Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
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www.HealthHelp.ca.gov

June 3, 2019

Via USPS Delivery and eFile

Ms. Kristen A. Miranda, President
Aetna Health of California Inc.
2850 Shadelands Drive
Walnut Creek, CA 94598

FINAL REPORT OF A ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA INC.

Dear Ms. Miranda:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended September 30, 2018 of the claims settlement practice and dispute resolution mechanism of Aetna Health of California Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on February 27, 2019. The Department accepted the Plan's electronically filed responses on April 15, 2019 and May 14, 2019 (Responses).

The Final Report includes a description of the compliance efforts included in the Plan's Responses, in accordance with Section 1382(c).

Section 1382(d) states, "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response(s). If so, please indicate which portions of the Plan's response(s) should be appended, and electronically file copies of those portions excluding information held confidential pursuant to Section

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in Health and Safety Code Section 1340 et seq.

1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's response(s) or wishes to modify any information provided to the Department in its Responses, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan (CAP) system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP # S19-R-176."
- Go to the "Messages" tab, then:
    - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
    - Select the deficiency(ies) that are applicable.
    - Create a message for the Department.
    - Attach and upload all documents with the name "Addendum to Final Report."
    - Select "Send Message."

As noted in the attached Final Report, the Plan's Responses did not adequately respond to the deficiencies raised in the Preliminary Report issued by the Department on February 27, 2019. The Plan is required to respond to any request for corrective actions contained within the attached Final Report within 30 days of receipt of the Final Report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Department's Office of Enforcement for appropriate administrative action.

Please file the Plan's response electronically via the CAP system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, click on the "Details" for "CAP # S19-R-176."
- Go to the "Data Requests" tab, then:
    - Click on the "Details" for each data request that does not have a status of "Complete."
    - Follow the instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement Refile).

The Department will also e-mail the Plan requesting all items that are still outstanding. The e-mail(s) will contain a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission of any addendum should be directed to Vijon Morales at 916-255-2447 or by e-mail at Vijon.Morales@dmhc.ca.gov. You may also e-mail inquiries to wpso@dmhc.ca.gov.

The Department will make the Final Report available to the public in 10 days from the Plan's receipt of this letter. The Final Report will be located at the Department's web site at http://www.dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

If there are any questions regarding the Final Report, please contact me at 916-255-2425 or by e-mail at Anna.Belmont@dmhc.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

Anna Belmont
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Bobby Antee, Compliance Lead, Aetna Health of California Inc.
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Nina Moua, Examiner, Division of Financial Oversight
Neetu Bhangu, Examiner, Division of Financial Oversight
Brianne Burkart, Attorney III, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Linda Armstrong, Staff Services Manager III, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF A ROUTINE EXAMINATION

OF

AETNA HEALTH OF CALIFORNIA INC.

FILE NO. 933 0176

DATE OF FINAL REPORT: JUNE 3, 2019

SUPERVISING EXAMINER: JENNIFER CLARK

OVERSIGHT EXAMINER: ANNA BELMONT

EXAMINER-IN-CHARGE: NINA MOUA

FINANCIAL EXAMINERS:

ERI FUKUDA

DANIIL RYBALKO

ERICA SHORT

BACKGROUND INFORMATION FOR AETNA HEALTH OF CALIFORNIA INC.

Date Plan Licensed:	August 6, 1987
Organizational Structure:	Aetna Health of California Inc. (Plan) is a wholly-owned subsidiary of Aetna Health Holdings, LLC, which is a wholly-owned subsidiary of CVS Health Corporation.
Type of Plan:	The Plan is a full service health care services plan that arranges for comprehensive health care services to commercial, point-of-service (POS) and Medicare Advantage enrollees.
Provider Network:	The Plan provides health care services by contracting with participating medical groups on a capitated basis and individual physicians on a discounted fee-for-service basis. Hospitals are compensated on a capitated, per diem or case rate basis.
Plan Enrollment:	The Plan reported 230,085 enrollees as of September 30, 2018, consisting of 215,612 commercial, 14,332 Medicare Risk and 141 POS.
Service Area:	Alameda, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Marin, Merced, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura and Yolo Counties.
Date of Prior Final Routine Examination Report:	November 13, 2018.

FINAL REPORT OF A ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA INC.

