MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

ANTHEM BLUE CROSS PARTNERSHIP PLAN

Contract Numbers: 03-76184
04-36068
07-65845
10-87049

Audit Period: September 1, 2012
Through
August 31, 2013

Report Issued: September 4, 2014
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I. INTRODUCTION

This audit report reflects the findings of the Department of Health Care Services (DHCS) audit of Anthem Blue Cross Partnership Plan, Inc. (Anthem or the Plan), a subsidiary of WellPoint, Inc. The audit period is September 1, 2012 through August 31, 2013.

Anthem provides medical managed care services to Medi-Cal beneficiaries under the provisions of Welfare and Institutions Code, Section 14087.3 and is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act. Anthem is a full-scope Medi-Cal managed care plan that operates in nine counties during the review period. The plan delivers care to Members under the Two-Plan model in all counties with the exception of Sacramento County, which is a Geographic Managed Care (GMC) model. Anthem delivers care to Members as a commercial plan in Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco and Santa Clara counties. The Plan delivers care as a Local Initiative in Tulare County.

At the local level, many of Anthem’s services are provided through Community Resource Centers (CRCs) operated by Anthem. The CRCs are local walk-in offices and store front centers that provide network physicians, members, and community agencies direct access to Anthem’s staff.

As of August 2013, the Plan served approximately 442,188 Members (413,094 Medi-Cal eligible Members and 29,094 Healthy Family Members).

This report presents the findings of the medical audit of Anthem and its compliance and implementation of four contracts to provide services in the nine counties listed below.

03-76184 (Commercial Contract)
Alameda County
Contra Costa County
San Francisco County
Santa Clara County

04-36068 (Local Initiative Contract)
Tulare County

07-65845 (Geographic Managed Care Contract)
Sacramento County

10-87049 (Commercial Contract)
Fresno County
Kings County
Madera County
II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of September 1, 2012 through August 31, 2013. The onsite review was conducted from November 12, 2013 through November 22, 2013. The audit consisted of documents review, verification studies, and interviews with the Plan personnel.

An Exit Conference was held on June 18, 2014 with the Plan. The Plan was allowed 15 calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report finding. The Plan submitted supplemental information after the exit conference which is reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability of Care, Members’ Rights, Quality Management (QI), and Administrative and Organizational Capacity.

Category 1 – Utilization Management

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used to measure performance on important dimensions of care and service. Plans annually monitor for under/over utilization based on selected HEDIS measures.

According to contract requirements, Plans must have internal mechanisms to track and monitor prior authorization, timeliness of determination and a process to integrate reports on review of number and types of appeals, denials, deferrals and modifications.

The Plan does not have an active method in place to detect under-utilization of services outside of the HEDIS studies.

Category 2 – Case Management and Coordination of Care

Based on the verification study, the Plan lacks:

- Documentation for coordination of care between PCPs (Primary Care Physicians) and specialists for California Children’s Services (CCS) and Early Intervention/Developmental Disabilities (EI/DD) Members.
- Documentation for the completion of Initial Health Assessments (IHA) in the medical records, and in some instances, IHAs completed outside of required timeframes.

Category 3 – Availability and Accessibility

The Plan does not have monitoring procedures to ensure that drugs prescribed in emergency circumstances are provided to or received by Members.
Category 4 – Member's Rights

The Grievance verification study revealed several cases where the grievance was closed without a complete investigation of the complaint. For Quality of Care grievances, lack of Medical Director review contributed to a substantial number of deficiencies.

The Plan failed to notify the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Contract Manager and the DHCS Information Security Officer of HIPAA breaches within the required time frame, as mandated by the contracts. Although Anthem has procedures for tracking suspected breaches, only incidents of confirmed unauthorized use or actual breaches of a certain degree of severity are reported to the DHCS. The Plan did not properly report all suspected or actual breaches.

Category 5 – Quality Management

The verification studies of medical records from the Plan’s provider locations indicate that providers failed to maintain complete and accurate medical records for all Members. In a separate verification study of Informed Consent (IC) documentation, the findings include improper completion of consent forms and not maintaining IC forms in the Members’ medical record.

Category 6 – Administrative and Organizational Capacity

The Plan failed to maintain a full-time qualified health educator to head the health education department. The Manager/Director of the Health Education Department shall possess a masters of public health degree (MPH) with an emphasis in health education.

The Plan does not follow its own policies to ensure that new provider training is received by all new providers as required by the Contracts.

The Plan did not report a potential fraud and abuse case to DHCS within the required time frame.
III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that the medical services provided to Plan Members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State’s Two-Plan Contract and Geographic Managed Care Contract.

