CONTRACT AND ENROLLMENT REVIEW – LOS ANGELES
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Aetna Better Health of California, Inc.

2023

Contract Numbers:	17-94600 Sacramento 17-94602 San Diego
Audit Period:	April 1, 2022 Through March 31, 2023
Dates of Audit:	April 17, 2023 Through April 27, 2023
Report Issued:	September 27 2023

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I. INTRODUCTION

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

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

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

The Plan will be closing its Medi-Cal lines of business in both Sacramento and San Diego counties on December 31, 2023.

As of March 31, 2023, the Plan served 27,943 members in Sacramento and 36,827 members in San Diego through the Medi-Cal line of business.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of April 1, 2022 through March 31, 2023. The audit was conducted from April 17, 2023 through April 27, 2023. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on August 25, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. On September 11, 2023, the Plan submitted a response. The results of our evaluation of the Plan's response are reflected in this report.

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

The prior DHCS was issued on December 21, 2022, for the audit period of April 1, 2021 through March 31, 2022. This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of its prior year's Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

There were no findings noted for this category during the audit period.

Category 2 – Case Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Access and Availability of Care

There were no findings noted for this category during the audit period.

Category 4 – Member's Rights

The Plan and subcontractors shall not submit claims or demand, or otherwise collect reimbursement for any services provided under this Contract from a Medi-Cal member. The Plan providers billed fully Medi-Cal eligible members for services which were covered under the contract.

The Plan is required to classify a complaint as a grievance. If the Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance. Any inquiry is a request for information that does not include an expression of dissatisfaction. The Plan did not properly classify and process members' expression of dissatisfaction as a grievance.

The Plan is required to implement and maintain a process to categorize a complaint as a grievance and not an inquiry when a member expresses to decline to file a grievance. The Plan did not implement and maintain a process to categorize a complaint as a grievance and not an inquiry when a member expressed to decline to file a grievance.

Category 5 – Quality Management

The Plan is required to monitor and impose corrective action to address noncompliance with subcontractors. The Plan did not impose corrective action and financial sanctions on subcontractors upon discovery of noncompliance with subcontract or other Medi-Cal requirements.

Category 6 – Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit was conducted from April 17, 2023 through April 27, 2023. 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: 21 medical and 30 delegated prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 15 appeals of medical prior authorizations were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment: Ten medical records were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Category 3 – Access and Availability of Care

Claims: 15 emergency services and ten family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation and Non-Medical Transportation: 22 records (12 Non-Emergency Medical Transportation and ten Non-Medical Transportation) were reviewed to confirm compliance with transportation requirements for timeliness and appropriate adjudication.

Category 4 – Member's Rights

Grievances: 72 standard grievances including 27 quality of care and 45 quality of service, ten exempt grievances, and 30 call inquiries were reviewed for timely resolution, response to the complainant, submission to the appropriate level for review, and translation in member's preferred language.

Category 5 – Quality Management

Potential Quality Issue: Four files were reviewed for evaluation and effective action taken to address needed improvements.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Aetna Better Health of California, Inc.

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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Billing Medi-Cal Members

The Plan and subcontractors shall not submit claims or demand, or otherwise collect reimbursement for any services provided under this Contract from a Medi-Cal member. *(Contracts Exhibit A, Attachment 8(6)(A))*

A provider of service under the Medi-Cal program shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal member, or from other persons on behalf of the member, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service. *(California Code Regulations (CCR), Title 22, section 51002(a))*

A provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or a person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services. *(California Welfare & Institutions Code, section 14019.4(a))*

Finding: The Plan providers billed fully Medi-Cal eligible members for services which were covered under the contract.

A review of the verification files revealed eight member grievances were associated with balance-billing error issues. Although the Plan confirmed members were released from financial responsibility and advised the balance bills were sent in error, the Plan did not have policy and procedures in place to ensure billing issues would not reoccur with the same subcontractors. In addition, there were no enforceable actions when the same subcontractors continued to submit claims to Medi-Cal members for covered services.

