DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

NON-ROUTINE SURVEY

OF

AETNA HEALTH OF CALIFORNIA INC.

A FULL SERVICE HEALTH PLAN

AUGUST 23, 2019

Non-Routine Survey Final Report
Aetna Health of California Inc.
A Full Service Health Plan

TABLE OF CONTENTS

EXECUTIVE SUMMARY

On March 16, 2018, the California Department of Managed Health Care (Department) notified Aetna Health of California Inc. (Plan) that it would conduct its scheduled Routine Survey pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The survey team conducted the onsite survey from August 14, 2018 through August 16, 2018.

Throughout the course of the Routine Survey, the Department encountered excessive delays by the Plan to obtain requested documents and information in a timely manner to conduct the survey. Prior to, and during the onsite survey, the Department provided the Plan with written instructions for submitting requested documents and information related to Plan operations. The Plan consistently failed to provide the requested information in a timely manner as instructed by the Department. The Plan's delay interfered with the Department's ability to timely conduct the Routine Survey.

On August 30, 2018, the Department notified the Plan that due to its continuous failure to follow the Department's written instructions, the remaining activities under the Routine Survey would be conducted as a Non-Routine Survey, pursuant to Section 1382(b) and Rule 1300.82.1(a)(1) and (3). In addition, the expenses related to completing the remaining survey activities would be charged to the Plan.

The Department assessed the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Access to Emergency Services and Payment
Prescription (Rx) Drug Coverage
Language Assistance

The Department identified **eleven** deficiencies during the Routine Survey. The 2018 Survey Deficiencies Table below notes the status of each deficiency.

2018 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	
	GRIEVANCES AND APPEALS	
1	**The Plan does not identify and track all issues within each grievance.** Rule 1300.68(e)(2).	**Not Corrected**

2	**The Plan does not resolve exempt grievances, and as a result, impermissibly processes grievances which are not closed by the end of the next business day as exempt.** Section 1368(a)(1); Section1368(a)(4)(B)(i); Rule 1300.68(a)(4); Rule 1300.68(d)(8).	**Not Corrected**
3	**The Plan processes grievances involving quality of care or quality of service as exempt, contrary to its policy, and does not adequately investigate potential quality issues from such grievances.** Section 1386(b)(1); Rule 1300.70(a)(1).	**Not Corrected**
4	**The Plan does not consistently provide immediate notification to enrollees of their right to contact the Department upon receipt of an expedited grievance.** Section 1368.01(b); Rule 1300.68.01(a)(1).	**Not Corrected**
5	**The Plan failed to demonstrate that it continuously reviews the operation of the grievance system to identify any emergent patterns of grievances and improve Plan policies and procedures.** Rule 1300.68(b)(1); Rule 1300.68(d)(2); Rule 1300.70(b)(2)(C).	**Not Corrected**
6	**The Plan's grievance form does not allow a member to preview and edit the form before sending.** Rule 1368.015(b) through (c)(2).	**Not Corrected**
	UTILIZATION MANAGEMENT	
7	**The Plan does not conduct adequate oversight of its delegates to ensure delegates consistently provide timely notice to enrollees and providers and include the reviewer's required contact information.** Section 1367.01(a), (h)(3), (h)(4), and (j).	**Not Corrected**
8	**The Plan does not conduct adequate oversight of its delegates to ensure delegates consistently provide enrollees with a clear and concise reason, a description of the criteria or guidelines used and the clinical reasons for decisions regarding medical necessity.** Section 1367.01(a), (h)(4), and (j).	**Not Corrected**
	ACCESS TO EMERGENCY SERVICES AND PAYMENT	
9	**The Plan does not provide all non-contracting hospitals in the state with Plan contact information needed to request authorization of post-stabilization care.** Section 1386(b)(17); Section 1262.8 (j) and (k).	**Not Corrected**

10	**The Plan does not account for the enrollee's subjective belief that he or she had experienced a medical emergency when evaluating the medical necessity of emergency services.** Section 1317.1(a), (b); Section 1371.4(c).	**Not Corrected**
	PRESCRIPTION (RX) DRUG COVERAGE	
11	**The Plan operates at variance with its basic organization documents by not allowing providers 24 hours to respond to its requests for additional information needed for drug authorizations.** Section 1367.24, Section 1367(e)(1); Section 1367.01(g), Section 1367.01(h)(1),(2) and (5), Section 1386(b)(1).	**Not Corrected**

SURVEY OVERVIEW

At least once every three years the Department evaluates each licensed health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975[1] through a routine survey that covers major areas of the plan's health care delivery system. Surveys are conducted pursuant to Section 1380 and include a review of the overall performance of the plan in providing health care benefits and meeting the health care needs of enrollees in the following areas:

Quality Assurance – Each plan is required to have a quality assurance program directed by providers and designed to monitor and assess the quality of care provided to enrollees, and to take effective action to improve the quality of care when necessary. The quality assurance program must address service elements, including accessibility, availability and continuity of care and must monitor whether the provision and utilization of services meets professionally recognized standards of practice.

Grievances and Appeals – Each plan is required to have a grievance system that ensures a written record and adequate consideration of grievances, appropriate and timely processing and resolution, continuous review to identify any emergent patterns of grievances, and reporting procedures to improve plan policies and procedures.

Access and Availability of Services – Each plan is required to provide or arrange for the provision of access to health care services in a timely manner, appropriate for the enrollees condition and consistent with good professional practice.

Utilization Management – Plan and delegate utilization management functions must ensure that decisions based on medical necessity are consistent with clinical criteria/guidelines, that utilization review and oversight operations are performed by appropriate personnel and that enrollees and requesting providers receive timely and appropriate information concerning approvals, denials and modifications of requested services. Plans must also ensure that utilization functions satisfy access and quality requirements.

Continuity of Care – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Access to Emergency Services and Payment – Each plan is required to ensure that emergency medical and behavioral health services are accessible and available, and that reimbursement for these services are made as appropriate. Plans

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

must also have post-stabilization procedures to ensure timely authorization of care or transfer of enrollees who are stabilized following emergency care.

Prescription (Rx) Drug Coverage – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescription drugs, benefits and services, and ensure benefit coverage is communicated to enrollees.

Language Assistance – Each plan is required to implement a language assistance program to ensure interpretation and translation services are accessible and available to enrollees.

The Department issued the Preliminary Report to the Plan on April 8, 2019. The Plan had 45 days to file a written statement with the Director identifying each deficiency and describing the action taken to correct each deficiency and the results of such action.

This Final Report describes the deficiencies identified during the survey, the Plan's compliance efforts, the status of each deficiency at the time of the Department's receipt of the Plan's 45-day response and actions for outstanding deficiencies requiring more than 45 days, which will be reassessed at a Follow-Up Survey.

PLAN BACKGROUND

The Plan was licensed as a full service health care plan on August 6, 1981 under the name Inland Health Plan. The Corporation underwent several name changes until the Department of Corporations approved the name change to Aetna Health of California, Inc. on January 25, 2002. The Plan is a for-profit, wholly-owned subsidiary of Aetna Health Holdings, LLC, which is a wholly-owned subsidiary of Aetna, Inc. The Plan has an administrative services agreement with Aetna Health Management, LLC, an affiliated company, for the provision of certain marketing, operating, administrative, pharmacy services, and employee benefits. CVS Health is the Plan's Pharmacy Benefits Manager, which provides administration of the Plan's retail pharmacy network contracting, prior authorization reviews, and claims administration.

The Plan is a full service plan that arranges for comprehensive health care services to enrollees of commercial groups, point-of-service products, and the Medicare Risk program. The Plan provides health care services by contracting with participating medical groups on a capitated basis, as well as direct contracts with individual physicians on a discounted fee-for-service basis. Hospitals are compensated on a capitated, per diem or case rate basis.

Currently the Plan offers the following commercial HMO products; HMO and Quality Point of Service (QPOS). Additionally a Medicare risk product is offered in Fresno, Kern, Los Angeles, Orange, Riverside, San Bernardino, and Ventura Counties. As of March 31, 2019, the Plan services 220,054 enrollees in 33 counties.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On April 8, 2019, the Department issued the Plan a Preliminary Report that described each deficiency, as well as the legal and factual basis for each deficient finding. In that report, the Department instructed the Plan to within 45 days of issuance of the Preliminary Report:

(a) Develop and implement a corrective action plan (CAP) for each deficiency, and
(b) Provide the Department with evidence of the Plan's completion of, or progress toward, implementing those corrective actions.

The following describes the Department's preliminary findings, the Plan's corrective actions, and the status of the deficiency following the Department's review of the Plan's compliance efforts.

DEFICIENCIES

GRIEVANCES AND APPEALS

Deficiency #1: The Plan does not identify and track all issues within each grievance.

Statutory/Regulatory Reference(s): Rule 1300.68(e)(2).

Assessment: The Department found that the Plan does not adequately categorize its exempt grievances. During onsite interviews, the Department asked the Plan for further details on the oversight process for exempt grievances processed by Plan staff.

The Plan's *Member Complaint and Appeal Policy, California HMO Amendment* (February 27, 2018) (Grievance Policy), describes the Plan's processes in tracking and monitoring grievances; however, the Grievance Policy does not address or explain how the Plan is able to describe the issues raised in the six categories under Rule 1300.68(e)(2).

During onsite interviews the Plan detailed limited oversight procedures, admitting that exempt grievances were not specifically reviewed for the accuracy of the information entered by Plan representatives. Plan staff further stated that there was not a specific standardized methodology for auditing exempt grievances.

File Review

The Department reviewed 37 exempt grievance files, which constitutes the universe of such files for the lookback period. Of the 37 files reviewed, 19[2] (51%) contained grievances with issues that were inadequately or incorrectly categorized. The following cases provide examples to illustrate this deficiency:

[2] Exempt Grievance DMHC Files: #1, #3, #4, #8, #10), #12, #13, #15, #18, #19, #20, #21, #24, #26, #28, #31, #3, #35, #36.

- **File #3:** The enrollee wished to file a complaint against the Plan for "being messed up and not customer friendly." The enrollee was upset because he requested a benefit override for his wife's prescription, which the Plan denied. The Plan told the enrollee to file an appeal, which the Plan closed because there was no denial on file.

The Plan categorized this grievance as "Benefits." While this classification may capture the enrollee's grievance regarding the benefit override request, it does not capture the enrollee's complaint regarding the Plan's overall system or its alleged poor customer focus.

- **File #8:** The enrollee complained about difficulties in making an appointment with her provider, and that the provider was ultimately unavailable during the scheduled appointment time. The enrollee also disputed the bill she received for the visit where she did not see a doctor.

The Plan categorized this grievance as "Interactions," which may capture the enrollee's grievance regarding the scheduling problems, but it fails to capture the enrollee's complaint regarding the missed appointment, and the disputed bill.

- **File #35:** The enrollee complained about the primary care provider refusing to provide services, even though the provider is listed as being in-network. The enrollee stated that they had to go to urgent care to receive treatment and now require follow up care. However, they have no assigned primary care provider.

The Plan categorized this grievance as "Quality of Care," which captured the enrollee's grievance concerning the provider's refusal to provide services, which resulted in the enrollee needing to seek care at an urgent care facility. However, this classification does not capture the enrollee's complaint regarding the Plan's inaccurate provider directory, or the enrollee not having an assigned primary care provider.

