DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

REPORT ON THE FOCUSED AUDIT OF AETNA BETTER HEALTH OF CALIFORNIA, INC. 2023

Contract Number: 17-94600 Sacramento

17-94602 San Diego

Audit Period: April 1, 2022 – March 31, 2023

Dates of Audit: April 17, 2023 – April 28, 2023

Report Issued: August 30, 2024

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I. INTRODUCTION

Background

In accordance with California Welfare and Institutions Code (W&I Code) section 14456, the Department of Health Care Services (DHCS) may conduct additional reviews outside of the annual medical audit when DHCS determines there is good cause.

DHCS directed the Contract and Enrollment Review Division to conduct focused audits of all contracting Medi-Cal Managed Care Plans (Plans) to evaluate current Plans' performance in the areas of Behavioral Health and Transportation services.

These focused audits differ from DHCS' regular annual medical audits in scope and depth. The annual medical audits evaluate the Plan's organizational structures, policies and procedures, and systems for compliance with contractual requirements. The focused audits examined the operational issues that may hinder appropriate and timely member access to medically necessary care. The focused audit engagement formally commenced in January 2023 through December 2023.

For the Behavioral Health section, the focused audit evaluated the Plan's monitoring activities of specific areas such as Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and Substance Use Disorder Services (SUDS). The focused audit also reviewed potential issues that may contribute to the lack of member access and oversight for SMHS, NSMHS, and SUDS.

The focused audit conducted a more in-depth look at current Plan operations/practices for executing the delivery of transportation services. The audit examined potential causes for the systemic issues surrounding the Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services, specifically when transportation is delegated to a transportation broker.

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 national partners, the Plan supports 2.7 million Medicaid members in 16 states. In January 2018, the Plan was a new Geographic Managed Care health plan in Sacramento and San Diego counties.

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

During the audit period, the Plan delegated transportation services to Access2Care, LLC, a transportation broker.

As of April 10, 2023, the Plan served 38,613 members in San Diego, and 28,833 members in Sacramento through its Medi-Cal line of business.

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS' focused audit for the period of April 1, 2022, through March 31, 2023. The audit was conducted from April 17, 2023, through April 28, 2023. The audit consisted of document review, surveys, verification studies, and interviews and file reviews with Plan representatives.

The Plan declined an Exit Conference to be held on June 25, 2024. The Plan was allowed 15 calendar days from the date of the originally scheduled Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the originally scheduled Exit Conference. The results of DHCS' evaluation of the Plan's response are reflected in this report.

The focused audit evaluated the areas of performance for Behavioral Health and Transportation services.

The summary of findings by performance area follows:

Performance Area: Behavioral Health

Category 2 – Case Management and Coordination of Care:

- Specialty Mental Health Services
- Non-Specialty Mental Health Services
- Substance Use Disorder Services Category 3 – Access and Availability of Care

The Plan is required to coordinate with the county Mental Health Plans (MHPs) to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and that the new provider accepts the care of the member. The Plan did not coordinate with the county MHPs to facilitate care transitions, guide referrals, and vice versa, and ensure that the referral loop is closed, and that the new provider accepts the care for members.

The Plan is required to refer members to the appropriate provider and ensure that the referral is to the appropriate delivery system for mental health services. Additionally, the Plan is required to refer individuals requiring alcohol and/or Substance Use Disorder (SUD) treatment services to county treatment programs. The Plan did not ensure members were referred to the appropriate delivery system for mental health services, either in the network or to the county MHP. Moreover, for members requiring SUD

treatment, the Plan did not ensure members were referred to the appropriate substance use treatment program.

Performance Area: Transportation

Category 3 – Access and Availability of Care

- Non-Emergency Medical Transportation
- Non-Medical Transportation

The Plan is required to provide an alternate NMT provider if the arranged NMT provider does not arrive at the scheduled pick-up time. The Plan did not provide an alternate NMT service when the NMT provider did not arrive at the scheduled pick-up time.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

On November 3, 2022, DHCS informed Plans that it would conduct focused audits to assess performance in certain identified high-risk areas. The focused audit was concurrently scheduled with the annual medical audit of the Plans. The focused audit scope encompassed the following sections:

- Behavioral Health - SMHS, NSMHS, and SUDS
- Transportation – NEMT and NMT services

The audit was conducted from April 17, 2023, through April 28, 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 the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 2 – Case Management and Coordination of Care

SMHS: No cases were available to evaluate care coordination with the county MHPs and compliance with All Plan Letters (APL) requirements.

NSMHS: Ten cases were reviewed to evaluate compliance with APL requirements.

SUDS: No cases were available to be reviewed to evaluate compliance with APL requirements.

Category 3 – Access and Availability of Care

NEMT: Ten cases were reviewed to evaluate compliance with APL requirements.

NMT: Ten cases were reviewed to evaluate compliance with APL requirements.

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

COMPLIANCE AUDIT FINDINGS

Performance Area: Behavioral Health – SMHS, NSMHS, and SUDS

Category 2 – Case Management and Coordination of Care

2.1 Care Management and Care Coordination

The Plan shall comply with all existing final Policy Letters and APLs issued by DHCS. (*Contract, Exhibit E, Attachment 2(1)(D)*)

The Plan is required to coordinate with county MHPs to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and that the new provider accepts the care of the member. (*APL 22-005 No Wrong Door for Mental Health Services Policy*)

Plan policy *7500.60, Mental Health/Substance Abuse Screening and Coordination* (revised 07/06/2022), states that the Plan must coordinate with the MHPs to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and that the new provider accepts the care of the member.

Finding: The Plan did not coordinate with the county MHPs to facilitate care transitions, guide referrals for members to a SMHS provider, and vice versa, and ensure that the referral loop is closed, and that the new provider accepts the care for members.

