

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.**

Contract Numbers: 17-94600 Sacramento  
17-94502 San Diego

Audit Period: April 1, 2018  
Through  
March 31, 2019

Report Issued: November 7, 2019

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## I. INTRODUCTION

Aetna Better Health of California, Inc. (Plan) is a subsidiary of Aetna, Inc. Headquartered in Hartford, Connecticut, Aetna, Inc. is one of the largest health care companies in the United States. Together with its national partners, the Plan supports 2.9 million Medicaid members in 15 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 pre-natal and postpartum 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 on January 1, 2018.

As of March 2019, the Plan served 8,287 members in San Diego and 5,914 members in Sacramento through the Medi-Cal line of business.

## II. EXECUTIVE SUMMARY

The DHCS, Audits and Investigations Division, Medical Review Branch, conducted an onsite audit of the Plan from April 22, 2019 through April 25, 2019. This report presents the results of DHCS full scope medical audit for the period of April 1, 2018 through March 31, 2019.

Through a risk assessment, discussions with management, and review of documentation, the audit team identified key areas to include in this review. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on October 14, 2019. 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 the report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

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

The audit period encompassed the Plan's first year of operation in California Medi-Cal Managed Care. The audit focused primarily on the Plan's development and implementation of systems and processes.

The summary of the findings by category as follows:

### **Category 1 – Utilization Management**

#### Utilization Management Underutilization

The Plan did not have mechanisms to detect underutilization of health care services. There was no evidence to support that the Plan monitors underutilization.

#### Delegated Entity Oversight

The Plan delegates prior authorizations. The audit found the delegated entities denied prior authorizations for medically necessary services. Unqualified individuals made a final denial determination without the delegated entity's Medical Director review. The Plan's oversight process was not instituted consistently with all delegated entities.

#### Prior Authorization Appeal Process

The denial of inpatient post stabilization services occurred during the audit period. These prior authorization decisions were not made by qualified individuals. The audit found the decisions were overturned on appeal.

## **Category 2 - Case Management and Coordination of Care**

### Initial Health Assessment

The Plan did not ensure the provision of an Initial Health Assessment (IHA) to new members within 120-calendar-days of enrollment. The Plan lacked oversight to monitor the provision of IHAs.

The Plan does not have a method to validate the completion of the IHA comprehensive health assessment components for preventative services, primarily children services.

### Behavioral Health Treatment

The Plan does not systematically track and report the number of authorized Behavioral Health Treatment (BHT) services. The audit identified incomplete information in the Plan's system to track and report the actual number of authorized BHT services. This led to inaccurate identification of members that receive BHT services.

### Non-Emergency Medical Transportation

The Plan does not have a mechanism to capture and submit data for Non-Emergency Medical Transportation (NEMT) services. The Plan's policy does not reference a mechanism to capture and submit data for NEMT services to DHCS.

### Continuity of Care

The audit identified factors that contributed to members not receiving the provision of continuity of care, including dissemination of information to educate members and a system to track, monitor, and ensure the provision of continuity of care in accordance with all contract requirements. The Plan's policies do not contain all requirements that describe the continuity of care request workflow. The policy excluded contractually required timeframes, retroactive requests process, telephone intake procedures, and member notification of approved requests.

## **Category 3 - Access and Availability of Care**

### Appointment Procedures and Monitoring Wait Times

The Plan did not meet the members' specialty appointments within the contractual timeframes.

### Access to Pharmaceutical Services

The Plan does not have a mechanism to monitor Emergency Department's compliance with the provision of outpatient prescription drugs in emergency situations.

## **Category 4 - Member Rights**

### Grievance System

The Plan exceeded Grievance Acknowledgement and Grievance Resolution timeframes.

### Confidentiality Rights

The Plan failed to report breaches and suspected security incidents to all required DHCS officers.

## **Category 5 - Quality Management**

### Network Provider Training

The Plan did not conduct provider training for all of its newly contract providers. In addition, when training was provided, it occurred outside contractual timeframes.

## **Category 6 - Administrative and Organizational Capacity**

### Health Education

The Plan failed to utilize a system to monitor health education program's effectiveness.

### **III. SCOPE/AUDIT PROCEDURES**

#### **SCOPE**

This audit was conducted by the DHCS, Medical Review Branch to ascertain that the medical services provided to the Plans' members comply with federal and state laws, Medi-Cal regulations and guidelines, and its State contract.

#### **PROCEDURES**

The onsite review was conducted from April 22 through 25, 2019. 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: 27 denied medical and 20 denied pharmacy prior authorization requests were reviewed. All claims were evaluated for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeal Procedures: 23 prior authorization appeals were reviewed. In addition, 21 prior authorization appeals each from two delegated entities were reviewed. All appeals were evaluated for appropriate and timely adjudication.

#### **Category 2 – Case Management and Coordination of Care**

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

California Children's Services (CCS): Six medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Initial Health Assessment: 30 medical records were reviewed for completeness and timeliness.

Behavioral Health Treatment Services: One medical record was reviewed for coordination of care between the Plan and providers.

Continuity of Care – Ten medical records were reviewed for completeness and timeliness.

Non-Emergency Medical Transportation and Non-Medical Transportation (NMT): Four NEMT and 30 NMT services were reviewed for accuracy, completeness, and timeliness of transportation services provided.

### **Category 3 – Access and Availability of Care**

Appointment Availability: 15 providers from the Plan's Provider Network were reviewed. The first available appointment was used to measure access to care.

Emergency Services and Family Planning Claims: 20 emergency service claims and 15 family planning claims were reviewed for appropriate and timely adjudication.

### **Category 4 – Member's Rights**

Grievance Procedures: 60 grievances (30 Quality of Service and 30 Quality of Care) were reviewed. All grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

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

### **Category 5 – Quality Management**

Provider Qualifications: Ten new provider training records were reviewed for the timeliness of Medi-Cal Managed Care program training.

### **Category 6 – Administrative and Organizational Capacity**

Fraud and Abuse: 11 fraud and abuse cases were reviewed for appropriate processing and reporting requirements.

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019  
**DATE OF AUDIT:** April 22, 2019 through April 25, 2019

**CATEGORY 1 - UTILIZATION MANAGEMENT**

<b>1.1</b>	<b>UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UM / MEDICAL DIRECTOR &amp; MEDICAL DECISIONS</b>
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**Utilization Management (UM) Program Requirements:**

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. ...(as required by Contract)

GMC Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

GMC Contract A.5.2.C

**Review of Utilization Data:**

Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.

GMC Contract A.5.4

**Referral Tracking System:**

Contractor is responsible to ensure that the UM program includes: ... An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

GMC Contract A.5.1.F

**Delegated Utilization Management (UM) Activities:**

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.

GMC Contract A.5.5

**Medical Director:**

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53913.5 whose responsibilities shall include, but not be limited to...

