DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

AETNA HEALTH OF CALIFORNIA INC.

DATE: AUGUST 20, 2025

Behavioral Health Investigation
Aetna Health of California Inc.

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (Department) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the Department licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975 and regulations promulgated thereunder (collectively, Knox-Keene Act).[1] The Department is conducting focused Behavioral Health Investigations (BHI) of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with California law and to assess whether enrollees have consistent access to medically necessary behavioral health care services. The full-service commercial health plans will be investigated in phases. The investigation of Aetna Health of California Inc. (Plan) was included in Phase Three.

On May 16, 2024, the Department notified the Plan of its BHI covering the time period of March 1, 2022 through February 29, 2024. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.[2] The investigation team interviewed the Plan from December 10, 2024 through December 12, 2024.

The BHI uncovered **13** Knox-Keene Act violations in the areas of Appointment Availability and Timely Access, Utilization Management, including Triage and Screening, Grievances and Appeals, and Quality Assurance:

1. The Plan fails to consistently identify, investigate, and document potential provider directory inaccuracies reported to the Plan.
2. The Plan's processes fail to ensure that enrollees are offered appointments within timely access standards when they call the Plan or submit grievances about requesting behavioral health appointments.
3. The Plan fails to consistently arrange for the timely provision of out-of-network behavioral health care for its enrollees.
4. The Plan does not include the correct information in its denial and modification letters to enrollees, including providing contact information for the wrong regulator.
5. The Plan failed to demonstrate that for concurrent review denials, care was not discontinued until the enrollee's treating provider had agreed to an appropriate care plan.
6. The Plan does not consistently identify oral expressions of dissatisfaction as grievances and fails to identify exempt grievances.
7. The Plan failed to demonstrate it maintains and periodically reviews the required log of exempt grievances.

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[1] The Knox-Keene Health Care Service Plan Act of 1975 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.

[2] For purposes of this Report, the term "behavioral health" or "behavioral health services" refers to mental health as well as substance use disorder conditions, and the services used to diagnose and treat those conditions.

8. The Plan does not timely notify behavioral health provider applicants of the status of their credentialing application.
9. The Plan's Maternal Mental Health program does not include quality measures to encourage screening, diagnosis, treatment and referral.
10. The Plan was unable to demonstrate that customer service staff are knowledgeable and competent regarding enrollee questions and concerns.
11. The Plan is operating at variance with its filed provider directory policies and procedures.
12. The Plan is operating at variance with its filed complaints, grievances and appeals policies and procedures.
13. The Plan is operating at variance with its filed utilization management policies and procedures.

Additionally, the Department identified the following **eight** barriers to care not based on Knox-Keene Act requirements in the areas of Appointment Availability and Timely Access, Grievances and Appeals, and Enrollee and Provider Experience:

1. The Plan has not demonstrated an effective process for collaboration and coordination of care between medical and behavioral health providers.
2. The Plan does not have a system to adequately track, monitor and review grievances in order to improve the delivery of behavioral health services.
3. The Plan's reimbursement practices create a barrier to increasing the number of in-network behavioral health care providers sufficient to meet the needs of its enrollees.
4. The Plan's electronic claim submission system is not adequately maintained to prevent improper denials, which creates a barrier to timely reimbursement.
5. The Plan does not track and trend repeat callers to identify patterns and problems that enrollees may experience in accessing behavioral health care.
6. The Plan's credentialing and contracting process creates barriers to providing services to enrollees.
7. The Plan's online provider portal is difficult for providers to navigate.
8. Behavioral health services, including specialty care, are not readily available at reasonable times to all enrollees throughout the Plan's service area.

This BHI Report also includes Plan initiatives or operations, if any, identified as potentially having a positive impact on the Plan's provision of and/or enrollee access to behavioral health services. In this case, the investigation identified no initiatives/operations resulting in positive impact on the Plan's provision of and/or enrollee access to behavioral health services.

The Plan is hereby advised that the findings and violations noted in this BHI Report will be referred to the Department's Office of Enforcement. The Department's Office of Enforcement will evaluate appropriate enforcement actions, which may include corrective actions and assessment of administrative penalties, based on the Knox-Keene Act violations. In the Phase Three Summary Report, the Department will provide recommendations for the barriers to care not related to Knox-Keene Act violations.

FRAMEWORK FOR THE BEHAVIORAL HEALTH INVESTIGATIONS

I. Background

Both California and federal laws require health plans to cover services to diagnose and treat behavioral health conditions. Senate Bill (SB) 855 (Wiener, 2020) made amendments to California's mental health parity law and requires commercial health plans and insurers to provide coverage for the medically necessary treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. Health plans must also provide all covered mental health and substance use disorder benefits in compliance with the Mental Health Parity Addiction Equity Act (MHPAEA). The MHPAEA requires health plans to provide covered benefits for behavioral health in parity with medical/surgical benefits.

Other Knox-Keene Act provisions and corresponding regulations establish standards for access to care, requiring health plans to provide or arrange for the provision of covered health care services, including behavioral health services, in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.[3] Plans must ensure enrollees can obtain covered health care services, including behavioral health services, in a manner that assures care is provided in a timely manner appropriate for the enrollee's condition.[4]

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. This included analysis of benefit classifications, cost sharing requirements and non-quantitative treatment limitations to determine if health plans were meeting parity requirements under MHPAEA. As a result of this focused compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA. Since the initial compliance review, the Department conducts ongoing review of MHPAEA compliance when plans make changes to policies or operations, or when licensing new health plans. Additionally, the Department has incorporated into routine medical surveys review for compliance and the enforcement of requirements of SB 855 (Wiener, 2020) that expanded the scope of access and coverage for behavioral health benefits.

II. Methods for BHIs

The BHIs involve evaluation of health plans' commercial products regulated by the Department.[5] To evaluate the Plan's operations for the review period of March 1, 2022

[3] Rule 1300.67.2.2(c)(1).
[4] Rule 1300.67.2.2(c)(2).
[5] The BHIs do not include plan products or plan enrollees covered by Medicare, California's Medi-Cal program, self-insured Administrative Services Organizations or non-Department regulated products.

through February 29, 2024, the Department requested and reviewed Plan documents, files, and data, and conducted interviews with Plan staff. The BHI involved reviewing and assessing the Plan's operations pertaining to the delivery of behavioral health services. The BHI focused on the following areas:

- Appointment Availability and Timely Access
- Utilization Management, including Triage and Screening
- Pharmacy
- Quality Assurance
- Grievances and Appeals
- Claims Submission and Payment
- Cultural Competency, Health Equity and Language Assistance
- Enrollee and Provider Experience

To further understand potential barriers to care from the perspective of enrollees and providers, the Department sought enrollee and provider participation in separate interviews concerning their experiences with the Plan. The Department reached out to stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the DMHC Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. In connection with the Plan BHI, the Department interviewed four providers and one enrollee whose input was considered for the Plan's BHI. The interviews were conducted between March 2024 and July 2024. The four providers serviced Los Angeles, San Diego and San Mateo counties and also provided state-wide telehealth services.

The enrollee raised issues including quality of care concerns with in-network providers, poor communication and problems with billing. The issues raised by interviewed providers included the lengthy credentialing and contracting process, low reimbursement rates, difficulty obtaining reimbursement rate increases, and poor communication. Providers also reported that the online provider portal was difficult to navigate and frequently provided inaccurate data. In addition, one provider stated that claims are frequently denied for no coverage or different coverage levels than stated by the Plan and that the Plan has poor communication especially regarding enrollee benefits and resolution of claims and billing issues.

PLAN BACKGROUND

Aetna Health of California, Inc., obtained its Knox-Keene license in 1981 and is headquartered in Concord, California. The Plan is a full-service health care service plan licensed to provide health care services to commercial and Medicare enrollees. The managed care plans include health maintenance organizations and point-of-service plans. As of December 31, 2023 (the final quarter of the BHI review period), the Plan had

215,860[6] enrollees in its commercial lines of business. The Plan operates in 30 counties in California.

[6] Source: DMHC Dashboard 2023, Q4.

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: The Plan fails to consistently identify, investigate, and document potential provider directory inaccuracies reported to the Plan.

Statutory/Regulatory Reference(s): Sections 1367.27(e)(1)(D), 1367.27(e)(2)(A)-(C), 1367.27(j)(3), 1367.27(o)(1) and 1367.27(o)(2)(B)

Supporting Documentation:

- *California Provider Directory Process – Print Directory* (Revised April 28, 2023)
- *Aetna Online Provider Search – California & All Providers Online Process* (Revised March 8, 2022)
- *California HMO Amendment to Member Complaint and Appeal Policy CA 001* (dated October 3, 2023)
- National Quality Oversight Committee Meeting Minutes (July 26, 2022 and July 25, 2023)
- Plan Inquiry Files (March 1, 2022 through February 29, 2024)
- Plan Out-of-Network Request Files (March 1, 2022 through February 29, 2024)
- Plan Grievance and Appeal Files (March 1, 2022 through February 29, 2024)
- Interview Document Requests sent to the Plan on December 14-16, 2024

Assessment: Plans are required to promptly investigate a reported inaccuracy of information in the provider directory or directories, and, if necessary, undertake corrective action within 30 business days of receipt of the report by either verifying the accuracy of the information or updating the information to ensure the accuracy of the directory or directories.[7] Plans must also document the receipt and outcome of each reported inaccuracy, including any updates or changes made to its directory or directories.[8]

In addition, plans are required to update their online provider directory, at least weekly, when a change is necessary after the completion of an investigation based on an enrollee complaint that a provider was not accepting new patients, was otherwise unavailable, or whose contact information was listed incorrectly.[9] A plan is further required to remove a provider from the directory when a provider retires or ceases to practice, a provider or provider group is no longer under contract with the plan, or when a contracting provider group is no longer associated with the provider group.[10]

Plan Documents

The Plan's *California Provider Directory Process – Print Directory* states that enrollees or members of the public may report suspected inaccuracies in the provider directory by

[7] Sections 1367.27(j)(3),1367.27(o)(1).
[8] Section 1367(o)(2)(B).
[9] Section 1367.27(e)(1)(D).
[10] Section 1367.27(e)(2)(A)-(C).

submitting a form on the Plan's website, by e-mail, or by telephone.[11] The procedure states that "[r]eports will be reviewed and if inaccuracies are found, updates to the provider directory will be made."[12] Similarly, the Plan's *Aetna Online Provider Search – California & All Providers Online Process* policy states that the "online Provider Search is updated 6 days a week …" and that inaccurate information may be reported on the Plan's website, by e-mail, or by telephone.[13] However, the policy does not address the Plan's process for investigating or correcting any reported inaccuracies.

The Plan's *California HMO Amendment to Member Complaint and Appeal Policy CA 001* tracks the language of Sections 1367.27(j)(3) and 1367.27(o)(1). The policy states that enrollees may report provider directory inaccuracies as grievances. The Plan will investigate via the grievance process and provide feedback to the appropriate Plan department to conduct further investigation and make any necessary corrections to the directories.

The Plan has documented in its National Quality Oversight Committee (NQOC) meeting minutes, for the review period, ongoing enrollee issues with the online provider directory. Specifically, with respect to attention deficit hyperactivity disorder providers, the Plan detailed the "online provider directory is often outdated, making it difficult for members to find providers who are currently in network, will be covered by their benefit plan and accepting new patients."[14]

The Plan's *2023 Behavioral Health Network Accessibility Analysis – National and States* identified the provider directory as a barrier for enrollees. The Plan specifically acknowledged that "[k]eeping the provider directory accurate is challenging due to the large volume of provider data collected in the Enterprise Provider Database" and "[p]roviders change their address/contact information or leave the network without informing Aetna."[15]

The Plan submitted a report of the Plan's efforts to track, verify, and resolve reported directory inaccuracies.[16] However, review of the Plan's call inquiry files demonstrated that enrollees reported numerous potential provider directory inaccuracies that were not tracked, investigated or resolved.

Interviews

During interviews, the Plan detailed a process whereby a customer service representative (CSR) completes a Network Assistance Form (NAF) ticket when an enrollee reports a provider directory inaccuracy. The CSR collects basic information from

[11] *California Provider Directory Process – Print Directory*, page 3.
[12] Id.
[13] *Aetna Online Provider Search – California & All Providers Online Process*, pp. 1-2.
[14] NQOC Meeting Minutes, 2022 Aetna Behavioral Health Quality Improvement Activity – Attention Deficit Hyperactivity Disorder, July 26, 2022, p.1366 of 1686.
[15] NQOC Meeting Minutes, 2023 Behavioral Health Network Accessibility Analysis – National and States, July 25, 2023, p. 545 of 1686.
[16] Response to Requests #88-89 on the Aetna Interview Document Requests (submitted by the Plan on January 10, 2025). The report detailed 27 reported inaccuracies for the review period: five were related to behavioral health (one address change; four no longer accepted Aetna Insurance) and the remaining 22 were related to medical providers.

the member regarding the provider, inputs the information in the NAF ticket, then submits the ticket to the Provider Data Services Team. The Provider Data Services Team and the network areas are responsible for investigating provider directory inaccuracies, and updating the provider directory as needed.[17] According to the Plan's CSR, the Plan does not update its provider directory when informed that a provider is not taking new patients and does not consider this an inaccuracy.

File Review

The Department reviewed 42 enrollee call inquiry files, including audio recordings of the calls, and determined seven[18] files involved reports of provider directory inaccuracies. There was no evidence in any of the seven (100%) files that the Plan took any action to investigate the reported inaccuracies.

The Department reviewed nine exempt and expedited grievance files. In three[19] of the files the enrollees complained that providers identified as in-network with the Plan were no longer accepting new patients or were no longer contracting with the Plan. In none (100%) of the three files did the Plan demonstrate it investigated or corrected the reported provider directory inaccuracies.

Case Examples

- **Inquiry File LFC Prov Sch #1:** Enrollee received a list of in-network psychiatrists but none of the providers were accepting new patients. Enrollee had called "six or seven providers who ha[d] no room." This query was not treated as a provider directory inaccuracy and there is no evidence that the CSR submitted a NAF ticket.

- **Inquiry File LFC_Prov Sch #23:** The enrollee was searching for a provider to screen for attention deficit/hyperactivity disorder. The enrollee found two providers in the Plan's provider directory; however, one did not accept the Plan's insurance, and the other was not accepting new patients. This query was not treated as a provider directory inaccuracy and there is no evidence that the CSR submitted a NAF ticket.

- **Inquiry File LFC IFP_Calls #24:** The enrollee was searching for a trauma therapist and was previously given a list of 30 providers, none of whom were accepting new patients. The enrollee's complaint was not treated as a provider directory inaccuracy and there is no evidence that the CSR submitted a NAF ticket.

- **Out-of-Network Request File LFD_OON_COV_MC #5:** The enrollee called in-network providers from a list supplied by Member Services, however the enrollee was unable to find an in-network provider accepting new patients. Authorization

[17] *See also* Response to Request #49 on the Aetna Interview Document Requests (submitted by the Plan on January 5, 2025).
[18] Plan Call Inquiry Files: LFC Esc_Calls 1, 2; LFC Prov_Sch: 1, 23; LFC IFP_Calls: 5, 24 and 25.
[19] Plan Grievance Files: LFF Exempt_Exp 1, 15, 16 (Files 15 and 16 are the same enrollee, different dates).

for out-of-network services was approved, but there was no documentation that the Plan addressed the reported inaccuracies.

- **Grievance File LFF Griev #24:** The enrollee filed a complaint informing the Plan that a representative emailed the enrollee a provider list, the enrollee's child established care with a provider from the list, and then subsequently discovered that the provider list was incorrect and that the provider they selected was not in-network. A single case agreement (SCA) was approved; however, the enrollee was seeking reimbursement for the appointments that preceded the SCA. The Plan approved the enrollee's request however there is no documentation that the Plan addressed the reported inaccuracy.

Conclusion: Sections 1367.27(e)(1)(D) and (e)(2)(A)-(C) require plans to update their online provider directory at least weekly when informed a provider is no longer accepting new patients or is no longer under contract with the plan. Sections 1367.27(j)(3) and 1367.27(o)(1) require health care service plans to promptly investigate a reported inaccuracy of information in the provider directory or directories, and, if necessary, undertake corrective action within 30 business days of receipt of the report. Section 1367.27(o)(2)(B) requires the receipt and outcome of each reported inaccuracy to be documented. Interviews with the Plan revealed that the Plan does not consider a report that a provider is no longer accepting new patients as a provider directory inaccuracy that must be investigated and corrected when necessary. Review of the Plan's files demonstrated that when enrollees reported potential provider directory inaccuracies, the issues were not documented, reported, investigated or escalated. Therefore, the Department finds the Plan in violation of these statutory requirements.

#2: The Plan's processes fail to ensure that enrollees are offered appointments within timely access standards when they call the Plan or submit grievances about requesting behavioral health appointments.