The Plan's record did not identify any members with SMHS; however, the Plan did not have a tracking system in place for members seeking mental health services, including tracking of referrals to and from the county MHPs. The Plan was unable to provide evidence of care transition and referral tracking.

In a written response, the Plan stated that: "Communication between the county MHP and managed care plans has historically been fragmented, the recent change in structure and data sharing exchange has provided a clearer process for reporting and escalation of issues and concerns. The transparency and collaboration will continue to support the efforts of the no wrong door approach." As a result, the fragmented communication impacted the Plan's ability to facilitate care transitions and guide referrals to MHPs, and to ensure that the referral loop is closed, and the provider accepts the care of the member.

If the Plan does not coordinate with the MHPs to facilitate care transitions and guide referrals for members, members may miss opportunities to access necessary SMHS.

Recommendation: Implement policies and procedures to ensure that the Plan coordinates with the county MHPs to facilitate care transitions, ensure non-duplication, and guide referrals for members receiving both NSMHS and SMHS concurrently.

2.2 Mental Health and Substance Use Disorder Services Referrals

The Plan shall comply with all existing final Policy Letters and APLs issued by DHCS. (Contract, Exhibit E, Attachment 2(1)(D))

If a member's primary care physician cannot perform an Initial Mental Health Assessment, the Plan must refer the member to the appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, either in the Plan's provider network or the county MHP's network, is made in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h) and APL 22-005. *(APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services)*

The Plan must identify individuals requiring alcohol and/or SUD treatment services and refer these individuals to county treatment programs. For individuals identified as requiring alcohol and/or SUD treatment services, the Plan must arrange for their referral to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin detoxification providers available through the Medi-Cal free-for-service program, for appropriate services. (*APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment*)

Plan policy *7500.60, Mental Health/Substance Abuse Screening and Coordination* (revised 07/06/2022), states that the Plan's network providers will refer members with significant impairment resulting from a covered mental health diagnosis to the county MHP. When a member has a significant impairment, but the diagnosis is uncertain, the Plan must ensure that the beneficiary is referred to the MHP for further assessment. Furthermore, individuals identified as requiring alcohol or SUD treatment services, the Plan must arrange for their referral to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin detoxification providers available through the Medi-Cal fee-for-service program, for appropriate services.

Finding: The Plan did not ensure members were referred to the appropriate delivery system for mental health services, either in the network or to the county MHP. Moreover, for members requiring SUD treatment, the Plan did not ensure members were referred to the appropriate substance use treatment program.

Review of the Plan's NSMHS, SMHS, and SUDS referral log did not demonstrate that the Plan ensured members were referred to the appropriate mental health and SUDS. Request for NSMHS, SMHS, and SUDS referrals resulted in no records of SMHS and SUDS referrals during the audit period. The Plan identified only 39 members receiving NSMHS in which were limited to members that required Plan authorization or referral; allowing the Plan to track. The Plan did not have an oversight and monitoring system to ensure that all referrals are made to the appropriate mental health and SUD system.

Furthermore, the review of annual oversight of the Plan's contracted provider networks had no indication that the Plan ensured all members were referred to the appropriate mental health and SUDS.

In the interview, the Plan stated that they can track referrals for members that require certain Plan authorization related to NSMHS. Additionally, the Plan can track members enrolled in care coordination. Otherwise, members who are not enrolled in the Plan's care coordination program and or did not require any type of mental health authorization, the Plan relied on the contracted providers in primary care settings to ensure members receive the mental health care. As a result, the Plan was unable to ensure members were referred to the appropriate delivery system for mental health services.

By not ensuring members are referred to the appropriate delivery system for mental health and SUDS, members may not receive necessary treatment.

Recommendation: Implement policies and procedures to ensure that members are referred to the appropriate provider and ensure that the referral is to the appropriate delivery system.

COMPLIANCE AUDIT FINDINGS

Performance Area: Transportation – NEMT and NMT

Category 3 – Access and Availability of Care

3.1 Alternate Non-Medical Transportation

The Plan shall comply with all existing final Policy Letters and APLs issued by DHCS. (*Contract, Exhibit E, Attachment 2(1)(D)*)

If the NMT provider does not arrive at the scheduled pick-up time, the Plan is required to provide an alternate NMT or allow the member to schedule alternate out-of-network NMT and reimburse for the out-of-network NEMT. (*APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses*)

Plan policy *4500.95, Emergent and Non-Emergent Transportation* (revised 07/27/2022), stated that if the provider does not arrive at the scheduled pick-up time, the Plan must provide alternate NMT or allow the member to schedule alternate out-of-network transportation and reimburse for the out-of-network transportation.

Finding: The Plan did not provide an alternate NMT when the NMT provider did not arrive at the scheduled pick-up time.

Ten NMT verification study samples were reviewed. Out of ten samples, three no-show cases were found where the drivers did not pick up the members. The members had to find their own way home. The Plan did not provide evidence that an alternate NMT was provided to any of the members.

In an interview, the Plan stated that they are unable to receive real-time information regarding late/no-shows transportation trips. Furthermore, the Plan does not have access to the transportation broker, Access 2 Care scheduling system. The Plan tracks the late/no-shows through the Plan's grievance system for monitoring, oversight, and corrective action only. As a result, the Plan is unable to ensure that an alternate transportation is provided to the member when the NMT provider does not arrive at the scheduled pick-up time.

By not providing timely transportation services, members may miss medically necessary appointments.

Recommendation: Implement policies and procedures to ensure that members are provided an alternate NMT when the NMT provider does not arrive at the scheduled pick-up time.