This is the final report (Final Report) for the quarter ended September 30, 2018 of a routine examination of the claims settlement practice and dispute resolution mechanism of Aetna Health of California Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on February 27, 2019. The Department accepted the Plan's electronically filed responses on April 15, 2019 and May 14, 2019 (Responses).

This Final Report includes a description of the compliance efforts included in the Plan's Responses to the Preliminary Report, in accordance with Section 1382(c). The Plan's Responses are noted in italics within this Final Report

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

The Department findings are presented as follows:

Part I.	Compliance Issues
Part II.	Nonroutine Examination

The Plan is required to respond to any request for corrective actions contained herein within 30 days of receipt of this Final Report.

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in Health and Safety Code Section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

PART I. COMPLIANCE ISSUES

A. PROVIDER DISPUTE RESOLUTION (PDR) MECHANISM

Rule 1300.71.38 states that all health care service plans must establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes.

1. PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS RESULTING FROM PDRs – Repeat Deficiency

Section 1371 and Rule 1300.71(i)(2) and (j) require a health care service plan, if the plan is a health maintenance organization, to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan. If an uncontested claim is not reimbursed within 45 working days after receipt, interest accrues at the rate of 15 percent per annum beginning with the first calendar day after the 45-working-day period. A plan that fails to automatically include interest due in its payment of the claim must pay a fee of $10 to the claimant.

Rule 1300.71(a)(8)(K) describes an “unfair payment pattern” as the failure to reimburse at least 95 percent of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Rule 1300.71.38(g) requires a plan to pay to the provider any outstanding monies determined to be due, and all interest and penalties within five working days of the issuance of the written determination if a provider dispute is determined in favor of the provider.

The Department’s examination disclosed that the Plan failed to pay or underpaid interest in nine out of 50 PDRs (a compliance rate of 82 percent). This deficiency was noted in the following PDR sample numbers: 4, 6, 9, 11, 14, 21, 27, 41 and 47. This deficiency was mainly caused due to independent practice associations (IPAs) authorizing services but not forwarding the authorizations to the Plan. This resulted in the Plan denying claims for missing authorization. Providers submitted PDRs with proof of authorization during the time of service, prompting the Plan to overturn its original decision and pay the claims. However, the Plan did not pay interest on the claims that were paid after 45 working days.

The Plan’s failure to pay interest correctly on late claim payments resulting from provider disputes is a repeat deficiency, as this issue was previously noted in the Department’s final report of routine examination dated January 19, 2017, for the quarter ended September 30, 2015. This examination disclosed that the Plan’s compliance efforts in response to the prior final report had not achieved the necessary levels of compliance with the Section and Rules cited.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of failure to pay interest on late claim payments resulting from provider disputes, as identified in the Department's prior examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed CAP that included the following:

a. Policy and procedures implemented to ensure PDRs are paid accurately including interest and penalties.

b. Training procedures implemented to ensure PDR processors are aware of and comply with the requirements of the above Section and Rules.

c. Audit procedures to confirm PDRs are paid accurately including interest and penalties.

d. Date the policy and procedures were implemented.

e. Identification of all overturned PDRs paid inaccurately, including interest and penalties, from January 19, 2017 (date of prior final report) through the date the corrective action was implemented by the Plan.

f. Evidence that interest and penalties, as appropriate, were paid retroactively for the PDRs identified in paragraph "e" above. This evidence was to include an electronic data file/schedule (Excel or Access) that identified the following:

   - Claim number
   - PDR number
   - Date of service
   - Date original claim received
   - Date new information received
   - Total billed
   - Total paid
   - Paid date (mail date)
   - Amount of interest paid
   - Date interest paid
   - Penalty amount paid, if applicable
   - Number of late days used to calculate interest
   - Total interest owed per claim
   - Check number for interest and penalty paid
   - Provider name
   - ER or Non-ER indicator

   The data file was to provide the details of all PDRs remediated, including the total number of PDRs, total additional claim payments and the total additional interest and penalties paid, as a result of remediation.

g. Management positions responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of the Preliminary Report, the Plan was required to submit with its response a timeline that committed the Plan to complete the CAP within 90 calendar days of receipt of the Preliminary Report. If the Plan was not able to meet this timeframe, it was required to provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan would also have to submit monthly status reports to the Department until the CAP is completed.