Statutory/Regulatory Reference(s): Sections 1367.03(a)(1), (a)(5), 1368(a)(1); Rules 1300.67.2.2(b)(2), 1300.67.2.2(c)(5), and 1300.68(a)(1), (a)(4)

Supporting Documentation:

- *QM 07 Member Access to Practitioner and Member Services – California* (Effective April 25, 2023)
- *California HMO Amendment to Member Complaint and Appeal Policy CA 001* (dated October 3, 2023)
- *BH Linkage Requests* (dated January 12, 2023)
- *Complaints and Appeals in IAM Portal* (dated June 20, 2024)
- *GPS Appeals and Complaint Status and Submission* (dated November 30, 2023)
- Plan Inquiry Files (March 1, 2022 through February 29, 2024)
- Plan Grievance and Appeal Files (March 1, 2022 through February 29, 2024)

Assessment: Plan grievance systems must have reasonable procedures to ensure that enrollee grievances are adequately considered and rectified when appropriate.[20] A grievance is defined as

> 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.[21]

A grievance is considered resolved when 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.[22]

A grievance "regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered health care services."[23] When an enrollee requests a behavioral health appointment, plans are required to offer appointments within specified timely access standards, the timeframe for appointments depends on the urgency of the needed service and the type of service.[24] For example, health plans must offer an appointment within 48 hours of a request for an urgent appointment for a service not requiring prior authorization and within 96 hours for a service requiring prior authorization.[25] Requests for non-urgent appointments with a specialist physician require offering an appointment within 15 business days of the request, and requests for non-urgent appointments with non-physician mental health care providers require the plan to offer an appointment within 10 business days of the request.[26] Follow-up appointments with a non-physician mental health or substance use disorder provider must be offered within 10 business days of the prior appointment for those undergoing a course of treatment.[27]

Therefore, when an enrollee notifies the Plan they are having difficulty obtaining a behavioral health appointment or are experiencing delays in scheduling an appointment, the Plan must consider the expression of dissatisfaction as a grievance and an initial request for an appointment.[28] When a request for an appointment is made, the Plan is required to offer an appointment within the applicable timely access standards.[29] Failure to do so means the Plan has not adequately considered and rectified or resolved the

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[20] Section 1368(a)(1).
[21] Rule 1300.68(a)(1).
[22] Rule1300.68(a)(4)
[23] Rule 1300.67.2.2(b)(2).
[24] Section 1367.03(a)(5); Rule 1300.67.2.2(c)(5).
[25] Section 1367.03(a)(5)(A)-(B); Rule 1300.67.2.2(c)(5)(A)-(B). "The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee." Section 1367.03(a)(5)(H); Rule 1300.67.2.2(c)(5)(H).
[26] Sections 1367.03(a)(5)(D), (E); Rules 1300.67.2.2(c)(5)(D), (E).
[27] Section 1367.03(a)(5)(F); Rule 1300.67.2.2(c)(5)(F).
[28] Rules 1300.68(a)(1), 1300.67.2.2(b).
[29] Section 1367.03(a)(5).

grievance.[30] Adequate consideration and resolution require offering the enrollee an appointment within timeliness standards because obtaining an appointment was the substance of the grievance.

Plan Documents

Review of the Plan's documents, including policies and procedures, grievance processes, customer service processes, and log data, demonstrated the Plan's processes fail to ensure enrollees are offered appointments when enrollees expressed difficulty finding an in-network behavioral health appointment. The Plan's QM 07 - *Member Access to Practitioner and Member Services – California* policy includes the timeliness standards for the various urgent and non-urgent appointment types. The Plan's *Member Complaint and Appeal Policy California HMO Amendment* describes the Plan's grievance processes in general. However, none of the policies specify a process for identifying grievances about delays or difficulties finding an appointment, nor do the policies address whether the Plan considered requests for appointments as initial requests for services.

In response to the Department's request for documents used by Plan customer service staff to recognize expressions of dissatisfaction, the Plan provided job aids and training documents. However, none of the Plan's documents describe a process for offering enrollees timely appointments when enrollees file grievances involving delays or difficulties finding an appointment.[31]

In response to the Department's request for documents used by Plan customer service staff when an enrollee is having difficulty obtaining a behavioral health appointment, the Plan provided a document entitled *BH Linkage Request*.[32] According to the document, when an enrollee has difficulty finding a provider, the Plan's linkage team may offer to help the enrollee find an available provider using specified search criteria. However, according to the Plan's *BH Linkage Request* document, this process takes five to 10 business days, and the linkage team does not schedule appointments on behalf of the enrollee. [33] Therefore, even if the linkage team locates a provider who is in-network and

[30] Rule1300.68(a)(4).
[31] The Plan provided documents with screenshots of the enrollee appeal process from the Plan website (*Complaints and Appeals in IAM Portal*) and screenshots showing how an employee is to enter a grievance in the Plan portal (*GPS Appeals and Complaint Status and Submission*). Response to Request #20 on the Plan Pre-Interview Document Requests (submitted by the Plan on October 24, 2024).
[32] The Plan provided two versions of its BH Linkage Request document. The initial document references an urgent or expedited process with a 24–48-hour turn-around-time with examples of appropriate requests including when an enrollee has exhausted the search for a provider, or the member has five days or less worth of medication. In those cases, a follow-up should take place in three business days. During interviews, Plan staff stated the Plan does not have an urgent linkage process contrary to the initial BH Linkage Request document provided by the Plan. Following interviews, the Plan submitted a new version of the BH Linkage Request document, which removed all references to the urgent request process. *BH Linkage Request* (revised March 18, 2025).
[33] Response to Request #22 on the Aetna Pre-Interview Document Requests (submitted by the Plan on October 25, 2024). According to the *BH Linkage Request* document, services provided via this process are further limited inasmuch as "[s]earches are not conducted for groups, ethnicity, or religion. However, we can search for Christian Counseling as a specialty. Only do op therapy and psychiatry; not hospitals". *BH Linkage Request* (revised March 18, 2025).

accepting new patients, the Plan does not ensure the enrollee is offered an appointment within the timely access standards because the linkage team is not involved in the scheduling of an appointment as noted in the BH Linkage Request document.[34] Therefore, the Plan's linkage request process is ineffective because the services are limited, the process is lengthy and the linkage team may not even make initial contact with the enrollee until a date beyond which the enrollee should have been offered an appointment that meets timeliness standards. Further, since the linkage team does not schedule appointments on behalf of enrollees, the Plan does not ensure those appointments are offered within timely access standards.

The Department also requested a report of the number of behavioral health linkage requests the Plan received during the review period from the Behavioral Health Line and the main Member Services Line, respectively. In response to both requests, the Plan advised that "This data is not reportable because it's not captured in a dedicated field that can be queried from the Plan's systems."[35] As a result of not having a process to track behavioral health linkage requests, the Plan is not able to monitor instances in which callers are accessing timely behavioral health appointments.

Interviews

During interviews, the Plan was asked how CSRs respond to requests for behavioral health appointments. The Plan's CSR responded that these situations are not referred to Grievances and Appeals and instead are referred to the behavioral health linkage process which can take up to 10 business days. The Plan's Senior Manager for Corporate Compliance stated behavioral health linkage requests are completed in five to 10 days and do not include an urgent process. They added that enrollees may also be referred to the separate behavioral health line when they are having difficulty obtaining an appointment.

The Plan was also asked how it ensures that behavioral health appointments are offered within timely access standards when the turnaround time for the linkage request is five to 10 business days. The Plan representative advised that the only process available is the linkage request. However, as stated above, the Plan's linkage request process is ineffective because the services are limited and the Plan does not offer the enrollee timely appointments.

The Plan was asked when an enrollee is having difficulty obtaining an appointment does the Plan escalate the issue through the standard grievance process. The Plan's CSR stated that if an enrollee expressed dissatisfaction with obtaining an appointment, the CSR will refer the call to a supervisor who has 48 hours to return the enrollee's call before the Plan will initiate a grievance on the enrollee's behalf. However, at an enrollee's request, the complaint is immediately escalated to a grievance, without waiting for a supervisor to return the enrollee's call.

[34] Grievance File LFF Exempt Exp #1 and Inquiry File LFC Esc_Calls #1, Inquiry File LFC Esc_Calls #2 and Inquiry File LFC Prov_Sch #6 are examples of enrollees not being offered appointments within timeliness standards via the linkage process.
[35] Response to Request #90-91 on the Aetna Interview Document Requests (submitted by the Plan on January 17, 2025).

File Review

The Department reviewed 42 enrollee call inquiry files, including the corresponding audio recordings, involving behavioral health related inquiries. In 11[36] of the 42 files, the enrollee expressly reported difficulty finding or obtaining an appointment with a behavioral health provider. None (100%) of the 11 files indicate the Plan offered enrollees timely appointments. The Department also found in 10 of those 11 files, the enrollee reported contacting the Plan on prior occasions to obtain an appointment. None of the 10 files indicate the Plan offered enrollee's timely appointments.

The Department reviewed nine exempt and expedited grievance files involving behavioral health issues. Three[37] of the nine files involve an enrollee having difficulty obtaining a behavioral health appointment but all three (100%) of the grievances were resolved with no documentation the enrollee was offered a timely appointment.

The Department reviewed 12 behavioral health standard grievance files categorized by the Plan as interactions, behavioral health, access, quality of care, and medical necessity. Two[38] of the 12 files were related to an enrollee having difficulty obtaining an appointment. Neither (100%) of these files indicate the Plan offered the enrollees timely appointments for behavioral health services.

Case Examples:

- **Grievance File LFF Exempt Exp #1 and Inquiry File LFC Esc Calls #1:** The same enrollee contacted the Plan multiple times regarding difficulty finding a behavioral health provider for the enrollee and the enrollee's child. The enrollee received multiple provider lists from the Plan in the prior three weeks to select an in-network behavioral health provider. The enrollee expressed dissatisfaction with their inability to schedule an appointment with any of the providers listed. The enrollee explained they spent "countless hours" contacting providers on the lists but were unable to obtain an appointment because providers were no longer contracted with the Plan, did not have appointment availability, or could not treat the enrollee as an adult (i.e., the provider only treated adolescents).

  During the call with the Plan, the enrollee stated, "I am frustrated . . . [because] I am paying for my services and I'm not getting any." The enrollee reported again that the Plan's directory information was not accurate when they stated, "[t]he things you are sending out, I'm told they are updated [but they are not]." The enrollee informed the customer service representative that a linkage request was already made, but it was unsuccessful, and she was still unable to get an appointment. The enrollee reiterated their dissatisfaction when they expressed, "I am so beyond upset … [a]ll I want is some help," and "it shouldn't be that I have to struggle." The enrollee requested escalation to a supervisor.

[36] Plan Inquiry Files: LFC Prov_Sch 1, 3, 4, 6, 11, 18, 23; LFC Esc_Calls Files 1, 2; LFC IFP_Calls 5, 24.
[37] Plan Grievance Files: LFF Exempt_Exp 1, 15, 16 (Files 15 and 16 are the same enrollee, different dates).
[38] Plan Grievance Files: LFF Gri_Cat 6, 10.

The CSR gave the enrollee contact information for another provider group that offered telehealth services, however there was no evidence in any of the files that the CSR verified whether the group was accepting new patients or if the enrollee had been offered an appointment.

- **Inquiry File LFC Esc Calls #2:** The enrollee reported they previously called the Plan on two separate occasions for a list of providers accepting new patients. The enrollee was eventually able to access a provider list, however the enrollee was advised that the providers were not accepting new patients or were not contracted with the Plan when the enrollee attempted to make an appointment. The enrollee stated, “I just need a list of people I can call that are accepting new patients and are in-network.” The CSR explained that the Plan updates its directory information, but also “there are going to be times, unfortunately lots of times, where there’s a disconnect with the provider, and for whatever reason their information is not updated.” The enrollee wanted a list, “even if it’s one in-network person that’s taking patients … The challenge is … these lists aren’t up to date … I can’t spend any more energy on this, I just need to walk away with a name or a couple of names today that I can call that I can confirm are accepting new patients and are in-network.”

  The CSR offered to submit a behavioral health linkage request which could take up to two weeks. The enrollee was upset upon hearing this information and stated, “The only thing standing in the way right now [of] getting the help I need is me dealing with Aetna and perhaps it’s a lost cause. The challenge in my experience, let’s say they get back to me within two weeks, now I have a name of someone who can see me … I’m not even in the position yet where I’ve nailed down an appointment, which probably won’t be next day. Just from my experience, realistically if I went that route, we’re talking at least a month before I get in to see somebody, which is probably not at this point something I’d be interested in. … I’m more than fine with you escalating this call and bumping me up to a manager. I just need to get a name, someone I can call to set up an appointment.” The CSR did not express any disagreement with the enrollee’s understanding of the behavioral health linkage request process.

  During the call, the CSR stated, “I understand you think a manager is going to do more, they have the same access I do. If it will make you happy, I will give you the name from my list, but I cannot guarantee you that they are still in the network and still taking new patients, that’s something you have to do.”

  The CSR provided the enrollee with the website for a telehealth provider, to which the enrollee appeared receptive. However, there is no documentation the enrollee was offered a timely appointment.

- **Inquiry File LFC Prov Sch #6:** The enrollee’s parent called the Plan seeking assistance finding a specialist for autism spectrum disorder testing. While the parent was placed on hold, the CSR called several providers in an attempt to find an autism specialist. The CSR was unsuccessful and offered to submit a behavioral health linkage request on behalf of the enrollee. The parent stated that

a linkage request was made six months prior, but they never received a response from the Plan, which is why they were contacting the Plan again.

The parent expressed frustration and stated, "I don't know what to do at this point. I don't know if I can trust that I'll be actually called back . . . or that the Plan will find [a provider]." The CSR acknowledged the previous linkage request did not yield any results and offered the enrollee the option of submitting a network deficiency request and using an OON provider. The parent seemed amenable to this option, however, there is no documentation that they were offered a timely appointment.

- **Call Inquiry File LFC_Prov_Sch #4:** The enrollee called the Behavioral Health Line seeking care for his wife. The enrollee informed the CSR that he had spoken with a care manager a week ago regarding a linkage request and had not yet received a list of mental health providers. Another CSR informed the enrollee that he would receive a response in 24-48 hours. The CSR informed the enrollee that the linkage request process could take up to two weeks. The enrollee expressed frustration and asked if there was a quicker way to get the information. The enrollee attempted to independently find a provider but was unsuccessful.

Conclusion: Review of Plan documents and case files along with information obtained from Plan interviews demonstrate the Plan does not identify expressions of dissatisfaction regarding a delay or difficulty in obtaining a behavioral health appointment as a request for an appointment, and the Plan's processes fail to ensure that enrollees are offered appointments within timely access standards when they call the Plan or submit grievances about requesting behavioral health appointments. The Plan thereby fails to adequately consider and rectify the enrollee's grievance. Accordingly, the Department finds the Plan in violation of Sections 1367.03(a)(5) and 1368(a)(1) and Rules 1300.67.2.2(b)(2), 1300.67.2.2(c)(5) and 1300.68(a)(1), (a)(4).

#3: The Plan fails to consistently arrange for the timely provision of out-of-network behavioral health care for its enrollees.

Statutory/Regulatory Reference(s): Sections 1367.03(a)(1), (a)(5), 1374.72(d), and Rule 1300.67.2.2(c)(1)

Supporting Documentation:

- *National Clinical Services (NCS) 512 Non-Participating Provider – California Amendment* (Effective January 20, 2024)
- *Network Deficiency* Procedure (undated)
- Plan Inquiry Files (March 1, 2022 through February 29, 2024)
- Plan Out-of-Network Request Files (March 1, 2022 through February 29, 2024)
- Plan Grievance and Appeal Files (March 1, 2022 through February 29, 2024)

Assessment: Health plans must provide or arrange for the provision of covered behavioral health care services in a timely manner appropriate for the nature of the enrollee's condition.[39] Plans must also ensure their networks have adequate capacity

[39] Section 1367.03(a)(1).

and availability of licensed health care providers to offer enrollees appointments within timely access standards.[40] If behavioral health services are not available within geographic and timely access standards, then Plan must arrange for coverage outside of the Plan's network.[41]

Plan Documents

The Plan's *National Clinical Services (NCS) 512 Non-Participating Provider – California Amendment* policy restates the Plan's obligation to arrange for out-of-network medically necessary behavioral health care when services are not available in-network. However, the policy does not describe a specific process for how the Plan would arrange for and cover the services of a non-participating behavioral health provider.

The Plan does have a process in which the enrollee can make a "network deficiency request" to obtain authorization for payment for services from an out-of-network provider when the enrollee cannot find an in-network provider. The Plan's *Network Deficiency* procedure requires the enrollee to provide the information below before proceeding with the request:

- All Providers [*sic*] information - TIN/NPI - all procedure codes and all dx codes
- The Providers [*sic*] Address, The Providers Tax ID, Any Procedure Codes and Any Diagnosis Codes.[42]

"[I]f they do not have the first two than [*sic*] the request cannot be initiated."[43] The Plan acknowledges that it "[c]an take 14 days depends on how quickly we verify information and get clinical info in from provider."[44] The Plan's network deficiency process essentially shifts the responsibility of arranging for out-of-network services from the Plan to the enrollee.

Interviews

During interviews, the Plan was questioned about the network deficiency procedure and the enrollee's obligation to provide the required information regarding the out-of-network provider. Plan representatives stated they only ask for this information if the enrollee already has it. However, as demonstrated in the below case files, the enrollee must provide the information before the Plan will initiate the network deficiency request.