Conclusion: Rule 1300.68(e)(2) requires the Plan to track and monitor grievances it receives. Further, the Plan's grievance system must be able to indicate the total number of grievances received and to describe the issue or issues raised in grievances. Plan staff did not detail any upgrades to the Plan's exempt grievance processes since the 2017 Follow-Up Report, which would allow the Plan's grievance system to categorize more than one issue for each exempt grievance. The Grievance Policy does not address or explain how the Plan is able to describe the issues raised in the six categories under Rule 1300.68(e)(2). In addition, the Plan did not provide evidence of any documented training, coaching, or auditing of staff entries, which would ensure accurate categorization. All of the grievances identified by the Department as containing multiple issues were documented by the Plan in only one issue category, which was either inadequate to address the multiple issues in the grievance, or did not accurately capture the nature of the enrollee's grievance.

This is a repeat deficiency from the Plan's last routine medical survey.[3]

[3] See the Department's 2015 Final Report issued on August 11, 2016 and the 2015 Follow-Up Report issued on January 4, 2018 (Deficiency #2).

TABLE 1
Tracking Multiple Issues in Enrollee Grievances

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievances	37	All Issues Within the Grievance are Categorized	18 (49%)	19 (51%)

Plan's Compliance Effort: The Plan submitted a response to the Department that provided a CAP to address the deficiency. The Plan's response specifically noted that the CAP addressed Deficiencies #1 and #2. The Department therefore had to determine which corrective actions were proposed to address Deficiency #1 from Deficiency #2. To address Deficiency #1, the Department determined that the Plan stated that it would revise its Aetna electronic policy *Member Complaints and Appeals – Traditional Customer Service* to describe the six categories under Rule 1300.68(e)(2) and how to address and resolve each category. The Plan reported specific revisions were made to each category within this policy as follows:

- Compliant/Appeal Handling
- Complaints: Overview
- Complaints: Types of Complaints
- Complaints: Quality of Care vs Quality of Service

The Plan also stated that it conducted training with Customer Service staff on May 10 and 17, 2019 to review its updated policy.

Final Report Deficiency Status: Not Corrected

The Department finds that the Plan has taken steps towards correcting this deficiency. The Plan stated it has revised its *Member Complaints and Appeals – Traditional Customer Service* to include the six categories under Rule 1300.68(e)(2) and how to address and resolve each category in addition to conducting training.

The Department cannot find this deficiency corrected. The Plan's CAP did not explain how its revisions to the *Member Complaints and Appeals – Traditional Customer Service* will improve the Plan's a Plan's ability to describe the issues raised in the six categories under Rule 1300.68(e)(2). The Department's review of the *Member Complaints and Appeals – Traditional Customer Service* was unclear how this document would identify all issues raised in exempt grievances to correct this deficiency. Further, the Plan indicated that training had taken place, but did not provide any details discussing how the training would address and correct this deficiency. Finally, the Plan's response did not address the Department's concern that the Plan's *Member Complaint and Appeal Policy, California HMO Amendment* (February 27, 2018) (Grievance Policy) does not address or explain how the Plan is able to describe the issues raised in the six categories under Rule 1300.68(e)(2).

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a CAP that addresses how the Plan intends to address the six categories under Rule 1300.68(e)(2). The Plan's response will also address with specificity which documents and/or policies and procedures were revised and how the revisions will correct this deficiency. The Plan will also address how it intends to provide oversight of these new processes. Finally, the Plan's response will discuss whether it will amend its Grievance Policy or any other relevant Plan policies and procedures and, if necessary, whether the revised policies and procedures will be submitted to the Department's Office of Plan Licensing (OPL) for review along with the proposed timeframes for taking such action.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of exempt grievance files to determine whether the Plan identifies and tracks all issues within each exempt grievance. The Department may also conduct interviews, review any relevant amended Plan policies and procedures, audit tools and results and any other information deemed relevant to this deficiency.

Deficiency #2: The Plan does not resolve exempt grievances, and as a result, impermissibly processes grievances which are not closed by the end of the next business day as exempt.

Statutory/Regulatory Reference(s): Section 1368(a)(1); Section 1368(a)(4)(B)(i); Rule 1300.68(a)(4); Rule 1300.68(d)(8).

Assessment: The Department found the Plan impermissibly processes grievances not resolved by the next business day as exempt. During onsite interviews, the Department asked the Plan why nearly all of the Plan's exempt grievances reviewed during the lookback period were not resolved. Plan staff explained that until late 2017, the Plan customer service representatives (CSRs) who were handling exempt grievances believed that when the exempt grievance "closed," the case was forwarded to Plan grievance staff who would continue to work on the case. Thus, the intake staff incorrectly believed they were no longer responsible for ensuring resolution of each grievance. Plan staff stated that training had taken place at the end of 2017 to ensure that staff were no longer handling grievances in this manner. However, the Department's file review found that all four of the exempt grievances received in 2018 were not resolved by the close of the next business day.

File Review

The Department reviewed the same 37 exempt grievance files referenced in Deficiency #1. Of the 37 files reviewed, 34[4] (92%) files had not been given adequate consideration or rectification, and thus, were not resolved by the next business day. The following cases provide examples to illustrate this deficiency:

[4] Exempt Grievance DMHC Files: #1, #3, #4, #5, #6, #7, #8, #10, #11, #12, #13, #14, #15, #17 (2017062703280), #18, #19, #20, #21, #2, #23, #24, #25, #26, #27, #28, #29,#30 (2017112803745), #31, #32, #33, #34, #35, #36, #37.

- **File #29:** The enrollee complained of poor care from a provider. The enrollee stated the provider used an expired vial to draw blood, and that the blood work could not be processed. The enrollee also stated that blood work that was ordered to be done was not done at the time of the appointment.

The Plan's resolution notes stated "Acknowledged Complaint" but did not detail any action taken to investigate this enrollee's grievance or provide any resolution to the enrollee.

- **File #31:** The enrollee complained of a long wait time and rude service from the primary care doctor. The member also complained about the person who sold them the policy, as they did not explain to the enrollee that they would need to see their primary care doctor to obtain referrals.

The Plan's resolution notes stated "Acknowledged Complaint" but do not detail any action taken to investigate this enrollee's complaint or provide any resolution to the enrollee.

- **File #37:** The enrollee complained that their primary care doctor had been changed five times without any requests for the changes or being informed of the changes.

The Plan's resolution notes stated "Acknowledged Complaint" but do not detail any action taken to investigate this enrollee's complaint or provide any resolution to the enrollee.

Conclusion: Section 1368(a)(4)(B) and Rule 1300.68(d)(8) define exempt grievances as those grievances received over the telephone and resolved by the close of the next business day that do not involve coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment. Rule 1300.68(a)(4) defines resolved as, "… the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority." The Department's review of Plan exempt grievance files established that the Plan failed to consistently document that grievances classified as exempt were resolved within one business day. Despite statements from Plan staff that there had been re-training for this issue and exempt grievances handled in 2018 should no longer be resolved incorrectly, the Department found that all 2018 exempt grievances in the review period were closed without a resolution.

This is a repeat deficiency from the Plan's last Routine Medical Survey.[5]

TABLE 2
Exempt Grievance File Review Resolved by Close of Next Business Day and Adequate Consideration and Rectification

[5] See the Department's 2015 Final Report issued on August 11, 2016 and the 2015 Follow-Up Report issued on January 4, 2018 (Deficiency #3).

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievances	37	Grievance Resolved by Close of Next Business Day	3 (8%)	34 (92%)
Exempt Grievances	37	Adequate Consideration and Rectification of the Grievance	3 (8%)	34 (92%)

Plan's Compliance Effort: As discussed in Deficiency #1, the Plan's response specifically noted that its CAP addressed Deficiencies 1 and 2. The Department therefore had to separate corrective actions taken to address Deficiency #1 from Deficiency #2. To address Deficiency #2, the Department determined that the Plan stated that it had updated its Aetna Strategic Desktop (ASD) system to include a new "reason code" to correctly identify grievances that should remain open for review and response by the Plan's Complaint Grievance and Appeals (CG&A) team. The ASD enhancement also alerts CSRs if they have selected an exempt grievance, that it will not get routed to the CG&A team. In these instances, the CSR will be required to note what action was taken to resolve the exempt grievance. The Plan also will update the ASD to make the notes section a "critical" field that requires the CSR to describe the corrective action taken.

The *Customer Service Policy* under the heading Complaints and Appeals: Routing Complaints now provides the steps/actions in the ASD that must be taken when an enrollee files a verbal or written complaint. The CSR must document in the notes field the actions taken to resolve exempt grievances.

The Plan also provided training for its CSRs regarding these new requirements. The Plan will include Customer Service Complaint Steps to the Plan's annual customer service training. The updated training will address proper documentation of the complaint resolution when the CSR marks the complaint closed. The training will also address when grievances should be left open for review by the Plan's CG&A team. CSR training was conducted on October 19, 2018, May 10, 2019 and May 17, 2019 and discussed proper documentation and resolution of grievances.

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions that the Plan has proposed and undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that the Plan has addressed this deficiency by updating its ASD system to improve its ability to distinguish grievances that should be handled and resolved by member services from grievances that should be handled by the Plan's CG&A team. The updated ASD is intended to improve the documentation regarding the handling of exempt grievances. In addition, the Plan has also provided CSR training regarding the handling of exempt grievances.

However, the Department is unable to consider this deficiency corrected because the Plan has not implemented its corrective actions. The Plan's CAP also does not provide details how the Plan's ASD enhancement will distinguish what grievances will remain open and forwarded to the Plan's CG&A team from those that are intended to be resolved by member services. The Plan also did not discuss its oversight process to ensure exempt grievances are processed appropriately.

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a CAP that addresses the status of the improvements made to the ASD system and a discussion of the Plan's oversight of these changes.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of exempt grievance files to determine whether the Plan documents the action taken to investigate the enrollee's grievance and/or the Plan's resolution provided to the enrollee. The Department may also conduct interviews, review any relevant Plan policies and procedures, audit tools and results and any other information deemed relevant to this deficiency.

Deficiency #3: **The Plan processes grievances involving quality of care or quality of service as exempt, contrary to its policy, and does not adequately investigate potential quality issues from such grievances.**

Statutory/Regulatory Reference(s): Section 1386(b)(1); Rule 1300.70(a)(1).

Assessment: The Department's file review established that the Plan is not consistently identifying all Potential Quality Issues (PQI) in exempt grievance files and that the Plan is not investigating the PQI to determine whether effective action needs to be taken to improve care. During interviews, Plan staff insisted that PQI would not be present in exempt grievance files. However, the Department's review of exempt grievances files established that PQI are present in exempt grievance files, and in the majority of files, the Plan failed to identify and address the PQI through its quality assurance (QA) program.

