DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

October 3, 2023

Cindy Chung, Sr. Manager, Business Compliance Officer
Aetna Better Health of California, Inc.
9350 Waxie Way Ste 2012
San Diego, CA 92123

RE: Department of Health Care Services Medical Audit

Dear Ms. Chung:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Aetna Better Health of California, Inc., a Managed Care Plan (MCP), from May 16, 2022 through May 25, 2022. The audit covered the period of April 1, 2021 through March 31, 2022.

All items have been evaluated and DHCS accepts the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

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

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Lyubov Poonka, Chief
Audit Monitoring Unit
Managed Care Quality & Monitoring Division

Department of Health Care Services
Enclosures: Attachment A (CAP Response Form)

cc: Joshua Hunter, Lead Analyst
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Lyubov Melnichuk, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Plan: Aetna Better Health of California (ABHC)

Review Period: 4/1/21 - 3/31/22

Audit Type: Medical Audit and State Supported Services

On-site Review: 5/16/22 - 5/25/22

MCPs are required to provide a CAP and respond to all documented deficiencies included in the medical audit report within 30 calendar days, unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Finding Number and Summary, 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text, and include additional detail such as title of the document, page number, revision date, etc. in the column “Supporting Documentation” to assist DHCS in identifying any updates that were made by the plan. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. Policies and procedures submitted during the CAP process must still be sent to the MCP’s Contract Manager for review and approval, as applicable in accordance with existing requirements.

Please note, DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP, therefore DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP, unless prior approval for an extended implementation effort is granted by DHCS.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.2.1 - Consultation for Information Necessary to Determine Treatment Requests: The Plan did not consult with the requesting provider to obtain additional information necessary to render medical PA determinations and prematurely denied requests. **Recommendation:** Ensure receipt of necessary clinical information to determine medical necessity before rendering PA decisions within 72 hours from receipt of expedited PA requests, or within five working days but no longer than 14 calendar days from receipt of routine PA requests.	The plan has taken immediate action by providing training to ensure the team notifies the provider and the enrollee, in writing, that the plan cannot make a decision and specify the information requested but not received. The plan also updated the desktop to ensure all PA requests are not prematurely denied.	1. PA Clinical Review Training 2. Updated Prior Authorization Clinical Review Desktop	1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised Desktop, "UM Clinical Request for Additional Information and Extension" (01/07/22) revised process to clarify requests for additional clinical information for concurrent review as well as prior authorization. **MONITORING AND OVERSIGHT** • Job Aid Audit Tool, "ABH Concurrent Review Audit Element Definition" (01/28/23) demonstrates the MCP has a review process of each member of the UM team to undergo a random audit of 5 cases per quarter. The Central Team will review these audit findings with the UM team members and provide additional training if needed regarding the appropriate UM process and use of criteria tools during 1:1 meetings to discuss audit findings. • Job Aid, "ABH Audit Team-Audit Frequency and Volume" (01/27/22) which defines the frequency and volume of audits to be conducted by the MCP. Experienced staff receives an audit once a quarter unless otherwise indicated. New Hires, once initial education is completed, will be audited monthly for the first three months unless otherwise noted. A total of five cases per staff member per audit will be reviewed.

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				• Job Aid Audit Tool, "ABH Prior Authorization Audit Element Definition" (01/28/22) demonstrates the MCP has a process to perform monthly random checks of denial authorizations beginning 04/23 (for March authorizations) to demonstrate the clinicians are complying with the process of requesting specific clinical information and using the extension process to avoid premature denials. • Quarterly Audits, "Clinician Audits", (Q1-2023) demonstrates the MCP conducts quarterly audits of their clinicians. The critical elements captured are: o Clear documentation of the need for clinical information and that outreach was made within the clinical note. o The number of attempts made for additional clinical information either meets or exceeds health plan policy. o Documentation of specific information requested when additional clinician is needed. o Was extension process followed correctly per health plan policy? The overall audit score for four clinicians audited in Q1 2023, which captured the critical elements mentioned above was 84.5%. **TRAINING** • Training, PowerPoint Presentation, "Clinical Review Training 2023" (01/20/23 and 01/24/23) as evidence the Plan staff were informed on the importance of contacting the requested provider

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				if there is missing information in regard to the medical PA request. In addition, the provider can be contacted by telephone or fax to request the specific missing information and advise the provider on the timeline to meet turnaround time. Ongoing training will be provided to tenured clinicians during 1:1s for audit reviews and documented in 1:1 meeting notes. **The corrective action plan for finding 1.2.1 is accepted.**
1.2.2 - Review Criteria for Medically Necessary Covered Services: The Plan did not provide medically necessary services covered by the Medi-Cal Provider Manual, which resulted in a delay in treatment for its members. **Recommendation:** Ensure that all medically necessary covered services included in the Medi-Cal Provider	The has taken immediate action to ensure medically necessary services criteria are not more restrictive than the Medi-Cal Provider Manual. The plan provided additional training for all team members regarding hierarchy of criteria and where to find prior authorization requirements so that appropriate criteria will be used, and the most restrictive criteria will not mistakenly be used. In addition to this measure, the plan is currently working on a process with our Pharmacy Director to process all J-code	1. Medical Necessary Criteria Job Aid 2. PA Clinical Review Training	2/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Job Aid, "Medical Necessity Criteria Hierarchy" (09/23/20) which details the hierarchy of criteria used for making medical necessity decisions. The first criteria used is the state and federal regulatory agency. **MONITORING AND OVERSIGHT** • Written Statement, "Plan Response" (02/27/23) "The UM team is audited quarterly by a central team using the tools submitted for review. Each member of the UM team undergoes a random audit of 5 cases per quarter. • The UM Manager will review these audit findings with the UM team members and provide additional training if needed