File Review

The Department reviewed a total of 61 files involving requests for out-of-network care. In 18[45] of the 61 files, the enrollee requested services from an out-of-network provider due

[40] Section 1367.03(a)(5).
[41] Section 1374.72(d).
[42] *Network Deficiency* Procedure (undated).
[43] *Id.*
[44] *Id.*
[45] Plan Out-of-Network Request Files: LFD OON_COV_MC 3, 5, 7, 10, 13, 15, 20, 21, 25, 30; LFD OON_COV_ATV 1, 2, 6, 23, 25-28.

to an inability to find an in-network provider. Of those 18, the Plan denied two[46] of the requests and there was no evidence in either of those two (100%) files demonstrating that the Plan assisted the enrollee in obtaining care with another provider.

The Department also reviewed 42 call inquiry files, including audio recordings of the calls. In 10[47] of the files, the enrollee had difficulty finding or obtaining an appointment with a behavioral health provider and in all 10 (100%) of the files the customer service representative failed to assist the enrollee in getting an appointment within the timely access standards in-network and did not arrange for a medically necessary out-of-network appointment.

The Department reviewed 32[48] grievance and appeals files. In five[49] of the files, the enrollee expressed difficulty obtaining an appointment with an in-network provider. There was no evidence in any (100%) of these files that the Plan arranged for the enrollees to obtain care outside the Plan's network.

Case Examples

- **Inquiry File LFD OON_COV_MC #7:** The enrollee was seeking therapy due to a traumatic event. The enrollee was unable to identify an in-network provider and called the Plan on March 3, 2023 requesting approval for an out-of-network provider. The Plan prioritized the case as emergent/urgent, however, the enrollee was not contacted until March 10, 2023 by a Utilization Management clinician who requested the name of the treating provider to verify licensure. Although the enrollee responded with the requested information on the same day, the Plan did not advise the enrollee of approval until March 15, 2023. The Plan did not provide timely assistance to an enrollee who was seeking services for a traumatic event since approval was provided after nine (9) business days.

- **Out-of-Network Request File LFD OON_COV_MC #30:** The enrollee's parent called requesting approval of an out-of-network provider because an in-network provider who treats children in the enrollee's proximity was not available. The approval was denied because the provider requested was unlicensed. The Utilization Management clinician informed the parent of the denial and appeal process. However, there is no documentation demonstrating that the Plan arranged for the enrollee to obtain care with another provider.

- **Inquiry File LFD OON_COV_ATV #26:** The enrollee's parent was unable to locate an in-network provider and requested coverage for an out-of-network provider specializing in Obsessive Control Disorder. The parent was informed the provider was unlicensed and would not be covered. The Utilization Management Clinician documented that the parent would call the facility to see if another provider was available. However, there is no evidence that the Utilization Management clinician offered to assist the parent in contacting the facility to

[46] Plan Out-of-Network Request Files: LFD OON_COV_MC 3, 30.
[47] Plan Inquiry Files: LFC Prov_Sch 3, 4, 6, 11, 18, 23; LFC Esc_Calls Files 1, 2; LFC IFP_Calls 5, 24.
[48] Plan Grievance Files: LFF GRI_CAT, LFF GRIEV, LFF Exempt_Exp.
[49] Plan Grievance Files: LFF GRI_CAT 6, 10; LFF GRIEV 11, 12; LFF Exempt_Exp 1.

connect with a licensed provider or arrange for the enrollee to obtain care with another provider.

- **Inquiry File LFC IFP_Calls #24:** The enrollee called and presented as emotional and frustrated because the enrollee was having difficulty finding a trauma therapist that was accepting new patients. The enrollee reported experiencing a medical emergency and needed the request to find a trauma therapist taken seriously. The enrollee previously received a list of 30 providers and "not a single [profanity removed] one of them is taking new patients." The CSR provided the enrollee with a list of trauma therapists but there is no indication that the enrollee was offered a timely appointment with an in-network provider, nor did the CSR arrange for out-of-network services.

- **Grievance File LFF Exempt Exp #1 and Inquiry File LFC Esc_Calls #1:** The same enrollee contacted the Plan multiple times regarding difficulty finding a behavioral health provider for the enrollee and the enrollee's child. The CSR educated the enrollee on network deficiency requests which would allow the enrollee to see an out-of-network provider at the in-network rate. The enrollee was informed that to do a verbal network deficiency request the enrollee needed to supply the Plan with key pieces of information from the provider: provider's name, address, phone number, tax identification number, national provider identifier number, all possible billing procedure codes and all possible billing diagnosis code. The enrollee informed the CSR they needed services immediately and was informed that the network deficiency request process could be approved the same day, but it could also take up to three business days if a clinician was not available.

Conclusion: Based on the Department's review of the Plan's case files and the Plan's policies and procedures, the Department has determined that the Plan is not arranging for out-of-network coverage within timely access standards when in-network coverage is not available. Furthermore, the Plan's "network deficiency request" process shifts the responsibility from the Plan to the enrollee to obtain information to initiate an out-of-network coverage request. Therefore, the Department finds the Plan in violation of Sections 1367.03(a)(1), (a)(5), and 1374.72(d), and Rule 1300.67.2.2(c)(1).

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

#4: The Plan does not include the correct information in its denial and modification letters to enrollees, including providing contact information for the wrong regulator.

Statutory/Regulatory Reference(s): Sections 1367.01(h)(4), 1368(a)(1), 1368.02(b); Rules 1300.68(a), (b)(2)

Supporting Documentation:

- Plan Utilization Management Case Files (March 1, 2022 through February 29, 2024)

Assessment: Section 1367.01(h)(1) requires responses regarding utilization management (UM) decisions to deny, delay, or modify health care services be communicated to the enrollee in writing and include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368.

Section 1368(a)(1) and Rule 1300.68(a) require every plan to establish and maintain a grievance system. As part of that system, the plan's obligation for notifying enrollees about the plan's grievance system must include information regarding the Department's review process, independent medical review system, and the Department's toll-free telephone number and website address.[50]

Section 1368.02(b) further requires the Plan to publish Department's toll- free telephone number, the Department's TDD line for the hearing and speech impaired, the plan's telephone number, and the Department's internet website address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The Department's telephone number, the Department's TDD line, the plan's telephone number, and the Department's internet website address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

> The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**insert health plan's telephone number**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

[50] Rule 1300.68(b)(2).

File Review

The Department reviewed 47[51] utilization management files and determined in five[52] files (11%) the Plan failed to provide the statement contained in Section 1368.02(b) and misidentified the correct state regulator to contact. The denial or modification letters issued to the enrollees advised that the Consumer Communications Bureau with the California Department of Insurance is available to assist enrollees with claims they feel have been wrongfully denied or rejected. The letters further provide the toll-free telephone number and website address for the California Department of Insurance.

Conclusion: The Plan is not compliant with 1367.01(h)(4) since its denial and modification letters do not include the correct information about filing a grievance in the format prescribed by section 1368.02(b). Providing contact information for the wrong regulator not only will confuse enrollees, but could result in unnecessary delays of submittal of standard or urgent grievances, which could result in delayed medically necessary treatment and harm to enrollees.

#5: The Plan failed to demonstrate that for concurrent review denials, care was not discontinued until the enrollee's treating provider had agreed to an appropriate care plan.

Statutory/Regulatory Reference(s): Section 1367.01(h)(3)

Supporting Documentation:

- Plan Utilization Management Files (March 1, 2022 through February 29, 2024)
- *National Clinical Services (NCS) 504 Timeliness Standards for Coverage Decisions and Notification – California* (Effective date December 19, 2023)
- *National Clinical Services (505) Denial of Coverage – California* (Effective date May 25, 2021)

Assessment: Section 1367.01(h)(3) requires that, "[i]n the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient."[53]

Plan Documents

The Plan's *National Clinical Services (NCS) 504 Timeliness Standards for Coverage Decisions and Notification – California* effective December 19, 2023 recites the requirements in Section 1367.01(h)(3), including the statutorily required timelines for notifying providers and enrollees of concurrent review decisions. The policy and procedure does not set forth a process for obtaining agreement from the treating

[51] LFA-1 Auth_Rev, LFA-2 UM_Auth.
[52] Utilization Management Case Files: LFA-1 Auth_Rev # 4, 6, 8; LFA-2 UM_Auth # 1, 3.
[53] Section 1367.01(h)(3) also requires plan decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services be communicated to the requesting provider within 24 hours and to the enrollee in writing within two business days of the decision.

provider prior to discontinuing care in the case of a concurrent review denial, delay or modification.

The Plan's *National Clinical Services (505) Denial of Coverage – California* effective May 25, 2021[54] restates the requirements in Section 1367.01(h)(3) and provides in the case of concurrent review "[f]or adverse determinations made by the Medical Director, the nurse will verbally notify the treating provider of the determination, the availability of peer-to-peer review, appeal rights, and that care may not be discontinued until a new care plan has been agreed upon. This will be documented in the UM system notes."

File Review

The Department reviewed 25 utilization management concurrent review denial files.[55] Eight[56] files involved administrative denials. In three (18%) of the remaining 17 files, all of which involved inpatient treatment, the Plan denied the requested level of care over the treating provider's objections. In all three cases, the attending physician advised the Plan during the peer-to-peer discussion that the enrollee was not ready for a lower level of care. There was no evidence in these files that a care plan appropriate for the medical needs of the enrollee had been agreed upon.

Case Examples:

- **Utilization Management File LFA-2 AUTH #5**: This file involved residential treatment care (RTC), which the Plan authorized through January 30, 2023.[57] On February 6, 2023, the provider requested a post denial peer-to-peer discussion, which subsequently took place on February 7, 2023. During the peer-to-peer, the attending physician stated the enrollee needed more time in RTC because of the history of aggression as evidenced by the enrollee attempting to drown their brother.[58] The file included the decision by the Plan's physician regarding the outcome of the peer-to-peer and stated medical necessity was not met for RTC and treatment could be safely and effectively provided in partial hospitalization level of care. The file stated the Plan notified the provider the same day "that the outcome of the post-denial decision peer-to-peer review is to uphold the issued denial. [The Plan] notified the facility of the member's right to an Appeal/Aetna Expedited Appeal (if applicable)." There is no indication in the file that the provider agreed to a care plan appropriate for the enrollee.

[54] The Plan provided the *National Clinical Services (505) Denial of Coverage – California* policy and procedure for 2022 (effective date May 25, 2021) and 2024 (effective date February 28, 2023). The 2022 policy and procedure is the most current version filed with the Department. With respect to adverse concurrent review decisions by the Medical Director, both policies state "the nurse will verbally notify the treating provider of the determination, the availability of peer-to-peer review, appeal rights, and that care may not be discontinued until a new care plan has been agreed upon. This will be documented in the UM system notes."
[55] LFA-2 AUTH.
[56] Utilization Management Case Files: LFA-2 AUTH # 18-25.
[57] Claims documents from the Plan indicate the Plan paid for services through February 6, 2023.
[58] Id., p. 5.

- **Utilization Management File LFA-2 AUTH #10**: This file involved inpatient treatment, which the Plan authorized through March 7, 2023. On March 8, 2023, the Plan denied additional residential treatment services and recommended intensive outpatient treatment (IOP). On March 9, 2023, the provider requested a peer-to-peer discussion, which subsequently took place on March 10, 2023. During the peer-to-peer, the provider reported the enrollee was just starting to improve and had a history of hospitalization. The provider wanted to ensure stability before stepping down to a lower level of care. The file included the decision by the Plan's physician regarding the outcome of the peer-to-peer and stated medical necessity was not met for RTC and that the member's symptoms and treatment can be managed in a lower level of care such as IOP. The file stated the Plan notified the provider the same day "that the outcome of the post-denial decision peer-to-peer review is to uphold the denial. [The Plan] notified the facility of the member's right to an Appeal/Aetna Expedited Appeal (if applicable)." There was no indication in the file that the provider agreed to a care plan appropriate for the enrollee.

- **Utilization Management File LFA-2 AUTH #13**: This file involved inpatient hospitalization, which the Plan authorized through May 23, 2023. On May 23, 2023, the Plan denied additional inpatient hospitalization and recommended RTC. The provider requested a post-denial peer-to-peer discussion, which took place on May 24, 2023. During the peer-to-peer, the attending physician stated the enrollee had only been compliant with the eating plan for three days, the enrollee's weight remained low and the enrollee had continued self-harming behaviors of daily scratching, which required a behavior plan to address these issues. The file included the decision by the Plan's physician regarding the outcome of the peer-to-peer and stated medical necessity was not met for inpatient hospitalization and the member's symptoms and treatment could be managed in a lower level of care such as RTC. The file stated the Plan notified the provider the same day "that the outcome of the post-denial decision peer-to-peer review is to uphold the denial. [The Plan] notified the facility of the member's right to an Appeal/Aetna Expedited Appeal (if applicable)." There was no indication in the file that the provider agreed to a care plan appropriate for the enrollee.

Conclusion: Based on review of case files and Plan policies, the Department determined that in conducting concurrent UM review of requested services, the Plan failed to comply with the requirements of Section 1367.01(h)(3). Specifically, the Plan failed to demonstrate that in the case of concurrent review, care was not discontinued until a care plan was agreed upon by the treating provider appropriate for the medical needs of the enrollee. Therefore, the Department finds the Plan in violation of Section 1367.01(h)(3).

GRIEVANCES AND APPEALS

#6: The Plan does not consistently identify oral expressions of dissatisfaction as grievances and fails to identify exempt grievances.

Statutory/Regulatory Reference(s): Sections 1368(a)(1), 1368(a)(4)(B)(i); Rules 1300.68(a)(1), 1300.68(d)(8)

Supporting Documentation:

- *Member Complaint and Appeal Policy* (implemented June 14, 2023)
- *Member Complaint Procedures* (implemented June 14, 2023)
- *Member Appeal Procedures* (implemented June 14, 2023)
- *California HMO Amendment to Member Complaint and Appeal Policy CA 001* (dated October 3, 2023)
- Plan Inquiry Files (March 1, 2022 through February 29, 2024)
- Interview Document Requests sent to the Plan on December 16, 2024

Assessment: Health plan grievance systems must have "reasonable procedures in accordance with Department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate."[59] Regulations define "grievance" as:

> [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 reconsider or appeal made by an enrollee or the enrollee's representative.[60]

In addition, when a health plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.[61] Rule 1300.68(a)(2) states a "complaint" is the same as a grievance.

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response.[62] These grievances are commonly referred to as exempt grievances.

Plan Documents

The Plan's *Member Complaint and Appeal Policy, Member Complaint Procedures,* and *Member Appeal Procedures* describe the Plan's national policy and procedures for the identification and resolution of enrollees' complaints, grievances, and appeals. The Plan also submitted their *California HMO Amendment to Member Complaint and Appeal Policy CA 001* (*CA HMO Amendment*), which is the controlling policy to the extent

[59] Section 1368(a)(1).
[60] Rule 1300.68(a)(1).
[61] *Id.*
[62] Rule 1300.68(d)(8).

California law deviates from the Plan's national policy. The Plan's *CA HMO Amendment* includes a definition of grievance that aligns with the definition in Rule 1300.68(a)(1) and includes an "oral expression of dissatisfaction." That document also acknowledges that if the Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.

The Plan also submitted documents in response to a request for training materials, job aids and scripts used by Plan customer service staff in the event an enrollee expresses dissatisfaction with the Plan and/or Plan services.[63] The Plan provided screenshots demonstrating how staff input complaints into the Plan's electronic system. [64] The Plan also provided eight job aides,[65] which detail that customer service staff should provide members with options and alternatives including the right to file a complaint. However, none of these documents detail how a CSR is trained to identify expressions of dissatisfaction.

Additionally, the Plan was asked to provide documents used to train customer service staff to recognize and escalate an issue to a grievance. In response, the Plan provided a document entitled *Complaints*.[66] The document describes terminology used for appeals and includes examples of "some of the more common complaint types". The Plan also provided a document entitled *GPS Documenting Complaints*[67], which shows how complaints are input into the Complaints and Appeals Tracking system (CATS). It states that if a complaint is closed, the CSR must select a resolution reason that most closely matches the actions taken to resolve the complaint. It also states that complaints listed as closed will be tracked and monitored in CATS.

The Plan was also asked to provide policies and procedures describing how customer staff are monitored for accuracy of information and handling of calls. The Plan provided a scoring tool entitled "2025 TOP ACES Quality Standard[68], which the Plan uses to rate customer service calls. This document includes scoring on whether the CSR correctly codes and documents a grievance.

The Plan was asked to provide customer service call audits and reports related to monitoring calls for accuracy of information, correct routing of grievances and recognition of complaints completed during the survey period. In response, the Plan provided a spreadsheet, but the data was national and not limited to California. [69] The document did not indicate how customer service representatives are monitored for accuracy of

[63] Crosswalk Request BHICS 7 and Response to Request #75 on the Aetna Interview Document Requests (submitted by the Plan on January 9, 2025).
[64] Response to Crosswalk Request BHICS7.
[65] Response to Request #75 on the Aetna Interview Document Requests (submitted by the Plan on January 9, 2025) ((1) Angry Callers; (2) Assisting Members in Distress; (3) Contract Servicing; (4) Identifying the Member's Needs; (5) Initiatives; (6) Members Asking for a Supervisor; (7) Resolving the Member's Issue; and (8) Delivering a Difficult Message).
[66] Response to Request #76 on the Aetna Interview Document Requests (submitted by the Plan on January 9, 2025).
[67] Id.
[68] Response to Request #78 on the Aetna Interview Document Requests (submitted by the Plan on January 9, 2025).
[69] Response to Request #79 on the Aetna Interview Document Requests (submitted by the Plan on January 9, 2025).

information, recognition of expressions of dissatisfaction and correct routing of grievances.