Plan Document Review

The Department reviewed the Plan's policy, *California Amendment to Policy/Procedure QM 63: Quality Management/Review of Potential Quality of Care Concerns California Amendment* (9/27/16) (California PQI Policy), which details how the Plan ensures review of PQI in California. The *California PQI Policy* states:

- An Aetna CA licensed Medical Director will review all (100%) of California HMO potential quality of care concerns and render a disposition as follows:
    - No Quality of Care
    - Potential Quality of Care or
    - Quality of Care and;

Final Action:
- Track and Trend,
- Immediate Suspension,
- Refer to CPC/NQOC any potential quality of care concerns on the further investigation grid or other potential quality of care concerns medical director merits CPC/NQOC review and include any action plan(s) submitted by the practitioner/provider and/or recommended by the Medical Director.

- An Aetna CA licensed Medical Director oversees and actively participates in the California HMO practitioner and provider potential quality of care processes.

In addition, *California PQI Policy* states the following definitions:

- **Potential Quality of Care (PQoC) Concern:** A potential quality of care concern is defined as a concern raised to the health plan by anyone internal or external that requires investigation as to whether the competence or professional conduct of an individual network practitioner, facility, or ancillary providers adversely effects, or could adversely affect, the health or welfare of a member.

- **Quality of Care Concern:** A determination that the competence or professional conduct of an individual practitioner, facility, or ancillary provider adversely affected, and or in the future could adversely affect, the health or welfare of a member.

The *California PQI Policy* further states:

> Externally identified Potential Quality of Care concerns are typically member complaints and QM receives notification from Customer Service. Other external concerns may be received via e-mail or mail.
>
> All member complaints must be received by Customer Resolution Teams (CRT) for documentation in the appropriate complaint tracking system. Member complaints received in QM from other departments that have not been recorded in the appropriate Customer Service System can be communicated to CRTs using the QM to CRT Member PQoC Complaint Form.
>
> All complaints will be tracked and counted in the appropriate customer service system.
>
> **Oversight**: A medical director oversees the practitioner and provider Potential Quality of Care processes.
>
> **Documentation**:

- All Potential Quality of Care concerns, investigations and decisions must be documented in the QM Issues Database.
- Regardless of the determination, all cases are internally tracked and trended.
- If reviewed by the CPC, documentation of the CPC disposition and action shall be included in the committee minutes.
- If reviewed by the NQOC, documentation of the NQOC disposition and action shall be included in the committee minutes

Investigation: The investigation includes, but is not limited to, the review of relevant documentation in systems such as:

- Customer Service documentation

File Review

The Department reviewed the same 37 exempt grievance files referenced in Deficiency #1. Of the 37 files reviewed, 32[6] (86%) exempt grievance files contained PQIs which were not elevated for clinical review.

- **File #10:** The enrollee complained of the quality of care received at a hospital and alleged that the facility billed for services not performed and that they stole personal property. The enrollee requested "a full investigation."

This case was closed by the Plan without review or resolution of the enrollee's quality of care and service concerns.

- **File #29:** The enrollee complained of poor care from a provider and stated that the provider used an expired vial to draw blood, and therefore his blood work could not be processed. The enrollee also stated that blood work which had been ordered was not taken during the appointment.

This case was closed by the Plan without review or resolution of the enrollee's quality of care and service concerns.

- **File #33:** The enrollee complained that his doctor was not cooperative with respect to the enrollee's gender reassignment process. The enrollee stated that the doctor was racist, homophobic and transphobic.

This case was closed by the Plan without review or resolution of the enrollee's quality of care and service concerns.

Conclusion: Rule 1300.70(a)(1) requires the Plan to document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Department's file review established that the Plan is not consistently identifying all PQIs in exempt grievance files and that the Plan is not

[6] Exempt Grievance DMHC Files: #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #18, #19, #21, #23, #25, #26, #27, #28, #29, #30, #31, # 32, #33, #34, #35, #36, #37.

investigating the PQIs to determine whether effective action needs to be taken to improve care. In addition, Section 1386(b)(1) provides grounds for disciplinary action should a plan operate in "any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure…unless amendments allowing the variation have been submitted to, and approved by, the director." The Department finds that the Plan is processing exempt grievances containing possible quality issues in a manner that is contrary to its policy by not conducting appropriate investigation or follow up if indicated.

TABLE 3
Exempt Grievance File - Plan review of Potential Quality of Care Issues

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievance	37	Potential Quality Issues Elevated for Review processed according to Plan's policy	5 (14%)	32 (86%)

Plan's Compliance Effort: The Plan's response stated reason codes in the ASD system were added to identify PQIs. As of May 4, 2019, the ASD routes PQIs to the Plan's CG&A team for review, resolution and response.

Final Report Deficiency Status: Not Corrected

The Department acknowledges the Plan has taken corrective action to enhance its ASD system to identify PQIs, and that as of May 4, 2019, ASD routes all PQIs to the Plan's CG&A for handling.

The Department cannot find this deficiency has been corrected. The Plan has not yet demonstrated that it has implemented its CAP to improve the Plan's ability to identify, handle and conduct appropriate investigation of PQIs raised by enrollees. The Plan's response also did not address how the "reason codes" will improve the Plan's ability to document PQI in the QM Issues Database, internally track and trend all cases, and document both the CPC's disposition and the National Quality Oversight Committee's (NQOC) disposition as required under the *California PQI Policy*. Accordingly, the Department finds this deficiency has not been corrected.

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining in greater detail a CAP that addresses how the Plan intends to process PQIs in accordance with its *California PQI Policy*. The Plan's response should address in detail how the Plan intends to improve its ability to identify PQIs for appropriate handling. The Plan's response should also discuss how the Plan intends to improve its ability to document PQI in the QM Issues Database, internally track and trend all cases, and document both the CPC's disposition and the NQOC's disposition as required under the *California PQI Policy*. Finally, the Plan should identify which of the

Plan's policies and procedures will be revised as a result of the Plan's CAP and the timeframes for submitting the revised policies and procedures (if any) for review by OPL.

To determine whether the Plan corrected this deficiency, the Department will conduct a Follow-Up Survey and review exempt grievance files to assess whether grievances containing quality issues were elevated for clinical review in accordance with the Plan's *California PQI Policy.*

Deficiency #4: The Plan does not consistently provide immediate notification to enrollees of their right to contact the Department upon receipt of an expedited grievance.

Statutory/Regulatory Reference(s): Section 1368.01(b); Rule 1300.68.01(a)(1).

Assessment: As part of its pre-onsite documentation, the Plan submitted its *Grievance Policy*. The policy details the Plan's California grievance procedures. The *Grievance Policy* states that its purpose is to meet the statutory and regulatory requirements specified in Rules 1300.68 and Sections 1368.015, 1368.1 and 1367.27, and that it is to be used in conjunction with the Plan's *Member Appeal Procedures* C.A. 001 to comply with California's statutory requirements. With regard to Expedited Review of Grievances (Rule 1300.68.01), the *Member Appeal Procedures* C.A. 001 and the *Grievance Policy* states:

> We have established procedures for expedited review of grievances where the enrollee's health or life is in serious or imminent danger, they are experiencing severe pain or there is threat to a limb or major bodily function. The procedures will include the required minimum elements as indicated.

During interviews, the Plan staff detailed the Plan's process of notifying the enrollee regarding their right to immediately contact the Department with respect to an expedited grievance. Plan staff verified that it is current procedure to advise the member of their rights immediately when an urgent grievance is received. Plan staff also verified that if current Plan procedures were followed, the case notes would explicitly state that the member had been informed of their rights.

File Review

The Department reviewed 40 expedited grievance files, which constitutes the universe of such files for the lookback period. Out of the 40 files reviewed, the Department found that in 27[7] (68%) of 40 expedited grievance files, the Plan did not provide adequate notification to the complainant and/or enrollee of their right to contact the Department. The following cases provide examples to illustrate this deficiency:

- **File #19:** The Plan received this grievance on January 30, 2018 and determined to meet criteria for expedited review on January 31, 2018. The Plan's case notes

[7] Expedited Grievance DMHC Files: #1, #2, #3, #5, #6, #7, #11, #14, #15, #18, #19, #20, #22, #23, #24, #25, #26, #28, #29, #30, #32, #35, #36, #37, #38, #39, #40.

state that the Plan returned a call to the enrollee at 2:37 PM on January 31, 2018 and that the Plan left a message requesting a call back.

The Plan's notes therefore indicate that the Plan called the enrollee requesting a return call from the enrollee. The notes do not explicitly state, per the Plan's staff statements made during onsite interviews that the enrollee had been informed of their rights, and there was no indication within the Plan's written entry or other case notes that the enrollee was ever advised of their rights.

- **File #26:** The grievance was received by the Plan on November 29, 2017, and determined to meet criteria for expedited review on November 30, 2017. The Plan's case notes stated that the enrollee was called at 9:05 on November 30, 2017 and that the Plan was only able to leave a message requesting a call back from the enrollee.

In addition, the Plan's case notes dated December 1, 2017 stated that a call was received from the enrollee's son, who was advised of their "DMHC rights." Thus, the Department determined that while the enrollee's representative was ultimately advised of the enrollee's rights, due to the delay, the enrollee had not been immediately informed of their right to contact the Department regarding the expedited grievance.

- **File #39:** The grievance was received by the Plan on January 8, 2018 and determined to meet criteria for expedited review on the same day. The Plan's case notes state that a call was made on 10:58 am on January 8, 2018 to the provider's office and at 11:02 am, the Plan left a message for the enrollee requesting a call back, and acknowledging "Unable to give DMHC rights at this time." Further documentation states that on January 9, 2018 at 3:23 pm, the Plan on its third and final attempt was able to leave a message requesting a call back and noting "unable to provide DMHC rights."

The Department finds that the notes establish that the enrollee was not advised of their right to contact the Department regarding their grievance.

Conclusion: Based on review of Plan documents and case files, as well as information obtained during interviews, the Department finds that the Plan fails to immediately inform enrollees and subscribers of their right to notify the Department of an expedited grievance in violation of Section 1368.01(b). Additionally, case files demonstrated that the Plan does not document immediate notification of this right in violation of Rule 1300.68.01(a)(1).

TABLE 4
Expedited Grievance File Review Immediate Notification

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT

Expedited Grievance	40	Enrollee and Grievant Immediately Notified of their right to contact the Department with their Grievance	13 (33%)	27 (67%)

Plan's Compliance Effort: In the Plan's written response, it agreed with the Department's findings for files 2, 6, 11, 14, 18, 20, 22, 24, 25, 28, 30, 32, 36, and 38. As a CAP, the Plan stated that it will update its workflow to ensure all nurses handling expedited grievances are aware of the Plan's requirements to contact enrollees. The Plan further explained that it will make an outbound call, document that it left a message, provide a return number, and request the enrollee call the Plan back. If the enrollee returns the call, the Plan will verbally provide the enrollee's rights to contact the Department. If the Plan does not receive a callback, it will send the enrollee a letter that provides the appeal rights to contact the Department. The Plan's CG&A team will inform the provider/physicians regarding the Department's appeal rights verbally and in writing.

The Plan respectfully disagreed with the Department's findings for sample files 1, 3, 5, 7, 15, 19, 23, 26, 29, 35, 39, and 40. In file 40, for instance, the Plan stated that it conveyed the Department's contact information after the enrollee called back. In file 37, the Plan was unable to contact the enrollee because it did not have a valid phone number. In the remaining files, the Plan explained that it called the enrollee, but was unable to make contact and therefore informed the enrollee of their right to contact the Department in writing. The Plan explained why it preferred not to leave voice messages. The Plan maintained that releasing any information by leaving the enrollee with a voice message (except that the Plan would like a call back) risks releasing personal health information (PHI) because the Plan cannot confirm that individuals other than the enrollee might hear the message. The Plan also contends that merely stating the enrollee has the right to contact the Department might provide information regarding a medical condition.