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Manual are provided to its members.	drug requests through Pharmacy for review; we expect this process to start by the end of February.			regarding the appropriate UM process and use of criteria tools during 1:1 meetings to discuss audit findings. • Additionally, the UM Manager will perform random checks of denial authorizations monthly starting in April (for March authorizations) to verify the clinicians are complying with the process of requesting specific clinical information and using the Extension process to avoid premature denial. 3 random denials per clinician will be audited by UM Manager. The findings will be documented and presented at 1:1 meetings with team members, at which time further education/training will be provided if needed." **TRAINING** • Training, PowerPoint Presentation, "Clinical Review Training 2023" (01/20/23 and 01/24/23) as evidence Plan staff have received updated desktop objectives listed below: o Determine the appropriate criteria with which to review the request. o Find the appropriate website for the DHCS criteria. o Ensuring we communicate to the provider the specific criteria we need to approve the authorization. • In addition, one slide presented gave the website address for the DHCS Medi-Cal Provider Manual. **The corrective action plan for finding 1.2.2 is accepted.**

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1.4.1 - Medical Director Involvement in the Grievance Process: The Plan's grievance system is not overseen by the Plan's Chief Medical Officer or the designated Medical Director. **Recommendation:** Develop and implement policies and procedures to ensure that a Medical Director actively participates in the grievance system.	The plan took immediate action to ensure the Chief Medical Officer (CMO) actively participates in the plan's grievance system. The CMO has been participating in the plan's monthly Grievance and Appeal Committees, overseeing the grievance trends and reviewing the Grievance Log.	1. 10.26.22 Grievance Committee Meeting Minutes 2. P&P 3100.90	10/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised P&P, CA 3100.90, "Member Complaint/Grievance" (02/23/23) has been updated to include the CMO or MD in the Grievance Committee to oversee trends, the grievance log, and grievance system. **IMPLEMENTATION** • Meeting Minutes, "Grievance Committee Meeting Minutes" (10/26/22 & 11/30/22) which ensures that the CMO was in attendance and participated in the grievance committee meeting. The CMO is reviewing grievance log and trending analysis. • Written Statement, "The CMO is aware of the Plan's grievance system. APLs related to G&A have been shared with the CMO. The Plan will develop additional training to provide the CMO on the oversight of the grievance system." **MONITORING/OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• Written Statement, "The Plan has communicated this requirement to the CMO and its designee. The Grievance Committee documents all attendees." **The corrective action plan for finding 1.4.1 is accepted.**
1.5.1 - Reporting Non-Compliance of Delegated Entities: The Plan did not report instances of subcontractors' non-compliance, imposition of corrective actions, or financial sanctions to MCOD Contract Managers within three business days of discovery or imposition. **Recommendation:** Develop and implement procedures to report subcontractors' non-compliance or imposition of corrective actions to MCOD Contract Managers within three	The Delegation Oversight (DO) Department has implemented quarterly monitoring of the delegates. When there are instances of the delegates' non-compliance, imposition of corrective actions or financial sanctions, the DO team will report to the Compliance Department immediately. Compliance will report this information to the MCOD Contract Manager within three (3) business days of discovery. Depending on the performance and remediation plan requested from the delegates, DO will request and monitor updates received from the delegates on a monthly or quarterly basis until the issue is being	1. Policy 8000.60 2. UM Denial Review IPA Performance Monitoring Desktop 3. UM Turn-around Time Monitoring Desktop	1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan Policy "8000.60 Delegation Oversight Responsibilities" ○ The Policy demonstrates that it aligns with APL 17-004 stating the Plan will report any significant non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under contract with DHCS to their MCOD contracts managers withing 3 business days of discovery or imposition. **OVERSIGHT & MONITORING** • Plan procedure "Desktop: IPA Medical Management Timeliness Monitoring" ○ The Plan's delegation oversight RN monitors the performance of the delegated entity, including the pre-delegation process & monitoring of contractually delegated services as well as standards dictated by federal, state, and accreditation guidelines, on a monthly or quarterly basis. [General Information, page 1]

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business days of discovery or imposition.	remediated.			○ The Plan recommends a benchmark of at least ninety percent compliance with standards. [General Information, page 1] ○ Procedure demonstrates that the Plan has revised to include "Aetna Better Health-CA Delegation Oversight will report any significant instances of non-compliance to its' Compliance Officer of any imposition, corrective actions, or financial sanctions for reporting to the DHCS MCOD Contract Managers within three business days of discovery or imposition." [General Information, page 1] • Plan procedure "Desktop: IPA Performance Monitoring using the SAR and NOA Denial Packets." ○ Procedure demonstrates that the Plan has revised to include "Aetna Better Health-CA Delegation Oversight will report any significant instances of non-compliance to its' Compliance Officer of any imposition, corrective actions, or financial sanctions immediately. Compliance Officer will report to the DHCS MCOS Contract Managers within three business days of discovery or imposition." [Step 10., page 3] **The corrective action plan for finding 1.5.1 is accepted.**
2. Case Management and Coordination of Care				
2.1.1 - Identification and Referral of CCS-Eligible Children: The Plan did not have a system to ensure members with CCS-	To ensure members with CCS-eligible conditions were identified and referred to the local CCS program, the plan has updated current CCS identified member list with specific CCS related	1. California Children's Services (CCS) Referral Process	2/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • California Children's Services (CCS) Referral Process updated to describe the MCP's process identifying and referring CCS eligible