The Department requested the Plan provide policies and procedures pertaining to the Plan's exempt grievance policy (sometimes referred to by the Plan as same day call resolution) and training documents and job aides provided to customer service staff pertaining to the Plan's exempt grievance policy. In response, the Plan submitted a document entitled *Types of Appeals and Complaints*, which did not include information regarding exempt grievances.[70] The Plan could not provide any responsive documents to demonstrate that customer service staff are trained in handling exempt grievances or that the Plan has a process for exempt grievances.

Interviews

During interviews, the Department asked how CSRs are trained to identify expressions of dissatisfaction. The Plan's CSR stated that an enrollee asking to speak to a supervisor is an expression of dissatisfaction. The CSR will assure the enrollee they can provide assistance and will refer the call to a supervisor at the enrollee's request. A supervisor response may take 24 to 48 hours. According to a Plan Manager, the supervisor will attempt to de-escalate and reduce frustration. The Plan Manager stated that if an enrollee can be de-escalated, a grievance would not be filed.

The Department also asked how exempt grievances are handled by customer service staff. The CSR advised that they were unaware what constituted an exempt grievance, nor were they aware of the process of entering an exempt grievance into the complaints and tracking system. They further stated that if the issue was resolved in one day, it was not considered a grievance. The CSR stated that they do not input exempt grievances on behalf of the enrollee and that is not their responsibility. The CSR helps with first-call resolution, but that process does not involve tracking any calls in the grievances system.

In contrast, the Plan's Business Operations Manager for grievances and appeals stated exempt grievances are processed through the customer service staff who are also responsible for oversight and review of exempt grievances. Plan representatives could not describe the exempt grievance process with certainty and which unit is responsible for reviewing the exempt grievance log.

File Review

The Department reviewed 42 enrollee call inquiry files, including audio recordings of the calls, involving behavioral health issues from members. The Department determined 11[71] of the 42 files involved an oral expression of dissatisfaction and four[72] of the 42 files should have been categorized as exempt grievances because the grievance was resolved in one day and did not involve coverage or medical necessity issues.

[70] Response to Request #82 on the Aetna Interview Document Requests (submitted by the Plan on January 9, 2025).
[71] Plan Call Inquiry Files: LFC IFP_Calls: 5, 12, 19, 23, and 24; LFC Esc_Calls 2; LFC Prov_Sch 1, 4, 6, 19, 23.
[72] Plan Call Inquiry Files: LFC IFP_Calls: 23; LFC Prov_Sch 13, 17, 21

Nevertheless, there was no evidence in any (100%) of the files demonstrating the Plan processed the files as grievances.

Case Examples

- **Call Inquiry File LFC_IFP_Call #5:** The enrollee called trying to find a therapist. The enrollee called one week prior and was told a list of providers would be sent, however the enrollee did not receive it. The enrollee attempted to find a provider using the Aetna app, however according to the enrollee “No one will cover Aetna.” The call was not escalated to a grievance.

- **Call Inquiry File LFC_IFP_Call #24:** The enrollee previously called the Plan and was given an incorrect provider list. During the present call, the enrollee was very frustrated and used profanities. The enrollee reported experiencing a medical emergency and needed the request to find a trauma therapist taken seriously. "I was on the phone for an hour for nothing. … I don’t want a list of doctors that aren’t taking patients, because that’s a waste of time … Make sure that they are … definitely taking patients … because this has happened before where I get a list and I call 30 [providers] and not a single [profanity removed] one of them are taking new patients." The call was not escalated to a grievance.

- **Call Inquiry File_LFC_Prov_Sch #4:** The enrollee spoke with a care manager one week prior and had not yet received the results of the linkage request. The CSR informed the enrollee that the linkage request process could take up to two weeks. The enrollee expressed frustration and asked if there was a quicker way to get the information. The enrollee attempted to independently find a provider but was unsuccessful. The call was not escalated to a grievance.

- **Call Inquiry File LFC Prov_Sch #19:** The enrollee’s primary care provider put in a referral for a therapy appointment with a behavioral health provider. The enrollee reached out to the behavioral health provider who instructed the enrollee to call the number on the back of the Plan insurance card. The CSR informed the enrollee that referrals are not necessary for behavioral health appointments. The enrollee stated on a previous call with the Plan the enrollee was informed that a referral was necessary. The enrollee expressed frustration with the misinformation and the process to get a behavioral health appointment. The call was not escalated to a grievance.

Conclusion: Based on review of Plan documents, inquiry audio files, and information obtained during interviews, the Department determined the Plan did not consistently identify grievances in calls received from enrollees as required by Section 1368(a)(1) and Rule 1300.68(a)(1). Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

#7: The Plan failed to demonstrate it maintains and periodically reviews the required log of exempt grievances.

Statutory/Regulatory Reference(s): Section 1368(a)(4)(B)(i) and Rules 1300.68(b)(1), 1300.68(d)(8)

Supporting Documentation:

- *California HMO Amendment to Member Complaint and Appeal Policy CA 001* (dated October 3, 2023)
- Plan's Grievance and Appeal Log (Log F)
- Pre-Interview Document Request sent to the Plan on October 18, 2024

Assessment: Plans are required to maintain a log of exempt grievances, including the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance.[73] A plan's designated officer is required to periodically review the exempt grievance log and identify any emergent patterns of grievances.[74]

Plan Documents

The Plan's *Member Complaint and Appeal Policy – California HMO Amendment* (*CA HMO Amendment*) states that the Plan will capture the required information for all verbal grievances that are resolved prior to the close of the next business day and maintain that information in the Plan's Complaint and Appeal Tracking System for 10 years.

The Plan was required to submit a log that included all grievances involving or related to behavioral health services (Log F). Of the 429 grievance entries detailed by the Plan on Log F, the Plan identified six as exempt grievances, 16 as expedited grievances, and the remaining grievances as "all other grievances".

The Department also requested the Plan provide a copy of the Plan's exempt grievance log. The Plan directed the Department to refer to the previously produced Log F, which contained six exempt grievances.[75] However, Log F was created specifically for purposes of this Behavioral Health Investigation in response to a Department request and was not a log of exempt grievances required to be maintained by the Plan in compliance with the requirements of Rule 1300.68(d)(8), which specifies the Plan maintain a log of exempt grievances that contain certain data. Furthermore, the Log F submitted by the Plan did not include all information required by Rule 1300.68(d)(8). Specifically, for the six identified exempt grievances, the Plan did not include the plan representative's name who took the call and resolved the grievance.

Conclusion: The Plan failed to demonstrate that it maintains the required log of exempt grievances and its designated officer periodically reviews an exempt grievance log to identify any emergent patterns of grievances. Therefore, the Department finds the Plan in violation of Section 1368(a)(4)(B)(i) and Rules 1300.68(b)(1) and 1300.68(d)(8).

[73] Section 1368(a)(4)(B)(i); Rule 1300.68(d)(8).
[74] Rules 1300.68(b)(1), 1300.68(d)(8).
[75] Response to Request #13 on the Aetna Pre-Interview Document Requests (submitted by the Plan on October 25, 2024).

QUALITY ASSURANCE

#8: The Plan does not timely notify behavioral health provider applicants of the status of their credentialing application.

Statutory/Regulatory Reference(s): Section 1374.197(a)

Supporting Documentation:
- *California Credentialing Process - External Procedure # 200-307.037* (effective January 1, 2023)
- Plan Credentialing Report
- *CA Initial State Regulatory Compliance Audit Results 01012023-02292024*

Assessment: In accordance with Section 1374.197(a), health plans that cover behavioral health services and credential behavioral health providers "shall assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Upon receipt of the application by the credentialing department, the…plan shall notify the applicant within seven business days, to verify receipt and inform the applicant whether the application is complete."

Plan Documents

The Plan's *California Credentialing Process - External Procedure # 200-307.037* describes how the Plan reviews new and renewing applicants to the Plan's network of providers.[76] On page two, the policy states "[a]ll CA initial practitioners must receive written notification of receipt of his/her complete or incomplete credentialing application within seven (7) business days after Aetna receives the practitioner's credentialing application."

The Department requested a report with specific data elements for all credentialing applications for behavioral health providers received by the Plan on and after January 1, 2023 (Plan Credentialing Report). Within the Plan Credentialing Report, the Plan failed to include the date the Plan notified the provider the application was received and whether the application was complete. [77] According to the Plan, their system for generating the credentialing report does not capture the requested date. The date is entered into general notes section and requires manual entry on the credentialing report.[78] After conducting a manual review of the applications, the Plan submitted a second Plan Credentialing Report with the requested date added for the first 10 providers and for the remainder of the providers the requested date was denoted as "N/A."[79] Of the 10

[76] Response to Request #30 on the Aetna Interview Document Requests (submitted by the Plan on January 5, 2025).
[77] Response to Crosswalk Request BHIUM23.
[78] Response to Request #12 on the Aetna Pre-Interview Document Requests (submitted by the Plan on September 27, 2024).
[79] Response to Request #12 on the Aetna Pre-Interview Document Requests (submitted by the Plan on September 27, 2024).

notification dates the Plan did provide, nine were outside the seven business day required notification period.[80]

A review of the second report revealed another discrepancy, the Plan included non-behavioral health providers and a provider whose contract was not in California. The Plan submitted a third Plan Credentialing Report, however the number of entries with the date the Plan notified the provider was reduced from 10 to four.[81] None of the four notification dates met the seven business day notification period.[82]

The Department also requested the Plan provide the percentage of credentialing applications where notification took place within seven business days. The Plan responded that of the 4,303 behavioral health provider applications processed during the applicable dates, there were 42 instances where the provider did not receive timely notification, and 4,261 providers did receive the requisite notice.[83] To support this assessment, the Plan provided a spreadsheet entitled *CA Initial State Regulatory Compliance Audit Results 01012023-02292024* (Audit Results), which contains data for credentialing applications and includes a Column Q for "CA – Manual Review for CA Status Letter."[84] The document contains 42 entries in Column Q where the Plan acknowledges that there is no verbiage in the general notes section and no letter acknowledging the provider received the requisite notice within seven business days. However, for the remaining 4,261 entries, Column Q is blank and there is no indication that the Plan notified the provider within seven business days of receipt of the application. Furthermore, the four providers for whom the Plan manually entered the notification date in the Plan Credentialing Report, were not identified in the Audit Results as receiving a notification outside the seven business day period. Therefore, the Department is unable to validate whether the information contained in the Audit Results is complete and accurate.

Conclusion: The Plan is required to notify a provider within seven business days of receipt of a credentialing application to verify receipt and inform the provider whether the application is complete.[85] The Plan acknowledged that its system does not automatically track the date of notification. The Plan's credentialing report, wherein the Plan manually entered information for the date of notification, demonstrates the Plan is not meeting the statutory timeframe. Furthermore, the documents submitted by the Plan do not support the Plan's assertion that it is meeting the requisite timeframe for credentialing applications. Therefore, the Plan is in violation of Section 1374.197(a).

[80] Id. (The notification dates ranged from nine to 44 days after the application was received.).
[81] Response to Request #25 on the Aetna Pre-Interview Document Requests (submitted by the Plan on October 30, 2024).
[82] Id. (The notification dates ranged from nine to 44 days after the application was received.)
[83] Response to Request #73 on the Aetna Interview Document Requests (submitted by the Plan on January 5, 2025).
[84] Response to Request #104 on the Aetna Interview Document Requests (submitted by the Plan on January 5, 2025).
[85] Section 1374.197(a).

#9: <u>The Plan's Maternal Mental Health program does not include quality measures to encourage screening, diagnosis, treatment and referral.</u>

Statutory/Regulatory Reference(s): Section 1367.625(a)

Supporting Documentation:

- *2022 Collaboration between Behavioral Healthcare and Medical Care Analysis*
- *2023 Collaboration between Behavioral Healthcare and Medical Care Analysis*
- *2023 Aetna Mental Wellbeing Annual Analysis of Behavioral Health Screening Programs and Program Descriptions*
- *2024 Aetna Mental Wellbeing Annual Analysis of Behavioral Health Screening Programs and Program Descriptions*
- *Provider Notice Maternal Mental Health Screening*

Assessment: Pursuant to Section 1367.625(a), a plan is required to develop a maternal mental health program designed to promote quality and cost-effective outcomes. Maternal mental health programs must "include quality measures to encourage screening, diagnosis, treatment and referral." The term "maternal mental health" is defined as "a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression."[86]

<u>Plan Documents</u>

The Department asked the Plan to provide a description of its maternal mental health program;[87] copies of quality measures, as well as documents demonstrating efforts to encourage and improve maternal mental health screening, diagnosis, treatment and referral;[88] and reports pertaining to the review, monitoring and tracking of the maternal mental health program.[89]

The Plan submitted its *Provider Notice Maternal Mental Health Screening* policy. The document details the screening tools providers may use for enrollees including Patient Health Questionnaire-9 (PHQ-9) for prenatal depression screening and the Edinburgh Postnatal Depression Scale for postnatal depression screening. However, there was no indication of monitoring or follow-up to determine how many enrollees were given the screening tool, how often a screening resulted in a referral for mental health services, or any other data regarding use of maternal mental health screening.

The Plan also provided its *2022* and *2023 Collaboration Between Behavioral Healthcare and Medical Care Analysis* in which it summarizes the partnership between the Aetna Maternity Program and the Aetna Behavioral Health Condition Management Case Management Program. Although the documents acknowledge the importance of behavioral health during pregnancy, there is no information regarding quality measures to encourage screening, diagnosis, treatment and referral.

[86] Section 1367.625(b)(2).
[87] Crosswalk Request BHIPRP1.
[88] Crosswalk Request BHIPRP6(b)(1), (2).
[89] Crosswalk Request BHIPRP6(b)(3), (4).

In addition, the Plan provided its *2023* and *2024 Aetna Mental Wellbeing Annual Analysis of Behavioral Health Screening Programs and Program Descriptions* which included Maternity Depression Screening and Prevention Program Data.[90] Although, the Maternity Depression Screening and Prevention Program Data documents five to six years of data on a national level demonstrating the low number of referrals, the Plan's document focuses on the conversion rate, i.e., the number of members referred that showed some evidence of behavioral health intervention. The Plan did not provide any outcome data on the Maternal Mental Health Program to determine the effectiveness of the program or identify any areas of needed improvement. This limits the Plan's ability to ensure it meets the needs of the enrollees.

In a post-interview request, the Department asked the Plan if it had identified barriers to referrals and whether the Plan had any outcome reports for the investigation period. In response, the Plan re-submitted the *2023 and 2024 Aetna Mental Wellbeing Annual Analysis of Behavioral Health Screening Programs and Program Descriptions*.[91] The Plan's response indicates it has no process to monitor the quality of its maternal mental health program or its compliance with program requirements.

Conclusion: Based on the documents provided, the Plan has not demonstrated its maternal mental health program is designed to promote quality and cost-effective outcomes, nor does it include quality measures to encourage screening, diagnosis, treatment and referrals, as required by Section 1367.625. Therefore, the Plan is in violation of this statutory requirement.

#10: <u>The Plan was unable to demonstrate that customer service staff are knowledgeable and competent regarding enrollee questions and concerns.</u>

Statutory/Regulatory Reference(s): Section 1367.03(a)(10); Rule 1300.67.2.2(c)(10)

Supporting Documentation:

- Board of Director (BOD) meeting minutes 2022, 2023, and 2024
- *Behavioral Health Advocate Audit Form* (undated)
- *Find Care* (undated)
- *Complaints Inquiry* (undated)
- *Escalation Process* (undated)
- *GPS Linkage Requests* (undated)
- *California HMO with IPA Plans* (undated)
- Spark BHI Audit

Assessment: Health plans must "ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not

[90] Response to Crosswalk Request BHIPRP6: Aetna Mental Wellbeing 2023 Annual Analysis of Behavioral Health Screening Programs and Program, p. 21; Aetna Mental Wellbeing 2024 Annual Analysis of Behavioral Health Screening Programs and Program, p. 23.
[91] Response to Request #63 on the Aetna Interview Document Requests (submitted by the Plan on January 5, 2024).

exceed ten minutes."[92] This statutory requirement has two components, a timeframe component and a knowledge and competency component. First, the wait time component limits the wait time to speak with a customer service representative to 10 minutes. Second, the customer service representative who speaks with the enrollee must be knowledgeable and competent about the enrollee's questions and concerns. Both components must be met for a Plan to comply with the statute.

Plan Documents

The Department requested policies and procedures, training materials, job aids, scripts and other documents pertaining to use by, or training of, customer service staff.[93] Requested documents included those measuring the quality of customer service, identifying and correcting problems enrollees face in navigating the customer service process, training materials, how customer service handle expressions of dissatisfaction and responding to requests for assistance finding behavioral health providers, among other things.

In response, the Plan provided several documents[94] including a *Behavioral Health Advocate Audit Form* which contains four pages of questions to assess the customer service staff performance. The *Find Care* document included screenshots of the online provider directory and how to input search parameters. The *Complaints Inquiry* document included screenshots of how to view and add complaints and appeals to the Plan's tracking system. The *Escalation Process* document details the steps for representatives to enter information into a form to escalate a call to a team lead or supervisor. The *GPS Linkage Requests* document demonstrates how to initiate a linkage request. However, none of the documents provided instruction or guidance on making appointments or providing other types of substantive assistance to enrollees.