During the interview, the Plan acknowledged their process did not prevent the improper billing of its members due to administrative errors.

When the Plan does not address improper billing of its members, this may discourage members from seeking medically necessary care.

Recommendation: Develop and implement policy and procedures to ensure that the Plan providers are prohibited from billing fully eligible Medi-Cal members for covered services.

4.1.2 Grievance Classification and Processing

The Plan is required to have a member grievance system in accordance with CCR, Title 28, sections 1300.68, and 1300.68.01; and Code of Federal Regulations (CFR), Title 42, sections, 438.402-424. (Contracts, Exhibit A, Attachment 14 (1))

The Plan is required to have procedures to ensure a member may file a grievance at any time to express dissatisfaction about any matter other than an action resulting in a Notice of Action. (Contracts, Exhibit A, Attachment 14 (2)(B) (1))

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

The Plan is required to have a grievance and appeal system in place for members. Plans must allow members to submit a grievance or appeal orally or in writing. (*CFR, Title 42, section 438.402)*

A complaint is the same as a grievance. If the Managed Care Plan (MCP) is unable to distinguish between a grievance and an inquiry, it must be considered a grievance. Any inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other MCP process. (*All Plan Letter (APL) 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Finding: The Plan did not properly classify and process members' expressions of dissatisfaction as a grievance.

A review of the transcribed inquiry log revealed members' expressions of dissatisfaction were not classified as grievances in three instances during the audit period. The Plan's Member Service Staff (MSS) did not follow its policy and procedures in classifying inquiries as grievances when the inquiries met the grievance definition.

- One instance, MSS assisted an upset member who had trouble with requesting a provider that speaks Mandarin. The inquiry was not classified as an exempt grievance.

- One instance, MSS assisted an upset member with a transportation issue. The inquiry was not classified as an exempt grievance.

- One instance, a member expressed an issue with making an appointment. The inquiry was not classified as a standard grievance.

During the interview, the Plan confirmed the existing monitoring system did not effectively capture the misclassification of call inquiries. The Plan acknowledged its MSS needed retraining on classifying members' expressions of dissatisfaction.

When the Plan does not properly classify and process members' expressions of dissatisfaction as grievances, it can result in failure to identify substandard and poor quality of medical care for members.

Recommendation: Revise and implement policies and procedures to ensure members' expressions of dissatisfaction are classified as grievances.

4.1.3 Filing Grievance

The Plan shall have a member grievance system in place in accordance with CCR, Title 28, sections 1300.68, and 1300.68.01; and CFR, Title 42, sections 438.402-424. *(Contracts, Exhibit A, Attachment 14 (1))*

The Plan is required to have a grievance and appeal system in place for members. Plans must allow members to submit a grievance or appeal orally or in writing. (*CFR, Title 42, section 438.402)*

The Plan must establish, implement, maintain, and oversee a grievance system to ensure the receipt, review, and resolution of grievances. The grievance system must operate in accordance with all applicable federal and state laws. The grievance system must include reporting procedures in order to improve the Plan's policies and procedures. (*APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan must not discourage the filing of grievances. A member need not use the word "grievance" for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by the Plan. If a member expressly declines to file a grievance, the compliant must still be categorized as a grievance and not an inquiry. (*APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Finding: The Plan did not implement and maintain a process to categorize a complaint as a grievance and not an inquiry when a member expressly declined to file a grievance.

A review of Plan's Desktop Procedures 4500.42D, *Accepting Member Grievance and Appeals Call*, revealed that the definition of declined grievance was not clearly delineated in the policy. There was no instruction provided to MSS when a member expressly declined to file a grievance.

During the interview, the Plan confirmed that if a member expressly declines to file a grievance during an inquiry call, the MSS would deem the complaint no longer meeting the grievance criteria and would categorize the complaint as an inquiry. Subsequently, in a follow-up interview, the Plan acknowledged and confirmed its Desktop Procedures need to be revised to align with the APL requirements.