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
eligible conditions were identified and referred to the local CCS program. **Recommendation:** Develop and implement mechanisms to ensure members are identified for CCS and referred to the local CCS program.	diagnosis. Identification will occur through stratification, Predicative Pathway Modeling, and enrollment files. Care Managers will refer members with CCS eligible conditions to the local CCS program and create a community resource referral event in care management platform for CCS referral. Care managers will set reminder tasks in care management platform every 14 days until confirmation is received that member is accepted into CCS. Once member is accepted, Care Manager will close active care management episode. If member is not accepted in CCS program, Care Manager will continue with current care management episode. The plan will enhance informatics report to target			children. On a monthly basis, assigned care management staff receives a list of eligible CCS members for outreach to confirm members are informed about CCS program. Parents or guardian of the eligible member who are interested in the program will be enrolled to care management. **MONITORING** • Screen shot from CM system as evidence on interim system to identify CCS eligible children. • March 2023 CA CCS Report which is used by the MCP to identify potential CCS members with specific CC related diagnoses demonstrate that the MCP fully implemented its corrective action. **The corrective action plan for finding 2.1.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	potentially eligible CCS members and will update the CM SOP to include the process of completing the review and creating CCS referrals to the local CCS agencies.			
2.1.2 - Early Start Program Eligibility Identification: 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. **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.	The plan has taken immediate action to identify children under three years of age who may be eligible to receive services from the Early Start Program by enhancing the reporting capabilities. The enhanced report is sent monthly to the care management team to perform outreach; a minimum of 2 attempts to reach member representative. Utilizing the enhanced report, care/case manager will be able to perform the following: 1. provide program information; assist	2. Early Start Program Referral	12/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • The Plan's policy 7000.43, Coordination of Member Care (revised September 2021), states the Plan will perform and obtain baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion that a member has a medical condition and qualifies for EI services or Early Start Program. The Plan will monitor and provide oversight through the collection of data, analyzing the data, identifying areas of improvement, and measuring the effectiveness of improvement actions annually. Coordination of activities are reported to the Plan's QM/UM Committee, Quality Management Oversight Committee (QMOC), and Board of Directors. (2022 Medical Audit Page 17) **TRAINING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	with referring member to local regional center for further evaluation. 2. Case manager will offer case management services to the member authorized representative or legal guardian. 3. Care manager will create a community resource referral in case management platform; creating a task for 2 week follow up. 4. CM Manager will maintain oversight which consists of monitoring events by type in care management platform to determine if a referral has documented follow up.			• Early Start Referral Job Aid instructs on methods for assisting identifying and referring children under three to receive services from the Early Start Program. The job aid to include the start of the process being the informatics targeted report the of the potential eligible members followed by the CM process steps. **MONITORING (FROM 2021 CAP)** • Early Identification Spreadsheet shows members identified for Early Start that are actively being followed by the regional center. (2021 CAP) • Well Child Outreach Call files demonstrate the MCP is conducting outreach for members eligible for Early Start. (2021 CAP) • Early Start Identification Members Outreach Report is used to identify potential eligible members. **The corrective action plan for finding 2.1.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2.3.1 - Behavioral Treatment Plans: The Plan did not ensure BHT treatment plans are reviewed no less than once every six months and contained transition, crisis, and exit plans. **Recommendation:** Revise and implement policies and procedures to ensure BHT treatment plans are reviewed, revised, and modified no less than once every six months and contain transition, crisis, and exit plans.	The plan's Behavioral Health Clinical Liaison will provide oversight and monitoring of the provider of BHT services. The liaison will outreach to the treatment provider no later than 5.5 months to ensure the provider will submit updated treatment plan to the plan. The plan will review the updated treatment plans to ensure all required elements, including a transition, crisis and exit plan are completed prior to the 6-month term date of the existing authorization.	1. CA ABA BHT Job Aid	1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy 7000.91 states the behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six (6) months by a BHT Service Provider (2022 Medical Audit Page 19) • ABA BHT Job Aid updated to instruct that approved BHT treatment Plans must include exit plan, transition plan and crisis plan. Only a determination that services are no longer medically necessary under the EPSDT standard can be used to reduce or eliminate services. The job aid instructs that the Plan's Behavioral Health Clinical Liaison will provide oversight and monitoring of the provider of BHT services. The liaison will outreach to the treatment provider no later than 5.5 months to ensure the provider will submit updated treatment plan to the plan. **MONITORING** • Examples of Behavioral Health clinical notes and authorization detail spreadsheet confirm that treatment plans are reviewed every sixth months. **(From 2021 CAP)** • CAP narrative from 12/19/22 describes improvements made to MCP's monitoring the review of BHT treatment plans.

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				• After approving an ABA (Applied Behavior Analysis) assessment and receiving the initial BHT Treatment Plan, approvals are for 6 months only. BHT Continuation authorizations are also approved for 6 months at a time. This is how the MCP confirms BHT treatment plans are reviewed once every 6 months. BHT requests/approvals/denials require a mandatory referral to Care Management services. The Care Manager assists the guardians/parents in navigating the available benefits, including BHT, and acts a resource for any issues for ongoing authorization for BHT. • The Behavioral Health Clinical Liaison is responsible for monitoring services to verify treatment plans are reviewed, revised, and modified no less than once every six months and include all required elements including a transition, crisis and exit plan. **The corrective action for finding 2.3.1 is accepted.**
3. Access and Availability of Care				
3.6.1 - Family Planning Claims Processing: The Plan incorrectly denied family planning claims.	The plan has taken immediate action to reconfigure the plan's claim system by removing PA requirements on family planning (FP) claims. This reconfiguration was completed in May 2022.	1. IT Ticket Closed Notification 2. Sample File #1 3. Sample File #2 4. Sample File #4	5/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "IT Ticket Closed Notification" which demonstrates that the plan has taken immediate action to reconfigure the plan's claim system by removing prior authorization requirements on family

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Recommendation: Revise and implement policies and procedures to ensure appropriate reimbursement of family planning claims.	Since the reconfiguration took plan, the plan has been reimbursing the PF claims timely. The verification study found the three claims were inappropriately denied were due to the IPA's responsibility. The plan has delegated arrangements with our IPA's and as such failed to fully research and review our full end to end response to ensure the claim was fully paid to the provider. Our universe just included claims that went to just one party and not both (the health plan and the delegate who share payment responsibility.) In the end all 3 claims that were perceived denied due to the information provided to the auditors were fully paid to the providers of the 3 claims. Please see supporting documentation to confirm that the 3 denied claims were paid as proof of			planning claims. This reconfiguration was completed in May 2022. (Closure Notification). • Desktop Procedures, "State Supported Services (SSS) & Family Planning Services" (06/11/23) to demonstrate the MCP's process to audit all SSS and Family Planning claims twice a year to verify that claims were paid and processed correctly. The Desktop Procedures outlines how to generate an audit report for SSS and Family Planning claims. (State Support & Family Planning Service Bi-Annual Audit Process). **MONITORING AND OVERSIGHT** • "Family Planning Claim Audit Results" (06/13/23) to demonstrate that the MCP has a self-monitoring process to confirm that family planning claims are processed correctly. Twice per year the MCP will review Family Planning claims with edit 1136 (Edit defers payment to the Independent Practice Association) and compare the information to encounter data to verify that the Independent Practice Association received the claim and processed it. Any gaps between the claim and the encounter will be remediated. Since there were no deficiencies in the audit, no further refresher training was needed. (Audit Result). **The corrective action plan for finding 3.6.1 is accepted.**