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**1.1**

**UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UM / MEDICAL DIRECTOR & MEDICAL DECISIONS**

- A. Ensuring that medical decisions are:
  - 1) Rendered by qualified medical personnel.
  - 2) Are not influenced by fiscal or administrative management considerations.
- B. Ensuring that the medical care provided meets the standards for acceptable medical care.
- C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- D. Developing and implementing medical policy.
- E. Resolving grievances related to medical quality of care.
- F. Direct involvement in the implementation of Quality Improvement activities.
- G. Actively participating in the functioning of the plan grievance procedures.

GMC Contract A.1.6

**Medical Decisions:**

Contractor shall ensure that medical decisions, including those by subcontractors and rendering providers, are not unduly influenced by fiscal and administrative management.

GMC Contract A.1.5

**SUMMARY OF FINDINGS:**

**1.1.1 Review of Utilization Data**

The Plan shall include within the Utilization Management (UM) Program mechanisms to detect both under- and over-utilization of health care services. The Plan's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request. *[Contract, Exhibit A, Attachment 5(4)]*

The Plan did not have mechanisms to detect underutilization of health care services.

The Plan's policy 7000.35, *Practitioner/Provider and Member Over/Underutilization of Services*, describes indicators used to detect both under- and over-utilization. Indicators described in the policy include a quality report, UM reports, medical management dashboard, complaints, grievances, pharmacy reports, practitioner audits e.g., ambulatory medical record review, prior authorization, and claim reviews. The policy includes the Plan's processes to monitor the results of corrective action taken.

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The Plan's policy 8000.60, *Delegation Oversight Responsibilities*, describes the Plan's responsibility to maintain appropriate structures and mechanisms to oversee delegated activities; and to review and approve, on an annual basis, the delegated organization's program that oversees the delegated function.

The Plan's 2018 UM Program Description identifies the Plan's mechanisms and indicators used to detect under- and over-utilization of health care services. According to the UM Program Description, "the medical management department staff determines indicators for identifying potential under- and over-utilization, including target and performance indicators." This was the Plan's first operational year; therefore, the UM evaluation was unavailable and the UM work plan is in process of being developed.

Quality Management/Utilization Management Committee, Member Services Committee, and Board of Director minutes were reviewed to identify the Plan's strategies to address both under- and over-utilization of health care services. There was no data to support that the Plan collects, monitors, analyzes, and evaluates utilization information to detect under-utilization.

Utilization reports were requested from the Plan to identify the Plan's efforts to monitor underutilization. There was no documentation to support that the Plan produced reports to monitor under-utilization. During the onsite interview, the Plan staff stated under-utilization is not monitored at the provider level due to low member enrollment.

The Plan's policies describe indicators to detect under-utilization, however, the procedures were not implemented and operationalized.

One of the primary goals of managed care is to ensure that members do not receive substandard care through under-utilization of health care services. Without efforts to monitor utilization to detect under-utilization, the Plan is unable to ensure that members receive quality medically necessary services.

### 1.1.2 Utilization Management Delegation Oversight

The Plan shall maintain policies and procedures, approved by DHCS, to ensure subcontractors fully comply with all terms and conditions of this Contract. The Plan shall evaluate the prospective subcontractor's ability to perform the subcontracted services, shall oversee, remain responsible, and accountable for any functions and responsibilities delegated. *[Contract, Exhibit A, Attachment 6(14)].*

The audit found that the Plan's delegated entities routinely denied prior authorizations for medically necessary services. There was no documentation to support a Medical Director, from the delegated entities, reviewed the prior authorization denial.

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The Plan's policy 8000.60, *Delegation Oversight Responsibilities*, describes the Plan's responsibility to ensure that its subcontractors and delegated entities comply with all applicable state and federal laws and regulations; contract requirements; reporting requirements; and other DHCS guidance including, but not limited to, All Plan Letters (APL). The policy describes the requirements from the *APL 17-004 Monitoring Subcontracted and Delegated Functions*.

Policy 7100.05, *Prior Authorization*, defines the Plan's and delegated entity's standards for prior authorizations. One objective listed in the prior authorization process is to "evaluate and determine medical necessity and/or need for additional supporting documentation." The policy states that authorization requests that do not meet criteria for the requested service, or for which there are no established medical necessity criteria, will be presented to a Medical Director for review. The Medical Director that conducts the review must have clinical expertise in treating the member's condition or disease and be qualified by training, experience, and certification/licensure to conduct the prior authorization functions in accordance with state and federal regulations.

Using the approved criteria and Medical Director's clinical judgment, a determination is made to approve, deny, or reduce the service. Only a Medical Director can reduce or deny a request for service based on a medical necessity review.

Review of the Plan's delegated activities indicate the Plan delegates utilization management, credentialing, and claims to six delegated organizations. The six organizations represent 13,113 members, a majority of the Plan's members. According to the Plan, delegates are audited prior to becoming active and at least annually thereafter.

Delegation Oversight Committee Minutes show discussions on Utilization Management (UM) oversight. Discussions include monitoring reports for service authorization denials, approval rates, and review of turn-around times.

The Plan stated that the annual independent physician association audits are ongoing. The audit is a desktop review and includes file reviews, policy reviews, and review of turn-around times.

The DHCS audit included review of two delegated entities' Inter-Rater Reliability (IRR) reports. The UM Work Plan reviewed for the first delegated entity showed that the last IRR testing occurred during the month of October 2018. UM staff reviewed and completed case studies to test the reviewer's knowledge. The IRR evaluates how the reviewer reads the criteria for appropriate authorization. There were inconsistencies noted for clinical staff, specifically nurses. The audit found that the Plan communicated these issues to the reviewer.

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The second delegated entity selected showed IRR testing from December 2018. The IRR indicates that although there were some inconsistencies noted with the Physician IRR, overall quality goals continue to be met. The delegated entity's Work Plan indicates that for clinical quality testing, the staff average is over 95 percent.

Verification studies were conducted for both delegated entities to verify compliance with prior authorization denials. The findings are as follows:

- Delegated Entity #1: 21 denied prior authorizations were reviewed. Eight prior authorizations were denied because the service was not a covered benefit and not medically necessary. The audit found that the services were a covered benefit and medically necessary. The criteria used to deny the services did not support the service requested. Additionally, there was no documentation to support a Medical Director reviewed the prior authorization denial.

Examples of denied requests included visits for palliative care pain follow-up for bladder cancer, antepartum visits in a pregnant female, ambulatory blood pressure monitoring in a 19 year old patient with severe hypertension, and smoking cessation in a young patient with a history of surgeries for tongue cancer.

- Delegated Entity #2: 21 denied prior authorizations were reviewed. Two prior authorization denials used incorrect criteria or misinterpreted the criteria which resulted in improper denial of the requested consultation services.

The fact that there was no evidence to support that a Medical Director reviewed the denial nor made a final determination contributed to the routine denial of prior authorizations from the Plan's delegated entities for medically necessary services. While the Plan has mechanisms in place to conduct oversight, the mechanisms were not effective with all delegated entities.

The Plan's responsibility is to ensure delegated entities comply with contract requirements in regards to prior authorizations. Failure to monitor the appropriateness of the prior authorization denial decisions can lead to members not receiving the care needed in a timely manner, which can result in adverse effects on members' health.