The Plan was also asked to provide a policy or job aid describing how customer staff are monitored for accuracy of information and handling of calls. The Plan provided a non-responsive training document entitled *California HMO with IPA plans*, which includes instructions on how to handle calls from enrollees who have a California HMO with IPA plan.[95]

The Plan was also asked to provide any audits and reports completed during the investigation period related to the quality of customer service. In response, the Plan provided a spreadsheet entitled *Spark BHI Audit*[96]; however, no explanatory information was provided with this spreadsheet. The spreadsheet appears to address calls from May 2024 through October 2024, which is outside of the review period. This lack of data regarding the evaluation of the customer service staff demonstrates that the Plan does

[92] Section 1367.03(a)(10); Rule 1300.67.2.2.(c)(10)
[93] Crosswalk requests BHICS1, BHICS4, BHICS5, BHICS7, BHICS8, BHICS9, BHICS10
[94] *Behavioral Health Advocate Audit Form*, *Escalation Process*, *Complaints Inquiry*, *Find Care*, *GPS Linkage Requests*
[95] Response to Request #18 on the Aetna Pre-Interview Document Requests (submitted by the Plan on October 25, 2024).
[96] Response to Request #19 on the Aetna Pre-Interview Document Requests (submitted by the Plan on October 25, 2024).

not have adequate processes in place to evaluate customer service representatives for knowledge and competence to assist with questions and concerns raised by enrollees.

Case Examples

The examples below demonstrate that the Plan's CSRs were not knowledgeable and competent about the variety of issues and questions raised by enrollees.

- **Inquiry File LFC Prov_Sch #4**: The enrollee called the Behavioral Health line seeking care for his wife. The enrollee informed the CSR that he had spoken with a care manager a week ago regarding a linkage request and had not yet received a list of mental health providers. The enrollee was previously informed that he would receive a response in 24-48 hours. The CSR stated that this was a "huge miscommunication," and the linkage request could take up to two weeks. The CSR advised the linkage request was initiated and that it is just a matter of waiting for a call from the linkage department.

- **Call Inquiry File LFC Prov_Sch #14:** The enrollee called asking about coverage for mental health benefits. The CSR advised that the enrollee must go through her medical group to get a provider, and that the enrollee should go through her medical group for everything. The enrollee asked how to find an in-network provider and the CSR gave the enrollee the phone number for the enrollee's medical group to obtain contact information for an in-network behavioral health provider. The CSR failed to assist the enrollee with finding an in-network provider and appeared to mistakenly confirm the enrollee's query that a referral was needed from her medical group as the enrollee had an HMO based plan.

- **Call Inquiry File LFC Prov_Sch #19**: The enrollee's primary care provider put in a referral for a therapy appointment with a behavioral health provider. The enrollee reached out to the behavioral health provider who instructed the enrollee to call the number on the back of the Plan insurance card. The CSR stated that a referral was not needed for behavioral health appointments. According to the enrollee, on a previous call with the Plan, the enrollee was informed that a referral was needed. The enrollee was irritated because she had been waiting for a referral and the misinformation caused a delay. The CSR apologized for the misinformation and stated the CSR the enrollee previously spoke to "could have been somebody from medical [i.e., the main customer service line] … [because] they're not trained in behavioral health [services]."

- **Call Inquiry File LFC IFP_Calls #12:** The enrollee called inquiring about coverage for inpatient programs for substance use disorder treatment. The enrollee wanted to know whether he had Medi-Cal or private insurance. The CSR stated the enrollee had "medical" insurance. During the call there appeared to be a misunderstanding with the CSR believing the enrollee was asking about "medical" benefits when the enrollee was asking whether he had Medi-Cal, i.e., coverage through California's Medicaid program. The CSR gave the enrollee names of in-network psychiatrists, because the CSR was unable to find an in-network facility in the enrollee's network. The CSR provided no information

regarding coverage for out-of-network services when in-network services were unavailable. The enrollee wanted to know whether he had options for another health plan with better coverage and the CSR transferred the enrollee to Covered California.

- **Grievance File LFF_Griev #1:** The enrollee was informed by a CSR that the Plan would cover 50% of enrollee's treatment from an out-of-network behavioral health therapist. The enrollee proceeded with treatment and the claim was denied. The enrollee was advised that the CSR provided incorrect information regarding coverage for out-of-network services and the enrollee appealed the denied claim to the Plan. The Plan reviewed the enrollee's call history and overturned the denial stating the Plan "will now allow coverage of the submitted charges up to the fifty (50) percent quoted to you … by an Aetna customer service representative."

Conclusion: Review of the Plan's documents and Inquiry Case Files demonstrate the Plan's customer service representatives are not consistently knowledgeable and competent regarding questions and concerns. Customer service representatives appear to lack sufficient training, are not monitored or evaluated for knowledge and competence, and audio calls demonstrate they are not always able to provide adequate assistance requested by enrollees. The Department therefore finds the Plan in violation of Section 1367.03(a)(10) and Rule 1300.67.2.2(c)(10).

#11: The Plan is operating at variance with its filed provider directory policies and procedures.

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation:
- *California Provider Directory Process – Print Directory* (Revised April 28, 2023)
- *Aetna Online Provider Search California & All Providers Online Process* (Revised March 8, 2022)
- *California HMO Amendment to Member Complaint and Appeal Policy CA 001* (dated October 3, 2023)
- Plan Inquiry Files (March 1, 2022 through February 29, 2024)
- Plan Out-of-Network Request Files (March 1, 2022 through February 29, 2024)
- Plan Grievance and Appeal Files (March 1, 2022 through February 29, 2024)
- Interview Document Requests sent to the Plan on December 14-16, 2024

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or filed amendments or material modification filings.[97]

Included among the types of documents required to be filed are provider directory policies and procedures.[98] Additionally, the Plan filed required annual compliance

[97] Sections 1386(b)(1), 1351, 1352.
[98] Section 1367.27(m)(1).

reports, some of which included the Plan's provider directory policies and procedures and the Plan's complaint and appeal policy.[99]

The Plan's *California Provider Directory Process – Print Directory* states that enrollees or members of the public may report suspected inaccuracies in the provider directory on the Plan's website, by e-mail, or by telephone.[100] The procedure states that "[r]eports will be reviewed and if inaccuracies are found, updates to the provider directory will be made."[101] Similarly, the Plan's *Aetna Online Provider Search California & All Providers Online Process* policy states that the "online Provider Search is updated 6 days a week …" and that inaccurate information may be reported on the Plan's website, by e-mail, or by telephone.[102] The Plan's *Member Complaint and Appeal Policy – California HMO Amendment* tracks the language of Sections 1367.27(j)(3) and 1367.27(o)(1), which require plans to promptly investigate a reported inaccuracy of information in the provider directory or directories, and, if necessary, undertake corrective action within 30 business days of receipt of the report by either verifying the accuracy of the information or updating the information to ensure the accuracy of the directory or directories.

As described in Violation #1, review of Plan case files demonstrated that when enrollees reported potential provider directory inaccuracies by stating a provider was not accepting new patients, the provider was not available or other potential inaccuracies, there is no evidence the Plan documented, investigated or determined an outcome of the potential inaccuracy, or made changes to the provider directory when an inaccuracy was confirmed, as required by the Plan's policies filed with the Department.

Conclusion: The Plan's customer service representatives do not consistently identify, document and submit for handling potential provider directory inaccuracies reported by enrollees. By failing to document, investigate and determine whether potential provider directory inaccuracies required changes to the provider directory, the Plan is operating at variance with its filed provider directory policies, in violation of Section 1386(b)(1).

#12: <u>The Plan is operating at variance with its filed complaints, grievances and appeals policies and procedures.</u>

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation:

- *California HMO Amendment to Member Complaint and Appeal Policy CA 001* (dated October 3, 2023)

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or filed amendments or material modification filings.[103]

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[99] See, i.e., eFiling #s 20161304, 20171710, 20181158, 20190404, 20201438, 20211873, 20221352, 20232336.
[100] *California Provider Directory Process – Print Directory*, page 3.
[101] Id.
[102] *Aetna Online Provider Search California & All Providers Online Process*, pages 1-2.
[103] Sections 1386(b)(1), 1351, 1352.

Included among the types of documents required to be filed are grievance policies and procedures.[104] The Plan's grievance policy and procedure was included in the sample Evidence of Coverage submitted with the Plan's initial application for licensure with the Department.[105] The most recent *Member Complaint and Appeal Policy – California HMO Amendment* (*CA HMO Amendment*) was attached as an exhibit to the Plan's filings demonstrating compliance with SB855.[106]

The *CA HMO Amendment* states the Plan will capture the required information for all verbal grievances that are resolved prior to the close of the next business day, i.e., exempt grievances, and maintain that information in the Plan's Complaint and Appeal Tracking System for 10 years.

As detailed in Violation #7 above, the Plan failed to demonstrate that it maintains a log of exempt grievance data as required by the Plan's policies filed with the Department.

Conclusion: By failing to document and maintain a log of exempt grievances as detailed in the Plan's *CA HMO Amendment*, the Plan was operating at a variance with its filed policies and procedures, in violation of Section 1386(b)(1). Therefore, the Department finds the Plan in violation of this statute.

#13: <u>The Plan is operating at variance with its filed utilization management policies and procedures.</u>

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation:

- *National Clinical Services (505) Denial of Coverage – California* (Effective date May 25, 2021)

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or filed amendments or material modification filings.[107]

Included among the types of documents required to be filed are utilization management policies and procedures.[108]

The Plan included an updated version of its utilization management policy and procedure as an amendment to the Plan's license application during a nonroutine survey by the Department.[109] The Plan's *National Clinical Services (505) Denial of Coverage – California* states in the case of adverse concurrent review decisions made by the Medical Director "the nurse will verbally notify the treating provider of the determination, the availability of peer-to-peer review, appeal rights, and that care may not be discontinued

[104] Section 1351(l).
[105] eFiling #20023220.
[106] eFiling #20211183.
[107] Sections 1386(b)(1), 1351, 1352.
[108] Sections 1351(m), 1367.01(b), 1367.01(j)
[109] eFiling #20180880.

until a new care plan has been agreed upon. This will be documented in the UM system notes."[110]

As detailed in Violation #5 above, the Plan failed to demonstrate a process for obtaining agreement from the treating provider prior to discontinuing care in the case of a concurrent review denial. Additionally, the Department's file review found that there was no documentation of agreement by the requesting provider prior to discontinuation of care.

Conclusion: By failing to document that a care plan has been agreed upon by the treating provider before discontinuing care as detailed in the Plan's *National Clinical Services (505) Denial of Coverage – California*, the Plan was operating at a variance with its filed policies and procedures, in violation of Section 1386(b)(1). Therefore, the Department finds the Plan in violation of this statute.

[110] The Plan provided the *National Clinical Services (505) Denial of Coverage – California* policy and procedure for 2022 (effective date May 25, 2021) and 2024 (effective date February 28, 2023). The 2022 policy and procedure is the most current version filed with the Department. With respect to adverse concurrent review decisions, both policies contain the same quoted language.

SECTION II: SUMMARY OF BARRIERS TO CARE NOT BASED ON KNOX-KEENE ACT VIOLATIONS

The following is an overview of the barriers to care the Department identified through its investigation of the Plan. Additional information on the barriers will be included in the Department's Phase Three Summary Behavioral Health Investigation Report.

For purposes of the BHIs, barriers to care mean those barriers, whether inherent to health plan operations or otherwise, that may create undue, unjustified, needless or unreasonable delays or impediments to an enrollee's ability to obtain timely, appropriate behavioral health care. As applied to providers, barriers refer to those barriers that result in undue, unjustified, needless or unreasonable delays or impediments to a provider's ability to provide timely, appropriate behavioral health services to an enrollee.

The barriers themselves may not rise to a violation of the Knox-Keene Act and/or Rules. The barriers may be caused by a combination of factors, such as a lack of certain provider types due to market conditions (i.e., supply of providers has not kept up with demand for services), health plan acts or omissions that do not arise to a violation of the Knox-Keene Act and/or Rules, circumstances that may not be covered by the Knox-Keene Act and/or Rules, or insufficient facts to support a finding of a violation of the Knox-Keene Act. Although barriers are not enforceable under the Knox-Keene Act, the Summary Report for each phase of the BHIs will include recommendations to reduce barriers and improve access to behavioral health services.

#1: <u>The Plan has not demonstrated an effective process for collaboration and coordination of care between medical and behavioral health providers.</u>

Summary: Coordination of care between medical and behavioral health providers and encouraging communication between the two providers can have a beneficial impact on enrollees. According to the Plan's documents, the Plan tracks coordination of care between behavioral health and medical care providers.

The Plan's *QM79: Measuring the Effectiveness of Continuity and Coordination of Care* policy outlines the process of monitoring and data collection to measure continuity and coordination of care across the health care network. The purpose of this data collection is "to identify opportunities to improve coordination of medical care, coordination of behavioral health care and coordination between behavioral health and medical care through data collection and analyses." This data which is collected from these coordination initiatives is reported to the National Quality Oversight Committee (NQOC) annually.

The December 13, 2022, NQOC meeting minutes note the lowest rate of practitioner to practitioner communication since 2017, with 2020 reflecting 66% as compared to 76% in 2017.[111] The Plan's Physician Practice Satisfaction Survey and Behavioral Health

[111] NQOC Meeting Minutes; 12/13/2022, p. 936 of 1686.

Practitioner Satisfaction Survey, revealed over 90% of practitioners indicated not being aware that coordination was reimbursable."[112]

The December 19, 2023 NQOC meeting minutes, included results from the National Behavioral Health Provider Experience Survey. "Practitioners indicated that they communicated with PCPs 34.2% of the time when permission was granted by the member (with a scale of "most of the time" or "always"). This is the lowest percentage in the past four years, with 2021 showing 37%, 2020 showing 52%, 2019 showing 52% and 2018 showing 67%."[113]

The February 27, 2024 NQOC meeting minutes included the 2024 Aetna Behavioral Health Treatment Record Review Analysis for California. While the data shows an improvement in documentation and practitioner communication for 2023, the Plan identified some opportunities for improvement with respect to record keeping practices and documentation and communication.[114]

Coordination of care between medical and behavioral health practitioners and encouraging communication would enhance patient quality of care and could improve enrollee outcomes. Despite tracking this data, the Plan has not showed improvement in this area which could impact patient care.

#2: <u>The Plan does not have a system to adequately track, monitor and review grievances in order to improve the delivery of behavioral health services.</u>

Summary: In response to a request for documents demonstrating how the Plan tracks and monitors behavioral health grievances, the Plan provided board of director reports for 2022, 2023 and 2024.[115] Each report's table of contents includes the Plan's review of the top five grievance categories for exempt and standard grievances along with appeals. The reports do not break out the grievances and appeals by behavioral health issues. When asked to provide reports of grievance data the Plan uses to track and trend outside of the board of director meeting minutes, the Plan responded with "none."[116]

During interviews, the Plan representatives were not able to describe the Plan's tracking and trending process and how quality of service issues are tracked and trended. Following interviews, the Department requested the Plan provide reports that demonstrate tracking and trending of grievances related to the quality of behavioral health services. In response, the Plan provided an Excel spreadsheet for all appeals (both medical as well as behavioral health) for their national membership with

[112] Id. p. 941.
[113] NQOC Meeting Minutes: 12/19/2023, p. 189 of 1686.
[114] According to the Plan, "Only about half of the 2023 records included a Release of Information (ROI) to enable the BH practitioner to communicate with the client's other practitioners." Id. at 43 of 1686. The Plan also noted, "Some BH practitioners report the belief that communication with the primary medical practitioner is relevant only when there is a medical diagnosis present or when there is other evidence of clinical necessity. Behavioral Health practitioners may not be fully aware of the importance of this communication and collaboration." Id. at 43-44 of 1686.
[115] Response to Crosswalk Request BHIGA8.
[116] Response to Request #14 on the Aetna Pre-Interview Document Requests (submitted by the Plan on October 25, 2024).

demographic data.[117] While the report details the resolution of each appeal, it does not demonstrate tracking or trending of grievances related to the quality of behavioral health services. The Plan also provided two Power Point presentations with commercial appeals category information for their national membership. [118] These documents were also non-responsive to the request.

The Plan was asked to provide policies and procedures, including those related to grievances and appeals, pertaining to tracking and trending issues and the circumstances that would require an investigation by the Plan. However, the Plan responded that it "has not identified any other documents or policies and procedures that are responsive to this request."[119]

As a result of not having a process for tracking and trending quality of service grievances related to behavioral health, the Plan is not able to identify quality of service issues and is unable to improve the delivery of behavioral health services.

#3: <u>The Plan's reimbursement practices create a barrier to increasing the number of in-network behavioral health care providers sufficient to meet the needs of its enrollees.</u>

Summary: The Plan's payment rates are considered low by providers and the Plan's reimbursement practices create barriers for providers, thus impeding the ability to improve access by increasing the number of network providers.

In the *Quality Management Aetna Health Inc. Of California Board of Directors Report* (March 14, 2024) (*Quality Management Report*) provided by the Plan, the number one category of complaints by providers for all quarters in 2023 was related to the use of incorrect contractor or negotiated rate. For the first three quarters of 2023, the number three category of complaints was incorrect non-participating fee schedule.[120]

Interviews with providers revealed their difficulties obtaining provider fee rate increases and lack of communication from the Plan regarding the ability to negotiate fee rates. File review also demonstrated provider's difficulty obtaining rate increases.