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	payment to the provider.			
3.6.2 - Processing of Misdirected Claims: The Plan did not have a system to identify and process misdirected claims within the required timeframes. **Recommendation:** Revise and implement policies and procedures to identify and process misdirected claims.	From January 2022 through April 2022, the plan manually reviewed claims each week to assure claims that were the responsibility of the delegates were appropriated sent to the IPA in order to meet the 10 day timeline for 95% of misdirected claims. In Q1, the plan had a 93% pass rate. In order to improve our pass rate, the plan worked with the IT department to create an automation tool based on specific criteria that aligned with our Division of Financial Responsibility document. The automation tool was designed and tested in early May, and we now have exceeded the 95% pass rate	1. Q1 2022 Quarterly Claim Settlement report 2. Q2 2022 Quarterly Claim Settlement report 3. Q3 2022 Quarterly Claim Settlement report		The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • DTP "CA Misdirected Claims Process" demonstrates that the MCP has procedures for processing misdirected claims within the required timeframes. A flat file is generated daily and sent to Office Ally. Office Ally will forward the claims electronically to the Independent Practice Association (IPA). Office Ally will generate the claims to paper for any that are not set up for electronic receipt or that were rejected when the claim was sent electronically, and the full misdirected claim process must be completed within 10 days of the original receipt date. (CA Misdirected Claims Process). **MONITORING AND OVERSIGHT** • "Quarterly Claim Settlement Reports" (2022 Q1 – 2022 Q3) which demonstrates that the MCP manually reviewed claims each week to assure claims that were the responsibility of the delegates were appropriately sent to the IPA in order to meet the

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	for Q2, Q3 and Q4 2022.The results were Q1 94.32 , Q2 95.23% , Q3 99.12% , and Q4 98.83%.			10-day timeline. The MCP had a 94.32% pass rate for Q1, 95.23% pass rate for Q2, 99.12% pass rate for Q3, and 98.83% pass rate for Q4. (Quarterly Claims Settlement Report). • Sample Daily Email, "Claims Misdirected" (03/23/23) which demonstrates that the MCP monitors misdirected claims daily. A daily email is sent to leadership and the Claims Manager, and the information is rolled up into the quarterly reporting. The report provides information on misdirected claims and the percentage of new claims redirected to the IPA within ten business days. The Claims Manager will review the claims manually if any pended claims jeopardize the 10-day turnaround time. Claims will be moved out of pending status and redirected to the IPA's. (Misdirected Claims Narrative). **The corrective action plan for finding 3.6.2 is accepted.**
3.8.1 - Physician Certification Statement: The Plan did not maintain a process to ensure utilization of the PCS forms to determine the appropriate level of service.	The plan has taken immediate action to remediate this finding by completing the following: 1. Revised P&P 4500.95, to comply with APL 22-008. Approval was received by DHCS on August 31, 2022. 2. Issued a Corrective	1. Transportation Policy A-CA 4500.95 2. DHCS Approval of Policy A-CA 4500.95 3. Corrective Action Notice to Access2Care	3/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan policy "4500.95 Emergent and Non-Emergent Transportation" ○ Policy demonstrates that the member must have an approved PCS form authorizing NEMT by the provider. [Responsibilities, page 8]

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Recommendation: Implement policies and procedures to ensure utilization of the PCS forms to determine the appropriate level of services.	Action Notice to Access2Care (A2C),our transportation broker, on August 16, 2022, regarding compliance with PCS form policy. 3. A2C call scripting was updated to inform members requesting NEMT that a PCS form is required and will direct members without an active PCS form to contact the plan's Member Services Department (August 2022). 4. The plan's Utilization Management (UM) Department processes the PCS forms, provides authorization to A2C, and stores PCS forms as required. The job aid was revised in March 2022 to extend the allowable	4. Access2Care Protocols Document 5. UM NEMT Job Aid		○ The Plan indicates that they will approve NEMT services when a PCS Form is submitted by the member's provider and use the PCS form to provide the appropriate mode of NEMT for members. [Responsibilities, page 11] • Plan procedure "NEMT UM Job Aid" demonstrates that the member must have a PCS form, otherwise the Plan cannot approve the NEMT request without it. [Page 1, Requirements for NEMT Services for Members, 3.] • Plan Process "PCS Form Process" ○ Broker provides the "Missing PCS Form" Report to the plan weekly. ○ The Report identifies members without a PCS form on file. ○ The plan reviews the Report, and the "Missing PCS Forms" will be traced and/or obtained from the indicated source to be sent to the Transportation Broker. ○ Once the PCS form is traced to either the IPA or provider, the plan will outreach to get the PCS form completed & forwarded back to the broker within 48 hours. ○ In addition, once the PCS Form Member Letter is approved by DHCS, the plan will send this letter to the member identified on the report. **OVERSIGHT AND MONITORING**