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**RECOMMENDATIONS:**

- 1.1.1 Develop and implement mechanisms to detect underutilization of health care services.
- 1.1.2 Develop and implement effective oversight procedures to ensure compliance of delegated entities adherence to contract requirements regarding prior authorizations.

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**1.3**

**PRIOR AUTHORIZATION APPEAL PROCESS**

**Appeal Procedures:**

There shall be a well-publicized appeals procedure for both providers and Members.  
GMC Contract A.5.2.E

Contractor is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with the Contractor.

GMC Contract A.8.13

Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor, or the Member is stabilized sufficiently to permit discharge. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor. Emergency Services shall not be subject to Prior Authorization by Contractor.

GMC Contract A.8.13.B.1

Contractor shall cover emergency medical services without prior authorization pursuant to 28 CCR 1300.67(g)(1). [GMC Contract A.9.7.A]

Post-stabilization care services following an emergency inpatient admission are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c).  
GMC Contract A.8.14

**SUMMARY OF FINDING:**

**1.3.1 Prior Authorization Appeal Process**

Post-stabilization care services following an emergency inpatient admission are covered and paid for in accordance with provisions set forth at *Code of Federal Regulations (CFR), 42, 422.113(c)*. [Contract, Exhibit A, Attachment 8(14)]

The Plan shall pay all claims submitted by contracting providers in accordance with this section, unless the contracting provider and contractor have agreed in writing to an alternate payment schedule. The Plan shall comply with *42 USC 1396a(a)(37) and*

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*Health and Safety Code Sections 1371 through 1371.39. [Contract, Exhibit A, Attachment 8(5)(A)]*

The Plan denied inpatient post stabilization services during the audit period. Post-stabilization care prior authorization decisions were made by unqualified individuals. The audit found all denied post stabilization claims were overturned on appeal by the appeal committee.

The Plan's policies describe its procedures for post stabilization care services. It's the Plan's policy that providers may initiate the necessary intervention to stabilize an emergency medical and/or behavioral health condition of a Plan member without seeking or receiving prospective authorization. When post-stabilization services are administered to maintain, improve, or resolve the member's stabilized condition, the Plan pays for post-stabilization care services without authorization.

A verification study was conducted to evaluate appropriateness and timely adjudication. During the audit period, 13 of 23 appeals were routine provider appeals for hospital claim denials. The verification study found that the stated reason for denial was no prior authorization for the inpatient post-stabilization care. Post-stabilization care services following an emergency inpatient admission should be covered and paid for by the Plan without prior authorization. Subsequently, all 13 provider appeals were overturned and paid by the Plan.

The audit identified the prior authorizations were initially denied by unqualified staff. The inpatient post-stabilization care were systematically denied without the review from a licensed healthcare professional. Further review of the medical records found that the members were treated in the emergency room and unable to return home without post stabilization care.

According to the Plan, its claims system is configured to stop inpatient claims from being processed without an authorization. If there is no authorization for the inpatient stay the claim pends to an analyst who then performs a review to see if there is an authorization on file, or if it meets continuity of care guidelines. If the claim does not meet continuity of care guidelines or if an authorization doesn't exist the analyst denies the claim.

As stated the providers were systematically denied timely payments which causes a delay in remuneration for services provided. Payment delays influence cash flow, which may have an impact on the provider's payment and expense cost structure.

### **RECOMMENDATION:**

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- 1.3.1 Ensure post-stabilization care services following an emergency inpatient admission are covered, paid for, and processed according to contractual requirements.

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**CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE**

**2.1**

**INITIAL HEALTH ASSESSMENT**

**Comprehensive Case Management including Coordination of Care Services:**

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the Member.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the Contractor, and shall include:

- 1) Initial Health Assessment (IHA);
- 2) Individual Health Education Behavioral Assessment (IHEBA);
- 3) Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs;
- 4) Direct communication between the provider and Member/family;
- 5) Member and family education, including healthy lifestyle changes when warranted; and
- 6) Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

GMC Contract A.11.1

**California Children's Services (CCS):**

Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program....(as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program...for the coordination of CCS services to Members.

GMC Contract A.11.9.A, B

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**2.1**

**INITIAL HEALTH ASSESSMENT**

**Services for Persons with Developmental Disabilities:**

Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers...for the coordination of services for Members with developmental disabilities.

GMC Contract A.11.10.A, E

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services with Regional Center staff, which includes identification of all appropriate services, which need to be provided to the Member.

GMC Contract A.11.10.C

**Early Intervention Services:**

Contractor shall develop and implement systems to identify children under 3 years of age who may be eligible to receive services from the Early Start program and refer them to the local Early Start program....Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

GMC Contract A.11.11

**Provision of Initial Health Assessment:**

Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR 53910.5(a)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

GMC Contract A.10.3.A

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**2.1**

**INITIAL HEALTH ASSESSMENT**

Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120-calendar-days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120-calendar-days of enrollment.

GMC Contract A.10.5.A

IHAs for Adults, Age 21 and older

Contractor shall cover and ensure that an IHA for adult Members is performed within 120-calendar-days of enrollment.

Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes...(as required by Contract)

GMC Contract A.10.6.A

Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.

Contractor shall make at least three documented attempts...Contact methods must include at least one telephone and one mail notification....

GMC Contract A.10.3.E

**SUMMARY OF FINDINGS:**

**2.1.1 Initial Health Assessments**

The Plan shall cover and ensure the provision of an Initial Health Assessment (IHA) to each new member within 120-calendar-days of enrollment and have procedures in place to monitor its completion. *[Contract, Exhibit A, Attachment 10, 3(A)]*

The Plan did not ensure the provision of an IHA to new members within 120-calendar-days of enrollment. According to the Plan's IHA log, the Plan enrolled 13,629 new members from April 1, 2018 to January 20, 2019. The audit identified 25 percent of new members completed an IHA.

According to the Plan's policy 7000.33, *Initial Health Assessment/Health Information Form/Member Evaluation Tool*, the Plan's contracted primary care providers are to

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complete an IHA on every member within 120-calendar-days of the member's enrollment. A Staying Healthy Assessment and Individual Health Education Behavioral Assessment (IHEBA) should be completed concurrently.

The Plan is responsible for coordination and oversight for the provision of the assessments. Plan interviews revealed the Plan did not have procedures in place to monitor IHA completion. Committee minutes lacked discussion of IHA methods to monitor areas for improvement. According to its policy, the Plan relies on network providers to generate reports with compliance rates for the Plan to review. However, there was no indication that the Plan reviewed or verified the data on a regular basis.

In addition, the Plan staff explained member outreach is conducted by its provider network. Providers are expected to make reasonable attempts to contact members until the IHA is completed. Although the contract requirements state that the Plan shall make at least three documented attempts, the Plan does not directly conduct member outreach attempts. The Plan lacked oversight to monitor the provision of initial health assessments.

The Plan's insufficient efforts to monitor IHAs contributed to the low compliance. This may prevent members from establishing care with primary care providers or obtain necessary health care within a timely manner.