Finally, the Plan contends that Section 1368.01(b) and Rule 1300.68.01(a)(1) provide authority for the Plan to notify enrollees of their rights in writing. The Plan cites Section 1368.01(b), which states, "the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance...." The Plan also cites Rule 1300.68.01(a)(1), which states in relevant part that "Notice need not be in writing, but may be accomplished by a documented telephone call."

Final Report Deficiency Status: Not Corrected

The Plan's response contends that the Plan has authority to provide notice in writing when responding to an expedited grievance. However, the Plan's response does not address the basis for this deficiency. The Department found that the Plan's expedited files lacked documentation that the enrollee had been informed of their rights to contact the Department, and that the Plan had not provided "immediate" notice to enrollees of their rights. The Plan's response does not address either basis for the deficiency. Further, the Plan does not discuss how providing a written response letter to the

enrollee will also meet the “immediate notification” requirement. Accordingly, the Department finds this deficiency has not been corrected.

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a CAP that addresses how the Plan intends to provide immediate notification to enrollees with respect to its written notification and provide oversight of these process changes. The Plan should identify which policies and procedures (if any) will be amended and the timeframes for submission to OPL for review, if applicable.

In order to confirm that the Plan’s actions result in correction of the deficiency, at the Follow-Up Survey the Department will conduct file review of expedited grievances to determine whether the Plan consistently provides immediate notification of the right to contact the Department and whether such notification is documented in files.

Deficiency #5: **The Plan failed to demonstrate that it continuously reviews the operation of the grievance system to identify any emergent patterns of grievances and improve Plan policies and procedures.**

Statutory/Regulatory Reference(s): Rule 1300.68(b)(1); Rule 1300.68(d)(2); Rule 1300.70(b)(2)(C).

Assessment: The Department reviewed the Plan’s *2017 and 2018 QM Program Description*. Under a section listed as the Accountability and Committee Structure, the 2017 *QM Program Description* explains the relationship between the Board of Directors (BOD) and the NQOC. The *QM Program Description* states that in California, the BOD delegates ultimate accountability for the management of the quality of clinical care and service for enrollees to the California Medical Director. In addition, the *QM Program Description* explains that the NQOC is responsible for “overseeing, coordinating and establishing company-wide initiatives to improve the safety of our members and our committees” including “complaints, grievances and appeals.” Finally, the *QM Program Description* states that the NQOC sends to the BOD annual reports on quality management (QM) and Care Management program activities.

The Department also reviewed the Plan’s *Complaints and Grievance Policy*. The *Grievance Policy* states that its purpose is to meet the statutory requirements of Rule 1300.68. The Department’s review established that the *Grievance Policy* does not address the requirement to have an officer designated with primary responsibility for the Plan’s grievance system as required under Rule 1300.68(b)(1).

During onsite interviews, the Department asked the Plan to elaborate on its monitoring of exempt grievances. The Plan stated that reports were generated by its grievance system, and that reports were reviewed by the BOD in California. However, after reviewing the Plan’s BOD meeting minutes and supporting documents, the Department was unable to locate documentation of the Plan’s review of exempt grievances. When asked which of the documents for the BOD demonstrated the Plan’s review of exempt grievances, the Plan stated that the reports titled *HMO Trending* and *Top 5 Complaint* contained information specific to exempt grievances. Yet, the Department’s review of

both reports established that the Plan only monitors turn-around time periods of 30 days. However, for exempt grievances, the required turn-around time frame for exempt and expedited grievances is one business day and 72 hours respectively. The Department's review of these reports established there was no information specific to exempt or expedited grievances. Thus, the Department determined the Plan's BOD does not specifically review exempt and expedited grievances.

Furthermore, the Department also determined that the Plan's incorrect or incomplete categorizations of grievances discussed in Deficiency #1 shows that the Plan's review of the *Top 5 Complaint* grievance categories would be inadequate. This report would not provide the Plan's governing body with accurate information regarding grievances.

Conclusion: Rule 1300.68(b)(1) requires that the Plan officer responsible for the grievance system must continuously review the operation of that system to identify any emergent patterns of grievances to improve Plan policies and procedures. Rule 1300.68(d)(2) further requires prompt review of grievance by the management or supervisor staff responsible for the services or operations which are the subject of grievances. Furthermore, Rule 1300.70(b)(2)(C) requires that the governing body and the QA Committee provide oversight of QA concerns. The Department's review of the Plan's *Grievance Policy* established that notably, the *Grievance Policy* does not address the requirement to have a designated officer as having primary responsibility for the grievance system under Rule 1300.68(b)(1). With respect to exempt and expedited grievances, the Department did not find evidence that the Plan's BOD and NQOC reviewed and discussed grievance data. Moreover, the Department determined that the data reviewed by these Plan entities in the reports titled *HMO Trending* and *Top 5 Complaint* was inaccurate and incomplete.

This is a repeat deficiency from the Plan's last Routine Medical Survey.[8]

Plan's Compliance Effort: The Plan's response disagreed with the Department's finding that this is a repeat deficiency from the 2015 Routine Survey. The Plan explained that in response to the Department's 2015 Routine Survey, it created a *Top 5 Complaints Report*, which is reviewed by the BOD quarterly. This Report discusses all grievances and appeals including standard, exempt and/or expedites. Therefore, the Plan's response contends the *Top 5 Complaints Report* discusses exempt grievances and does not only monitor 30-day turn-around times. The Plan further clarified that its *Quality Management Report* discusses turn-around times.

The Plan also explained that since July 2017, the Plan's *California Trending Report* tracks grievance trends in California. The Plan's Senior Director of Service Operations and her staff monitor grievances to improve Plan policies and procedures by distributing a monthly tracking/trending report to California as well as the Plan President, Service Operations, Market Compliance, Complaints Grievance and Appeals Business Compliance Officer and the Customer Service Director. The Plan provided the *CA*

[8] See the Department's 2015 Final Report issued on August 11, 2016 and the 2015 Follow-Up Report issued on January 4, 2018 (Deficiency #8).

Trending Report for Grievances and Appeals Report which lists the grievance review areas monitored by the Senior Director of Service Operations.

Finally, to demonstrate the extensive information reviewed by the BOD, the Plan attached all documents that were reviewed at the January 2018 BOD meeting. These documents included the *Third Quarter 2017 QM Report* and *Spreadsheet Top Five Potential Quality of Care for 2017*.

Final Report Deficiency Status: Not Corrected

In the Follow-Up Report issued on January 4, 2018, Deficiency #8 found that the Plan did not review grievances, including exempt grievances, with enough specificity to find emerging patterns. The Plan responded by stating it would develop reports with more specificity regarding grievances to be submitted for review by the BOD. However, in the Follow-Up Report with regard to Deficiency #8, the Department found the Plan had not corrected this deficiency even though the Plan had reported the top five grievance categories to the Board. During the Follow-Up review, the Department reviewed a number of other Plan documents including the Plan's fourth quarter *2016 Public Policy Meeting Minutes*, *HMO Trending Reports, Quality Management Report* and *Board of Directors Meeting Minutes*. After reviewing these documents, the Department noted that Deficiency #8 was not corrected because the Plan still did not "demonstrate that details for all grievance categories were being reviewed by the Quality Management Committee or Board of Directors." The Department specifically noted that the Plan did not provide specific reports on exempt grievances that had been elevated to the Quality Management Committee or BOD. In the Follow-Up Report, the Department noted its concern that the Plan's reports combined the data on exempt and standard grievances.

The Plan's response to the current survey again asserts that the *Top 5 Complaint Report* tracks all aspects of grievances including exempt and expedited grievances, and is reviewed quarterly by the BOD. The Plan further explains that its Senior Director of Service Operations and staff monitor grievances to improve Plan policies and procedures by distributing a monthly tracking/trending report to the Plan's California staff and other high level employees. Finally, the Plan also provided documents reviewed by the BOD at the January 8, 2018 meeting to demonstrate how the Plan reviews for exempt grievances.

The Department's review of the documents attached to the Plan's response established that none of the documents specifically discusses exempt or expedited grievances. The Department acknowledges that these documents contain data regarding grievances. However, the data for exempt and/or expedited grievances is not specifically detailed in any of the reports and documents submitted with the Plans' response including the *Top 5 Complaint Report*. Thus, even assuming there is any data for exempts or expedites, it is combined with the data for all other grievances, which was a concern previously raised in the Department's Follow-Up review. Thus, the Department has determined the Plan's BOD does not specifically review information regarding exempt and/or expedited grievances.

In addition, the Plan's response does not address the issue raised in this deficiency that the Plan's *Grievance Policy* does not address the requirement to have an officer

designated with primary responsibility for the Plan's grievance system as required under Rule 1300.68(b)(1). Finally, the Plan's response does not address whether the Plan intends to amend its relevant policies and procedures with respect to handling exempt and expedited grievances. Accordingly, the Department finds this deficiency has not been corrected.

Within 60 days of the issuance of this Final Report, the Plan shall submit a supplemental response outlining a CAP that addresses how the Plan intends to specifically address exempt and expedited grievance issues in its reports and provide a status report on the Plan's compliance efforts. The Plan's response will identify which policies and procedures (if any) will be amended and discuss timeframes for submitting the policies and procedures for review by OPL, if applicable. The Plan should also discuss how the Plan will provide oversight of this issue and the requirement to have an officer designated with primary responsibility for the Plan's grievance system.

At the Follow-Up Survey, the Department will assess whether the Plan can demonstrate that it continuously reviews the operation of the grievance system to identify any emergent patterns of grievances and improve Plan policies and procedures. The Department's review will include a review of relevant reports and any revised policies and procedures to determine how the Plan handles issues resulting from exempt and expedited grievances.

Deficiency #6: The Plan's grievance form does not allow a member to preview and edit the form before sending.

Statutory/Regulatory Reference(s): Section 1368.015(b) through (c)(2).

Assessment: The Department reviewed the Plan's website and found that the website does not provide easy access to the Plan's online grievance submission procedure through a hyperlink on the homepage or member services portal clearly identified as "GRIEVANCE FORM," nor does it allow an enrollee to preview and edit their grievance prior to submitting it. The Department reviewed the Plan's website both prior to and during the onsite survey. In both reviews, the Department accessed the Plan's online grievance submission procedure from the home page through several steps—first selecting the option, "Individuals and Families;" then selecting the option, "Member Rights and Resources"; and finally selecting the option "Complaints, Grievances & Appeals." A hyperlink labeled, "CALIFORNIA GRIEVANCE FORMS" can be accessed only via this last option. As part of these website reviews, the Department also found that the Plan's grievance form does not allow the grievant to preview and edit the text prior to submittal.

During interviews, the Department questioned the Plan as to when the website had lost the functionality to preview and edit grievances before submitting, as this had been corrected several months prior to the Survey and as part of the previous Routine Survey conducted by the Department. The Plan was unable to provide an answer as to when it had updated the system.