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	authorization period to up to 12 months to comply with APL 17-010 and current APL 22-008. 5. A2C developed a daily report of members requesting NEMT services without a PCS form. The plan's care management staff utilizes that report to perform outreach to members and/or members' providers to secure updated PCS forms. In addition to requesting updated PCS forms, those members not already in active care management are invited to participate in care management. (December 2022). 6. Root cause analysis was conducted to identify trends for			• Plan policy "4500.95 Emergent and Non-Emergent Transportation" ○ A quarterly report is presented at the Joint Operations Meetings (JOM) where a review of operational performance & solutions to any deficiencies are created. The meetings include the transportation broker, health plan delegation oversight, plus vendor management. [Responsibilities, page 14-15] • "NEMT Updated Scheduling" demonstrates requested NEMT trips that are nonurgent & without a valid PCS form on file, will be denied. The requester is informed that NEMT services require a PCS form. • Transportation Broker Tracker "NEMT Missing PCS Form" ○ The broker developed a daily report of members requesting NEMT services. ○ The Plan's care management staff utilizes the report to perform outreach to members and/or members' providers to secure updated PCS forms. **The corrective action plan for finding 3.8.1 is accepted.**

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	members with NEMT needs who do not have current PCS forms on file (Oct 2022 to Jan 2023). The plan will take the following actions to ensure A2C obtains the PCS forms prior to rendering NEMT services: 1. The plan's Care Management team will continue to conduct outreach and this process will be added to the Job Aid by 2/2023. 2. Members who still do not have a PCS form on file will be sent a letter to explain the PCS process. A PCS form will be included. 3. A Provider Bulletin will be sent to all providers to reinforce			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	the need for PCS forms to authorize NEMT services. 4. Discuss PCS form process and compliance in Joint Operating Meetings for IPA. (From February 2023 and ongoing.) 5. A targeted Provider Bulletin will be sent to dialysis centers, encouraging their participation to ensure their clients have active PCS forms. (March 2023)			
3.8.2 - Unenrolled NMT Transportation Providers: The Plan did not ensure contracted NMT providers were enrolled in the Medi- Cal program.	The plan has taken immediate action to ensure contracted NMT providers were enrolled in the Medi-Cal program in order to pay NMT service claims. The plan has shared this requirement with our transportation broker, A2C.	1. Transportation Policy, A-CA 4500.95 2. ABHCA Transportation Providers	3/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan Policy "4500.95 Emergent_Non-Emergent" ○ All NEMT & NMT providers must comply with the enrollment requirements of APL 19-004.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Recommendation: Revise and implement policies and procedures to ensure NMT providers are enrolled in the Medi-Cal program.	As a result, AC2 has performed the following: 1. Notified providers who had not yet been registered by Medi-Cal that they could no longer provide services for the plan's members. (Q3 2022) 2. Updated their network trip assignment protocols to prevent non-registered providers from being assigned to the plan's members. (Q3 2022) 3. Provides a monthly report to the plan that includes the Medi-Cal registration status of all providers servicing the plan's members. (Q3 2022 and ongoing) 4. Provides a monthly report to the plan of non-registered providers with pending status to			○ NEMT & NMT providers may participate in Aetna's network for up to 120 days, pending the outcome of the enrollment process. ○ Any NEMT or NMT provider who has been denied enrollment in the Medi-Cal program or when the 120 days has expired will have its contract terminated. **MONITORING AND OVERSIGHT** • Plan Policy "4500.95 Emergent_Non-Emergent" ○ The Plan tracks the 120-day period, from application date to adjudication of the application or expiration of the 120-day time period. ○ The Plan will only re-initiate a contract when the provider has successfully been enrolled as a Medi-Cal provider. ○ If requirements are not met the Plan has a process of escalating remediation, including corrective action for non-compliance. • Plan Procedure "Screening and Enrollment Desktop" ○ On a monthly basis, the plan's Network Relations team utilizes the screening & enrollment tracking spreadsheet to monitor providers who have a pending Medi-Cal enrollment. • "Transportation Provider Roster 2023" ○ The Transportation Roster was reviewed & approved by MCQMD Transportation SME as of 07/25/2023.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	monitor additional provider capacity that may be available in the future upon complete registration. (Q3 2022 and ongoing) 5. Provides a monthly report of claim activity to validate that only Medi-Cal registered providers are being utilized. (Q3 2022 and ongoing) To ensure ongoing compliance, the plan will conduct an audit of 2022 trips to validate utilization of providers that are Medi-Cal registered exclusively and will investigate the feasibility of a claim-based edit to ensure that claims for non-registered transportation providers cannot be paid. Alternative, a post payment recovery project may be employed to enforce the use			**The corrective action plan for finding 3.8.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	of only Medi-Cal registered providers. (March 2023)			

3.8.3 - Unenrolled NEMT Transportation Providers:
 	
The Plan did not ensure contracted NEMT providers were enrolled in the Medi- Cal program.
 	
Recommendation:
Revise and implement policies and procedures to ensure NEMT providers are enrolled in the Medi-Cal program.
	The plan has taken immediate action to ensure contracted NEMT providers were enrolled in the Medi-Cal program in order to pay NEMT service claims. The plan has shared this requirement with our transportation broker, A2C. As a result, AC2 has performed the following:
	1. Notified providers who had not yet been registered by Medi-Cal that they could no longer provide services for the plan's members. (Q3 2022)
	2. Updated their network trip assignment protocols to prevent non-registered providers from being assigned to the plan's
		1. Transportation Policy, A-CA 4500.95
		2. ABHCA Transportation Providers
			3/2023	The following documentation supports the MCP's efforts to correct this finding:
				
				POLICIES AND PROCEDURES
				
				• Plan Policy "4500.95 Emergent_Non-Emergent"
				  ○ All NEMT & NMT providers must comply with the enrollment requirements of APL 19-004.
				  ○ NEMT & NMT providers may participate in Aetna's network for up to 120 days, pending the outcome of the enrollment process.
				  ○ Any NEMT or NMT provider who has been denied enrollment in the Medi-Cal program or when the 120 days has expired will have its contract terminated.
				