### 2.1.2 Comprehensive Health Assessments

The Plan shall ensure the performance of the initial comprehensive history and physical exam. *[Contract, Exhibit A, Attachment 10(6)(A)]*

An IHA consists of a comprehensive history and physical examination and the IHEBA that enables a provider of primary care services to comprehensively assess the member's current acute, chronic and preventive health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this Contract. *[Contract, Exhibit A, Attachment 10(3)]*

The Plan has no methodology to validate the completion of the comprehensive health assessment components for preventative services, primarily children services.

The audit found the Plan's procedure to monitor health assessments lacked a system to detect disparities between encounter data and member's medical records. There was no comparative analysis conducted for completed health assessments. Therefore, the Plan was unable to measure whether a comprehensive IHA was rendered to the member by the physician.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

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IHAs must be monitored to assess and manage the acute, chronic, and preventive health needs of members.

**RECOMMENDATIONS:**

- 2.1.1 Ensure the provision of an Initial Health Assessment to new members within 120-calendar-days of enrollment.
- 2.1.2 Implement procedures to monitor Initial Health Assessment completion, as required by contract requirements.

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2.3

### BEHAVIORAL HEALTH TREATMENT

#### **Services for Members under Twenty-One (21) Years of Age**

Contractor shall ensure the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and EPSDT Supplemental Services for Members under 21 years of age, including those who have special health care needs. Contractor shall inform Members that EPSDT services are available for Members under 21 years of age, provide comprehensive screening and prevention services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, and lead toxicity screening), and provide treatment for all medically necessary services.

For Members 3 years or older, Contractor shall require a Comprehensive Diagnostic Evaluation before Members receive BHT services.

GMC Contract E.A.10.5.G

#### **ALL PLAN LETTER 18-006 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21**

The MCP is responsible for the provision of EPSDT supplemental services to include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions that develop or restore, to the maximum extent practicable, the functioning of a member with Autism Spectrum Disorder (ASD). The MCP must ensure all children, including children with ASD, receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening exam indicates the need for further evaluation of a child's health, the child must be referred for medically necessary diagnosis and treatment without delay. The MCP is required to:

1. Inform members that EPSDT services are available for members under 21 years of age
2. Provide access to comprehensive screening and prevention services in accordance with the most current Bright Futures periodicity schedule
3. Provide access to comprehensive diagnostic evaluation based upon recommendation of a licensed physician and surgeon or a licensed psychologist for treatment of ASD including all medically necessary services, including but not limited to, BHT services
4. Ensure appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the contract
5. Ensure coverage criteria for BHT are met.

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### 2.3

### BEHAVIORAL HEALTH TREATMENT

For individuals diagnosed with ASD who are under the age of three with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, the MCP must ensure appropriate referrals are made to the Regional Center and Special Education Local Plan Area (SELPA) for Regional Center services and supports and/or special education services, respectively.

#### **MCP Approved Treatment Plan**

MCPs must ensure that BHT services are medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist. Delivered in accordance with the member's MCP-approved behavioral treatment plan. Provided by California State Plan approved providers as defined in SPA 14-026.9 Provided and supervised according to an MCP-approved behavioral treatment plan developed by a BHT service provider credentialed as specified in SPA 14-026 and the MCQMD ALL PLAN LETTER 18-006 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

BHT services are provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific member being treated and that has been developed by a BHT Service Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider. The behavioral treatment plan may be modified if medically necessary. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

#### **Continuity of Care (APL 18-006)**

MCPs must ensure continuity of care in accordance with existing contract requirements, ALL PLAN LETTER 18-006, and Health & Safety Code Section 1373.96 for the provision of BHT services.

#### **Delegation Oversight (APL 18-006)**

The MCP must ensure that delegates comply with all applicable state and federal laws and regulations, contract requirements, and DHCS guidance, including APLs for the provision of BHT services

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### SUMMARY OF FINDINGS:

#### **2.3.1 System to Monitor Behavioral Health Treatment Services**

The Plan is responsible for covering and ensuring the provision of medically necessary Behavioral Health Treatment (BHT) services to eligible members under 21 years of age as required by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate. *[Contract, Exhibit A, Attachment 10(5)(G)]*

BHT services must be provided, observed, and directed under an approved behavioral treatment plan. The approved behavioral treatment plan must...clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services. *[All Plan Letter (APL) 18-006 Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21]*

The Plan does not have an established system to track and report the actual number of authorized BHT services. This led to inaccurate identification of members that receive BHT services. The Plan's policy and procedures did not contain all the contractual requirements to ensure all elements for the provision of BHT services.

The Plan submitted a list of members receiving BHT services. This list contained only one member. Other documents reviewed showed the Plan identified more than one member that received BHT services.

During the onsite interview, the Plan reported approximately 30 members received BHT services. The Plan stated that BHT oversight is limited to the review of grievance records. Additionally, the Plan contributed the discrepancy between the different member lists as "a data gap" from the BHT reporting process and the Applied Behavior Analysis authorizations.

Another discrepancy in the Plan's process to monitor BHT services is the lack of a method to ensure BHT treatment plans contain all required elements. According to contract requirements and *APL 18-006*, an approved behavioral treatment plan should contain the following required elements: transition plan, crisis plan, and exit plans.

The audit found a discrepancy in the Plan's method to ensure BHT treatment plans contained all the required elements. While the plan's policy contains the required contractual language, the job aid used as part of its procedures excluded elements. The job aid assists the Plan with procedures to determine BHT medical necessity for

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behavioral health services. The job aid does not specifically include procedures to review whether a crisis plan is contained within the BHT treatment plan.

During interviews, the Plan stated Facility Site Reviews conducted by the Plan have a medical record review component that includes a treatment plan evaluation, but could not confirm whether members receiving BHT services are selected for the medical record review sample.

When BHT services are not tracked and monitored, there is no systemic way to assess the extent to which a program has achieved its intended results. Missed opportunities occur without an outcome measurement system to identify and address potential quality improvement issues related to BHT services.

**RECOMMENDATIONS:**

- 2.3.1 Establish a system to monitor Behavioral Health Treatment services to ensure the provision of services complies with contract requirements.

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**2.4**

**NON-EMERGENCY MEDICAL TRANSPORTATION/  
NON-MEDICAL TRANSPORTATION**

**Non-Emergency Medical Transportation** means ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2 rendered by licensed providers.

COHS/GMC/2-Plan Contracts E.E.1 Definitions

**Non-Emergency Medical Transportation Requirements**

NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when it is prescribed in writing by a physician, dentist, or podiatrist. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 12501.

MMCD All Plan Letter 17-010

**NEMT Physician Certification Statement Forms**

MCPs (Medi-Cal managed care health plans) and transportation brokers must use Physician Certification Statement (PCS) forms to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization.

MMCD All Plan Letter 17-010

**Non-Medical Transportation** means transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

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**2.4**

**NON-EMERGENCY MEDICAL TRANSPORTATION/  
NON-MEDICAL TRANSPORTATION**

**Non-Medical Transportation Requirements**

NMT has been a covered benefit when provided as an EPSDT service. Effective July 1, 2017, NMT is a Medi-Cal managed care benefit for all members to obtain medically necessary covered services. Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver.