During a demonstration, the Plan performed a walk-through of their online grievance system and was unable to show that its website had a preview and edit functionality. During this demonstration, the grievance form was submitted immediately after completion, and did not offer the grievant an opportunity to preview and edit prior to submission.

Conclusion: Section 1368.015(b) requires the Plan's online grievance submission procedure to be accessible through a hyperlink clearly identified in upper case letters as "GRIEVANCE FORM." Section 1368.015(c)(2) requires the grievance form to be enabled for preview and editing by the enrollee prior to submittal. As a result of two reviews of the Plan's website, the Department determined that the Plan's online grievance procedures fails to meet these requirements.

This is a repeat deficiency from the Plan's last Routine Medical Survey.[9] Notably, the 2015 Routine Survey Follow-Up Report found the deficiency had been corrected, but the Plan has apparently reverted to its non-compliant online grievance process.

Plan's Compliance Effort: In its response, the Plan stated the preview and edit functionality was restored.

Final Report Deficiency Status: Not Corrected

The Department has determined that this deficiency has not been corrected. The Department's review of the Plan's website established that the Plan's online grievance submission procedure includes a hyperlink on the homepage clearly identified as "GRIEVANCE FORM." In addition, the Department confirmed the form allows the enrollee to preview and edit their grievance prior to submitting it. However, the Department's review also established that if the enrollee selects to file a "Complaint," the Online Grievance Form now asks the enrollee whether they wished to file a "formal grievance." Asking this question is not in compliance with Rule 1300.68(a)(1) and (2) which defines a grievance as follows:

> Grievance'' means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a' grievance and an inquiry, it shall be considered a grievance.
>
> "Complaint" is the same as "grievance.

Thus, there is no distinction between a grievance and "formal grievance." The enrollee's act of filing of a complaint is the same as filing a grievance. The Department finds this deficiency has not been corrected based on the question of whether the enrollee would like to file a "formal grievance" in addition to the history regarding this deficiency.

[9] See the Department's 2015 Final Report issued on August 11, 2016 and the 2015 Follow-Up Report issued on January 4, 2018 (Deficiency #7).

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a CAP that addresses how the Plan intends to address the question regarding asking the enrollee whether they wish to file a formal grievance and bring its website into compliance.

UTILIZATION MANAGEMENT

Deficiency #7: The Plan does not conduct adequate oversight of its delegates to ensure delegates consistently provide timely notice to enrollees and providers and include the reviewer's required contact information.

Statutory/Regulatory Reference(s): Section 1367.01(a), (h)(3), (h)(4), and (j).

Assessment: The Department found that the Plan does not ensure that it provides sufficient oversight to ensure that all entities to which it delegates utilization management (UM) functions perform those functions in accordance with statutory requirements. Section 1367.01(a) requires that the Plan and "any entity with which it contracts for services that include utilization review or UM functions ... or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section." Section 1367.01 addresses various aspects of utilization review, including denial communications, use of criteria or guidelines, and decision turn-around times, among others. Section 1367.01(j) requires the Plan to review compliance with these requirements as part of the Plan's QA program.

The Plan contracts with delegates to provide healthcare services to its enrollees. The Plan delegates UM functions covered under Section 1367.01. The Plan's policies and procedures establish that the Plan is responsible for oversight of these delegated UM functions. However, pursuant to the Plan's policies and procedures, if the delegate is accredited by the National Committee on Quality Assurance (NCQA), the Plan does not perform an audit of that delegate. The Department found that the Plan did not perform an audit of two delegates (of the four reviewed) because they were accredited by NCQA.

The Department reviewed files from four Plan delegates. The Department found that the Plan did not audit two delegates because both were accredited by NCQA. In addition, the Department's file review of the four delegates' UM determinations established that the written notifications to enrollees were not in compliance with the requirements of the Plan's written policies and procedures.

Plan Document Review

The Plan requires its delegates to follow its policies and procedures. *QM 68 Delegated Care Management Policy* (effective date July 27, 2017) states that "delegation is a process through which Aetna contractually agrees to grant an external entity (Delegated Entity) the ability to perform specified functions or activities on its behalf. The Plan remains responsible for the oversight of delegated activities, whether they are fully or

partially delegated. Each Delegated Entity must demonstrate conformance to Aetna's program requirements and guidelines for delegated activities."

The Plan uses an excel file, *UM Commercial Denial File Worksheet*, to perform audits of delegate denial letters. The worksheet template notes: "Refer to the Industry Collaborative Effort (ICE) Timeliness Grids for timelines applied in California." The Department determined the ICE Timeliness Grid included compliant timeframes for the delegates' decisions. The Department observed that one UM Commercial Denial File Worksheet for Delegate A, signed by the Plan auditor August 7, 2017, noted "NCQA accredited" and "auto credit" in the worksheet indicating no audit was performed. The Department also found no evidence of documented file review for Delegate A by the Plan.

In addition, the *UM Commercial Denial File Worksheet* delegate audit tool does *not* include a field for verification of the health care reviewer's name and contact number, and therefore the Plan cannot audit whether the delegate's UM written denial notifications to providers contains this required information.

The Plan may not audit delegates that have been accredited by NCQA. Plan Policy *QM 68, Delegated Care Management Policy*, notes on page 10:

> If an entity demonstrates current NCQA Managed Care Organization (MCO) or Managed Behavioral Health Care Organization (MBHO) accreditation, the entity may not require an assessment for certain delegated activities.

With regard to enrollee requests for out-of-network services, the Plan requires a clinical review and decision of the request based on medical necessity. *NCS 505-01, Denial of Coverage Policy*, page 2, states that clinical denials include requests for treatment or consultation by a non-participating provider (whether or not a specific procedure/service was requested).

The Plan's *NCS 504-01 and 504-02, Timeliness Standards for Coverage Decisions and Notification Policy, California Amendment,* provides the following timeframes regarding UM denials:

- Decisions to … deny based on medical necessity … shall be made in a timely fashion … not to exceed five business days from the plan's/insurer's receipt of the information reasonably necessary and requested by the plan/insurer to make the decision.

- Decisions to … deny requests by providers for authorization prior to, or concurrent with, the provision of health care shall be communicated to the requesting provider within 24 hours of the decision.

- [N]otification to enrollees of "all denial determinations are communicated in writing to the member within two business days of the decision …."

Finally, *NCS 505-01*, *Denial of Coverage Policy, California Amendment* (revised February 27, 2018) requires the written response to include the decision maker's contact information:

- Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.

File Review

The Department reviewed 65 delegate UM denial files randomly selected from a universe of 666 files. The denials were issued by four Plan delegates: Lakeside Community Healthcare, Bakersfield Family Medical Center, Valley Care IPA, and the Premier Group (which includes Alamitos, Brookshire, and Lakewood IPAs). All 65 cases were decided in whole or in part on the basis of medical necessity. The Department's file review established the following:

- Notification of the decision was not made within five business days of receipt of necessary information.
  - Of the 65 files reviewed, seven files were expedited cases and two involved retrospective review and the Department determined these nine files met the required notification timeframes of 72 hours and 30 days respectively. Of the remaining 56 files, seven[10] (13%) did not meet the required five-business day timeframe for notification.
- The provider was not notified within 24 hours of the denial decision.
- Two[11] files of the 65 files involved retrospective reviews and were excluded from the Department's review, as retrospective reviews do not require notice within 24 hours. Of the remaining 63 files involving prior authorization (routine, expedited and concurrent review), 26[12] (41%) of the files demonstrated noncompliance on the part of the delegate by failing to notify the requesting providers within 24 hours of the denial decision. Written notification to the enrollee was not made within two business days of denial decision:
  - Of the 65 files, eight[13] (12%) files did not send the required written notice to the enrollees within two business days of the denial decision.
- The written denial to the provider did not include the name and telephone number of the health care reviewer/professional responsible for the decision:

[10] DMHC File #3, File #11, File #13, File #16, File #17, File #41, File #56.
[11] DMHC File #41, File #59.
[12] DMHC File #8, File #31, File #52, File #53, File #55, File #11, File #12, File #13, File #17, File #37, File #56, File #69, File #70, 2nd Overpull DMHC File #13, File #19, File #20, File #21, File #23, File #42, File #44, File #45, File #46, File #60, File #61, File #62, File #72.
[13] DMHC File #11, File #12, File #13, File #17, File #41, File #56, File #69, File #20.

- Of the 65 files, 15[14] (23%) files did not provide the health care professional's name or telephone number in written denials to the requesting providers. All 15 files involved the same delegate.

Conclusion: Based on review of Plan's policies and procedures and file review, the Department determined the Plan failed to ensure its delegates' written denial decisions comply with the notification timing requirements and provider contact information under Section 1367.01 (h)(3) and (4). Therefore, the Department finds the Plan in violation of Section 1367.01(j).

The Plan's failure to comply with the five-day business day requirement is a repeat deficiency from the Plan's last Routine Medical Survey.[15]

TABLE 5
Delegate UM Decisions

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Delegate UM Denial Files	56	Denial decision made within five business days of receipt of necessary information	49 (88%)	7 (12%)
Delegate UM Denial Files	63	Provider was notified within 24 hours of the denial decision	37 (59%)	26 (41%)
Delegate UM Denial Files	65	Delegate notified enrollee of denial in writing within two business days of denial decision	57 (88%)	8 (12%)
Delegate UM Denial Files	65	The name and telephone number of the health care reviewer/professional responsible for the decision is included in written denials to requesting provider	50 (77%)	15 (23%)

Plan's Compliance Effort: The Plan's response stated that it had updated the *UM Audit Tool* in October 2018. The Plan indicated that the UM tool updates should improve its ability to comply with state requirements. Specifically, the Plan added Column G,

[14] DMHC File #18, File #19, File #20, File #21, File #22, File #23, File #42, File #43, File #44, File #45, File #46, File #60, File #61, File #62, File #72.
[15] See the Department's 2015 Final Report issued on August 11, 2016 and the 2015 Follow-Up Report issued on January 4, 2018 (Deficiency #10).

which states, “ALL legislation marked in this column must be reviewed in each applicable file. If one or more fail in a file, mark ‘Meets State Regs’ as No and explain in Comments field on File Review Tab.” The Plan also added Column #32, which states, “Meet State Regs? ALL state-specific file review requirements from applicable State tab must be met. If one or more fail, score as NO and explain in Comments field.”

The Plan also stated that as of May 2019, all delegates will be audited for all applicable requirements regardless of whether the delegate has been accredited by NCQA.

Final Report Deficiency Status: Not Corrected

The Department finds that the Plan has implemented corrective action by updating the Plan’s *UM Audit Tool* for delegate files and by auditing all delegates regardless of NCQA accreditation. However, the Plan had not yet implemented this new audit tool and no results were provided for the Department’s review. Accordingly, the Department finds this deficiency has not been corrected.

The Department will conduct file review at the Follow-Up Survey to assess whether the Plan’s UM denial letters from delegates consistently meet the timing requirements discussed in this deficiency and include the name and telephone number of the health care reviewer/professional responsible for the decision. In addition, the Department will confirm the Plan’s implementation of its revised audit tool and a review a sample of audit results. The Department will review any revised policies and procedures related to the Plan ensuring that the UM denial letters from the Plan’s delegates comply with the requirements of Section 1367.01.