The Plan disagreed that the above deficiency is a repeat deficiency, as the reason for the current deficiency differs from the deficiency noted in the January 19, 2017 final report. The Plan stated that the current deficiency identified above was mainly due to IPAs authorizing services but not forwarding the authorizations to the Plan. This resulted in the Plan denying claims for missing authorization. Providers submitted PDRs with proof of authorization during the time of service, prompting the Plan to overturn its original decisions and pay the claims. However, the Plan did not pay interest on the claims because at the time of the PDR the Plan believed the original claims were processed correctly. The Plan reviewed the date of receipt of the IPA/medical group authorization submissions and determined that interest and/or penalty would apply if the IPA/medical group authorization was submitted prior to the original submission of the claim. The prior deficiency was due to the Plan's failure to pay interest correctly on late claim payments as a result of the Plan's failure to use the original date of receipt of an incorrectly processed claim. This deficiency was corrected and not noted in the current exam.

<u>Plan CAP IPA Authorization Response:</u>
The Plan stated there are two underlying issues with the current deficiency: 1) receipt and data entry of authorizations submitted by IPAs/medical groups, and 2) the Plan's oversight of IPA/medical group submissions of authorizations. The Plan implemented a workflow change effective April 22, 2019 to address these underlying issues. In addition, the National Quality Management Team started evaluating the receipt of authorizations from IPAs/medical groups as the Precertification Team was reporting a backlog of three weeks. The Precertification Team trained new additional staff to perform an initial "scrub" of the data. In addition, management received approval to hire three more staff to increase production and the review of data. The Precertification Team is currently working within a two-week timeframe.

The Clinical Team Director, Clinical Delegation Oversight Manager, and Precertification Team Supervisor will oversee the IPA/medical group authorization workflow change.

<u>Plan PDR and Claim Interest and Penalties Response:</u>
The Plan's Claims Department is responsible for reprocessing claims resulting from PDRs. The Plan provided the following interest policy and procedures: State Interest and Prompt Payment, California State Interest Requirements and California Claim

Payment and Notification Requirements. In addition, the Plan responded that its Claims Department processors complete annual California Title 10 and California Title 28 claims interest and penalty requirements trainings.

In addition, the Plan provided the following policies and workflow documenting the auditing process followed by its Claims Auditing Program: ACAS Post Pay Quality Assessment Program, ACAS Prepay Quality Assessment Program and Claim Quality End to End Audit Workflow. The policies were updated March 28, 2019.

Plan Response for Identification of Overturned PDRs:
The Plan stated that it is still in the process of identifying overturned PDRs paid inaccurately. The Plan requested a 90-day extension to identify claims paid up to April 15, 2019. The data for the report will not be available until mid-May 2019. The data is pulled based upon AB1459 claims data and that data is only pulled on a quarterly basis. When the claims are identified, the turnaround time is 30 days, or longer, depending on the volume.

The Compliance Operations Lead and Claims Operations Director will oversee the completion of the project.

The Department finds that the Plan's compliance efforts are not fully responsive to the corrective action required. The Plan did not complete the remediation of overturned PDRs paid inaccurately.

The Plan is required to submit the following:

- **Identification of all overturned PDRs paid inaccurately, including interest and penalties, from January 19, 2017 through the date the corrective action was implemented by the Plan.**

- **Evidence that interest and penalties, as appropriate, were paid retroactively for the PDRs identified in paragraph above. This evidence is to include an electronic data file/schedule (Excel or Access) that identifies the following:**

    - **Claim number**
    - **PDR number**
    - **Date of service**
    - **Date original claim received**
    - **Date new information received**
    - **Total billed**
    - **Total paid**
    - **Paid date (mail date)**
    - **Amount of interest paid**
    - **Date interest paid**
    - **Penalty amount paid, if applicable**
    - **Number of late days used to calculate interest**

- **Total interest owed per claim**
- **Check number for interest and penalty paid**
- **Provider name**
- **ER or Non-ER indicator**

  The data file is to provide the details of all PDRs remediated, including the total number of PDRs, total additional claim payments and the total additional interest and penalties paid as a result of remediation.

- **The Plan is also required to submit monthly status reports to the Department until the CAP is completed.**

2. REJECTING PDRS

Rule 1300.71.38(a)(1) and (2) defines a contracted and non-contracted provider dispute as a provider's written notice to the plan challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

Rule 1300.71.38(b) states that whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address, for filing a provider dispute.

Rule 1300.71.38(c) states the plan and the plan's capitated provider shall establish written procedures for the submission, receipt, processing and resolution of contracted and non-contracted provider disputes.