MMCD All Plan Letter 17-010

**Non-Medical Transportation Authorization**

MCPs may authorize NMT for each member prior to the member using NMT services. The MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter.

MMCD All Plan Letter 17-010

**Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards**

MCPs are contractually required to meet timely access standards (28 CCR Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)). MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MMCD All Plan Letter 17-010

**Conditions for Non-Medical Transportation Services:**

- MCP may use prior authorization processes for approving NMT services and shall re-authorize services every 12 months when necessary.

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### NON-EMERGENCY MEDICAL TRANSPORTATION/ NON-MEDICAL TRANSPORTATION

- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments not related to medically necessary covered Medi-Cal benefits.
- The member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license.
  - Has no working vehicle available in the household.
  - Is unable to travel or wait for medical or dental services alone.
  - Has a physical, cognitive, mental, or developmental limitation.

MMCD All Plan Letter 17-010

#### Written Member Information

The Member Services Guide ... shall include the following information: ...12)

Procedures for obtaining any transportation services to Service Sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.

COHS/GMC/2-Plan Contracts E.A.13.4.D

### SUMMARY OF FINDING:

#### 2.4.1 Non-Emergency Medical Transportation Physician Certification Statement Forms

The Plan is to cover non-emergency medical transportation services (NEMT), as provided for in California Code of Regulations, Title 22, section 51323, subject to the Plan's Physician Certification Statement (PCS) form except when a member is

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transferred from an acute care hospital, immediately following an inpatient stay at an acute level of care, to a skilled nursing facility, or an intermediate care facility.

The Plan is required to use a DHCS approved PCS form to determine the appropriate level of transportation service for members. The PCS forms must include at a minimum: function limitations justification, date of service needed, mode of transportation needed, and certification statement.

The Plan is required to have a mechanism to capture and submit data from the PCS form to DHCS. The Plan is required to cover medical transportation subject to utilization controls. *[All Plan Letter (APL) 17-010 Non-Emergency Medical and Non-Medical Transportation Services and Welfare and Institutions Code, Section 14132(i)]*

The Plan does not have a mechanism to capture and submit data for NEMT services. The Plan's policy 4500.95, *Emergent and Non-Emergent Transportation*, does not reference a mechanism to capture and submit data for NEMT services. As required by *APL 17-010*, each Plan must have a mechanism to capture and submit data from the PCS form to DHCS.

The Plan's policy states that the Plan and the transportation broker will use a DHCS approved PCS form to determine the appropriate level of service for members. However, the Plan did not use a DHCS approved PCS form nor did they have a mechanism to capture and submit data to DHCS for NEMT services.

The Plan utilizes an independent transportation vendor to provide NEMT and NMT services. NEMT is a benefit provided by the Plan and is based on a member's medical necessity. Requests for NEMT are subject to prior authorization. For NEMT transportation requests, a provider certification and signature is required on the PCS form for Plan approval. NMT service is for routine medical or other eligible non-medical appointments.

During the audit period, 259 members received transportation services. A verification study was conducted to determine adherence to transportation criteria such as, variety of modes of transportation; mileage reimbursement for transportation, verification of the Physician Certification Statement form, and the prior authorization process. Four samples were selected for NEMT services and 30 samples for NMT services were selected from transportation logs provided by the Plan.

### Non-Emergency Medical Transportation

The verification study found that all four NEMT samples excluded the Physician Certification Statement form and were not subject to prior authorization. According to the Plan's policy, NEMT services are subject to prior authorization and a written prescription from a physician. However, the policy excluded a procedure to review all requested NEMT services submitted.

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In an interview, Plan staff stated that as part of the review with the transportation vendor the Plan identified an issue with its PCS process. Additionally, Plan staff acknowledged that the Plan did not require a prior authorization to process requested NEMT services.

### Non-Medical Transportation

The verification study found that the Plan did not require prior authorization for NMT services. According to the Plan's policy, conditions for NMT transportation services detail how that Plan may use prior authorization processes for approving NMT services and reauthorize services every 12 months when necessary as outlined in *APL 17-010*.

In an interview, Plan staff stated, "we made a decision early on that we will not require prior authorization for these services [NMT] services as it is important to both the member and the providers that there aren't restrictions for this important service." The Plan did not demonstrate that services were provided. The Plan did not submit any supporting documentation such as vendor invoices, transportation claims, and/or prior authorization records associated with any of the 30 samples selected for review.

Without utilization controls, the Plan is unable to determine the appropriate level of transportation services, ensure the use of the PCS form, and capture and submit the required data to DHCS.

The Plan must adhere to contract requirements to meet transportation benefits and specified criteria to ensure members have access to all medically necessary services and access to medically appropriate transportation. Without a DHCS approved PCS form, transportation services may be inconsistent.

### **RECOMMENDATION:**

- 2.4.1 Develop a mechanism to capture and submit data for transportation services to adhere to contract requirements to obtain a DHCS approved Physician Certification Statement form. Revise and implement policies and procedures to establish utilization controls for transportation services.

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### 2.5

### CONTINUITY OF CARE

Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law and the MCP contracts. All MCP members with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services that have been receiving through Medi-Cal FFS or through another MCP.

Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to an MCP for continuity of care. When this occurs, the MCP must begin to process the request within five working days following the receipt of the request. However, the request must be completed in three calendar days if there is risk of harm to the member. The continuity of care process begins when the MCP starts the process to determine if the member has a pre-existing relationship with the provider.

MCPs must accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, the MCP may take any necessary information from the requestor over the telephone.

MCPs shall accept and approve retroactive requests for continuity of care that meet all continuity of care requirements noted above and in 1-3 below. The services that are the subject of the request must have occurred after the member's enrollment into the MCP, and the MCP must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into the MCP. MCPs shall only approve retroactive requests that meet the following requirements:

1. Have dates of services that occur after the effective date of this APL;
2. Have dates of services within 30-calendar-days of the first day of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
3. Are submitted within 30-calendar-days of the first service for which retroactive continuity of care is being requested.

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**2.5**

**CONTINUITY OF CARE**

The MCP should determine if a relationship exists through use of data provided by DHCS to the MCP, such as Medi-Cal FFS utilization data.

Each continuity of care request must be completed within the following timeline:

- Thirty calendar days from the date the MCP received the request;
- Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the member.

A continuity of care request is considered completed when:

- The member is informed of his or her right of continued access;
- The MCP and the out-of-network FFS or prior MCP provider are unable to agree to a rate;
- The MCP has documented quality of care issues; or
- The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30-calendar-days.

Upon approval of a continuity of care request, the MCP must notify the member of the following within seven calendar days:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period; and
- The member's right to choose a different provider from the MCP's provider network.