PROCEDURE

The onsite audit of Anthem Blue Cross Partnership Plan (Anthem Blue Cross) was conducted from November 12, 2013 through November 22, 2013. The audit included a review of the Plan’s contracts with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 30 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness review, and communication of results to Members and Providers.

Appeals Process: 30 appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

CCS Members: 24 medical records were reviewed to determine if coordination of care occurs between the Plan and the CCS providers.

EI/DD Services: 20 medical records were reviewed to determine if coordination of care occurs between the Plan and the Regional Center.

IHA: 48 medical records were reviewed to determine if IHAs were provided within contractual time frame.

Category 3 – Availability and Accessibility

Emergency Service Claims: 60 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 61 family planning claims were reviewed for appropriate and timely adjudication.
Category 4 – Member’s Rights

Grievance Procedures: 140 grievances were reviewed. Seventy (70) Quality of Care grievances and seventy (70) Quality of Services grievance files were reviewed for timely resolution, response to complaint, and submission to the appropriate level for review.

Category 5 – Quality Management

Medical Records: 122 medical records were reviewed for compliance with contract requirements.

Informed Consent: 25 claims were reviewed for the completion of the Informed Consent form number PM 330.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 5 provider training records requested were reviewed for completion of new provider training within the required time frame.

A description of the findings for each category is contained in the following report.
### CATEGORY 1 - UTILIZATION MANAGEMENT

#### 1.1 UTILIZATION MANAGEMENT PROGRAM

**Utilization Management (UM) Program Requirements:**
Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. ...(as required by Contract)
GMC/2-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
GMC/2-Plan Contract A.5.2.C

**Under- and Over-Utilization:**
Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.
GMC/2-Plan Contract A.5.4

#### SUMMARY OF FINDINGS:

The Plan has policies and procedures in place to implement its Utilization Management (UM) Program.

The Plan has qualified staff responsible for the UM program and medical decisions are not influenced by fiscal and administrative management. The program has established evaluation criteria and standards to approve, modify, defer or deny services. Established guidelines and criteria to approve services are utilized and implemented by the UM physicians and nurses. Consistency is insured through annual Inter-Rater Reliability testing of the UM physicians and nurses.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used to measure performance on important dimensions of care and service. The Plan's 2012 Assessment of Potential Under- and Over-Utilization report encompasses HEDIS survey results for 2011. The purpose of under- and over-utilization analysis is to facilitate the delivery of appropriate care by monitoring the impact of Utilization Management (UM) Programs and to identify and correct potential over and under-utilization trends.

Based on the review of the 2012 Assessment of Potential under- and over-utilization report, the report highlights a greater emphasis on over-utilization. Under-utilization is noted with ER visits, hospital discharges, and back surgeries, however, there is no analysis for the under-utilization or interventions implemented to remedy the under-utilization or re-measurements planned to follow the intervention. (Contract Reference: Exhibit A, Attachment 5.4)

#### RECOMMENDATION:

Ensure that there are mechanisms in place to detect and act on identified under-utilization of services.
COMPLIANCE AUDIT FINDINGS (CAF)

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DATE OF AUDIT: November 12 thru 22, 2013

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

California Children’s Services (CCS):
Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program... (as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program... for the coordination of CCS services to Members.

GMC/2-Plan Contract A.11.9.A, B

SUMMARY OF FINDINGS:

The Plan has policies and procedures for identifying and referring children with California Children’s Services (CCS) eligible conditions to the local CCS program. The policy states that CCS program services must be provided by CCS paneled/approved providers. Authorization for such services must be received from the CCS program. The policy further states that Anthem Blue Cross contract Providers will be responsible for identifying and referring children with CCS eligible conditions to the local CCS program.

Through the Member Handbook, the Plan informs Members that the CCS Program provides health and case management services for certain serious medical conditions for Members less than 21 years of age. If a child has a serious medical condition, he or she may be eligible for care under CCS. Members are informed that more information about the CCS program can be obtained by calling Anthem Blue Cross’ Member Services.

Through the Provider Manual, the Plan educates network providers regarding CCS through the use of office orientations, the Provider Newsletter, and collaborative training efforts with the local CCS program.

The Plan has Memorandum of Understanding between Sacramento, Tulare, Fresno, Santa Clara and Alameda County Department of Public Health and CCS which states that children with potential CCS eligible conditions receive necessary appropriate care to treat their eligible CCS condition. Children identified as CCS eligible gain access to the CCS program through referrals from Primary Care Providers (PCPs), hospital personnel, Anthem Blue Cross Staff and community agencies or school.