<u>Case Examples</u>

- **<u>Provider Complaints and Disputes File LFE Prov Appeal #26</u>**: The provider had difficulty receiving a response from the Plan regarding his request for a rate increase during the three-year contract cycle. The provider advised that if he did not receive a response, he wanted to be removed from the network. The Plan reached out to the provider who responded that "he is only asking for what other

[117] Response to Request #100 on the Aetna Interview Document Requests (submitted by the Plan on January 5, 2025), Request #100.xlsx.
[118] Response to Request #100 on the Aetna Interview Document Requests (submitted by the Plan on January 5, 2025), Request #100.pptx; Request #100 Part 2.pptx.
[119] Response to Request #102 on the Aetna Interview Document Requests (submitted by the Plan on January 10, 2025).
[120] Quality Management Aetna Health Inc. of California Board of Directors Report, March 14, 2024 (4th Quarter 2023), pp18-19Provider Complaint and Appeal Turnaround Times (TAT)].

commercial insurances are paying." The Plan informed the provider that he had a three-year contract with the Plan and was unable to terminate the contract until it expired. The Plan was not willing to negotiate the provider's rates mid-contract despite the provider's assertion that there was a shortage of in-network providers in his area.

As demonstrated by the Plan's *Quality Management Report,* the Plan's primary complaint from providers is that the incorrect contractor or negotiated rate is applied in the claims process. Furthermore, interviews with providers and file review demonstrated that the rates paid by the Plan are perceived by the providers as low and providers are unable to increase their contracted rate during the term of a contract, which could hinder provider participation in the Plan.

#4: The Plan's electronic claim submission system is not adequately maintained to prevent improper denials, which creates a barrier to timely reimbursement.

Summary: In reviewing provider appeals related to claim payments, the Department found that two claims had been denied on the grounds that a referral was required. During interviews, when questioned as to why the claims were denied when no referral was required, the Plan advised that these claims were incorrectly auto-adjudicated by the Plan's claims system. The Plan's claims system was subsequently updated in May 2024, to allow these types of behavioral health claims to be auto-adjudicated without referral. [121] However, the claims identified by the Department were adjudicated in a two-year time period before correction and issues were not identified until a provider appeal was initiated. It is unclear how many additional claims were improperly auto-adjudicated during this period without correction by the Plan.

- **Provider Complaints and Disputes File LFE Prov Appeal #5**: The provider's claim was denied on January 18, 2023 due to a lack of a prior authorization. The provider appealed on February 24, 2023, and the Plan reprocessed the claim to allow for payment. The Plan's notes indicated "Claim is payable with no referral since mental health." The claim was paid on March 2, 2023, and the resolution letter was sent to the provider the same day.

- **Provider Complaints and Disputes File LFE Prov Appeal #6**: The provider's claim was denied on December 1, 2021 due to lack of a referral. The in-network provider appealed on March 29, 2022, and the Plan reprocessed the claim on April 18, 2022, because "no referral is needed for mental health direct access." The claim was paid on April 20, 2022, and the resolution letter was sent to the provider the same day.

Automatic denials of claims for behavioral health services that do not require prior authorization or referral, can be a roadblock and delay services. Providers were required to file appeals for claims which were improperly denied due to auto-adjudication. The first

[121] Response to Request #36 on the Aetna Interview Document Requests (submitted by the Plan on January 6, 2025).

case was identified and corrected in April 2022, but the issue persisted into 2023. The Plan confirmed that this issue was not corrected until May 2024.

#5: <u>The Plan does not track and trend repeat callers to identify patterns and problems that enrollees may experience in accessing behavioral health care.</u>

Summary: In response to a request that the Plan provide documentation demonstrating the Plan tracks repeat callers, the Plan responded, “There is no tracking documentation of repeat callers.”[122]

During interviews, the Plan was asked how the Customer Service team was trained to deal with enrollees who stated that they had called previously for the same issue, and if the process was different for callers seeking behavioral health providers. The CSR advised that they attempt to solve the issue or initiate a linkage request if the issue was related to obtaining an appointment.

<u>Case Examples</u>

- **<u>Inquiry File LFC Prov_Sch #6</u>**: The enrollee’s parent called the Plan seeking assistance finding a specialist for autism spectrum disorder testing. The parent stated that a linkage request was made six months prior, but they never received a response from the Plan, which is why they were contacting the Plan again. The parent expressed frustration and stated, "I don't know what to do at this point. I don’t know if I can trust that I’ll be actually called back . . . or that the Plan will find [a provider]."

- **<u>Call Inquiry File_LFC_Prov_Sch #4:</u>** The enrollee spoke with a care manager one week prior and had not yet received the results of the linkage request. The CSR informed the enrollee that the linkage request process could take up to two weeks. The enrollee expressed frustration and asked if there was a quicker way to get the information. The enrollee attempted to independently find a provider but was unsuccessful.

- **<u>Grievance File LFF Exempt Exp #1 and Call Inquiry File LFC Esc_Calls #1:</u>** The same enrollee contacted the Plan multiple times regarding difficulty finding a behavioral health provider. The enrollee reported they received multiple provider lists from the Plan three weeks ago to select an in-network behavioral health provider. The enrollee expressed dissatisfaction with their inability to schedule an appointment with any of the providers listed. The enrollee informed the customer service representative that a linkage request was already made, but it was unsuccessful, and she was still unable to get an appointment. The enrollee reiterated their dissatisfaction when they expressed, “I am so beyond upset … [a]ll I want is some help,” and “it shouldn’t be that I have to struggle.”

- **<u>Call Inquiry File LFC Esc_Calls #2:</u>** The enrollee reported they called the Plan previously, on two separate occasions, for a list of providers accepting new patients. The enrollee was eventually able to access a provider list, however the

[122] Response to Crosswalk Request BHICS13.

> enrollee was advised that the providers were not accepting new patients or were not contracted with the Plan. Enrollee requested “please escalate the call so I can speak to a manager.” The CSR advised that a manager would not have any additional providers, enrollee advised “escalation is so I can lodge a complaint”. The CSR offered a linkage request and advised “the Linkage team will get back to you in 48 hours and the very latest is two weeks.”

By not having a process to track repeat callers, the Plan is unable to monitor instances in which callers are not getting the assistance they require and therefore cannot fully evaluate the effectiveness of customer service operations. Moreover, enrollees who call repeatedly and fail to get the assistance they need may be unable to obtain timely, appropriate health care services.

#6: The Plan’s credentialing and contracting process creates barriers to providing services to enrollees.

Summary: Interviews with providers indicate the Plan’s credentialing process is lengthy and cumbersome due to infrequent responses from the Plan. Providers stated the credentialing and contracting takes over a year to complete with frequent periods, lasting weeks and sometimes months for the Plan to respond to provider inquiries. According to one provider, the long process equates to access to care roadblocks for enrollees as it restrains or limits available providers. The prolonged credentialing and contracting process to become an in-network provider for the Plan creates delays in expanding the provider network and delays in providing services to enrollees.

#7: The Plan’s online provider portal is difficult for providers to navigate.

Summary: During interviews with the Department, providers complained about difficulty navigating the Plan’s online provider portal. According to one provider, the Plan’s portal requires an unnecessary amount of steps to determine enrollee and provider eligibility and it is difficult to verify co-insurance, co-pay and applicable Current Procedural Technology codes. Providers also reported that the portal was difficult to use and frequently provided inaccurate data. Provider issues with the Plan’s portal related to claims and benefit information is a barrier to providers ensuring timely access and quality care for enrollees.

#8: Behavioral health services, including specialty care, are not readily available at reasonable times to all enrollees throughout the Plan’s service area.

Summary: Plan documents revealed persistent gaps in network adequacy for behavioral health services, including specialty care, in certain geographic areas. These deficiencies, addressed through reliance on non-participating providers, indicate that behavioral health services are not consistently readily available at reasonable times to all enrollees throughout the Plan’s service area.

In the *2023 Aetna Behavioral Health Network Access Analysis*, the Plan identified 82 examples of members unable to find in-network providers within geographic or specialty

requirements.[123] Of those, 34 requests were for a licensed marriage and family therapist (LMFT), 17 requests were for a clinical psychologist, 9 requests were for a medical doctor, and 8 requests were for a licensed clinical social worker (LCSW). In the *2022 Aetna Behavioral Health Network Access Analysis*, the Plan identified 84 examples where enrollees were unable to find in-network providers to meet the enrollee's geographic or specialty needs.[124] 29 of the requests were for a LMFT, 13 requests were for a LCSW, and 12 requests were for a clinical psychologist.

File Review

The Department reviewed a total of 61 files involving requests for out-of-network care. In 18[125] (30%) of the 61 files, the enrollee requested services from an out-of-network provider due to an inability to find an in-network provider. Of those 18, the Plan approved 16[126] (89%) requests thereby acknowledging that the Plan did not have the requisite in-network provider to meet the enrollee's behavioral health needs.

Case Examples

- **Out-of-Network Request File LFD OON_COV_ATV #1:** Enrollee requested a psychiatrist for treatment of depression and anxiety. The Plan documented the out-of-network provider requested was approved as the enrollee was unable to find an in-network provider taking new patients.

- **Out-of-Network Request File LFD OON_COV_ATV #23**: Enrollee requested a provider specializing in OCD. The Plan documented the request was approved as there were no available in-network providers in the area.

- **Out-of-Network Request File LFD OON_COV_ATV #28**: Enrollee's parent requested an out-of-network provider to treat enrollee's anxiety. The Plan documented the request was approved as there were no available in-network providers in the area.

- **Out-of-Network Request File LFD OON_COV_MC #7**: Enrollee requested therapy for a traumatic event and was unable to find an in-network provider. The Plan documented that an in-network provider was not available and the request for out-of-network services was approved.

Based on the documents provided and the case files reviewed, the Plan has not demonstrated that behavioral health services, including specialty care, are readily available at reasonable times to all enrollees throughout the Plan's service area.

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[123] *2023 Aetna Behavioral Health Network Accessibility Analysis, (NQOC:12/19/2023; Appendix B)* pp.17-20 of 835.
[124] *2022 Behavioral Health Network Accessibility Analysis, (NQOC:11/15/2022; Appendix C)* pp.652-658 of 835.
[125] Plan Out-of-Network Request Files: LFD OON_COV_MC 3, 5, 7, 10, 13, 15, 20, 21, 25, 30; LFD OON_COV_ATV 1, 2, 6, 23, 25-28.
[126] Plan Out-of-Network Request Files: LFD OON_COV_MC 5, 7, 10, 13, 15, 20, 21, 25; LFD OON_COV_ATV 1, 2, 6, 23, 25-28.

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified 13 Knox-Keene Act violations and eight barriers to care not based on Knox-Keene Act requirements.

The Plan was afforded an opportunity to respond to any factual errors in this Report.

The Plan is required to submit a corrective action plan (CAP) that is reasonably calculated to correct the 13 identified Knox-Keene Act violations by **August 26, 2025**.

The Plan must submit its Response, if any, and CAP 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 shown below to view and submit the documents required:

- Click the e-Filing link.
- Click the Online Forms link
- Under Existing Online Forms, click the Details link for the DPS Routine Survey Document Request titled, DPS 2024 Mental Health Investigation– Document Request.

This Report, along with the Plan's submitted CAP will be sent to the Office of Enforcement for review and appropriate enforcement action, which may include corrective actions and assessment of administrative penalties. A copy of the Report that includes any appropriate factual corrections, along with the CAP and any Barriers Statement submitted by the Plan, will be posted to the Department's website.

APPENDIX A

APPENDIX A. INVESTIGATION TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS

Name	Title
Holly Pearson	Assistant Chief Counsel
Tammy McCabe	Attorney IV
Jennifer Sharifi	Attorney III
Owen Zion	Attorney III
Oksana Meyer	Staff Services Manager III, Plan Surveys Chief
Kimberly Galli	Staff Services Manager II, BHI Manager
Ryan Chan	Health Program Specialist II, Team Lead

CONSULTANT TEAM MEMBERS: MAXIMUS FEDERAL SERVICES, INC.

Name	Title
Joan Kirby	Project Manager
Dr. Beverly Grimshaw	Investigator
Dr. Andrew Mendonsa	Investigator
Alessandra Beers	Investigator
Martha Crowley	Investigator
Julie Morgan	Investigator
Carol Brooke	Nurse Manager

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: Aetna Health of California Inc.

Name	Title
Michael Brown	Senior Manager, Corporate Compliance
Tina Lee	Lead Director, Corporate Compliance
Cara Romasco Peter	Lead Director, Project Program Management
Christa Le Gallo	Executive Director, RX Operations
Neil Greene	Executive Director, Client Audit
Christina Wu	Lead Director, Market Compliance
Laura Pentland	Senior Analyst, Market Compliance
Dr. Deborah Fernandez-Turner	AVP, Deputy CMO
Dr. Pegah Mehdizadeh	Executive Director, Regional MD
Erica Adjei	General Management Development Program I
Gabby Ventura	Senior Counsel, West Region
Dori Guest	Senior Analyst, Regulatory Affairs
Karey Ponist	Senior Manager, Clinical Health Services
Sarah Bramich	Associate Manager, Clinical Health Services
Lynn Watson	Senior Principal Clinical Leader, Clinical Health Services
Amber Stokes	Manager, Project Management
Wendy Metts	Senior Principal Clinical Leader

Name	Title
Karen Seger	Manager, Delegated Credentialing
Yvonne Malanga	Senior Manager, Quality Management Credentialing
Staci Groland	Senior Manager, Clinical Delegation Quality Oversight
Laura L St. John	Senior Analyst, Provider Data Services
Charlotte Howell	Senior Analyst, Business Analytics
Angela Wolfe	Manager, Project Management
Daniella Ulloa	Senior Manager, Service Operations
Sheila Mitchell	Manager, Project Management
Sixto Gutierrez III	Senior Analyst, Business Analytics
Tyler Broussard	Senior Analyst, Business Analytics
Laura Pentland	Senior Analyst, Market Compliance
Erica Adjei	General Management Development Program I
Dr. Shelley Doumani-Semino	SMD BH
Dr. Dot Verbrugge	VP, Clinical Quality
Kristina Allen	Senior Manager, Client Audit
Ashley Littlefield	Lead, Manager, Business Compliance
Kelly Lenhart	Clinical Pharmacy Manager
Michael Chang	Executive Director, Formulary Administration Medical Affairs
Devin Luxner	Manager Client Services

Name	Title
Julie Knoop	Senior Manager, Client Services
Joesph Benson	Lead Director
JuanKamulo Bondad	Lead Director
Dr. Taft Parsons III	Interim Chief Health Equity Officer
Myrna Torresdey	Lead Director, Program Management
Edward West	Lead Director Project Management
Dante Gray	Lead Director, Program Management
Kimberly Rustem	Executive Director, Strategic Planning
Sheila Gehman	Lead Director, BH Data Science
Marla Serapiglia	Senior Manager, BH ABH
Michelle Rodriguez	Senior Analyst, BH ABH Clinical Claim Reporting, Spec Services
Yolanda Tovar	Supervisor Claim Operations
Liz Heffley	Senior Manager, Service Operations Patti Roode, Senior Manager, Project Management
Ashley Hale	Senior Manager, Network Management
Michael Okula	Lead Director
Taylor Lister	Senior Analyst
Suzanne Hall	VP, Regional Network Lead
Talaya Schwartz	Lead Director
Mark Taylor	Executive Director

Name	Title
Laura St. John	Senior Analyst, Provider Data Services

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

A-1 – Prior and Retrospective Review Utilization Management Authorizations, Modifications and Denials for BH Services

LFA-1 AUTH REV (Files Reviewed: 24)

Plan File #
221014014839
230105008058
231213062403
220419057432
221214059345
220729006837
220906010128
220608041285
230919032629
230315046389
220324094032
220720056204
240108097430
220909066630
221026092728
230801089809

Plan File #
230919032629
230823000639
221205005806
221118099114
220928017606
221010076786
221111006905
220707038457

LFA-1 UM _PHARM (Files Reviewed: 8)

Plan File #
23-074903720
23-071869800
23-068440050
22-066501891
22-065914818
23-070643801
23-067542367
23-072468789

LFA-1 SPEC_PRECERT (Files Reviewed: 9)

Plan File #
7853146
7751480
7463457
7452235
7248901
7109188
6133171
5499987
4969424

A-2 – Concurrent Review Utilization Management Authorizations, Modifications and Denials for BH Services

LFA-2 UM_AUTH (Files Reviewed: 22)

Plan File #
220329060470
240215019478
220718009940
221229080359
221114061701
230905073616

Plan File #
230814078535
230809045759
230912094652
221006016083
230201030371
220728092040
230502066179
230630075403
220328035801
240226006855
230213053670
230511057617
231219032547
230406056605
221112053408
220803077820

LFA-2 AUTH (Files Reviewed: 25)

Plan File #
230911033661
230831053661

Plan File #
221123000331
230223079279
221121034381
230430097009
220428031314
231002053480
231024080465
230210004734
240117092125
220504030314
230516092784
230309088922
230406056605
230523006544
230526033732
230228008857
230725055153
240215019478
231125081165
240207018108
230915018847