Deficiency #8: The Plan does not conduct adequate oversight of its delegates to ensure delegates consistently provide enrollees with a clear and concise reason, a description of the criteria or guidelines used and the clinical reasons for decisions regarding medical necessity.

Statutory/Regulatory Reference(s): Section 1367.01(a), (h)(4), and (j).

Assessment: The Department found that the Plan does not ensure that it provides sufficient oversight to ensure that all entities to which it delegates UM functions perform those functions in accordance with statutory requirements. Section 1367.01(a) requires that the Plan and “any entity with which it contracts for services that include utilization review or UM functions ... or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.” Section 1367.01(h)(4) requires a clear and concise explanation of the reasons for the Plan’s decision to deny, delay or modify requests based on medical necessity, a description of the clinical criteria or guidelines and the clinical reasons. Section 1367.01(j) requires the Plan to review compliance with these requirements as part of the Plan’s QA Program.

The Plan contracts with delegates to provide healthcare services to its enrollees to perform UM functions covered under Section 1367.01. The Plan’s policies and

procedures establish that the Plan is responsible for oversight of these delegated UM functions. The Department found that the Plan did not perform an audit of two delegates because both were NCQA accredited.

The Department reviewed delegate UM denial files. The Department's review found that all four delegates' UM written notifications denying health care services did not consistently include a clear and concise explanation to the enrollee, a description of the criteria or guidelines relied upon for the decision, and clinical reasons as required by Section 1367.01(h)(4).

Plan Document Review

As discussed in Deficiency #7, the Plan requires its delegates to comply with the requirements in the Plan's policies and procedures. Also, the Plan may not audit delegates that are NCQA accredited.

Based on NCS 505-01, *Denial of Coverage Policy*, the Plan classifies requests for services from an out-of-network provider as a request that requires a clinical decision based on medical necessity. Page 7 of this policy states that written communications to enrollees for denials based on medical necessity must include "… a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity."

The Department's review of the Plan's UM *Commercial Denial File Worksheet* for one delegate, signed by the Plan's auditor August 7, 2017 noted "NCQA accredited" and "auto credit." There was also no evidence that the Plan documented its file review.

File Review

The Department reviewed the same 65 delegate UM denial files referenced in Deficiency #7. All 65 cases cited medical necessity as a basis for the denial and therefore the Department reviewed all 65 files to determine whether the Plan's denial letter complied with the requirements in Section 1367.01(h)(4).

Insufficient citation to Clinical Criteria/Clear and Concise

In 42[16] (65%) of the 65 files, the Department determined that for all four delegates, the description of criteria in the UM denial letter was deficient because it was too general or encompassed a range of possible criteria. The Department determined that the denial letters contained either a vague citation to numerous clinical criteria that the Plan may have relied upon or in other instances citations to non-clinical criteria such as a Plan policy or guideline not specific to the enrollee's condition. As a result, the enrollee would likely have a difficult time understanding from these letters the specific clinical criteria relied upon by the delegate or understanding the basis to provide additional information. The Department therefore determined these delegate UM denial letters did not contain

[16] DMHC File #1, File #2, File #3, File #6, File #8, File #9, File #31, File #32, File #33, File #34, File #35, File #52, File #53, File #54, File #55, File #11, File #12, File #13, File #16, File #17, File #37, File #38, File #41, File #56, File #70, 2nd Overpull DMHC File #13, File #26, File #28, File #29, File #30, File #47, File #48, File #49, File #63, File #18, File #19, File #21, File #23, File #42, File #43, File #44, File #72.

a clear and concise explanation of the reasons for the Plan's decision. The following cases provide examples to illustrate this aspect of the deficiency:

In eight[17] files from a single delegate, the Department found all eight UM denial letters exemplified this deficiency. Each of the eight letters was identical. The Department determined that the letters' vague reference to various clinical criteria and non-clinical "plan benefit documents" was not specific enough to qualify as a citation to clinical criteria. As a result, the letters failed to be clear and concise. Each of the eight letters state:

> Dear [Member],
> After review, we have made a decision about coverage for the following health care services for the member named above. The service requested is being denied by […] because there is lack of medical necessity. This decision was based on your medical information. We use nationally recognized guidelines and resources, such as MCG criteria, Clinical Policy Bulletins available at [Hyperlink to Plan website], as well as plan benefit documents to support these coverage decisions.

- **File #56:** In this file, the UM denial letter contains a general reference to various clinical criteria and non-clinical guidelines and is therefore not clear and concise. The letter states:

  > To treat your Pain in left knee we have approved a physical therapy with... We use nationally recognized clinical guidelines and resources, such as MCG criteria, Clinical Policy Bulletins available at [Hyperlink to Plan website], as well as plan benefit documents.

Insufficient citation to Clinical Reasons

In 40[18] (62%) of the 65 files, the Department determined that for all four delegates, the UM denial letters did not provide a specific clinical reason or reasons based on the enrollee's clinical condition as the basis for the Plan's medical necessity decision. In other instances, the Department's review established that these letters did not contain any clinical reasoning. The following cases provide examples to illustrate this aspect of the deficiency:

In the eight files[19] set forth above, none of the UM denial letters provide a clinical reason for the denial.

[17] DMHC File #1, File #2, File #6, File #31, File #32, File #35, File #53, File #55.
[18] DMHC File #1, File #2, File #6, File #31, File #32, File #33, File #34, File #35, File #52, File #53, File #54, File #55, File #11, File #12, File #13, File #16, File #37, File #38, File #41, File #56, File #70, 2nd Overpull DMHC File #13, File #26, File #28, File #29, File #30, File #47, File #48, File #49, File #63, File #65, File #18, File #19, File #21 (17101801700034400000), File #22, File #23, File #42, File #43, File #44, File #72.
[19] DMHC File #1, File #2, File #6, File #31, File #32, File #35, File #53, File #55.

- **File #26:** In this file, the delegate's denial letter does not contain clinical rationale. Rather, the emphasis for the "denial" is that the enrollee's request for a heart specialist is available in-network.

The UM denial letter states:

> The service requested is being modified by […] because there is lack of medical necessity. This decision is based on your medical information. Per […] Preferred Provider Policy (UM-031) requests for non-contracted providers may be redirect [sic] to a preferred provider as long as the service is medically necessary; the service can be provided by an in-network provider and is non-emergent. Dr. XXX is a non-contracted provider. The request for a heart specialist for your heart disease is available within your network. You have been approved to see Dr. XXX, a qualified healthcare provider/group and our preferred provider.

Conclusion: Based on review of Plan's policies and procedures and file review, the Department determined that the Plan failed to ensure its delegates' written UM denial decisions comply with the requirements under Section 1367.01(h)(4) to provide a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the medical necessity decision. Therefore, the Department finds the Plan in violation of Section 1367.01(j).

TABLE 6
UM Denial – Clear and Concise, Citation to Clinical Criteria or Guidelines and Clinical Reasons

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Delegate UM Denial Letters	65	Denial letters includes a reason for denial in clear and concise language	23 (35%)	42 (65%)
Delegate UM Denial Letters	65	Denial letters included a description of the clinical criteria or guidelines used	23 (35%)	42 (65%)
Delegate UM Denial Files	65	Denial letter included a clinical reason / rationale for the decision	25 (38%)	40 (62%)

Plan's Compliance Effort: The Plan's response stated the corrective action was identical to Deficiency #7.

Final Report Deficiency Status: Not Corrected

The Department finds that the Plan has implemented corrective action by updating the Plan's *UM Audit Tool* for delegate files and by auditing all delegates regardless of NCQA accreditation. However, the Plan had not yet implemented this new audit tool and no results were provided for the Department's review. Accordingly, the Department finds this deficiency has not been corrected.

The Department will conduct file review at the Follow-Up Survey to assess whether the Plan's delegate UM denial letters consistently meet the requirements of Section 1367.01(h)(4). In addition, the Department will confirm the Plan's implementation of its revised audit tool and a review a sample of audit results. The Department will review any revised policies and procedures related to the Plan ensuring that the UM denial letters from the Plan's delegates comply with the requirements of Section 1367.01.

ACCESS TO EMERGENCY SERVICES AND PAYMENT

Deficiency #9: **The Plan does not provide all non-contracting hospitals in the state with Plan contact information needed to request authorization of post-stabilization care.**

Statutory/Regulatory Reference(s): Section 1386(b)(17); Section 1262.8 (j) and (k).

Assessment: Review of Plan policies and procedures, documents, and information from interviews with Plan personnel revealed that the Plan is not compliant with timely notification requirements or process requirements concerning post-stabilization care. Plan staff confirmed during interviews that the Plan's policy and practice for making available contact information for non-contracting hospitals is via the Department's website in which this information is embedded. The Department's review of the Plan's Policy (ER CA 4) confirmed the Plan relies on its website to convey this contact information.

The Plan's *ER CA 4: Non-Contracted Hospital Notification Policy* states under the California amendment: "This policy is written to meet regulatory and statutory requirements under the California Health and Safety Code 1317.4a.(b)(1) and (c)(1)" and states:

> The hospital contact information posted on the CA DMHC website shall be verified annually by the plan. The annual review of this information will be performed during the annual review and approval of this amendment.
> www.hmohelp.ca.gov [hmo help links to the DMHC Dashboard]
> Aetna Health of California, Inc.
> Precertification Call Center
> 800.624.0756

The Department tested the contact information provided by the Plan and determined that the process is burdensome. The user must first access the Department website (http://www.hmohelp.ca.gov/), then click on "Contact Information" from the dashboard menu. The next screen provides contact information for "Member Services" and a link to the Plan's website. The user must click on the Plan's link, and then proceed to move through additional screens in order to reach a section titled, "For non-participating

health care providers." Once connected to that site, the user then clicks on the option, "Contacting us by phone," to locate the appropriate contact information for the Plan.

The Plan does not have a process in place to notify noncontracting hospitals in the state at least annually of its contact information in accordance with the requirements of Section 1268. Section 1262.8(j) requires plans to provide all noncontracting hospitals in the state with contact information needed to request authorization for post stabilization care when plan enrollees receive emergency medical care from the noncontracting hospital. Section 1371.4, concerning authorization for emergency services, states that noncontracting hospitals shall not be required to make more than one telephone call to a health plan pursuant to Section 1268.2 to the telephone number provided to the hospital by the plan. While Section 1268.2(k) states the Department must make the contact information for plans available on the Department website, that requirement does not relieve a health plan of its obligation under Section 1268.2(j). Further, making the information available on the Plan's website would put the onus on each noncontracting hospital to search and obtain the Plan's contact information. Section 1262.8(j) places the obligation on health plans to provide the hospitals with the information, and to do so annually.

Conclusion: The Department finds the Plan out of compliance with Sections 1262.8(j) and 1386(b)(17) for not sending the annual notification to non-contracting hospitals for authorization of post-stabilization care.

Plan's Compliance Effort: The Plan stated that in the third quarter of 2019, it will send a communication to all non-contracted California hospitals that will advise the hospital of the specific telephone number to contact Aetna for authorization of post-stabilization care. The Plan will also maintain its contact information on Aetna and the Department's websites and will update contact information at least annually or as necessary.