In a verification study, twenty-four (24) medical records with CCS-eligible conditions were reviewed. Eighteen of 24 medical records for Anthem Blue Cross Members with CCS-eligible conditions lacked documentation of coordination of care with local programs to provide continuity of the medically necessary covered diagnostic, preventive and treatment services.

Although the Plan has written policies for identifying and referring children with California Children’s Services (CCS) eligible conditions to the local CCS program, there was no evidence of monitoring and tracking Members for coordination of care between Primary Care Providers (PCPs) and specialty providers.

RECOMMENDATION:

Ensure that CCS-eligible Members are monitored and tracked for coordination of care between Primary Care Providers (PCPs) and specialty providers occurs.
## COMPLIANCE AUDIT FINDINGS (CAF)

**PLAN:** Anthem Blue Cross Partnership Plan  
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### 2.3 EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

**Services for Persons with Developmental Disabilities:**  
Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers for the coordination of services for Members with developmental disabilities.

GMC/2-Plan Contract A.11.10.A, E

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services with Regional Center staff, which includes identification of all appropriate services, which need to be provided to the Member.

GMC Contract A.11.10.C

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

2-Plan Contract A.11.10.C

**Early Intervention Services:**  
Contractor shall develop and implement systems to identify children under 3 years of age who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

GMC Contract A.11.11

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

2-Plan Contract A.11.11

### SUMMARY OF FINDINGS:

The Plan has developed and implemented systems to identify children who may be eligible to receive services from the Early Start program. These Members are being referred to the local Early Start Program.

A Memorandum of Understanding for the coordination of services has been executed, implemented and followed by the Plan. The Plan and Regional Center facilitate coordination of comprehensive services and medical care for the Regional Center and Early Start eligible Members.
# COMPLIANCE AUDIT FINDINGS (CAF)

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Case management notes show the Plan provides case management and care coordination to the Members to ensure the provision of all medically necessary covered services. Case management records for four (4) eligible Members were requested to evaluate the effectiveness of the Plan's case management function. Three out of four records reflected care coordination between Anthem Blue Cross and local Regional Centers. One record showed no documentation or referral to a local Regional Center or Early Start Program and no case management notes.

In a verification study, a total of twenty (20) medical records with El/DD-eligible conditions were reviewed. Seven of 20 medical records lacked documentation of coordination of care with local programs to provide continuity of the medically necessary covered diagnostic, preventive and treatment services for its Members. Also lacking in these seven records is documentation of the Members El/DD medical condition or assessments to identify El/DD conditions. (Contract Reference: Exhibit A, Attachment 11:11)

**RECOMMENDATIONS:**

- Develop and implement procedures for the identification of Early Intervention/Developmentally Disabled (El/DD) Members and ensure coordination of care with the Regional Center.

- Develop a monitoring system to ensure that the El/DD eligible Members receive primary care services and there is coordination of care that occurs between Primary Care Provider (PCP) and El/DD specialists.
## COMPLIANCE AUDIT FINDINGS (CAF)

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### 2.4 INITIAL HEALTH ASSESSMENT

#### Provision of Initial Health Assessment:
Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR 53910.5(a)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

GMC Contract A.10.3.A

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

2-Plan Contract A.10.3.A

#### Provision of IHA for Members under Age 21
For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

GMC/2-Plan Contract A.10.5

#### IHAs for Adults, Age 21 and older
Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes... (as required by Contract)

GMC Contract A.10.6

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes... (as required by Contract)

2-Plan Contract A.10.6

Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.

Contractor shall make at least three documented attempts... Contact methods must include at least one telephone and one mail notification....

GMC Contract A.10.3.E

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

2-Plan Contract A.10.3.D

### SUMMARY OF FINDINGS:

The Plan has policies and procedures to address the completion of the Initial Health Assessment (IHA) for Members under the age of 18 months and for those Members over the age of 18 months to include completion within appropriate timeframes and office visit criteria.

The Provider Operations Manual states primary care physicians must perform an Initial Health Assessment for all new Members age 18 months and older within 120 days of enrollment and all Members under the age of 18 months within 60 days of enrollment. A review of the medical records confirmed that Providers are seeing new Members within the required timeframes for IHA completion.
COMPLIANCE AUDIT FINDINGS (CAF)

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The Member Handbook states the primary care provider will perform an IHA and discuss the Member's health and medical history to assess and educate the Member of their specific health care needs. Providers reviewed show clear documentation of a comprehensive office visit with patient education on specific health care topics.