Plan File #
240117092125
230504045406

B – Benefit/Coverage/Experimental Denials of BH Services

LFB AUTH_REV (Files Reviewed: 28)

Plan File #
220531092538
231024083811
230902025234
240227051793
240226024853
221118096136
230426000827
221031027583
240208066381
240129006123
230405016221
230814003325
240129001931
240108099558
220907014104

Plan File #
240104095916
231130029879
230426000425
231215039829
220328041820
240125006417
230112097249
231117086466
220705096340
230330072797
221021003917
230517030410
230808020409

LFB_Pharm AD (Files Reviewed: 2)

Plan File #
23-076949350
22-063557314

LFB SP_AD Pharm (Files Reviewed: 11)

Plan File #
7155003
7063472
6732359
7208330
7042915
6524815
6129807
5467623
5134270
4963961
4809719

C – Enrollee Inquiry Contacts

LFC IFP_CALLS (Files Reviewed: 15)

Plan File #
76421357
77488478
79331582
92180712
64294042

Plan File #
81533744
75518297
81846707
72199267
80269172
107978510
107990563
102719843
97034168
100478984

LFC Esc_Calls (Files Reviewed: 2)

Plan File #
006084643175
006137267122

LFC Prov_Srch (Files Reviewed: 25)

Plan File #
006106031901
006148593933
006147053135

Plan File #
006140438661
006178423672
006077319660
006091141262
006176648960
006106674310
006164265410
006155409919
111353161
006113861374
006148688937
006106662004
006138503306
006183013175
006143467523
006108762274
006178087929
006103458491
006161883165
006148610933

Plan File #
006119082955
006167907712

D – Enrollee Requests for Out-of-Network Coverage for a BH Provider

LFD OON_COV_ATV (Files Reviewed: 30)

Plan File #
512182210000000
8417322210000000
7316669010000000
3385239110000000
9400030210000000
4899411210000000
3072326110000000
4784700210000000
7173898110000000
2065358110000000
9542960210000000
4927784900000000
9764639110000000
39604110000000
16066110000000

Plan File #
3765956110000000
8626712210000000
1167979110000000
4773460210000000
2389551210000000
5626940210000000
6924954110000000
1267660210000000
8058869110000000
6258731210000000
4121851210000000
2433941210000000
8741580210000000
8284873110000000
6848572210000000

LFD OON_COV_MC (Files Reviewed: 31)

Plan File #
220504035414
230203083098

Plan File #
231024075232
231228087959
231229028352
230331003072
230304026389
240126053978
231113018883
231227063121
240124047579
240119069687
230511055274
230220060192
230601059146
220713035108
231009086787
220803081266
240119086065
231201081862
220505057084
230623043937

Plan File #
231212004030
231218084529
220606086659
231018013625
240223020073
230925022556
231212004331
240209027618
230808099333

E – Provider Complaints and Disputes

LFE PROV_APPEAL (Files Reviewed: 26)

Plan File #
2022012300126
2022041401981
2023030600085
2022111901027
2023022805134
2022032901320
2023052304493
2023120801317

Plan File #
2022121700882
2022111103538
2022081602497
2022022401771
2022022302373
2023110900971
2023061700922
2023082300248
2023041103879
2022070702378
2023060803493
2022112500384
2022052602779
2023031401737
2023020102640
2022060601062
2023122203274
2023070504616

F – Grievances and Appeals

LFF GRIEV (Files Reviewed: 13)

Plan File #
2022033004309
2022120802648
2023010903830
2023012800483
2023010602819
2022062403672
2022091204628
2022052302679
2023052202155
2022112101813
2022030303874
2022040704334
2023111604541

LFF GRI_CAT (Files Reviewed: 12)

Plan File #
2022032203577
2022110703706
2022122401344

Plan File #
2023011601850
2023042503832
2023051603568
2023052604544
2023081804537
2023090604415
2023121904199
2023122804228
2024011004548

LFF EXEMPT_EXP (Files Reviewed: 9)

Plan File #
2022041304027
2022050302139
2022052403685
2022080203758
2022090104214
2023051704390
2023052503640
2023052604192

Plan File #
2023081004540

LFF MULTI_GRI (Files Reviewed: 23)

Plan File #
2022052603302
2022060603497
2022082904429
2022120903749
2023012303393
2022121903629
2023020804648
2023040801169
2023041400616
2023050903957
2023060604195
2023061302252
2023061303138
2023062804058
2023070702851
2023071501620

Plan File #
2023072002972
2023072003977
2023092504308
2023111003652
2023112203076
2023120803697
2023122203082

H – Claims for BH Services

LFH DAILY_DRUG (Files Reviewed: 17)

Plan File #
230034338975832999
230312526321858998
230470813924847999
230572881976842999
230581835299850999
230911512685843999
231171464069840999
231171640769844999
231351001062847999
231382958533828992

Plan File #
231865843300858998
232024457367861998
233212962157812999
233250946333864999
233385022602814996
233536374665866999
233615822521825999

LFH IFP_CLAIMS (Files Reviewed: 20)

Plan File #
EJAC8GKFP
E2Y16NSG0
EVAC9G63N
EFFC9X30J
EQTX8HQGF
EBY2BB1R6
E9AC6TG9T
E9AC8R296
ELY1797WM
EVAC6S2DN

Plan File #
E3AC58NP5
EK37BL8X8
E6Y127LLW
ELFC8441B
EHY2B91F4
EBFC9YHS0
EC37B3JRC
E0Y19BKZY
EBFC8D6WH
E53661CZT

LFH HNO_CLAIMS (Files Reviewed: 20)

Plan File #
EJY11YH8G 00
EXTX5B070 00
E2PCWKS82 00
E6FC22RGP 01
ENPC7X1YG 01
E9RVZHMFT 02
EC362QVJ9 00

Plan File #
EAJMZ9PQX 00
EGJM6R7K1 00
EWFC08JY1 00
E2FC13SVD 00
EYY17Y0LZ 00
E6Y11QBL6 00
EGACXRDG3 00
EZJMYWJ3L 00
EFY2BGMKN 00
EVTXZW9MK 00
E1JM6KXZB 00
E1TXZVKFZ 00
E3JMZY23J 01

LFH RX_CLAIMS (Files Reviewed: 15)

Plan File #
230097055719834998
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231505416655866999
233240699375845999

Plan File #
233355034383810999
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232165601076813997
230956690016838999
230484510583844999
233095598810864999
233636433028834999
233554841960857999
232960895396855999

I – Potential Quality Issues (PQI)

LFI PQOC_PQI (Files Reviewed: 6)

Plan File #
36216084
36748487
36849087
36947964
37272282

Plan File #
37803209

Log J – BH (MH/SUD) ER Services

LFJ ER_VISITS (Files Reviewed: 8)

Plan File #
EA364XQ1W
ETJM3ST7T
EXTX5D5MD
E7JMXX418
EG365691B
PYPCVF7HP
ESPCYLVNT
ECTX18GQ9

Aetna Health of California Inc.
Corrective Action Plan
Response

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Appointment Availability and Timely Access
	Deficiency #1
Deficiency Statement	**The Plan fails to consistently identify, investigate, and document potential provider directory inaccuracies reported to the Plan.** **Regulatory Citation:** Sections 1367.27(e)(1)(D), 1367.27(e)(2)(A)-(C), 1367.27(j)(3), 1367.27(o)(1) and 1367.27(o)(2)(B)
Corrective Action Plan Response	Due to the impacts of the COVID-19 pandemic, there was a substantial increase in the number of providers seeking to join the Aetna network. In response, we opened all specialties for participation, which led to a significant influx of provider applications. This surge was a contributing factor to longer-than-anticipated turnaround times for contracting and credentialing. During plan years 2022–2023, the Plan identified significant backlogs within two key business units: Network Operations and Provider Data Services which contributed to delays in resolving provider directory inaccuracies. Additionally, reliance on manual data entry, and the absence of a standardized process increased the risk of inaccuracies. For plan years 2024–2025, both units have successfully met or exceeded target turnaround times, reflecting substantial operational improvements. To further strengthen directory accuracy and ensure timely issue resolution, the Plan has implemented a series of corrective actions focused on process standardization, automation, escalation protocols, and staff training. These updates are effective immediately unless otherwise noted below, and are designed to support regulatory alignment and improve member experience. **Corrective Actions:** • Standardized the Network Assistance Form (NAF) submission process with clear issue and sub-issue definitions to improve reporting accuracy. Please see "DEF-1_NAF_SOP." • Introduced automated validation checks prior to PRMS ticket creation to reduce manual errors and accelerate processing. • Established an escalation protocol for high-priority SB137 cases, with defined turnaround times to ensure timely resolution. • By September 30, 2025, we will revise our Network Operations department policies to define provider unavailability (e.g., not accepting new patients) as a directory inaccuracy requiring investigation, aligning with SB137 and regulatory expectations. • Customer Service Representatives (CSRs) will participate in training sessions in September 2025, focused on identifying and addressing provider availability and directory concerns, utilizing the attached "DEF-1 NAF Training Document. • The Plan is developing a new CSR Training Program, scheduled for implementation by November 3, 2025. • The Network Operations team is implementing weekly evaluations of NAF submission and resolution times and will perform monthly audits of provider update cases to ensure accuracy. • The Network Operations team will deliver quarterly refresher training to reinforce protocols and consistent handling of provider directory issues.
Supporting Documentation Name(s)	DEF-1_NAF SOP 20250820.docx DEF-1 NAF Training Document.docx

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Appointment Availability and Timely Access
	Deficiency #1
Implementation Date of Corrective Action(s) (Anticipated or Completed)	8/22/2025 - 10/31/2025

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Appointment Availability and Timely Access
	Deficiency #2
Deficiency Statement	**The Plan's processes fail to ensure that enrollees are offered appointments within timely access standards when they call the Plan or submit grievances about requesting behavioral health appointments.** **Regulatory Citation:** Sections 1367.03(a)(1), (a)(5), 1368(a)(1); Rules 1300.67.2.2(b)(2), 1300.67.2.2(c)(5), and 1300.68(a)(1), (a)(4)
Corrective Action Plan Response	The Plan is committed to ensuring that members receive timely access to behavioral health services based on the urgency of their needs. When a member contacts the Plan with an urgent concern or expresses risk of harm to themselves or others, Customer Service Representatives (CSRs) are trained to immediately connect the member with a Crisis Clinician. Crisis Clinicians are equipped to assess the situation and take appropriate action, including scheduling urgent appointments or initiating Wellness Checks when necessary. For non-urgent needs, CSRs proactively assist members by offering to contact providers while the member remains on the line. When appropriate, telehealth options are also presented to help expedite access to care. If a member indicates that they are experiencing ongoing difficulty accessing services, a linkage request is initiated to ensure follow-up and resolution within 10 business days. To further strengthen our support for timely appointment access, the Plan is finalizing an enhanced CSR Training Program, scheduled for implementation by November 3, 2025. The program will extend the new hire training period from 3.5 to 8 weeks, allowing for deeper learning and skill development. The updated program will include specific guidance on assisting members with obtaining timely appointments based on the level of urgency. Once finalized, it will be used in conjunction with "DEF-6 Grievances Workflow" training, which outlines the appropriate steps for identifying and documenting appointment-related concerns as grievances. While the Plan cannot finalize appointments on behalf of members due to provider office policies—such as prepayment requirements or cancellation penalties—we work to empower members with the information and support they need to complete the scheduling process directly with providers. **Corrective Actions:** • Implement the updated CSR Training Program by November 3, 2025, with focused training on appointment access protocols based on urgency. • Enroll CSRs in September 2025 training sessions, including instruction on proper documentation of member concerns, utilizing "DEF-6 Grievances Workflow." • Reinforce CSR protocols for connecting members to Crisis Clinicians and initiating linkage requests when appropriate.
Supporting Documentation Name(s)	DEF-6 Grievances Workflow.docx

	Appointment Availability and Timely Access
	Deficiency #2
Implementation Date of Corrective Action(s) (Anticipated or Completed)	9/1/2025 – 11/3/2025

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Appointment Availability and Timely Access
	Deficiency #3
Deficiency Statement	**The Plan fails to consistently arrange for the timely provision of out-of-network behavioral health care for its enrollees.** **Regulatory Citation:** Sections 1367.03(a)(1), (a)(5), 1374.72(d), and Rule 1300.67.2.2(c)(1)
Corrective Action Plan Response	The Plan reviewed the case examples cited and determined that out-of-network (OON) coverage was approved within California mandated turnaround times in 16 of the 18 cases. There are two cases where we agree that remediation should have occurred. In case file, LFD OON_COV_MC #30, we were not able to assist the member and suggested that they find their own provider in error. The second file, LFD OON_COV_MC #7, OON coverage was approved however, the Plan did not meet the required turnaround time. It is the Plan's position that these were isolated incidents and do not reflect a broader pattern of failing to assist members with out-of-network care. After the timeframe of the BH Investigation files, the Plan has taken steps to strengthen support for members seeking OON care. We have provided training to our clinicians to ensure they are fully equipped to assist members with OON care, and the Plan has increased staffing ratios to improve responsiveness. Additionally, as outlined in DEF-1, the Plan has expanded its network of behavioral health providers and is updating the Network Assistance Form process to improve directory update timeframes and reduce reliance on out-of-network referrals. The Plan is developing enhanced training for its Customer Service Representatives (CSRs), as described in DEF-2, to ensure timely and appropriate assistance with out-of-network care is provided and properly documented within our systems. These process enhancements include monitoring efforts to reinforce compliance and are expected to close any remaining gaps and reinforce the Plan's commitment to continuous improvement.
Supporting Documentation Name(s)	
Implementation Date of Corrective Action(s) (Anticipated or Completed)	08/20/2025-11/3/2025

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Utilization Management, Including Triage and Screening
	Deficiency #4
Deficiency Statement	**The Plan does not include the correct information in its denial and modification letters to enrollees, including providing contact information for the wrong regulator.** **Regulatory Citation:** Sections 1367.01(h)(4), 1368(a)(1), 1368.02(b); Rules 1300.68(a), (b)(2)
Corrective Action Plan Response	In 2022, Aetna migrated to a new Utilization Management (UM) system, MedCompass. Following the transition, a system configuration issue was identified that resulted in UM letters for California fully insured HMO commercial members incorrectly referencing the California Department of Insurance (CDI) instead of the appropriate regulator, the Department of Managed Health Care (DMHC). This issue was promptly investigated and resolved on December 16, 2022. Since that time, no additional occurrences have been identified. Evidence of the correction is provided in the form of UM denial letters, which include the updated regulatory information. These letters are bookmarked and included in the document titled "Def 4_UM01_StdMedNec Denial Letters Member and Provider."
Supporting Documentation Name(s)	DEF-4_UM01_StdMedNec Denial Letters Member and Provider.pdf
Implementation Date of Corrective Action(s) (Anticipated or Completed)	12/16/2022

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Utilization Management, Including Triage and Screening
	Deficiency #5
Deficiency Statement	**The Plan failed to demonstrate that for concurrent review denials, care was not discontinued until the enrollee's treating provider had agreed to an appropriate care plan.** **Regulatory Citation:** Section 1367.01(h)(3)
Corrective Action Plan Response	When a denial for continuation at a particular level of care is issued, the provider may request a post-denial peer conversation to further discuss the denial. Following that discussion, if the Medical Director determines that continuation of treatment at the level of care that was denied continues to not meet medical necessity, the provider is given an alternative level of care that is available to meet the needs identified in the member's care plan. While this process was being followed in practice, documentation of the care plan agreement and alternative level of care was not consistently captured. To align with the Plan's National Clinical Services (505) Denial of Coverage – California policy, the Plan is actively revising its workflows and job aids to instruct staff to document care plan agreements and alternative level of care discussions. Once those updates have been made, staff will be reeducated on the documentation process. On August 22, 2025, our Medical Directors were instructed to consistently document the care plan agreement and alternative level of care offered during the peer-to-peer review process. **Corrective actions:** • By October 30, 2025, the Plan will update its documentation protocols to include care plan agreements and alternative level of care conversations occurred. • Re-educate staff on the revised documentation process once updates are finalized. • On August 22, 2025, Medical Directors were instructed to consistently document care plan agreements and alternative level of care discussions during peer-to-peer conversations.
Supporting Documentation Name(s)	
Implementation Date of Corrective Action(s) (Anticipated or Completed)	8/22/2025 - 10/31/2025