Final Report Deficiency Status: Not Corrected

As of the date of the Plan's response, the Plan had not created or sent the proposed notice to the hospitals. Thus, the Department cannot asses the content of the notice and whether it informs non-contracting facilities how to contact the Plan both during business hours and after hours to request authorization for post-stabilization care. In addition, the Plan's response did not address whether it intends to revise its policies, procedures and other applicable documents so that the Plan's operations comply with these requirements. The Plan's response also did not specify how the Plan intends to ensure compliance. The Department therefore determined that this deficiency has not been corrected.

At the Follow-Up Survey, the Department will review the Plan's notice to non-contracted facilities, and determine whether the Plan provides annual notification to all non-contracting facilities, as required by Section 1262.8(j). The Department may also review revisions to operational documents to ensure compliance

Deficiency #10: The Plan does not account for the enrollee's subjective belief that he or she had experienced a medical emergency when evaluating the medical necessity of emergency services.

Statutory/Regulatory Reference(s): Section 1317.1(a), (b); Section 1371.4(c).

Assessment: Based on the Department's review of Plan documents, Emergency Room (ER) claim denial files, and information obtained during staff interviews, the Department determined the Plan improperly denies payment for emergency services in cases in which the enrollee reasonably believed that an emergency existed.

Plan Document Review

Plan Policy, *Hospital Emergency Policy*, page 1, which was modified on August 15, 2016, invokes the "prudent layperson" standard states:

> For all products that have provisions or limitations pertaining to ER visits, we follow the prudent layperson ER policy in the Balanced Budget Act of 1997. Under this act, an emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in [serious jeopardy to health, serious impairment of bodily functions, serious dysfunction of any bodily organ or part].

Plan policy*, Claim and Call Policy*, page 1, which was modified on March 15, 2011 similarly invokes the prudent layperson standard. Page 1 states:

> For all products that have provisions or limitations pertaining to ER visits, we follow the prudent layperson ER policy in the Balanced Budget Act of 1997.

Plan policy, *Emergency Services and Call Handling Policy, California HMO Amendment* for 2016 and 2017 invokes a "reasonable" person standard, which complies with Section 1371.4(a) through (c). Page 14 of the policy states:

> DMHC Guidance-Because California standards offer more consumer protection and do not prevent application of the ACA, the Plan must use the standard set forth under Section 1317.1(b) and Section 1371.4(c). California law requires coverage based only on the enrollee's reasonable belief of the existence of an emergency medical condition. This standard is subjective and imputes no obligations on the enrollee to act "prudently" or possess "an average knowledge of health and medicine," as the ACA standard does.
>
> Due to the guidance provided by the DMHC we are applying the California legislation for the definition of what constitutes an Emergency medical condition and coverage for an emergency medical condition.

Despite the existence of Plan policy*, NCS 527-01 Emergency Services and Call Handling Policy and 527-02 Emergency Services and Call Handling Policy with CA Amendment*, the Department's file review of ER claim denials established that the Plan used the prudent layperson standard during the survey period. Pursuant to Section 1371.4(c), health plans may deny payment for emergency services and care only if "the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed ... [or] in cases when the plan enrollee did not require emergency services and care and '*the enrollee reasonably should have known that an emergency did not exist*.'" The Department's All Plan Letter APL 17-017 (APL 17-017) reiterates the appropriate standard for health plans to follow when providing reimbursement for emergency services. APL 17-017 further reminds health plans that whether or not the enrollee reasonably believed he or she had an emergency medical condition is a subjective standard based on the enrollee's mindset.

File Review

The Department reviewed 30 ER claim denial files. In 28[20] (93%) of the 30 files, the denial letters to enrollees included the phrase: "It is our determination that the above prudent layperson requirement was not met." In addition, the following paragraph appeared in the 28 denial letters:

> It is our determination that the above prudent layperson requirement was not met. The clinical review findings indicate the treatment was for a non-emergent medical condition and could have been provided in another location.

Conclusion: Section 1371.4(c) and Section 1317.1(b) permits a plan to deny payment for emergency service and care to a provider only when the enrollee did not require emergency care and when the enrollee reasonably should have known that an emergency did not exist from their subjective viewpoint. The Department's review of the Plan's *Emergency Review Policy*, file review, and interviews established that the Plan applies the "prudent layperson" standard and does not consider the enrollee's subjective viewpoint to review emergency files. Therefore, the Department finds the Plan in violation of these statutory requirements.

Finally, the Department requests the Plan to note the specific instructions regarding the Plan's CAP in the Section I: Discussion of Deficiencies section on page 7.

TABLE 7
ER Denial Files – Applying Review Standard that Accounts for the Enrollee's Subjective Viewpoint

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT

[20] ER Files: DMHC File #3, File #4, File #5, File #6, File #8, File #9, File #10, File #12, File #13, File #14, File #15, File #16, File #17, File #18, File #19, File #2, File #22, File #23, File #24, File #25, File #26, File #27, File #28, File #29, File #30, File #41, File #42, File #43.

ER Claim Denial Files	30	Payment for emergency medical services may be denied if the enrollee did not require emergency services and the enrollee did not experience a medical emergency from his or her subjective viewpoint.	2 (7%)	28 (93%)

Plan's Compliance Effort: The Plan represented it re-reviewed all 30 ER claim denial files reviewed by the Department and determined that these claims were reviewed appropriately under the California "reasonable belief" standard. The Plan stated it complied with the California requirements regarding emergency services, which state, "The enrollee reasonably believed they had an emergency medical condition. The standard is subjective and takes into consideration whether the enrollee's belief was reasonable given the enrollee's age, personality, education, background and other similar factors." However, the Plan also acknowledged that its denial letters created confusion by referring to the Prudent Layperson standard. To avoid confusion, in the third quarter of 2019, the Plan will update the California emergency letter template to remove any reference to the Prudent Layperson standard.

The Plan stated that it completed a refresher training to current staff, which emphasized the California requirements of the "reasonable belief" requirements.

The Plan also explained that it inadvertently provided the Department with policies and procedures for handling emergency claims that were not specific to California. The specific documents were *Hospital Emergency Policy* (modified effective August 15, 2016) and *Claim and Call Policy* (modified effective March 15, 2011).

The Plan stated that it previously provided policies and procedures related to handling of emergency claims that were applicable to California, they are as follows:

- Policy NCS 527-01: *Emergency Services and Call Handling Policy* (January 21, 2017)
- Policy NCS 527-02: *Emergency Services and Call Handling Procedure* (January 21, 2017), and
- California Amendment to Policy NCS 527-01 & Procedure 527-02: *Emergency Services and Call Handling Policy, California HMO Amendment* (September 2, 2016).

Final Report Deficiency Status: Not Corrected

The Department acknowledges the Plan has proposed to revise its California emergency letter template to reflect the appropriate standard for reviewing claims for emergency services in California. However, it is not clear whether the Plan's proposal to use the "reasonable belief" standard will appropriately account for the enrollee's subjective belief whether he/she had experienced an emergency. The Department's all plan letter, APL 17-017, reminds health plans that whether or not the enrollee reasonably believed he or she had an emergency medical condition is a subjective standard based on the enrollee's point of view. Further, as of the date of the Plan's response, the Plan had not implemented the California emergency letter template and

the “reasonable belief” standard. The Plan also did not demonstrate it is appropriately reviewing emergency claims or discuss how it intends to provide oversight of this issue. Accordingly, the Department finds this deficiency has not been corrected.

At the Follow-Up Survey, the Department will conduct ER file review to determine whether the Plan is appropriately evaluating the medical necessity of emergency services by accounting for the enrollee’s subjective belief that he or she had experienced a medical emergency. The Department will also review the California emergency letter template and any revised policies and procedures.

In addition, the Plan’s response also failed to address the Director’s requirement to perform retroactive review of *all denied claims* (in addition to the 30 claims reviewed by the Department) adjudicated on or after February 1, 2017. The Plan was directed to assess *all* ER denial claims by assessing whether from each enrollee’s subjective point of view, the ER claim should have been approved as required by Section 1371.4(c). The Plan’s response only indicates it had re-reviewed the 30 responses reviewed by the Department. The response also failed to provide any analysis to support that the Plan appropriately applied the subjective standard for review required by California law. For each ER claim that the Plan determines should have been approved, the Director requires the Plan to readjudicate the claim in the manner discussed below.

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response providing an update regarding the Director’s requirement to retroactively review all ER claims denied by the Plan on the basis of “prudent layperson,” “reasonable belief”, or similar grounds, on or after February 1, 2017. The Plan’s response must include a spreadsheet of all ER claims that were denied since February 1, 2017 and include the following:

- claim number,
- basis for denial,
- clinical reason for the denial,
- facility name,
- amount billed, interest/penalty paid, total amount paid and
- date of readjudication.

For all claims denied on the basis of medical necessity, the Plan must specify on the spreadsheet that the Plan considered whether the enrollee, from his or her subjective point of view, believed that emergency medical services were needed or whether the Plan denied the ER claim by considering non-subjective review criteria. For each ER claim that the Plan determines it should have approved, the Plan must provide evidence that it readjudicated the claim or provide a date the Plan will issue payment. The Plan’s response will describe the Plan’s process used to identify overpayments made by enrollees or payments to providers. The Plan’s response will quantify the total number of claims reviewed, the total number readjudicated, the total number upheld as correctly denied, the billed amount for each claim, the amount readjudicated by the Plan and evidence of readjudication.

Finally, the Plan will also provide an update regarding implementation of the new review standard for ER claims and a discussion on how that standard is being applied to review

ER claims. The Plan's response will also describe any revisions to Plan policies and procedures and the dates they will be submitted to OPL for review and how the Plan intends to provide oversight of this issue.

PRESCRIPTION (RX) DRUG COVERAGE

Deficiency #11: The Plan operates at variance with its basic organization documents by not allowing providers 24 hours to respond to its requests for additional information needed for drug authorizations.

Statutory/Regulatory Reference(s): Section 1367.24, Section 1367(e)(1); Section 1367.01(g), Section 1367.01(h)(1),(2) and (5), Section 1386(b)(1).

Assessment: The Department determined that the Plan is operating at variance with policies previously filed with the Department and in effect during the survey review period relative to its pharmacy denials. The Department reviewed the Plan's policy and procedure *RX-131*a, *Obtaining Authorization for Medications Requiring Medical Exception Policy* (Rx Medical Exception Policy). The *Rx Medical Exception Policy* describes the Plan's process for reviewing and processing requests for medication or medication services that are not on the Plan's formulary. The policy states that if the request for an exception is incomplete, the Plan will attempt to contact the prescribing provider for additional information and that the physician or physician's office will have 24 hours to provide the missing and/or additional information. However, the Department's file review established that the Plan's Pharmacy Benefit Management (PBM) delegate does not consistently follow the Plan's policy by allowing the provider 24 hours to submit all required information.

Section 1367(e)(1) requires services to be available to enrollees at reasonable times consistent with good professional practice. Section 1367.01(h)(1) and (h)(2) require plans to make UM denial determinations in a timely fashion appropriate for the nature of the enrollee's condition. Section 1367.01(h)(5) provides that if the Plan becomes aware that it will not meet the decision timeframe in Section 1367.01(h)(1) or (2), it is required to notify the provider and the enrollee, in writing, that it cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required and provide the provider and enrollee of the anticipated date on which a decision may be rendered. Additionally, Section 1367.24(a) requires plans to have an expeditious process by which providers can obtain authorization for non-formulary drugs. By issuing non-formulary denials without first obtaining necessary information, the Plan's process for obtaining authorizations is not expeditious because authorizations may be delayed and not rendered in a timely manner for the enrollees' condition. In addition, by denying the requested exception without obtaining all information, in order to meet turn around timeframes, the Plan fails to provide proper notification of its delay in reviewing the request to the provider and enrollee as required by Section 1367.01(h)(5).