				MONITORING AND OVERSIGHT
				
				• Plan Policy "4500.95 Emergent_Non-Emergent"

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	members. (Q3 2022) 3. Provides a monthly report to the plan that includes the Medi-Cal registration status of all providers servicing the plan's members. (Q3 2022 and ongoing) 4. Provides a monthly report to the plan of non-registered providers with pending status to monitor additional provider capacity that may be available in the future upon complete registration. (Q3 2022 and ongoing) 5. Provides a monthly report of claim activity to validate that only Medi-Cal registered providers are being utilized. (Q3 2022 and ongoing) To ensure ongoing compliance, the plan will conduct an audit of 2022 trips to validate utilization of providers that are Medi-Cal			○ The Plan tracks the 120-day period, from application date to adjudication of the application or expiration of the 120-day time period. ○ The Plan will only re-initiate a contract when the provider has successfully been enrolled as a Medi-Cal provider. ○ If requirements are not met the Plan has a process of escalating remediation, including corrective action for non-compliance. • Plan Procedure "Screening and Enrollment Desktop" ○ On a monthly basis, the plan's Network Relations team utilizes the screening & enrollment tracking spreadsheet to monitor providers who have a pending Medi-Cal enrollment. • "Transportation Provider Roster 2023" ○ The Transportation Roster was reviewed & approved by MCQMD Transportation SME as of 07/25/2023. **The corrective action plan for finding 3.8.3 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	registered exclusively and will investigate the feasibility of a claim-based edit to ensure that claims for non-registered transportation providers cannot be paid. Alternative, a post payment recovery project may be employed to enforce the use of only Medi-Cal registered providers. (March 2023)			
4. Member Rights				
4.1.1 - Grievances Classified as Call Inquiries: The Plan did not appropriately classify and process call inquiries as member grievances. **Recommendation:** Develop and implement policies and procedures to ensure proper classification of call inquiries as grievances.	To ensure proper classification of call inquiries as grievances, the plan has remediated this issue by re-educating the MSRs to ensure they identify calls with an expression of dissatisfaction as grievances and to forward those calls to the G&A Department. The plan also implemented an audit process by reviewing incoming call samples. The audit identified several calls that should have been sent to G&A in August and September. Those call	1. Member Services Desktop 4500.42D 2. Policy 4500.54 Member Services Quality Review Process 3. GA Call Tracking audit spreadsheet 4. GA Call Tracking Audit Process		The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • P&P, CA-4500.54, "Medicaid Member Services Quality Review Process" (12/22) demonstrates the MCP has a quality review process. All quality review results are documented, and results discussed with the applicable staff member. Scores from each review are accumulated monthly and an average score determined. A minimum average equal to or greater than the 95% benchmark is expected each month. Standardized processes for performance assessments include a consistent sampling methodology. **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	notes were then forwarded to G&A. With the implementation of the audit process, the plan saws an improvement after 4 weeks. The plan continues to monitor calls and have identified zero misclassification of call inquiries as grievances from October through December 2022. Please see our attached audit tracker showing the calls reviewed and those identified. (Password = "Goteam22!")			• Audit, "GA Call Tracking Audit" (08/22 – 12/22) demonstrates the MCP has a weekly audit to review incoming call samples for proper classification of call inquiries as grievances. All Member Service's (MS) call logs are reviewed by the Manager or Supervisor of MS. The call logs are downloaded to an excel spreadsheet and the "search and find" function is used in excel to enter key words that might indicate a grievance that was not coded as grievance and appeal. • Audit Process, "GA Weekly Call Tracking Audit" (08/22) demonstrates that the MCP developed a weekly process to confirm Member Service (MS) staff is routing all complaints, grievances and appeals through the call tracking system to the G&A Department. This audit process was implemented on 02/24/23. • Audit Tool, "Monthly MSR Call Audit" (05/10/22) demonstrates the MCP has a monthly audit tool to confirm the MSR's are coding and documenting a grievance appropriately. All calls are recorded while logged into the phone queue. To confirm a fair mixture of call reviews, the reviews (at a minimum, 4 per month, per MSR unless otherwise noted) are to be completed at random using a mixture of calls the MSR's receive. • Monthly Audit, "G&A Monthly Audits", (08/22 – 02/23) demonstrates a total of 23,646 calls audited in an eight-month period. There was a compliance rate of 99%. **TRAINING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• Meeting, "ABHCA Team Meeting" (08/26/22) which confirms that a discussion was held with Team Members in regard to CA 4500.42D (Accepting Member Grievance and Appeals Calls) to confirm that the grievance issue meets the grievance criteria. **The Corrective Action for finding 4.1.1 is accepted.**
4.3.1 - Privacy Breach and Notifying Required Entities within 24 Hours: 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. **Recommendation:** Implement policies and desktop procedures to ensure breaches or suspected security incidents are reported to	The plan has taken immediate actions to ensure notification of privacy breach is communicated to the Compliance Department first via email to the compliance inbox and to copy the Compliance Officer and Senior Compliance Analyst. This will ensure the notification will be received and prompt investigation and reporting will be timely reported to DHCS. The plan developed a new Privacy training to reeducate staff on how to report privacy incidents to Compliance and has updated the desktop procedure.	1. Reporting Privacy Incident Desktop 2. Privacy Incident Narrative 3. Privacy Incident Reporting Training 4. Tracking Tool for Breaches & Security Incidents	1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • P&P, "4.3.1 ABHCA Reporting HIPAA Incidents to DHCS-DESKTOP_Redline" which reflects the 24 hours, 72 hours, and 10-day reporting requirements to DHCS. • The MCP demonstrated the P&Ps are effectively working by providing samples of Incident Reporting (4.3.1_4.3.2_4.3.3_Privacy Incident Reporting 1), (4.3.1_4.3.2_4.3.3_Privacy Incident Reporting 2), Narrative (4.3.1_Narrative) and DHCS Email Confirmation (4.3.1_Email Confirmation). **TRAINING** • Training via PowerPoint Presentation, "4.3.1_Privacy Incident Reporting Training January 2023" which demonstrates that the MCP conducted refresher training to current staff and training for