The Plan’s contracts state that the contractor shall make reasonable attempts to contact a Member to schedule an IHA. In the documentation provided there was no documentation to support Provider’s attempts to schedule IHA’s on all new Members. (Contract Reference: 2-Plan Exhibit A, Attachment 10.3D/GMC Exhibit A, Attachment 10.3E)

During the onsite, the Plan staff discussed outreach programs to educate Members on IHA requirements, staff visits to Provider locations to provide education to the new Providers regarding IHA completion requirements, and that the Plan encourages its new Providers to obtain the IHA even if beyond the required dates.

In a verification study, forty-eight (48) medical records were reviewed. Five of 48 medical records exceeded the timeframe to perform the IHA, furthermore, 5 of 48 medical records failed to document a comprehensive office visit making the office visit ineligible to qualify as an IHA.

In the Plan’s response to the IHA finding, the Plan asserts Providers receive monthly reports of all of its Members who have not received an IHA. This assists Providers to monitor effective completion within the required time frame. In addition, as evidence that an IHA was attempted, the Plan’s policies state “practitioners must document in the medical record unsuccessful attempts to contact a Member, attempts to schedule an IHA, missed appointments or the Member’s refusal to schedule an IHA."

However, the sampled Member’s medical records reviewed had insufficient documentation to record unsuccessful attempts and exceeded the required time frame for completion of an IHA.

RECOMMENDATIONS:

- Ensure that Providers complete the Individual Health Assessments for all new Members within the timelines stipulated in the contract.

- Ensure Contractors document attempts to contact a Member and schedule an IHA in the Member’s medical record.
COMPLIANCE AUDIT FINDINGS (CAF)

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CATEGORY 3 - ACCESS AND AVAILABILITY OF CARE

3.7

ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:
Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours.... Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation.

GMC Contract A.10.8.G.1

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.

SUMMARY OF FINDINGS:

The Plan's policy, Oversight of Hospital Emergency Room Emergency Drug Furnishing Requirements (CA_PEXX_308) requires each contracted hospital to maintain policies and procedures for emergency access to medications for Members receiving treatment from the hospital's emergency room.

The Plan’s policy, Pharmacy and Therapeutics, Medical Quality and Management (CA_UMMC_127) indicates that a 72-hour emergency supply of medication may be dispensed to a Member if the prescribing provider and pharmacy clinical reviewer determine that it is appropriate and medically necessary.

The Plan contracts with Express Scripts, Inc., as the Pharmacy Benefits Manager to provide claims adjudication, rebate contracting, and pharmacy network ownership. The Plan's monitoring and oversight practices include monthly reports provided by Express Scripts, Inc. An annual oversight audit is performed.

The Pharmacy and Therapeutic (P&T) Process consists of two interdependent committees, the Clinical Review Committee (CRC) and the Value Assessment Committee (VAC). The purpose of the CRC is to clinically review drugs for efficacy, safety, effectiveness, and clinical aspects in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The purpose and function of the VAC is to make recommendations regarding the formulary/tier assignment or formulary/tier edits applied to covered prescription medication in accordance with CRC decisions.

The Plan's hospital contract with facility Providers stipulates that contracting hospitals are required to provide a sufficient quantity of emergency drugs until the Member can reasonably be expected to have a prescription filled.

Information about the Plan's arrangements to provide pharmacy services to Members and information regarding the formulary is shared with Members via the Member Handbook, the formulary, and the Plan's website. The Plan's Provider Directory provides information on the Plan's numerous pharmacy networks; however, the Plan has a limited number of 24-hour retail pharmacies.
The Plan provided the ER Drug Furnishing Report FY 2013 for the period June through December 2013. The report reflects ER Program Initiative questionnaire responses related to Members' last ER visit identified through monthly claims data extract. According to this data, 1,058 Members answered “Yes” to an ER visit that required the Member to continue taking medication after leaving the ER. Based on Member responses, Members who received a prescription for a medication from the ER totaled 920.

Of the 920 Members, 759 filled a prescription and 47 Members responded they received enough medication to last three (3) days. However, 84 members responded “NO” to the question “Did the ER supply you with enough medication to last 3 days?” No analysis of the data was performed by the Plan. Additionally, no issues were noted in the P&T Committee Minutes.

Based on the information reviewed from the medication related questions, the hospital compliance with the provision of medication in emergency circumstances is six percent. The Plan's method used to monitor provision of drugs prescribed in emergency circumstances does not meet contract requirements.

The compliance with the emergency drug provision requirement is monitored through Member grievances and any issues are discussed at quarterly P&T Committee meetings.