Plan Document Review

The Plan's Rx Medical Exception Policy provides the following definition for *Medical Exception*:

> [T]he process, by which coverage is determined, based upon medical necessity, for (a) formulary excluded drugs which are not covered under closed formulary benefit plans, and (b) drugs subject to step-therapy. This process also applies when exceptions are made to certain co-payment or cost-sharing requirements in accordance with the terms of a benefits plan or applicable law under some pharmacy benefit designs. Medical Exceptions are not available to request coverage of drugs contractually excluded under a health benefit plan.

The *Rx Medical Exception Policy* states:

> Medical Exception requests are pre-service (prospective) reviews/decisions.
>
> Determinations are based solely on the clinical information available at the time of the review.

The policy also states that the Plan will consider an exception "If a prescription order is written for (a) a formulary-excluded drug for a member with a closed formulary benefit plan, or (b) a step-therapy drug, such prescription may be covered as a medical exception if it is medically necessary."

The policy explains the Plan's review process if the request for an exception is incomplete:

> If a request is incomplete and a favorable decision cannot be made, the technician will attempt to contact the prescribing practitioner for additional information. The physician or physician's office will have 24 hours to provide the missing and/or additional information.
>
> If waiting 24 hours for response will place the request at risk of missing overall TAT,[21] a reasonable time will be allowed for response within/reflective of the overall TAT requirements for the request as per appropriate compliance TAT.
>
> If the practitioner is non-responsive or such information is not available from the prescriber's office, the request will be considered based on the information submitted.[22]

Finally, the policy explains what information should be included in the Plan's written notification:

[21] TAT- Turn-around-time.
[22] Aetna Pharmacy Management RX-131a, Obtaining Authorization for Medications Requiring Medical Exception Policy, pages 4 and 5, section: "What happens if the request for exception is incomplete?"

Aetna provides letter templates to CVS-Caremark for implementation on CVS-Caremark systems.

All denial notifications will be in writing in the form of a denial letter. Denial letters will contain the following:

Specific reason for determination;

Reference to the plan provision on which the determination was made, or;

Reference to the medical necessity criteria applied.

Description of any additional material needed for further review including why the information is needed.

File Review

The Department reviewed two batches with a total of 104 denial files. The first set of denial files (Batch 1) yielded only three files that were denied based on medical necessity, which prompted the Department to select an additional sample (Batch 2) for file review. Of the 104 files, 55[23] files were denied because the Plan did not receive adequate information or the provider did not provide the required clinical information. The Department also found that 14[24] were denied based in whole or in part on medical necessity; 28 files were denied based on benefit exclusion; three files were denied because the requests were submitted on an incorrect form. The remaining four[25] files were eliminated from Department review because they were incomplete or did not include adequate information for a thorough review of the file.

The Department's finding that 55 out of 100 denial files were denied for lack of, or inadequate information raised concerns given the high number of denials. Out of the 55 files, the Department's review found that 34[26] (62%) files demonstrated that the file was not kept open for 24 hours to allow providers to submit additional information as provided by the Plan's policy. The summaries below demonstrate the Department's finding:

- **File #16:**

[23] Batch 1: DMHC File #16, File #17, File #25, File #30, File #68, File #71, File #75 and File #80, Batch 2:DMHC File #1, File #2, File #3, File #4, File #6, File #8, File #9, File #11, File #12, File #13, File #15, File #16, File #17, File #18, File #19, File #22, File #23, File #25, File #26, File #27, File #28, File #29, File #30, File #31, File #32, File #33, File #35, File #36, File #37, File #38, File #40, File #42, File #43, File #44, File #45, File #46, File #47, File #48, File #49, File #51, File #52, File #53, File #54, File #55, File #56, File #58, File #60.
[24] Batch 1 Files: DMHC File #20, File #21, File #78.
Batch 2 Files: DMHC File #5, File #7, File #10, File #20, File #21, File #34, File #39, File #50, File #57, File #59, File #61.
[25] Batch 1: DMHC File #10, File #72, Batch 2: DMHC File #14, File #24.
[26] Batch 1: DMHC File #16, File #25, File #30, File #68, File #71 File #75 and File #80 (17-002830845), Batch 2: DMHC File #1, File #2, File #3, File #4, File #15, File #25, File #26, File #27, File #28, File #30, File #31, File #32, File #33, File #35, File #36, File #37, File #38, File #40, File #42, File #43, File #44 File #45, File #46, File #47, File #51, File #52, File #60.

File Notes:
8/9/17, 9:56 pm "MDO (MD Office) closed sent to CA pending."
8/9/17, 9:56 pm "All information received"

Time from attempt to closing of request: 1 minute

- **File #17:**

File Notes:
4/25/17, 7:52 pm "OBC (outbound call) attempted MDO closed sent to CA Pending"
4/25/17, 7:52 pm "All information received"

Time from attempt to closing of request: 1 minute

- **File #25:**

File Notes:
9/21/17, 2:55 pm "Received universal form with clinical information. (Prior Authorization Form) OBC, on hold 2 mins. Closed as pending."

Time from attempt to closing of request: 1 minute

- **File #30:**

File Notes:
1/14/18, 2:31 pm "unspecified Note to MDO: Please complete criteria form following the prompts after (EACH) question. THANK YOU"
1/14/18, 3:21 pm "Additional information is needed to make a determination regarding the prior authorization for the requested medication" Request denied.

Time from attempt to closing of request: 50 minutes

- **File #68:**

File Notes:
1/12/17, 11:57 am "need the form – in order to make a determination please compete form by answering question #, following prompts carefully then call or fax us back. Thank you."
1/13/17, 8:36 am "PA denied due to lack of info"

Time from attempt to closing of request: 20.5 hours

Conclusion: Section 1367.24(a) requires that the Plan maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary non-formulary prescription drug. Section 1386(b)(1) prohibits the Plan from operating at variance with the basic organizational documents and provides for disciplinary action. A review of Plan's *Rx Medical Exception Policy* and pharmacy denial files found that the Plan does not follow its policy to allow providers 24 hours to submit additional information necessary to process pharmacy authorization requests. As a result, the Department finds the Plan's review process is not expeditious by ensuring that providers may obtain authorization for medications without undue delay. By

delaying the review and approval process, prescription drug services are not readily available at reasonable times to enrollees. Finally, the Plan is not providing required notification to providers and enrollees regarding its delayed review. Accordingly, the Department finds the Plan out of compliance with Section 1367.24, Section 1367(e)(1); Section 1367.01(g), and Section 1367.01(h)(1),(2) and (5).

TABLE 8
Pharmacy Denial File Reviews for Lack of Information

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Pharmacy Denials Based on Lack of Information	55	Plan allowed 24 hours for providers to respond to request for additional information	21 (38%)	34 (62%)

Plan's Compliance Effort: The Plan's written response respectfully disagreed with the Department. The Plan reviewed the 34 files at issue and determined it did not require additional information to complete its review. Thus, the Plan contends that the section "What happens if the request for exception is incomplete?" from its *Rx Medical Exception Policy* is not applicable. The Plan also determined that the timing of the Plan's determination in each of the 34 files was processed within the prescribed timeframes in accordance with *RX_1.1e_131a Appendix A - APM State UR Grid_2018*. The Plan concluded that its process ensures that decisions are made timely and the enrollee has access to appropriate care for their condition.

The Plan provided further clarification regarding its handling process for prescription drugs. The Plan explained that it places a courtesy call to the prescribing physician to confirm that the request form is complete and accurate as submitted. However, if the Plan is not able to reach the prescribing physician, it proceeds with the review and provides a determination based on the completed form as submitted.

The Plan further explained that if the prescriber discovers the original request form is not complete, the provider may re-submit a new request with additional information that may provided the basis for a Plan approval.

Final Report Deficiency Status: Not Corrected

The Plan's response contends that none of the 34 files at issue required additional information in order for the Plan to make a determination. As a result, the Plan states that none of these files required the Plan to "pend" the decision in order to obtain additional information as provided under its Rx Medical Exception Policy.

However, the Plan's response does not address the basis for this deficiency and raises additional questions as to why these were even pended for additional information, if none was required. Even assuming that none of the 34 files at issue required additional information, the Plan's response does not affirm whether the Plan's review process, in practice, actually waits until it receives all requested information before issuing a

determination. The Plan's response does not address the Department's file review findings that in some instances the Plan denied requests minutes after making a request for additional information. In addition, the Plan's discussion that providers may re-submit new requests with additional information only supports the Department's determination that the Plan's review process is not expeditious and potentially results in unnecessary delays. The provider's re-submission of a request is a delay in the review process. Finally, the Plan's response does not indicate whether the Plan intends to provide training to Plan staff that may have responsibility for reaching out to providers to obtain information. The Plan's response also does not describe how the Plan intends to provide oversight of this issue and the concerns it raises regarding an enrollee's ability to obtain medically appropriate prescription drugs in a timely manner. Accordingly, the Department finds this deficiency has not been corrected.

Within 60 days of the issuance of this Final Report, the Plan shall submit a supplemental response outlining a CAP that addresses all elements of this deficiency and provides a status report on the Plan's compliance efforts including an assessment by the Plan regarding the number of requests the Plan has pended after requesting additional information. The Plan will discuss whether such pended requests are being handled in an appropriate manner and whether the Plan is obtaining all necessary information before issuing a denial. The Plan's response will also specify how the Plan intends to provide oversight of this issue and specify whether any policies and procedures will be amended to address this issue and whether any policies and procedures will be submitted to OPL for review.

At the Follow-Up Survey, the Department will review the Plan's pharmacy denial files, relevant policies and procedures, and the results of the monitoring processes implemented by the Plan to identify whether pharmacy files are being appropriately pended to obtain necessary information. The Department may also conduct interviews and review any other documents deemed relevant.

SECTION II: SURVEY CONCLUSION

The Department has completed its Non-Routine Survey. Where indicated, the Plan shall submit a supplemental 60 day response through the Department's Web Portal. In addition, the Department may request subsequent supplemental responses to assess progress with the Plan's corrections actions.

If the Plan's corrective actions result in revisions to documents and/or information previously submitted to the Department's OPL, or new documents required to be filed as an Amendment or Notice of Material Modification, please submit those documents to the Department's eFiling Web Portal using the File Documents link. Please indicate in the Exhibit E-1 that the filing is in response to the survey. All applicable documents must be submitted as an Amendment or Notice of Material Modification, as applicable (see Section 1352 and Rule 1300.52.4).

The Department will conduct a Follow-Up Review of the Plan and issue a Report within 18 months of the date of this Final Report.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web Portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

Once logged in, follow the steps below to submit the Plan's response to the Final Report:

- Click the eFiling link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the **DPS Routine Survey Document Request** titled, **2018 Routine Full Service Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.