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Grievances and Appeals
	Deficiency #6
Deficiency Statement	**The Plan does not consistently identify oral expressions of dissatisfaction as grievances and fails to identify exempt grievances.** **Regulatory Citation:** Sections 1368(a)(1), 1368(a)(4)(B)(i); Rules 1300.68(a)(1), 1300.68(d)(8)
Corrective Action Plan Response	The Plan acknowledges that oral expressions of dissatisfaction were not consistently identified and documented as grievances, and that exempt grievances were not properly recognized, based on some of the call samples reviewed during the investigation. The Plan is currently updating and finalizing a new CSR Training Program, which will extend the new hire training period from 3.5 to 8 weeks to support deeper learning and skill development. The updated program is scheduled for implementation by November 3, 2025, and will include training focused on identifying and documenting grievances. Additionally, training sessions for existing CSRs will be held in September 2025, utilizing the "DEF-6_Grievances_Workflow" document, which provides detailed guidance on the required steps to initiate a grievance. The Plan enhanced its call auditing process to monitor for accurate identification and documentation of grievances. In January 2025, the number of calls audited daily increased from two to 25, and a dedicated Low Satisfaction Auditor was assigned to review calls flagged with low satisfaction scores. An additional auditor is scheduled to be hired by the end of 2025 to further support this effort. The Plan's auditing tool has also been updated to include grievance-specific review criteria. The revised tool, titled "DEF-6 Behavioral Health Advocate Audit Form," includes targeted questions on grievance identification and logging (located on page 2, items 26–27, and page 3, items 7–8). This enhanced tool will be implemented following the September 2025 training sessions. CSR Team Leads and Supervisors will review audit results weekly to identify opportunities for individualized coaching and department-wide training, as needed. **Corrective Actions:** • Implement the extended CSR Training Program by November 3, 2025, with an 8-week duration and emphasis on grievance identification and documentation. • Conduct CSR training sessions in September 2025 using the "DEF-6_Grievances_Workflow" to reinforce proper grievance handling. Following the September 2025 training sessions, the Plan will utilize the updated audit form, "DEF-6_Behavioral Health Advocate Audit Form" to assess grievance identification and logging accuracy by our CSRs.
Supporting Documentation Name(s)	DEF-6 Grievances Workflow.docx DEF-6 Behavioral Health Advocate Audit Form.docx

	Grievances and Appeals
	Deficiency #6
Implementation Date of Corrective Action(s) (Anticipated or Completed)	9/1/2025 – 11/3/2025

	Grievances and Appeals
	Deficiency #7
Deficiency Statement	**The Plan failed to demonstrate it maintains and periodically reviews the required log of exempt grievances.** **Regulatory Citation:** Section 1368(a)(4)(B)(i) and Rules 1300.68(b)(1), 1300.68(d)(8)
Corrective Action Plan Response	The Plan's designated system for tracking grievances is the Complaints, Appeals, and Grievance Tracking System (CATS). This system houses all grievance types, including exempt grievances, and captures the name of the Plan representative who received and resolved the grievance, in accordance with Rule 1300.68(d)(8). When data was submitted to the Department, staff identification fields were inadvertently omitted from the exempt grievance records. The revised log, titled "DEF-7_Log_F_Revised," now includes this information in columns AC and AD, identifying the staff member who handled each exempt grievance. The Plan maintains an established process for grievance reporting that includes a review by the Plan's Board of Directors (BOD), as outlined in the California HMO Member Amendment to Policy CA 001. The data presented to the California BOD includes exempt grievance types, as specified by the California DMHC requirements for annual reporting as well as the Plan's Policy. This data is requested from the Grievance and Appeal team on a quarterly basis and reviewed internally by the Plan's California Legal and Market Compliance team. Upon review, communication occurs with the Plan's Grievance and Appeal team to determine if there were any issues identified that may have caused a fluctuation in the exempt grievance data. This quantitative and qualitative data thoroughly explains the prior quarter's exempt grievances. To strengthen compliance and oversight, the Plan is nevertheless implementing several additional actions. The Plan's Customer Service Representatives (CSRs) will attend grievance focused training sessions during September 2025, utilizing "DEF-6_Grievances Workflow." The Plan's call auditing tool, "DEF-6_Behavioral Health Advocate Audit Form," has been updated to monitoring for the proper identification and monitoring of grievances, including exempt grievances (located on page 2, items 26–27, and page 3, items 7–8). In addition to the existing oversight by the Plan's BOD, our Grievance and Appeals team is developing a new grievance trending report that includes all grievances, including those related to dissatisfaction not tied to an adverse determination. This report will separately trend medical and behavioral health grievances. The Plan will collaborate with the DMHC to finalize it, then will establish distribution channels across the organization. The Plan will develop a process document to support the report and its distribution by December 31, 2025. **Corrective Actions:** • Expand CSR training and auditing programs to include focused instruction on identifying and documenting exempt grievances, utilizing the training document "DEF-6_Grievances_Workflow" and the auditing document "DEF-6 Behavioral Health Advocate Audit Form." • Develop a new grievance trending report that includes all grievances and share a prototype of the trending report with the DMHC by September 30, 2025.

	Grievances and Appeals
	Deficiency #7
	• Finalize the report and establish a distribution list for review and action within 30 days of receiving Department feedback. • Create a documented process for the trending and review process, to be completed by December 31, 2025.
Supporting Documentation Name(s)	DEF-7_Log_F_Revised DEF-6 Grievances Workflow.docx DEF-6 Behavioral Health Advocate Audit Form.docx
Implementation Date of Corrective Action(s) (Anticipated or Completed)	9/1/2025 – 12/31/2025

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Quality Assurance
	Deficiency # 8
Deficiency Statement	**The Plan does not timely notify behavioral health provider applicants of the status of their credentialing application.** **Regulatory Citation**: Section 1374.197(a)
Corrective Action Plan Response	During the review period, the Plan experienced a significant increase in provider applications, largely driven by expanded network participation following the COVID-19 pandemic. To accommodate this surge, all specialties were opened for contracting, resulting in higher-than-usual application volumes. The Plan was also transitioning to a new Provider Onboarding system designed to streamline and automate the credentialing process. This system has since improved operational efficiency and enhanced visibility into application status and turnaround times. Over the past several years, the Plan has focused on aligning internal operations with performance expectations through targeted resource allocation, improved inventory tracking, and the establishment of production benchmarks. These efforts have resulted in sustained improvements in processing times for provider contracting and credentialing. To support timely communication with provider applicants, the Plan updated its system processes to automatically send notification letters upon the receipt of a credentialing application. The Plan will revise applicable credentialing policies, procedures, and user guides to reflect the updated notification protocol. **Corrective Actions:** • On August 22, 2025, the Plan updated its process to send notification letters at the time of application receipt. • By September 15, 2025, the Plan will revise applicable documentation to reflect the updated notification protocol.
Supporting Documentation Name(s)	
Implementation Date of Corrective Action(s) (Anticipated or Completed)	8/22/2025 - 9/15/2025

	Quality Assurance
	Deficiency # 9
Deficiency Statement	**The Plan's Maternal Mental Health program does not include quality measures to encourage screening, diagnosis, treatment and referral.** **Regulatory Citation**: Section 1367.625(a)
Corrective Action Plan Response	The Plan is providing the Department with documentation to support that it's maternal mental health program includes a comprehensive set of quality measures and provider and member resources that directly support screening, diagnosis, treatment, and referral, as required by California Health and Safety Code Section 1367.625(a). These measures include annual screening rate improvement goals, with a 73% increase over baseline in postpartum depression screenings achieved to-date for our commercial members. Refer to "DEF-9_Aetna Maternity Dashboard MMH," for trend data and associated code sets. The program uses CPT-based metrics to benchmark screening and treatment rates, and supports providers through CME training, culturally competent tools, and reimbursement incentives such as value-based care models. Further, it supports pregnant and postpartum members directly to offer them perinatal depression screening digitally and through case management telephonic support, which have driven an 8.4% lift in screenings and enabled targeted outreach, as shown on page 2 of "DEF-9_MHS Q4 2024 Readout." Additionally, to improve treatment outcomes, the Plan has proactively expanded access to trained maternal mental health providers across 49 states including California, and continues to work with mental health provider partners to expand access to in-network care. These initiatives support a structured, data-driven approach to improving maternal mental health outcomes, which include provider and member engagement techniques, such as: • Notifying providers of resources, coding and reimbursement opportunities through multiple channels, including: ○ Our provider newsletter Office Links. Please see page 45 of "DEF-9_Officelink_March-2025." ○ Through screening tools, available on Aetna.com (https://www.aetna.com/health-care-professionals/patient-well-being/depression-screening-tools-resources.html). ○ Through the sponsorship of a provider training database (https://www.mmhla.org/database). • Identifying and messaging pregnant and postpartum members through behavior change campaigns, such as: ○ DEF-9_MaternalMentalHealth_Questionaire ○ DEF-9_MaternalMentalHealth_EM-Hit1-Prenatal ○ DEF-9_MaternalMentalHealth_EM-Postpartum ○ DEF-9_MaternalMentalHealth_EM-Resources Further, as a broader enterprise CVS Health has been recognized for its support and advocacy to address maternal health through a variety of partnerships with organizations, such as Postpartum Support International, the Maternal Mental Health Leadership Alliance, the Policy Center on Maternal Mental Health leadership alliance, and as an HRSA Maternal Mental Health Hotline Champion (https://mchb.hrsa.gov/programs-impact/national-maternal-mental-health-hotline/champions). These initiatives are

	Quality Assurance
	Deficiency # 9
	actively leveraged by the Plan's members and providers, helping to expand access to maternal mental health resources, support services, and evidence-based care across the state.
Supporting Documentation Name(s)	DEF-9_ Aetna Maternity Dashboard MMH.pptx DEF-9_Officelink-March-2025.pdf DEF-9_MaternalMentalHealth_Questionaire.pdf DEF-9_ MaternalMentalHealth_EM-Hit1-Prenatal.pdf DEF-9_ MaternalMentalHealth_EM-Postpartum.pdf DEF-9_ MaternalMentalHealth_EM-Resources.pdf DEF-9_MHS Q4 2024 Readout.pptx
Implementation Date of Corrective Action(s) (Anticipated or Completed)	

	Quality Assurance
	Deficiency # 10
Deficiency Statement	**The Plan was unable to demonstrate that customer service staff are knowledgeable and competent regarding enrollee questions and concerns.** **Regulatory Citation**: Section 1367.03(a)(10); Rule 1300.67.2.2(c)(10)
Corrective Action Plan Response	The Plan is undertaking a comprehensive redesign of its Customer Service Representative (CSR) training and quality assurance programs. The updated training curriculum will be implemented by November 3, 2025, and will include new job aids and workflows designed to improve issue identification and resolution during member calls. Additionally, the training period for new CSRs will be extended from 3.5 weeks to 8 weeks to support deeper learning and skill development. Training materials have been updated to reflect the most current workflows and include new guidance on identifying trigger words to recognize complaints and grievances. Please see the complaint and grievance example sections located on page 2 of "DEF-6 Grievances Workflow." This will be utilized to conduct refresher training sessions in September 2025, focused on accurately identifying and logging grievances. The Plan's CSR call auditing process includes one dedicated auditor conducting 25 audits daily, in addition to our Team Leads, who audit new hire calls to ensure training retention and performance consistency. In Q2 of 2025, we added a Low Satisfaction Auditor, who reviews all calls that received a low satisfaction survey score and plan to hire another auditor by December 31, 2025. Audits are conducted via SharePoint. CSRs are scored for each question using, "Yes", "No" or "Not Applicable," and feedback for those questions that are scored negatively. Once an audit is saved, the results go directly to our CSRs and their supervisors to review for coaching opportunities. Team leaders and supervisors meet weekly to monitor for trends and to identify opportunities for additional education. Coach plans are established if a CSRs audit score average falls below 90% for the month. After the September 2025 training sessions are completed, the Plan will use its enhanced auditing tool, "DEF-6_Behavioral Health Advocate Audit Form," which has been updated to include quality and resolution-based evaluations. **Corrective Actions:** • Launch redesigned CSR training program by November 3, 2025, with extended training duration and updated materials. • Hold CSR refresher training sessions in September 2025, focused on identifying and documenting grievances, as indicated in "DEF-6 Grievances Workflow." • Conduct more robust call audits, following the September 2025 CSR training sessions, utilizing the "DEF-6 Behavioral Health Advocate Audit Form." • Designated a Low Satisfaction Auditor in Q2 of 2025 and will hire another auditor by December 31, 2025.
Supporting Documentation Name(s)	DEF-6 Grievances Workflow.docx DEF-6 Behavioral Health Advocate Audit Form.docx

	Quality Assurance
	Deficiency # 10
Implementation Date of Corrective Action(s) (Anticipated or Completed)	9/1/2025 – 12/31/2025

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Quality Assurance
	Deficiency # 11
Deficiency Statement	**The Plan is operating at variance with its filed provider directory policies and procedures.** **Regulatory Citation**: Section 1386(b)(1)
Corrective Action Plan Response	Due to the impacts of the COVID-19 pandemic, there was a substantial increase in the number of providers seeking to join the Aetna network. In response, we opened all specialties for participation, which led to a significant influx of provider applications. This surge was a contributing factor to longer-than-anticipated turnaround times for contracting and credentialing. During plan years 2022–2023, the Plan identified significant backlogs within two key business units: Network Operations and Provider Data Services which contributed to delays in resolving provider directory inaccuracies. Additionally, reliance on manual data entry, and the absence of a standardized process increased the risk of inaccuracies. For plan years 2024–2025, both units have successfully met or exceeded target turnaround times, reflecting substantial operational improvements. To further strengthen directory accuracy and ensure timely issue resolution, the Plan has implemented a series of corrective actions focused on process standardization, automation, escalation protocols, and staff training. These updates are effective immediately unless otherwise noted, and are designed to support regulatory alignment and improve member experience. **Corrective Actions:** • Standardized the Network Assistance Form (NAF) submission process with clear issue and sub-issue definitions to improve reporting accuracy. Please see "DEF-1_NAF_SOP." • Introduced automated validation checks prior to PRMS ticket creation to reduce manual errors and accelerate processing. • Established an escalation protocol for high-priority SB137 cases, with defined turnaround times to ensure timely resolution. • By September 30, 2025, we will revise our Network Operations department policies to define provider unavailability (e.g., not accepting new patients) as a directory inaccuracy requiring investigation, aligning with SB137 and regulatory expectations. • Customer Service Representatives (CSRs) will participate in training sessions in September 2025, focused on identifying and addressing provider availability and directory concerns, utilizing the attached "DEF-1 NAF Training Document. • The Plan is developing a new CSR Training Program, scheduled for implementation by November 3, 2025. • The Network Operations team is implementing weekly evaluations of NAF submission and resolution times and will perform monthly audits of provider update cases to ensure accuracy. • The Network Operations team will deliver quarterly refresher training to reinforce protocols and consistent handling of provider directory issues.
Supporting Documentation Name(s)	DEF-1_NAF SOP 20250820.docx DEF-1 NAF Training Document.docx

	Quality Assurance
	Deficiency # 11
Implementation Date of Corrective Action(s) (Anticipated or Completed)	08/20/2025-11/3/2025

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Quality Assurance
	Deficiency # 12
Deficiency Statement	**The Plan is operating at variance with its filed complaints, grievances and appeals policies and procedures.** **Regulatory Citation**: Section 1386(b)(1)
Corrective Action Plan Response	The Plan's designated system for tracking grievances is the Complaints, Appeals, and Grievance Tracking System (CATS). This system houses all grievance types, including exempt grievances, which are closed prior to the close of the next business day. When the Plan's grievance log was submitted to the Department, staff identification fields were inadvertently omitted from the exempt grievance records. The revised log, titled "DEF-7_Log_F_Revised," includes this information in columns AC and AD, identifying the name and title of the staff member who handled each exempt grievance. To ensure exempt grievances are identified and documented by our CSRs, the Plan is developing a new Training Program which will be implemented by November 3rd, 2025. The new program will extend our training sessions from 3.5 to 8 weeks. Additionally, we've developed a new workflow that clearly defines a grievance and outlines the correct documentation process, including all relevant information. Please refer to document, "DEF-6 Grievances Workflow," which will be used in CSR training sessions being held in September 2025. **Corrective Actions:** • The plan has included a revised log, which includes staff who handled exempt grievances. Please see, "DEF-7_Log_F_Revised." • Launch redesigned CSR training program by November 3, 2025, with extended training duration and updated materials. • Hold CSR refresher training sessions in September 2025, focused on identifying and documenting grievances, as indicated in "DEF-6 Grievances Workflow."
Supporting Documentation Name(s)	DEF-7_Log_F_Revised DEF-6 Grievances Workflow
Implementation Date of Corrective Action(s) (Anticipated or Completed)	9/1/2025 - 12/31/2025

CA DMHC Behavioral Health Investigation
Corrective Action Plan Response

	Quality Assurance
	Deficiency # 13
Deficiency Statement	**The Plan is operating at variance with its filed utilization management policies and procedures.** **Regulatory Citation**: Section 1386(b)(1)
Corrective Action Plan Response	When a denial for continuation at a particular level of care is issued, the provider may request a post-denial peer conversation to further discuss the denial. Following that discussion, if the Medical Director determines that continuation of treatment at the level of care that was denied continues to not meet medical necessity, the provider is given an alternative level of care that is available to meet the needs identified in the member's care plan. While this process was being followed in practice, documentation of the care plan agreement and alternative level of care was not consistently captured. To align with the Plan's National Clinical Services (505) Denial of Coverage – California policy, the Plan is actively revising its workflows and job aids to instruct staff to document care plan agreements and alternative level of care discussions. Once those updates have been made, staff will be reeducated on the documentation process. On August 22, 2025, our Medical Directors were instructed to consistently document the care plan agreement and alternative level of care offered during the peer-to-peer review process. **Corrective actions:** • By October 30, 2025, the Plan will update its documentation protocols to include care plan agreements and alternative level of care conversations occurred. • Re-educate staff on the revised documentation process once updates are finalized. • On August 22, 2025, Medical Directors were instructed to consistently document care plan agreements and alternative level of care discussions during peer-to-peer conversations.
Supporting Documentation Name(s)	
Implementation Date of Corrective Action(s) (Anticipated or Completed)	8/22/2025 - 10/31/2025