The MCP must notify the member 30-calendar-days before the end of the continuity of care period about the process that will occur to transition his or her care 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*

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### **SUMMARY OF FINDING:**

#### **2.5.1 Continuity of Care**

For fee-for-service Medi-Cal members who are transitioning into Medi-Cal Managed Care, the Plan is responsible for ensuring the provision of continuity of care. The continuity of care provision is for medically necessary and covered services for eligible members with pre-existing provider relationships. The Plan shall approve retroactive requests that meet criteria. The Plan must accept requests over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. Upon approval of a continuity of care request, the Plan must notify the member within seven calendar days of the following: The request approval; the duration of the continuity of care arrangement; the process that will occur to transition the member's care at the end of the continuity of care period; and the member's right to choose a different provider from the Plan's provider network. *[Health and Safety Code Section 1373.96 and All Plan Letter (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*, does not contain required language that describes the continuity of care request workflow. Examples of elements excluded include, retroactive requests process, telephone intake procedures, and member notification of approved requests.

The Plan's policies do not clearly describe how retroactive requests are submitted to the Plan, how it is directed to case managers for review, and how it is monitored to ensure process completion. There was no process established for retroactive requests. Additionally, the audit found that the Plan did not receive retroactive requests during the audit period. During the interview, the Plan stated that if these types of requests were submitted to the Plan, case managers would review the case and work with the UM Department to determine whether to approve or deny the request. The retroactive request process was not listed in the workflow diagram submitted by the Plan.

The Plan's policies do not list methods by which direct or retroactive continuity of care requests are submitted, e.g., by phone. The Plan explained that in practice, requests are received over the telephone, according to the requester's preference, and without requiring the completion of a paper or computer form.

The Plan's policies excluded the timeframe and procedures for the notification requirements. During the Plan interview, no confirmation was given whether members are sent notification within seven calendar days from approval date. The Plan does not monitor whether requests meet timeframe requirements.

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Ten medical records and documents were reviewed to determine compliance with contract requirements for the following: time frames, completion of the continuity of care request process, and notification letters. Medical records from the verification study showed that except for an approval notification to the member and the duration of continuity of care arrangement, the Plan does not follow all notification letter guidelines specified in *APL 18-008*. The notification letters excluded language in regards to a transition process after continuity of care and the member's right to choose a different provider from the Plan's provider network.

The verification study results show nine out of ten members did not meet continuity of care criteria requirements: For two members, the notification letters lacked instructions for transition and an option for members to choose an in-network provider. For seven members, there was insufficient documentation of the continuity request determination process.

In addition to the excluded elements from the Plan's policy and procedures, the audit identified other factors that may contribute to members not receiving appropriate continuity of care.

First, the methods the Plan utilizes to disseminate information to educate its members for the provision of continuity of care is limited to the member's Evidence of Coverage handbook. There was no other method to inform members of the provision of continuity of care, such as through the Plan's website or member newsletters. Without utilization of major mediums for information dissemination members and providers may lack adequate information on how to request for the continuity of care provision.

Secondly, the Plan lacks a system to effectively track, monitor, and ensure the provision of continuity of care in accordance with all contract requirements. The Plan acknowledged that it lacks an established system for tracking and monitoring continuity of care requests.

Continuity of care promotes improved health outcomes and coordination of health care resources. Without procedures, the Plan is unable to ensure medically necessary continuity of care for its members in a timely manner.

### **RECOMMENDATION:**

2.5.1. Develop and implement a process to ensure policy and procedures meet Contract and All Plan Letter policy requirements to ensure the provision of continuity of care.

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### CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

#### APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

**Appointment Procedures:**

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children’s preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

GMC Contract A.9.3.A

Members must be offered appointments within the following timeframes:

- 3) Non-urgent primary care appointments – within ten business days of request;
- 4) Appointment with a specialist – within 15-business-days of request;

GMC Contract A.9.4.B.

**Prenatal Care:**

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two weeks upon request.

GMC Contract A.9.3.B

**Monitoring of Waiting Times:**

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers’ offices, telephone calls (to answer and return), and time to obtain various types of appointments...

GMC Contract A.9.3.C

#### **SUMMARY OF FINDING:**

##### **3.1.1 Appointment Procedures and Monitoring Wait Times**

The Plan is required to ensure members obtain appointments for routine care, routine specialty care, and initial prenatal care visits within the contractual timeframes. Routine primary care appointments must be offered within ten business days, routine specialty care within 15 business days, and initial prenatal visit within two weeks of a request.

*[Contract, Exhibit A, Attachment 9(3)(B) and (4)(B)]*

In accordance with *Welfare & Institutions Code section 14182(c)(2)*, the Plan must “ensure and monitor an appropriate provider network, including primary care physicians,

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specialist, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area..." [Contract, Exhibit A, Attachment 6(6)]

The Plan did not ensure routine specialty care appointments were available within 15 business days of request.

On a quarterly basis, the Plan evaluates provider network adequacy. According to its policies, the Plan presents an analysis that includes a comparison of results against standards or goals trended over time. Assessment includes practitioner availability data and appointment accessibility data for access to specialty care services. The analysis also relates member experiences to determine if there are issues specific to particular geographic areas, types of practitioners, or providers.

In its Annual Network Certification, DHCS determined that the Plan be given "Pass with Conditions" for both Sacramento County and San Diego County, which means that the Plan did not fully meet the standard. DHCS imposed a temporary standard requiring the Plan to authorize access to out-of-network providers and/or services if services are not available in-network within the timely access standards. Based on its procedures, the Plan produces a Letter of Agreement/Memorandum of Understanding with out-of-network providers to provide services that otherwise cannot be provided by a network provider.

However, interviews with the Plan staff found the provider network expansion challenging, in particular for specialists and specialty services. For providers found to be non-compliant with appointment standards, the Plan is still in the process of implementing a corrective action. Furthermore, Geo Access Reports show that for several cities in San Diego County, there are members without access to adult and pediatric primary care providers. In addition, the Grievance Committee Meeting Minutes discusses the number of complaints related to access to care, which the Plan determined to be the primary drivers of appeals and grievances.

The auditor conducted a telephone survey of 15 providers selected from the Plan's Provider Directory from Sacramento and San Diego counties. These providers were surveyed to obtain the first available appointment dates. The survey found specialty providers did not meet the required timeframe for the first available appointment. Two specialists were not accepting new patients, and two specialists exceeded the timeframe for a first available appointment.

Overall, access to care within the contractual timeframes is essential for ensuring comprehensive quality health care for Plan members. The lack of access to care could result in hospitalization and long-term negative effects on patient health outcomes.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

**DATE OF AUDIT:** April 22, 2019 through April 25, 2019

**RECOMMENDATION:**

3.1.1 Ensure members' specialty appointments are obtained within the contractual timeframes.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

**DATE OF AUDIT:** April 22, 2019 through April 25, 2019

**3.4**

**ACCESS TO PHARMACEUTICAL SERVICES**

**Pharmaceutical Services and Prescribed Drugs:**

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours.... Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation.

GMC Contract A.10.8.G.1

Part of these requirements shall be met by having written policies and procedures, including, if applicable, written policies and procedures of Plan's network hospitals' policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency room medication dispensing requirements are met, including, if applicable, specific language in network hospital subcontracts.