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 24 hours by email or fax.				new staff regarding reporting suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes. **MONITORING AND OVERSIGHT** • "4.3.1_Tracking Tool_Breaches and Security Incidents" which demonstrates that the MCP has a self-monitoring process to track the reporting of suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes. The following categories monitored are as follows: Date and Time of Incident, Date and Time MCP Became Aware of Incident, PIR Submitted to DHCS 24hr, 72hr, and 10 Day (4.3.1_Tracking Tool_Breaches and Security Incidents). **The corrective action plan for finding 4.3.1 is accepted.**
4.3.2 - Privacy Breach and Filing an Incident Report within 72 Hours: The Plan did not provide an updated DHCS Privacy Incident Report to the DHCS Program Contract Manager, DHCS Privacy Officer,	The plan has taken immediate actions to ensure notification of privacy breach is communicated to the Compliance Department first via email to the compliance inbox and to copy the Compliance Officer and Senior Compliance Analyst. This will ensure the notification will be received	1. Reporting Privacy Incident Desktop 2. Privacy Incident Narrative 3. Privacy Incident Reporting Training 4. Tracking Tool for Breaches & Security Incidents	1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • P&P, "4.3.1 ABHCA Reporting HIPAA Incidents to DHCS-DESKTOP_Redline" which reflects the 24 hours, 72 hours, and 10-day reporting requirements to DHCS. • The MCP demonstrated the P&Ps are effectively working by

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
and DHCS Information Security Officer within 72 hours of discovery. **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.	and prompt investigation and reporting will be timely reported to DHCS. The plan developed a new Privacy training to reeducate staff on how to report privacy incidents to Compliance and has updated the desktop procedure.			providing samples of Incident Reporting (4.3.1_4.3.2_4.3.3_Privacy Incident Reporting 1), (4.3.1_4.3.2_4.3.3_Privacy Incident Reporting 2), Narrative (4.3.1_Narrative) and DHCS Email Confirmation (4.3.1_Email Confirmation). **TRAINING** • Training via PowerPoint Presentation, "4.3.1_Privacy Incident Reporting Training_January 2023" which demonstrates that the MCP conducted refresher training to current staff and training for new staff regarding reporting suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes. **MONITORING AND OVERSIGHT** • "4.3.1_Tracking Tool_Breaches and Security Incidents" which demonstrates that the MCP has a self-monitoring process to track the reporting of suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes. The following categories monitored are as follows: Date and Time of Incident, Date and Time MCP Became Aware of Incident, PIR Submitted to DHCS 24hr, 72hr, and 10 Day (4.3.1_Tracking Tool_Breaches and Security Incidents). **The corrective action plan for finding 4.3.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.3.3 - Privacy Breach and Filing a Complete Incident Report within Ten Days: The Plan did not provide a completed Privacy Incident Report to all required DHCS entities within ten working days of discovery. **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	The plan has taken immediate actions to ensure notification of privacy breach is communicated to the Compliance Department first via email to the compliance inbox and to copy the Compliance Officer and Senior Compliance Analyst. This will ensure the notification will be received and prompt investigation and reporting will be timely reported to DHCS. The plan developed a new Privacy training to reeducate staff on how to report privacy incidents to Compliance and has updated the desktop procedure.	1. Reporting Privacy Incident Desktop 2. Privacy Incident Narrative 3. Privacy Incident Reporting Training 4. Tracking Tool for Breaches & Security Incidents	1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • P&P, "4.3.1 ABHCA Reporting HIPAA Incidents to DHCS-DESKTOP_Redline" which reflects the 24 hours, 72 hours, and 10-day reporting requirements to DHCS. • The MCP demonstrated the P&Ps are effectively working by providing samples of Incident Reporting (4.3.1_4.3.2_4.3.3_Privacy Incident Reporting 1), (4.3.1_4.3.2_4.3.3_Privacy Incident Reporting 2), Narrative (4.3.1_Narrative) and DHCS Email Confirmation (4.3.1_Email Confirmation). **TRAINING** • Training via PowerPoint Presentation, "4.3.1_Privacy Incident Reporting Training_January 2023" which demonstrates that the MCP conducted refresher training to current staff and training for new staff regarding reporting suspected security incidents or

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Officer within ten working days of discovery.				unauthorized disclosures of PHI to DHCS within the required timeframes. **MONITORING AND OVERSIGHT** • "4.3.1_Tracking Tool_Breaches and Security Incidents" which demonstrates that the MCP has a self-monitoring process to track the reporting of suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes. The following categories monitored are as follows: Date and Time of Incident, Date and Time MCP Became Aware of Incident, PIR Submitted to DHCS 24hr, 72hr, and 10 Day (4.3.1_Tracking Tool_Breaches and Security Incidents). **The corrective action plan for finding 4.3.3 is accepted.**
6. Administrative and Organizational Capacity				
6.2.1 - Notification Regarding Changes in Member's Circumstances: The Plan did not have a method to notify DHCS of information the Plan received regarding	When members report to the plan that there is a change in circumstance such as change in address, phone number, income or death, the plan will collect that information and store in a database so that the plan can provide timely notification to DHCS. In turn,	To be provided	2/2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • 4500.50D Responding to Member Calls 3.2023 o The Plan submitted a revised procedure directing representatives to update members' changes in circumstances (income, physical address change, or member death) and complete an Enrollment update using a template

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
changes in a member's circumstance. **Recommendation:** Develop and implement policies and procedures to ensure DHCS is notified of changes in a member's circumstance.	we also ask the member to report these types of changes in household to their local county office. Any employee of the plan that obtains any of these changes, he or she will send the information to the Enrollment Unit Inbox for staff to input into a tracking database. The Enrollment Unit will send updates bimonthly to the Compliance Officer who in turn will provide the information to the Contract Manager at DHCS. In order to implement this process, in the next 30 days the plan will: 1. Train Member Services Department to ensure all member services representatives are familiar with the process when they receive such calls			which is sent to the Enrollment Unit Inbox & tracking database o MCP Compliance Officer sends update to DHCS. • Process Flow for change in Member Status_rev 3.31.2023 o The Plan created a DTP guide for representatives to follow to record changes in member circumstances complete with respective follow-up actions, departments, and timeframes **MONITORING AND OVERSIGHT** • Redacted CA Change in Member Circumstances (4/25/23) o The Plan submitted a revised tracking mechanism to identify and resolve members' discrepancies. o Enrollment comments and completion date columns for each case indicate progress • CA Change in Mbr Status Tracking Tool DRAFT (3/27/23) o The Plan submitted an initial draft of a tracking tool used to detect discrepancies in members' change in circumstances. **TRAINING** *The Plan sent an all-staff email instructing personnel to create the "Change in Member Circumstances" template on Outlook and attached respective procedures ("New Process", 3/24/23)* • Team Meeting 4.4.23