If the Plan does not accurately categorize the complaint as a grievance and not an inquiry when a member expressly declines to file a grievance, this may prevent the Plan from addressing care and service quality problems.

Recommendation: Revise and implement policies and procedures to accurately categorize members' complaints.

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CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

5.1.1 Quality Improvement Oversight

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting regardless of the number of contracting and subcontracting layers between the Plan and the providers. (*Contracts, Exhibit A, Attachment 4, section (1))*

The Plan must also have in place policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of noncompliance with the subcontract or other Medi-Cal requirements. *(APL 17-004, Subcontractual Relationships and Delegation)*

The Plan must establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services furnished to members. (*CFR, Title 42, section 438.330(a))*

Plan Policy 8000.70, *Quality Management Oversight (revised 02/2022).* explained the quality improvement cycle steps to include and identify key areas to focus improvement opportunities and determine root causes. The process outlined the plan to develop implementation of Corrective Action Plan, carry out plan, reevaluate to assess effectiveness, and revise implementation plan or increase intensity of Corrective Action Plan accordingly.

Finding: The Plan did not impose corrective action and financial sanctions on subcontractors upon discovery of noncompliance with Medi-Cal requirements.

A verification study revealed eight member grievances were associated with balance-billing error issues. Although, the Plan's Grievance and Appeal Department identified balance-billing errors as a top grievance issue. During the interview, the Plan confirmed there was no corrective action issued with subcontractors to address the balance-billing errors during the audit period. The subcontractors continued to send bills to members.

Without follow-up of non-compliant subcontractors, the Plan may lack the ability to take effective action to address any necessary improvements in the service delivered to members.

Recommendation: Develop and implement policies and procedures to impose corrective action upon discovery of noncompliance.

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REPORT ON THE MEDICAL AUDIT OF

Aetna Better Health of California, Inc.

2023

Contract Numbers:	17-94601 Sacramento 17-94603 San Diego State Supported Services
Audit Period:	April 1, 2022 Through March 31, 2023
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I. INTRODUCTION

This report presents the results of the audit of Aetna Better Health of California, Inc. (Plan) compliance and implementation of the State Supported Services contracts with the State of California. Contracts cover abortion services with the Plan.

The review was conducted from April 17, 2023 through April 27, 2023. The audit covered the audit period from April 1, 2022 through March 31, 2023. It consisted of document reviews and interviews with the Plan's staff.

An Exit Conference with the Plan was held on August 25, 2023. There were no deficiencies found for the audit period on the Plan's Sate Supported Services.

❖ COMPLIANCE AUDIT FINDINGS ❖

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STATE SUPPORTED SERVICES

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology (CPT) Codes: 59840 through 59857. Health Care Financing Administration Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and Z0336.
(Contracts, Exhibit A, Section 1)

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

The Plan's policy 8300.20, *Family Planning and Reproductive Health* (revised December 2020), stated that abortion services are covered by the Medi-Cal program as a physician service. Abortion is a covered benefit regardless of the gestational age of the fetus and are, by nature, sensitive services. All Managed Care Plans (MCPs) must implement and maintain procedures that ensure confidentiality and access to these sensitive services. MCPs, providers, independent practice associations, preferred provider groups and all delegated entities that provide physician services must not require medical justification and prior authorization for outpatient abortion services. MCPs are responsible to provide, or arrange to provide, abortion services.

The Plan maintained a list of CPT Codes for procedures and related services that are exempt from prior authorization that the Plan's Claims Department used in auto payment of claims processing. The Plan's claims system configuration ensured no prior authorization was needed. The billing codes for sensitive services that are exempt from prior authorization included the CPT Codes 59840 through 59857.

Based on the review, no deficiencies were noted for the audit period.

Recommendation: None.