Although the Plan has developed the Policies to monitor compliance with emergency drug dispensing requirement, the Plan does not have specific monitoring procedures in place to ensure the provision of drugs prescribed in emergency circumstances are required by the contract. (Contract Reference: Exhibit A, Attachment 10.8.G.1)

RECOMMENDATION:

Develop monitoring procedures to ensure the provision of prescribed drugs in emergency circumstances.
**CATEGORY 4 – MEMBER’S RIGHTS**

### 4.1 GRIEVANCE SYSTEM

**Member Grievance System and Oversight:**
Contractor shall implement and maintain a Member Grievance System in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g)), and 1300.68.01, 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).

GMC Contract A.14.1

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).

2-Plan Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858,... (as required by Contract)

GMC/2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

GMC/2-Plan Contract A.14.3.A

Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential members...Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor’s Service Area, and by the Contractor in its group needs assessment.


**SUMMARY OF FINDINGS:**

The Plan has policies and procedures in place for the Members to file a grievance in writing or through calling the Customer Care Center. Members may also designate a representative to file on their behalf. The customer service representative forwards all grievances, including those from the delegated entities, to the Grievances and Appeals Department; there is no delegation of the Grievance and Appeals process. Members are informed of the Grievance process from the Member Handbook.

Quality of Care issues, including denials based on lack of medical necessity, denial of expedited resolutions of a grievance, or any grievance involving clinical issues are resolved by a health care professional with appropriate clinical expertise in treating the member's condition or disease.

All practitioners are evaluated for a history of trends during the past 36 months prior to the current grievance. This information is captured on a 36 month rolling report from the electronic medical management system for quality of care grievances and a 12 month rolling report for quality of service grievances.

All Quality of Care grievances are submitted to a Medical Director who was not involved in the initial determination for action, unless there is evidence that no quality of care issue is evident, or when the provider has not responded to requests for information. The latter issue raises the possibility that quality of care issues are incompletely...
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resolved without a Medical Director review (i.e. if the provider does not respond, there is no Medical Director review even if a Quality of Care issue exists). On review of the Grievance questionnaire submitted by DHCS to the Plan, the Plan stated that the Nurse Appeals Senior (not the Medical Director) is responsible for the final resolution determination of medical grievances. The Contract states that all Quality of Care issues need referral to the Medical Director (Attachment 14.2.E) though the current process allows for all identified Quality of Care cases, through their intake process, to be evaluated by the clinical grievance nurse who then determines which case needs to be seen by the Medical Director.

A verification study reviewed 140 grievances, including 70 Quality of Care and 70 Quality of Service cases. All of the grievances were resolved in a timely fashion. However, review of the individual cases revealed multiple issues.

Quality of Care cases are identified by the Grievance and Appeal Staff pursuant to Policies Member Grievance Process (GAXX-015), Provider Grievance Process (GAXX-028) and Internal Potential Quality Issue Process (GAXX-022). At the onsite visit, the Chief Medical Officer and Grievance Director stated that the initial review of the grievance was performed by the clinical associates (nurses) and that only cases where a nurse is not able to make a severity level determination are forwarded to a Medical Director. This is in violation of the contract where all Quality of Care cases need to be referred to the Medical Director. This step in the Grievance review accounted for a large majority of the cases not receiving a Medical Director/physician review. Under this process, the Medical Director is not involved in the case review until the very end and only "if needed". The resolution letter is often sent out within the thirty day requirement and prior to the Medical Director review. (Contract Reference: 2-Plan Exhibit A, Attachment 1.6.E,G/GMC 14.2.D, E)

There were also incomplete evaluations of the grievance cases. Medical records from the physician's office and/or emergency room were not present for review. As stated above, the lack of a Medical Director review also contributed to the incomplete evaluation. (Contract Reference: Exhibit A, Attachment 14.1)

Several cases also involved multiple grievance issues but the resolution letter did not address all issues. Similar issues were identified in the previous audit in 2010. (Contract Reference: 2-Plan Exhibit A, Attachment 14.1)


Several cases of potential quality of care issues, resulting in delays of care, were inadequately evaluated. There was no documentation that these cases were forwarded on for quality review. (Contract Reference: Exhibit A, Attachment 14.2.C,D,E)

In summary, numerous deficiencies were noted. The lack of a Medical Director review of all quality of care cases contributed to a substantial number of deficiencies. Incomplete collection of medical records contributed to incomplete evaluation of the cases. Resolution letters were sent out within the thirty day requirement without a Medical Director review. On occasion, resolution letters were sent out with incomplete translation into the identified threshold language. