provide evidence of investigating or monitoring PQIs. The Plan's National Quality Oversight Committee description indicated it meets at least ten times a year to conduct reviews of PQI issues and complaints. However, the Plan stated there were no meeting minutes to provide since "no cases have met further investigation requirements." According to the Plan's QAPI Evaluation for 2020, the Plan identified PQIs as an area of improvement and indicated the need for reinforcement of PQI definition and process.

If the Plan does not have a system in place to monitor, evaluate, and take effective action to address its PQI processes, there is the potential to miss pertinent information during the PQI investigation process. This could lead to substandard care issues not being captured, which could cause members harm.

Recommendation: Develop and implement policies and procedures to monitor, evaluate, investigate, and take effective action to address PQI processes.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Aetna Better Health of California, Inc.
AUDIT PERIOD: April 1, 2019 through March 31, 2021 **DATE OF AUDIT:** April 19, 2021 through April 30, 2021

5.2	PROVIDER QUALIFICATIONS

5.2.1 Monitoring of New Provider Orientation

The Plan is required to ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. The Plan shall conduct training for all providers within ten-working-days after the Plan places a newly contracted provider on active status. (*Contract, Exhibit A, Attachment 7(5)(A))*

The Plan's policy 8100.45, *Provider Credentialing, Recredentialing and Screening/Enrollment* (revised January 2020), states the Plan will conduct new provider orientations within ten-working-days after a provider is placed on active status.

Finding: The Plan did not have an effective monitoring process to ensure that all providers received training within ten-working-days after the Plan placed a newly contracted provider on active status.

This was a prior audit finding, which identified that the Plan did not conduct provider training for all of its newly contracted providers within the contractual timeframes. As part of the CAP, the Plan updated its policy to include providing, tracking, and monitoring of new provider orientations. However, review of the Plan's policy found that the Plan did not delineate its process to monitor new provider orientations.

A verification study found 19 of 22 provider files had discrepancies. The audit found two instances of provider attestation forms completed 106 to 113 days beyond the ten-working-day timeframe. Additional findings included no attestation forms, inability to identify training completion date, and whether the training was self-guided or in-person. Furthermore, attestations excluded the date the Plan received the form and a signature from Plan personnel to acknowledge receipt.

The Plan's current process to monitor new providers and acknowledge receipt of attestation forms is ineffective in ensuring all providers received training within the required ten-working-days. The Plan reviewed the new provider training files and attestation forms, and acknowledged its lack of consistency in documenting the receipt of new provider attestation forms. During the interview, the Plan stated its current desktop procedure is outdated. Plan staff also expressed challenges in obtaining the attestation forms from providers.

New provider orientation is an integral part of training network providers. Without an effective process to monitor, the Plan cannot ensure providers operate in full compliance with the Contract and all applicable federal, state, and local regulations to meet program requirements. The quality of care provided to members may suffer when providers lack training on the Medi-Cal Managed Care program.

This is a repeat of 2019 audit finding 5.2.1 – Network Provider Training.

Recommendation: Develop and implement an effective system to monitor and ensure training of newly contracted providers within ten-working-days, after the Plan places a newly contracted provider on active status, as required by the Contract.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

AUDIT PERIOD: April 1, 2019 through March 31, 2021
DATE OF AUDIT: April 19, 2021 through April 30, 2021

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1	HEALTH EDUCATION PROGRAM

6.1.1 Monitoring of Subcontractors' Delivery of Health Education

The Plan is required to implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion, and patient education for all members. In addition, the Plan shall monitor the performance of subcontractors that deliver health education programs and services to members, and implement strategies to improve performance and effectiveness. *(Contract, Exhibit A, Attachment 10(8)(A))*

Finding: The Plan did not have a system to monitor the performance and effectiveness of subcontractors that deliver health education programs to members.

The audit identified deficiencies to monitor health education effectiveness of Independent Physician Associations (IPAs). The Plan did not have a mechanism in place to monitor subcontractors' delivery of health education, which was also a finding in the prior audit.

The prior audit's CAP included updating policies. However, the Plan's policy 8300.05, *Prevention and Wellness Program* (revised July 2020), did not include a process to monitor its subcontractors' health education effectiveness.

Furthermore, the CAP stated the Plan would increase delegation oversight. The Plan initiated a Delegation Oversight Department to collect health education processes from IPAs. However, this Department was still under development at the time of the audit. Additionally, the Plan discussed development of an IPA scorecard to oversee and evaluate IPA compliance with health education. According to the Delegation Oversight Committee (DOC) meeting minutes, IPA scorecards contain metrics and utilization patterns. The Plan delayed implementation of the IPA scorecard due to COVID-19.

The audit found the Plan lacked evidence to support monitoring of its subcontractors. The Plan's DOC meeting minutes indicated the Plan's contracts with IPAs did not contain monitoring of health education procedures.

During the interview, the Plan acknowledged it does not monitor effectiveness of health education interventions and could not verify if members received education from subcontractors.

If the Plan does not monitor its subcontractors, the Plan cannot ensure subcontractors have an effective health education program and identify ways to improve. This can cause members to not receive the educational material or resources needed to achieve improved health and wellness or maintain a healthy lifestyle.

This is a repeat of 2019 audit finding 6.1.1 – Health Education Program.

Recommendation: Develop and implement a system to monitor the performance and effectiveness of subcontractors' health education programs.

MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Aetna Better Health of California, Inc.

2021

Contract Numbers:	17-94601 Sacramento 17-94603 San Diego State Supported Services
Audit Period:	April 1, 2019 Through March 31, 2021
Report Issued:	September 16, 2021

TABLE OF CONTENTS

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, 2019 through March 31, 2021. The review was conducted from April 19, 2021 through April 30, 2021, which consisted of document review of materials provided by the Plan and interviews with Plan's administration and staff.

An Exit Conference with the Plan was held on August 19, 2021.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Aetna Better Health of California, Inc.

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STATE SUPPORTED SERVICES

The Plan is required to provide, or arrange to provide, to eligible members State Supported Services, which include abortion and abortion-related services. *(State Supported Services Contract, Exhibit A(1))*

The prior audit found that the Plan's policy 8300.20, *Family Planning/Reproductive Health*, did not specifically state the Plan's responsibility to provide, or arrange to provide, abortion services. In addition, the Plan's Provider Manual did not contain verbiage clarifying that abortion is a covered benefit.

In accordance with the Corrective Action Plan, the Plan updated its policy to include the requirement that members can access abortion services in and out of network without prior authorization. Review of the Plan's Provider Manual also confirmed that the information was revised to clarify that abortion services are covered.

The Plan's policy 8300.20, *Family Planning/Reproductive Health* (revised December 2020), states that members can access abortion services in and out of network without prior authorization. In a verification study, the audit found that 39 of the 40 sampled abortion and abortion-related service claims were processed appropriately.

The audit found no discrepancies in this section.

Recommendation: None.