The Department's examination disclosed that the Plan failed to adequately inform providers of its PDR mechanism and procedures for filing PDRs. The Plan rejected PDRs submitted in writing, containing all required claim information and a clear explanation of the disputed item, because they were missing the Aetna Provider Complaint and Appeal Form (PDR Form) specific to the Plan. The PDR notice on the denial explanation of benefits (EOB) sent to providers states: "If you disagree with this determination, please send your dispute in writing… To obtain a provider dispute form or for additional information, please call…" It does not inform providers that the PDR Form is mandatory or that a PDR will be rejected if not submitted on the PDR Form. This deficiency was noted in PDR sample number 16 and paid sample number 21.

The Plan was required to provide a CAP to ensure providers are adequately informed that the PDR Form was mandatory and that a PDR will be rejected if not submitted on the PDR Form. In addition, the Plan was required to state the date of implementation, and the management position(s) responsible for ensuring ongoing compliance.

The Plan disagreed with this deficiency, stating the policy requiring submission of the PDR Form went into effect March 1, 2017. The Plan identified several mechanisms it has in place informing providers of the change to the PDR filing procedures, including the following:

- *The Aetna Provider Disclosure Form, which was provided to all in-network providers through its NaviNet system in April 2017. The Plan also stated that non-par providers can register for NaviNet, and they are encouraged to do.*
- *Contracted and non-contracted providers can request the Plan's PDR procedures.*
- *Contracted and non-contracted providers can review the Plan's PDR procedures through Aetna.com.*
- *When a provider submits an appeal and the Plan rejects it for missing information, the PDR Form is sent to the provider to complete the appeals process.*
- *Provider EOBs provide the following information:*
  a. *Appeal rights available to patients residing in California.*
  b. *If you disagree with this determination, please send your dispute in writing to: Correspondence Unit, P.O. Box 24019, Fresno, CA 93779-4019.*
  c. *To obtain a provider dispute form or for additional information, please call 800-624-0756.*

The Plan stated the original request for PDR sample number 16 was missing the initial denial date and reconsideration denial date. The provider only specified the date of service and the claim number. There was information missing to complete the PDR so the Plan requested the provider to fill out the PDR Form and send it back to complete the PDR process.

The Plan stated that original PDR request for Paid claim sample number 21 was missing information. The Plan requested the provider to resubmit the PDR with the PDR Form, which the provider did.

The Department finds that the Plan's compliance efforts are not responsive to the corrective action required. Aetna's Provider Disclosure Form and Provider EOB do not clearly inform providers that the PDR Form is mandatory, or that a PDR will be rejected if not submitted on the PDR Form.

The Plan is required to provide a CAP to ensure providers are adequately informed that the PDR Form is mandatory and PDRs will be rejected if not submitted on the PDR Form. In addition, the Plan is required to state the date of implementation, and the management position(s) responsible for ensuring ongoing compliance.

PART II. NONROUTINE EXAMINATION

The Plan is advised that the Department may conduct a nonroutine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to the Preliminary Report. The cost of said examination will be charged to the Plan in accordance with Section 1382(b).

No response is required to this Part.

Aetna
21215 Burbank Blvd.
Suite 620
Woodland Hills, CA 91364

June 13, 2019

Sent Electronic Transmission: https: //wpso.dmhc.ca.gov/secure/login/

Anna Belmont
Corporation Examiner IV, Supervisor
Department of Managed Health Care
Office of Financial Review
Division of Financial Oversight
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Final Report of a Routine Examination of Aetna Health of California Inc.

Dear Ms. Belmont,

Aetna Health of California Inc. (Plan) is in receipt of the Final Report of the Routine Examination, issued by the Department of Managed Health Care (Department) dated June 3, 2019 (Final Report). The Plan appreciates the opportunity to append the Final Report.

The Plan is committed to continually improving the quality of service we provide to our enrollees, providers and customers, and appreciate the feedback provided during the routine examination.

Sincerely,

Bobby Antee
Compliance Lead
Aetna Compliance Operations

cc: Kristen A. Miranda, President
Rajini Sharma, Counsel West Region
Pritika Dutt, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Nina Moua, Examiner, Division of Financial Oversight
Neetu Bhangu, Examiner, Division of Financial Oversight
Brianne Burkart, Attorney III, Office of Plan Licensing

Linda Armstrong, Staff Services Manager III, Help Center
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring