DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE MEDICAL SURVEY
OF
AETNA HEALTH OF CALIFORNIA, INC.

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: AUGUST 3, 2006
DATE ISSUED TO PUBLIC FILE: AUGUST 13, 2006

Final Report of a Routine Medical Survey
Aetna Health of California, Inc.
A Full Service Health Plan

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a Routine Medical Survey of Aetna Health of California, Inc. (the "Plan") from February 13 to 16, 2006. This is a Final Report of findings and deficiencies from this Routine Medical Survey. The Department conducts a Routine Medical Survey of each licensed health care service plan at least once every three years to evaluate compliance with the requirements of the Knox-Keene Act (the "Act"). The Survey addresses four areas: Quality Management, Grievances and Appeals, Access and Availability of Services, and Utilization Management.

Background

The Plan was incorporated in the State of California on August 10, 1979 as Foundation Health of San Bernardino, Inc. and was licensed as a full-service health care service plan on August 5, 1981 (then named Inland Health Plan). Two other California health care service plans – Aetna Health Plans of Northern California, Inc. and Aetna Health Plans of San Diego, Inc. – were merged into Aetna Health of California in 1996. The corporation has had several name changes. Most recently, the Department of Corporations approved the name change to Aetna Health of California, Inc. effective June 25, 2002. Aetna Health of California is wholly owned by Aetna Health Management Inc.

In 1999, Aetna U.S. Healthcare acquired Prudential Healthcare, which included existing Prudential operations in California. Prudential Healthcare of California remained an independently licensed and operating health maintenance organization (HMO) until December 31, 2001.

Currently, the Plan offers three commercial HMO products (Commercial HMO, Quality Point of Service and US Access). Additionally, a Medicare risk product is offered in selected areas of Los Angeles, Orange, Riverside and San Bernardino counties.

Survey Results

Survey Deficiencies

The Department identified one compliance deficiency during the current Routine Medical Survey (See Section II, Table 3). The Plan has not fully corrected this deficiency at the time of this Final Report.

See Appendix A for an explanation of the Department's approach in surveying California health plans licensed by the Department.

Survey Findings

In accordance with Section 1380(g) of the Act, Department analysts offer advice and assistance to the plan as deemed appropriate. This Preliminary Report references such advice and assistance in the form of survey findings. Members of the survey team identified weaknesses in Plan operations that have potential to become deficiencies in the future. Section III of this report references the survey findings offered for consideration by the Plan. The Plan has implemented measures to address these findings.

SECTION I SURVEY HISTORY

Table 3 presents a schedule of survey activities conducted by the Department at the Plan in the past three years.

TABLE 1

SURVEY ACTIVITY	DATE
2003 Routine Survey On-Site Visit	February 24-27, 2003
2003 Preliminary Report	May 8, 2003
Final Report for 2003 Routine Survey	August 13, 2003
Follow-up Report Issued to Plan	January 06, 2005
2006 Routine Survey On-Site Visit	February 13-16,2006
2006 Preliminary Report Issued	April 27, 2006
Final Report for 2005 Routine Survey	August 3, 2006

Table 2 below lists Enforcement Action(s) taken by the Department within the past 24 months based on completed investigations where sufficient evidence was found to support allegations that the Plan has committed violations of the Act.

TABLE 2

CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 166229 **Citation(s):** Section 1368.02(b)	Plans are required to provide the statutory paragraph on all written notices and responses to enrollees under the grievance process. The enrollee received a denial letter that excluded the entire statutory paragraph.	September 27, 2005
Enforcement No. 04-062 **Citation(s):** Section 1368, 1368.01(a) Rule 1300.68	Plans are required to provide an enrollee with a written response to a grievance within 30 calendar days of the Plan's receipt of the grievance. The Plan acknowledged that the enrollee's grievance was filed on August 28, 2003 and not resolved until September 30, 2003.	December 1, 2004

CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 158760 **Citation(s):** Rule 1300.68(g)(1-5)	The Plan had provided a timely response; however, the Plan failed to provide all of the required information, as required by section 1300.68(g)(1-5).	November 5, 2004
Complaint No. 1458748 **Citation(s):** Rule 1368.01(a)	The Plan received the enrollee's grievance on April 21, 2003 and did not respond until May 28, 2003.	July 23, 2004

SECTION II. DISCUSSION OF SURVEY DEFICIENCIES

Table 3 below lists the one deficiency identified during the current survey. The Plan received a Preliminary Report regarding this deficiency. In that report, the Plan was instructed to: (a) develop and implement a CAP for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

TABLE 3

SUMMARY OF 2006 SURVEY DEFICIENCIES		
#	**DEFICIENCY STATEMENT**	**STATUS**
UTILIZATION MANAGEMENT		
1	**The Plan does not adequately oversee delegates to ensure that they are compliant with the timeframes for denial decisions and notifications as set forth by the Act.** [Section 1367.01(a), Section 1367.01(h)(1)&(3)]	Not Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

UTILIZATION MANAGEMENT

Deficiency 1: **The Plan does not adequately oversee delegates to ensure that they are compliant with the timeframes for denial decisions and notifications as set forth by the Act.**

Documents Reviewed:

- UM audit tool

Criteria: Section 1367.01(a), Section 1367.01(h)(1)-(5)

Conditions: The audit tool the Plan uses to conduct oversight of entities to which it delegates Utilization Management responsibilities does not include appropriate content and detail to allow auditors to properly assess whether the delegated entity's timeframes for Utilization Management decisions are within the requirements of the Act. One assessment standard contained in the Utilization Management audit tool (Section 5) states that the delegate makes a decision within 15 calendar days after receipt of a non-urgent prior-authorization request. The Act specifies that the timeframe to make a decision is within five business days after receipt of necessary information.

A second standard contained in the audit tool under Section 5 states that the delegate gives electronic or written notification of the decision within 15 calendar days after receipt of a non-urgent prior authorization request. The Act specifies that the timeframe for communication to the requesting provider is within 24 hours of making the denial decision for non-urgent prior authorizations. The Act also specifies that the timeframe for written communication to the enrollee and provider is within two business days of the denial decision for non-urgent prior authorizations.

The flaws of the Plan's audit standards and overall audit system employed to monitor its delegated entities suggest that deficiencies, if any, are not appropriately identified.

Implications: It is the Plan's responsibility to ensure that delegated entities comply with the law. To do this, the Plan is required to have adequate oversight procedures including tools used to execute them. Using poorly designed or flawed audit tools prevents the Plan from adequately monitoring its delegated entities.

Corrective Actions: Within 30 days following notice to a plan of a deficiency, the Plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: In its response the Plan stated that, effective May 10, 2006, it had implemented revised audit tools for evaluating entities to which Utilization Management responsibilities had been delegated.

The Plan submitted the following documents:

- UM Delegation Commercial Denial File Review Worksheet – Non-Emergency Services
- UM Delegation Authorization TAT for Requested Services

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that the Plan has revised its audit worksheets and implemented these revised tools. Although the worksheets collect the required data on timeframes, the worksheets do not specify the timeframe standards against which the Plan will compare Delegate performance to determine compliance nor were related documents (e.g., auditor instructions) submitted listing the timeframes. The Department was, therefore, unable to verify that auditors are measuring against the appropriate timeframes when assessing the results of the data collection.

At the time of its Follow-up Review, the Department will review Plan auditors' use of the revised tools and timeframes to verify that Delegates are being monitored appropriately.

SECTION III. DISCUSSION OF SURVEY FINDINGS

The list below summarizes a survey finding identified during the current survey. Survey findings do not rise to the level of an actual deficiency. They are offered to advise and assist the Plan in ongoing improvement efforts. The Department considers it beneficial for the Plan to review, evaluate and take action as appropriate on findings listed in this Preliminary Report.

Utilization Management

- The Department reviewed four retrospective denial files. The denial decision was communicated to the enrollee within 30 days in only two of the files. The Plan stated it identified an internal problem of delay of receipt of case information for the claims processing department, and in turn, a delay in conveying the information to the Utilization Management department.

  The Department suggests the Plan continue to address the internal processing problem of denial decisions to ensure consistent communication within 30 days. Untimely communication of denial decisions may hinder enrollees' exercise of grievance/appeal rights and/or may result in an enrollee or provider continuing with a course of treatment or services which will later be denied, resulting in financial cost to that enrollee or provider.

Plan's Response

The Plan reported that it has implemented measures to support the closure of all retrospective reviews within appropriate timeframes. The Plan has piloted a transfer policy that limits the number of transfers of mail items among units. As a result, the Plan has noted significant improvements in the timely distribution of retrospective review cases to the appropriate department(s) and timely communication of decisions within 30 days.

SECTION IV. SURVEY CONCLUSION

The Department has completed its Routine Medical Survey of the Plan. The Department will conduct a Follow-up Review of the Plan and issue a Follow-up Report within 18 months of the date of the Final Report to determine whether all deficiencies that were uncorrected at the time of the final report have been corrected [see Health and Safety Code Section 1380(i)(2)]. Please note that the Plan's failure to correct deficiencies identified in the survey report may be grounds for disciplinary action against the plan as provided by Health & Safety Code section 1380(i)(1).

A P P E N D I X A

A. THE MEDICAL SURVEY PROCESS

The Department conducts a routine medical survey of each licensed health care service plan at least once every three years in order to evaluate the plan's compliance with the Knox-Keene Act (the "Act"). Generally, the Department evaluates a plan's performance in four major areas:

(1) **Quality Management** – Each plan is required to assess and improve the quality of care it provides to its enrollees.

(2) **Grievances and Appeals** – Each plan is required to resolve all grievances and appeals in a professional, fair and expeditious manner.

(3) **Access and Availability of Services –** Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

(4) **Utilization Management** – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

The table below summarizes survey activities and corresponding timeframes.

SURVEY ACTIVITY: PRELIMINARY REPORT	TIMEFRAME
Notification Letter and Request for Documents	Prior to on-site visit
Routine Survey On-Site Visit Conducted	At least once every three years
Preliminary Report due from the Department to the Plan	Within 60-80 days from last day of on-site visit
Report of Correction of Deficiencies due from Plan to the Department [Rule 1300.80.10]	30 calendar days from date of receipt of Preliminary Report
SURVEY ACTIVITY: FINAL REPORT	**TIMEFRAME**
Final Report due from the Department to the Plan	Within 170 days from the last day of the on-site visit
Response from Plan to Department on any matters in Final Report	Within ten calendar days from receipt of Final Report. Included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the on-site visit

SURVEY ACTIVITY: FOLLOW-UP REPORT	TIMEFRAME
Follow-Up Review Conducted	Any time within 16 months of date Final Report issued to the Public File
Follow-Up Report due from the Department to the Plan	No later than 18 months from the date the Final Report is issued to the Public File
Response from Plan to Department on any matters in Follow-Up Report	Within ten calendar days from receipt of Follow-Up Report. Included in Public File with Follow-Up Report
Follow-Up Report due to the Public File [Section 1380(i)(2)]	No later than 18 months from the date the Final Report is issued to the Public File

Survey Preparation
A routine medical survey includes a pre-on-site assessment, a site visit at the Plan, a review of documents, interviews with plan staff and a review of the oversight of the plan's provider network. The survey begins when the Department provides notice and supplies the plan with a questionnaire and a list of documents to be completed and submitted to the Department prior to the on-site visit. Materials are reviewed by the survey team and linked to Plan survey compliance assessments. In advance of the site visit, the Department provides the Plan a list of materials (e.g., case files, reports) to be available to the survey team upon arrival.

On-Site Visit
During the on-site visit, the survey team reviews materials and conducts interviews with plan staff and possibly with providers.

Preliminary Report
Within 60-80 days of the on-site visit, the Department provides the plan with a Preliminary Report, which details deficiencies and survey findings. Preliminary and Final Reports are deficiency and finding-based reports; therefore, only specific areas found by the Department to be deficient or of concern are included in these reports. Omission of other areas of the plan's performance from the reports does not necessarily mean that the plan is in compliance with the Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the plan's performance in other areas.

Plan's Response to the Preliminary Report
All deficiencies cited in the Preliminary Report require corrective actions by the plan. Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency. For those deficiencies that may reasonably be

expected to require a longer period than 30 days to remedy, a plan may submit evidence that the plan has initiated remedial action to achieve an acceptable level of compliance.

The plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The plan's response to the Department's identified deficiencies, including a corrective action plan;

(2) If the corrective action plan is fully implemented, the plan should provide evidence that the deficiencies have been corrected;

(3) If the corrective action plan cannot be fully implemented by the time the plan submits its response, the plan should submit evidence that remedial action has been initiated and is on the way to achieving acceptable levels of compliance. Include a time schedule for implementing the corrective action and a full description of the evidence the plan will submit for the Department's Follow-Up Review that will demonstrate the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the plan's response indicates that the development and implementation of corrective actions will not be completed by the time the plan files its response, the plan should file any policies and procedures required for implementation as plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the plan should file both a clean and redline version of revised policies and procedures through the Department's web portal. The plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the web portal. The plan is not to submit its entire response to the Preliminary Report through the Department's web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review and consideration of the plan's response to the Preliminary Report, the Department will issue a Final Report. The Final Report will first be issued to the plan, followed by a copy to the public file not more than 180 days from the conclusion of the on-site survey. The report is available to the public by mail or on the Department website at: http//www.dmhc.ca.gov/library/reports/med_survey.

The Final Report will contain the deficiencies and findings as they were reported in the Preliminary Report, a summary of the plan's response and the Department's determination concerning the adequacy of the plan's response. The plan's failure to correct deficiencies

identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

Reports on all surveys, deficiencies and correction plans shall be open to public inspection after the Plan is given an opportunity to review the report and respond within 45 days of the date the Plan received the report from the Department. A Final Report will be issued after review of the Plan's response and will exclude any survey information and legal findings and conclusions determined by the Director to be in error, describes compliance efforts, identifies corrected deficiencies and describes remedial actions for deficiencies requiring longer periods to remedy. (Section 1380(h)(2)).

At the same time the Department makes the Final Report available to the public, a summary of the report will be issued to the public file. One copy of the summary is available free of charge to the public by mail. Additional copies of the summary and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The plan may submit additional responses to the Final and Summary Reports any time before or after the reports are issued.

Follow-Up Review
The Department may contact the Plan by letter and/or conduct a Follow-Up Review to confirm correction of deficiencies identified in the Final Report. (See Health and Safety Code Section 1380(i)(2)). Deficiencies left uncorrected will be subject to review and disciplinary action as appropriate pursuant to Health & Safety Code Section 1380(i)(1).

A P P E N D I X B

B. OVERVIEW OF PLAN OPERATIONS

The table below summarizes the information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire:

PLAN PROFILE

Type of Plan	Full Service Medical		
Service Area(s) *(Counties, in full or in parts)*			
Commercial	Alameda Contra Costa Fresno Kern Los Angeles Marin Orange Placer	Riverside Sacramento San Bernardino San Diego San Francisco San Joaquin San Luis Obispo San Mateo	Santa Barbara Santa Clara Santa Cruz Solano Sonoma Stanislaus Ventura Yolo
Medicare	Fresno Kern	Riverside	San Bernardino

Number of Providers	**Primary Care**	**Specialty Care**
	10,321	32,789

Number of Enrollees as of 12/31/05	**Product Lines**	**Enrollees**
	HMO	259,791
	QPOS	6,997
	US Access POS	2,507
	Total	**269,295**

The discussion below presents a brief overview of the Plan's operations in each of the four program areas that were examined during the Department's Routine Medical Survey.

OVERVIEW OF PROGRAMS

QUALITY MANAGEMENT

The Plan has a comprehensive Quality Management Program. The Quality Oversight Committee is the managing committee that reports to the Board of Directors. The Quality Oversight Committee is composed entirely of Plan staff. Several committees report to the Quality Oversight Committee, including those responsible for behavioral health and medical services integration and for credentialing decisions. The Quality Advisory Committee, which also reports to the Quality Oversight Committee, provides participating provider input into clinical Quality Improvement Activities.

The Plan collects HEDIS® [1] and CAHPS[2] data on an annual basis at the medical group/ Independent Physicians Association level, as well as at the aggregate Plan level. HEDIS® measures include clinical care and preventive health services. The Plan conducts annual medical record documentation audits of primary care providers, focusing on the continuity and coordination of care. The Plan monitors access to health care services, Plan-level customer service access, enrollee complaints and UM denial appeals.

The Plan produces an annual evaluation of its quality management activities, detailing successes and opportunities to improve.

GRIEVANCES AND APPEALS

The Plan's President has primary responsibility over the Plan's grievance systems. Day-to-day operation of the process is delegated to the Grievance and Appeal Manager.

Two Plan policies, "Member Complaint and Appeal Policy" and "California Amendment to Member Complaint and Appeal Policy", establish standards for the evaluation, monitoring and resolution of enrollee grievances.

The Plan defines an appeal as a verbal or written request by an enrollee or his/her authorized representative requesting a change in an initial determination/decision. The Plan defines a complaint as any oral or written expression of dissatisfaction/concern (other than an appeal) by an enrollee or his/her authorized representative regarding services provided by the Plan, a network health care professional or a vendor.

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[1] Health Employee Data Information Set ® ("HEDIS") is a set of standardized performance measures designed to provide information to consumers for comparison of the performance of managed health care plans. HEDIS® is sponsored by and is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

Grievance policies and the Evidence of Coverage state that enrollees may file grievances within 180 days of an incident or an adverse benefit determination (including coverage and health services decisions). The Plan's Internet website also allows for on-line filing of grievances. Plan policies require that acknowledgment letters be sent within five calendar days of receipt of grievances and resolution be made within 30 days.

The Plan's Customer Service and the Medical Resolution Team are trained to address the linguistic and cultural needs of enrollees. The Plan uses the AT&T Language Line to assist enrollees whose primary language is not English. This service is available 24 hours a day, seven days a week. The Plan also has a Spanish-speaking Hotline staffed by Spanish-speaking Customer Service Professionals and it offers a Spanish version of the Plan's Member's Right and Responsibilities information sheet. For the hearing and speech-impaired, the Plan has a toll-free TDD telephone. To serve visually-impaired enrollees, the Plan provides an automated, speech-recognition system that is available 24 hours a day, seven days a week. The content of materials may also be read aloud to enrollees.

ACCESS AND AVAILABILITY OF SERVICES

The Plan has established standards to guide its performance in a number of areas, including:

- the geographic availability of its providers;
- the waiting time for emergency, urgent, preventive and routine appointments with PCPs and specialists;
- after-hours care;
- telephone availability; and
- in-office wait time.

The Plan monitors its performance against its standards using tools such as:

- geographic mapping of facility/practitioner locations in comparison with enrollee locations;
- enrollee satisfaction surveys, including the CAHPS satisfaction survey; and
- enrollee complaint volume and trend reports.

The Plan uses a number of approaches to promote and improve access to its services, including:

- requiring corrective action plans of providers which do not meet standards;
- information websites for providers and enrollees;
- enrollee and provider newsletters and educational materials;
- outreaches with employers;
- increases in the number of bilingual employees; and
- provider recruitment.

UTILIZATION MANAGEMENT

The Plan is a mixed network model HMO with a large percentage of enrollees in delegated provider medical groups and independent practitioner associations. A small percentage of enrollees are assigned to direct contract providers and the Plan is responsible for all UM functions of these enrollees.
UM functions are overseen by the Patient Management Workgroup. The Patient Management Workgroup reports to the Quality Oversight Committee. The National Pharmacy and Therapeutics Committee reports to the Quality Advisory Committee.
The Plan maintains several general medical management programs including inpatient census and concurrent review, prior authorization, and case management functions. There are also focused medical management programs such as care coordination and disease management programs.

The Plan oversees UM delegation with annual audits of every delegated provider. The audit results are presented to the Regional Management Delegation Committee and corrective action plans are reviewed. The Regional Management Delegation Committee reports to the Board of Directors.

A P P E N D I X C

C. LIST OF SURVEYORS

The Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Steve Bechtold	Counsel, Division of Enforcement

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Erick M. Davis MD MPH MBA	Quality Management Surveyor
Laurence Ikeda, MD	Utilization Management Surveyor
Patricia Allen, M.ED	Access and Availability of Services Surveyor
Rose Leidl, R.N.	Grievances and Appeals Surveyor
Bernice Young	Grievances and Appeals Surveyor

A P P E N D I X D

D. LIST OF STAFF INTERVIEWED

The following key Plan officers and staff were interviewed during the onsite survey at the Plan.

Aetna Health of California, Inc.	
Carlo Braza	Grievance and Appeal Manager
Leonard Harvey	Medical Director
Mollie Allan	Quality Manager
Reina Galanes	Compliance Manager
Len Harvey, M.D.	Medical Director
Linda Perkins	UM
Jeanette Franke	Delegation Supervisor
Michael Brodeur, R. Ph.	Pharmacy Services Manager
Phyllis Brooks	Pharmacy Services Manager
Terri Schroeder	Quality Management Regional Director
Vivian Khalil	Quality Manager

A P P E N D I X E

E. LIST OF ACRONYMS

Acronyms	Definition
CAHPS	Consumer Assessment of Healthcare Providers and Systems
HEDIS®	Health Employer Data Information Set
HMO	Health Maintenance Organization
PCP	Primary Care Provider
QI	Quality Improvement
QM	Quality Management
UM	Utilization Management

A P P E N D I X F

F. APPLICABLE STATUTES AND REGULATIONS

The following are the specific citations used in this Routine Medical Survey Report as the basis for the deficiency:

UTILIZATION MANAGEMENT

Deficiency #1: **The Plan does not adequately oversee delegates to ensure that they are compliant with the timeframes for denial decisions and notifications as set forth by the Act.** [Section 1367.01(a), Section 1367.01(h)(1)&(3)]

Citations:

Section 1367.01(a)

A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrently with, the provision of health care services to enrollees, or that delegated these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

Section 1367.01(h)(1)&(3)

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with, the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonable necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In 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.

A P P E N D I X G

G. LIST OF PROVIDERS INTERVIEWED

The following are provider representatives who were interviewed during the on-site survey at the Plan.

Aetna Health of California, Inc.	
Palo Alto Medical Foundation	
Jean Babowal	Manager Utilization Review
Meg Durbin, M.D.	Medical Director
Children's Physicians Medical Group	
Deb Larsen	UM/QI Director
Allan Seid, M.D.	Medical Director
Katie Earle	UM/QM Delegation Coordinator
Mary Kay Elnes	Contracts Manager