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	2. Have the Enrollment Unit develop a simple tracking database 3. Enrollment Unit will be informed of process for disseminating the changes in member circumstances to the Compliance Officer 4. Review desktop 4500.05D to determine if the plan will create their own distinct desktop to follow change in circumstance database that does not include all enrollment discrepancies and limit to change in circumstances standalone desktop.			o The Member Services met to discuss and review procedures for Changes in Member Circumstances **The corrective action plan for finding 6.2.1 is accepted.**
6.2.2 - Verification of Services Delivered By Network Providers: The Plan did not verify if services delivered by	The plan is currently developing a process to verify that services delivered by network providers were received by members.	1. IT Ticket - Request (Verification of Services process needed for CA) ID	90 days	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
network providers were received by members. **Recommendation:** Develop and implement policies and procedures to verify if services delivered by network providers were received by members.	Action Taken Includes: • Submitted IT ticket on 1/5/2023 to begin development of criteria, automation of member letter and finalization of sending 500 letters per month. • Developed list of excluded codes (such as sensitive services). Awaiting description of codes so Medical Director can review and approve list. (See EOB Suppression Rules) • Developed Member Letter. Sent to DHCS on 1/12/2023 for approval. Upon approval, letter will be translated into all required threshold languages.	CRQ000000691271 2. EOB Suppression Rules 3. Member Letter (Draft) 4. 4500.02D Verification of Services Inquiry Desktop		• Desktop Procedure 4500.02D - Verification of Services (VOS) Inquiry – FINAL (3/27/23) o The Plan submitted a revised P&P outlining the verification of services process o Letters are sent to a random sample of members confirming that billed services were indeed provided, staff members then: o (1) document the call and confirm whether the member received the services in the VOS letter o (2) when discrepancies are identified, the representative informs member, the case is forwarded to the Special Investigations Unit (SIU), and the case's details are documented (provider's name, service, claim amount, etc.) o (3) complete a Fraud Referral form **MONITORING AND OVERSIGHT** *The IT request was submitted 1/5/23 to start building the VOS process; the Plan received approval from DHCS 3/14/23 and the automated tool will generate letters starting 5/15/23* IT Ticket – Initiation of Development & Automation of Monthly VOS Member Letters o The ticket requires a monthly sample of 500 to be automatically sent o Letters are also translated across threshold languages o Healthcare compliance professionals determine who reviews and approves letters before they get sent out

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	• Developed Member Service Desktop.			o Sensitive services are excluded and are listed in the "EOB Suppression" spreadsheet (e.g. pregnancy, HIV/AIDS, family planning, behavioral health, etc.) • "EOB Suppression" – approved by Medical Director (3/27/23) o This spreadsheet contains a list of excluded codes encompassing sensitive services that would be omitted in VOS letters, adhering to EOB Suppression Rules • VOS Member Letter (Draft) [3/27/23] o The Member letter explicitly states that the letter is not a bill and is meant to detect potential fraud • Translated VOS Member Letters [4/25/23] o The Member letter explicitly states that the letter is not a bill and is meant to detect potential fraud – translated across threshold languages **The corrective action plan for finding 6.2.2 is accepted.**
SSS. State Supported Services				
SSS.1 - The Plan denied payment of claims related to State Supported Services. **Recommendation:**	One of the ten claims was denied in error due to the UD modifier. Per DHCS requirements, qualified providers can bill under the 340B drug payment process and must use the UD	1. Configuration Ticket to fix UD modifier in QXNT	2/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "IT Configuration Ticket" (01/24/23) to demonstrate that the plan has submitted a configuration ticket to remove the edit and allow

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Ensure abortion service claims are reimbursed within 45 working days.	modifier. The plan has submitted a configuration ticket on 1.24.2023 to remove the edit and allow modifier UD pay for state supported services. This fix is expected to be completed by 2/2023. For the remaining claims, the plan assures that the claims system is correctly configured to pay abortion service claims within 45 working days. The plan has delegated arrangements with our IPA's and as such failed to fully research and review our full end to end response to ensure the claim was fully paid to the provider. Our universe just included claims that went to just one party and not both (the health plan and the delegate who share payment responsibility.) The plan will ensure to provide a more accurate claims report to capture the paid date from			modifier UD pay for state supported services. (Configuration Ticket). • "Claim Screenshot" (02/24/23) to demonstrate that the plan has reconfigured the claim system to allow payment to providers that are non-participating and well as participating to be paid without an authorization for state supported services claims. (Claim Screenshot). • Desktop Procedures, "State Supported Services (SSS) & Family Planning Services" (06/11/23) to demonstrate the MCP's process to audit all SSS and Family Planning claims twice a year to verify that claims were paid and processed correctly. The Desktop Procedures outlines how to generate an audit report for SSS and Family Planning claims. (State Support & Family Planning Service Bi-Annual Audit Process). **MONITORING AND OVERSIGHT** • "State Supported Service Claim Audit Results" (06/11/23) to demonstrate that the MCP has a self-monitoring process to verify that State Supported Service claims are processed correctly. Twice per year the MCP will review State Supported Service claims with edit 1136 (Edit defers payment to the Independent Practice Association) and compare the information to encounter data to confirm that the Independent Practice Association received the claim and processed it. Any gaps between the claim and the encounter will be remediated. Since there were no

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	the IPA when claims are denied due to IPA's responsibility.			deficiencies in the audit, no further refresher training was needed. (Audit Result). **The corrective action plan for finding SSS.1 is accepted.**

Submitted by Aetna Better Health Of California: [Signature on file] **Date:** 01/27/2023
Title: CEO, Aetna Better Health of California