GMC Contract A.10.8.G.3

**SUMMARY OF FINDING:**

**3.4.1 Access to Pharmaceutical Services**

The Plan must ensure access to at least a 72-hour supply of a medically necessary, covered outpatient drug when the drug is prescribed 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)]*

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

The Plan's policy 7000.64, *Emergency Services*, excluded contractual language to describe how the Plan and the Plan's network hospitals will monitor compliance with the requirements. According to Plan interviews, the Plan stated that there are no procedures to monitor contracted emergency providers to ensure members were provided an emergency drug provision.

Members that visit the emergency room are susceptible to readmission. And without medically necessary medication, there is a potential to have serious health consequences.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

**DATE OF AUDIT:** April 22, 2019 through April 25, 2019

**RECOMMENDATION:**

- 3.4.1 Revise and implement policies and procedures to describe how the Plan and/or Plan's network hospitals will monitor compliance with contracted Emergency Departments in the provision of emergency medication. In addition, ensure the Plan monitors compliance with these requirements.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

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**CATEGORY 4 – MEMBER’S RIGHTS**

**4.1**

**GRIEVANCE SYSTEM**

**Member Grievance System and Oversight:**

Contractor shall implement and maintain a Member Grievance System in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).

GMC Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract)

GMC Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

GMC Contract A.14.3.A

**SUMMARY OF FINDING(S):**

**4.1.1 Member Grievance System**

The Plan is required to resolve each grievance and provide notice to the member as quickly as the member’s health condition requires, within 30-calendar-days from receipt of the grievance. The Plan is required to send a written acknowledgment within five calendar days of receipt. The Plan is required to send a written resolution within 30-calendar-days of receipt. *[Contract, Exhibit A, Attachment 14(1)(B) and California Code of Regulations, Title 28, section 1300.68(d)(1)]*

The Plan exceeded Grievance Acknowledgement, Grievance Resolution, and Grievance Status Notification timeframes.

A verification study of 30 quality of service grievances were reviewed for adequate and timely resolution, response to complainant, and submission to the appropriate level of review. The verification study found the following notification delays:

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** Aetna Better Health of California, Inc.

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- Nine acknowledgement letters sent to the members exceeded five calendar days. The Plan sent member letters between 6 to 11 calendar days after receipt of the grievance.
- Two grievances were not resolved within 30-calendar-days and did not have resolution letters sent to the members within 30-calendar-days. Resolution letters to the members were sent between 31 to 39 calendar days after receipt of the grievance.

During the audit period, the Plan attributed the problem to insufficient resources in its Grievance Department.

Untimely grievance letters may lead to delayed patient care and have an impact on clinical outcomes for members.

### **RECOMMENDATION:**

- 4.1.1 Ensure grievance letters are sent to members and resolutions are resolved within contractual timeframes.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

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**4.3**

**CONFIDENTIALITY RIGHTS**

**Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:**

Business Associate agrees:

**Safeguards.** To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316....

GMC Contract G.III.C.2

**Breaches and Security Incidents.** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) 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 in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.
2. **Investigation and Investigation Report.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information ...to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

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**4.3**

**CONFIDENTIALITY RIGHTS**

3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within 10-working-days of the discovery of the breach or unauthorized use or disclosure.

GMC Contract G.III.J

**SUMMARY OF FINDING:**

**4.3.1 Breaches and Security Incidents**

The Plan shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident. Upon discovery of a breach or a suspected security incident, the Plan shall notify DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 24 hours by email or fax.

Thereafter, the Plan is required to investigate such security incidents and submit a Privacy Incident Report within 72 hours to DHCS. Within ten-working-days of the breach discovery or unauthorized use, a complete Privacy Incident Report is to be submitted to DHCS. *[Contract, Exhibit G.III.J]*

The Plan failed to report breaches or suspected security incidents to all three required DHCS officers.

A verification study sampled cases to determine compliance with reporting breaches or suspected security incidents to DHCS. The Plan reported five cases to DHCS. The cases were reviewed for investigation timeliness and reporting requirements. The results found the Plan did not report breaches, suspected security incidents, and Privacy Incident Reports to each of the required DHCS officers. Some correspondence only notified the Privacy Officer, for some it included the Privacy Officer and Information Security Officer.

The Plan did not notify all three DHCS officers due to exclusion from email carbon copy communication.

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.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

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**RECOMMENDATION:**

- 4.3.1. Develop a process to ensure the Plan reports breaches or suspected security incidents to all required DHCS officers.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019  
**DATE OF AUDIT:** April 22, 2019 through April 25, 2019

**5.2**

**PROVIDER QUALIFICATIONS**

**Credentialing and Re-credentialing:**

Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.

Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

GMC Contract A.4.12

**Provider Qualifications:**

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered....Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

GMC Contract A.4.12.A

**Provider Training:**

Contractor shall 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. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within 10-working-days after the Contractor places a newly contracted provider on active status...Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS.

GMC Contract A.7.5

**Delegated Credentialing:**

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities...

GMC Contract A.4.12.B

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019  
**DATE OF AUDIT:** April 22, 2019 through April 25, 2019

### SUMMARY OF FINDING:

#### **5.2.1 Network Provider Training**

The Plan shall ensure that all network 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 ensure that network provider training relates to Medi-Cal Managed Care services, policies, procedures, and any modifications to existing services, policies, or procedures.

Training shall include methods for sharing information between the Plan, network provider, member and/or other healthcare professionals. The Plan shall conduct training for all network providers within ten-working-days after the Plan places a newly contracted Network Provider on active status. [Contract, Exhibit A, Attachment 7(5)(A)]

The Plan did not conduct provider training for all of its network providers. When training was provided, the audit found instances that the training occurred outside of the contractual timeframes.

Review of the Plan's policy 8100.45 *Provider Credentialing, Recredentialing and Screening Enrollment*, found that the policy excluded the requirement to train network providers within ten business days as required by the Contract.

Additionally, the audit found that the Plan failed to monitor the provider training. The Plan did not ensure it maintained a system to accurately track the orientation date in relation to the network provider's start date.

A verification study was conducted to ensure that all network providers received training in regards to the Medi-Cal Managed Care program. During the audit period, the Plan contracted with 301 new providers. Ten providers were randomly selected to review. Of the ten, two exceeded the ten-day period, dates ranged from 46-days after enrollment to ten months after enrollment. Four providers did not receive training from the Plan. The verification study results show the Plan's network providers lack consistent training.

During Plan interviews, the Plan shared that the training data and enrollment dates are recorded in two different systems. Because the two systems are separate, they are not compatible to share information that would allow the Plan to maintain accurate data. The Plan acknowledged the exclusion on the contractual language in its policy and the challenges presented by two separate systems.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

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Plan staff also stated the Plan has not developed a system to correlate that the orientation occurred within ten business days of the provider entering the system, and the Plan had not documented when new provider packets were mailed.

New provider orientation is an integral part of training network providers. The Plan's failure to monitor its system can lead to missed or delayed training. Providers without knowledge of Medi-Cal Managed Care program resources ultimately affects provider network adequacy and quality of care.

**RECOMMENDATION:**

- 5.2.1 Develop a process to ensure the Plan conducts training for all network providers within ten-working-days after the Plan places a newly contracted network provider on active status.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

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**CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY**

**6.1**

**HEALTH EDUCATION PROGRAM**

**Health Education:**

1. Contractor shall implement and maintain a health education system that provides the organized programs, services, functions, and resources necessary to deliver health education, health promotion and patient education to assist Members improve their health and manage illness.
2. Contractor shall ensure administrative oversight, direction, management, and supervision of the health education system by a qualified full-time health education director or manager possessing a master of public health degree (MPH)...
3. Contractor shall conduct a Health Education, Cultural and Linguistic Group Needs Assessment (GNA) to identify the health education, cultural and linguistic needs of Members, and utilize the findings for continuous development and improvement of contractually required health education programs and services.
5. Contractor shall ensure the organized delivery of health education programs and services, at no charge for Members...(as required by Contract)
6. Contractor shall provide health education programs and services directly and/or through subcontractors that have expertise in delivery of health education programs and services....(as required by Contract)
7. Contractors shall maintain a health education system that provides educational interventions addressing the following health categories and topics and ensure that these programs are available and accessible to Members upon referral by providers and also upon the Member's request....

GMC Contract A.10.8.A

**SUMMARY OF FINDING:**

**6.1.1 Health Education Program**

The Plan shall implement and maintain a health education system that provides the organized programs, services, functions, resources necessary to deliver health education, health promotion and patient education to assist members to improve their health and manage illness. The Plan shall provide health education programs and services directly through subcontractors that have expertise in delivery of health education programs and services. *[Contract, Exhibit A, Attachment 10(8)(A)]*

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

**DATE OF AUDIT:** April 22, 2019 through April 25, 2019

The Plan shall adopt and maintain appropriate health education program standards/guidelines, policies/procedures, and conduct appropriate levels of evaluation, e.g. formative process, impact and outcome evaluation, to ensure access, availability, and effectiveness in achieving health education program goals and objectives. The Plan shall maintain documentation that demonstrates effective implementation of all DHCS health education requirements under this Contract. *[Contract, Exhibit A, Attachment 10(8)(A)(11)]*

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)(12)]*

The Plan failed to utilize a system to measure health education effectiveness. There was no information to support that the Plan collects data to document changes and evaluate the health education's effectiveness over time. The audit identified deficiencies to monitor effectiveness for the independent physician associations that deliver health education, to inform providers of health education, and resources.

A review of the Plan's education materials, questionnaire responses, and newsletters identified that the Plan implements and maintains a system for health education that includes services such as educational interventions. Health education services are directly given by the Plan through Member Newsletters, the Plan's website, and provider onsite visits. The Plan informs members of health education available through a web portal.

Additionally, through the questionnaire responses, the Plan identified areas of health education interventions. An intervention is a combination of program elements or strategies designed to produce behavior changes or improve health status among individuals or an entire population. Interventions may include educational programs, new or stronger policies, improvements in the environment, or a health promotion campaign.

During the interview, the Plan acknowledged it does not monitor effectiveness of health education interventions.

The Plan is unable to link positive health outcomes without an effective health education measurement. Nor is the Plan able to determine whether changes were made to reduce health-risk behaviors. A system to measure health education effectiveness aids in the identification of potential issues and consideration of ways to improve the provision of health education. The Plan's failure to monitor its health education can lead to missed program goals or desired health care outcomes.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

**DATE OF AUDIT:** April 22, 2019 through April 25, 2019

**RECOMMENDATION:**

- 6.1.1 Maintain a system to monitor the performance of the Plan and its subcontractors that deliver health education programs, and implement strategies to improve performance and effectiveness.

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.**

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

Audit Period: April 1, 2018  
Through  
March 31, 2019

Report Issued: November 7, 2019

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## I. INTRODUCTION

This report represents the audit findings of Aetna Better Health of California, Inc. (Plan) State Supported Services contracts No. 17-94601 and 17-94603 (Hyde Amendment Family Planning Services). The State Supported Services contract covers contracted abortion services with the Plan. The contract covers abortion services funded only with State funds, as these services do not qualify for federal funding.

The on-site audit was conducted from January 22, 2019 through January 25, 2019. The audit period is April 1, 2018 through March 31, 2019 and consisted of document review of material supplied by the Plan and interviews conducted on-site. An Exit Conference was held on October 14, 2019 with the Plan.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** Aetna Better Health of California, Inc.

**AUDIT PERIOD:** April 1, 2018 through March 31, 2019

**DATE OF AUDIT:** April 22, 2019 through April 25, 2019

### CATEGORY 1 - UTILIZATION MANAGEMENT

#### STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

##### **Abortion**

Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:

Current Procedural Coding System Codes\*: 59840 through 59857

HCFA Common Procedure Coding System Codes\*: X1516, X1518, X7724, X7726, Z0336

*\*These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*

State Supported Services Contract Exhibit A.1

#### **SUMMARY OF FINDING(S):**

The Contract (also referred to as the Hyde Contract) requires the Plan to provide, or arrange to provide, state supported services for Current Procedural Terminology codes 59840 through 59857 and Healthcare Common Procedure Coding System codes X1516, X1518, X7724, X7726, and Z0336. Members may go to any provider in- or out-of-network for all abortion services without prior authorization.

The Plan is responsible for the provision of State Supported Services to members from in-network and out-of-network providers. The Plan provides State Supported Services as outlined in the Plan's policy to fulfill the requirements of *All Plan Letter (APL) 15-020* to implement and maintain procedures that ensure confidentiality and access to abortion services.

The Plan's policy 8300.20 *Family Planning/Reproductive Health*, addresses abortion services that are covered by the Medi-Cal program as a physician service. Abortion services are, by nature, sensitive services. While the policy contained the requirements from *APL 15-020*, the policy does not specifically state that it is the Plan's responsibility to provide, or arrange to provide, abortion services.

During the interview, the Plan stated that State Supported Services claims are paid without review of medical records or prior authorization. Additionally, the services are not flagged for internal review or pended for medical necessity for both in-network and out-of-network providers.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** Aetna Better Health of California, Inc.

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The Plan's Provider Manual states that abortion is a covered benefit regardless of the gestational age of the fetus. The Plan does not require medical justification and authorization. However, a different section of the Provider Manual outlines that the Plan does not cover certain services, including elective abortions. The Provider Manual contains contradictory language which may result in confusion to whether the sensitive services are a covered benefit. The Plan acknowledged the discrepancy and stated that the verbiage will be removed to make it clear that abortion is indeed a covered benefit.

The Plan did not have grievances due to access to abortion and/or abortion-related procedures and the payment of State Supported Services.

### **RECOMMENDATION:**

- 7.1.a Revise the Plan's policy to state that it is the Plan's responsibility to provide, or arrange to provide, abortion services.
- 7.1.b Revise the Plan's Provider Manual to remove the verbiage regarding abortion to clarify that it is a covered benefit.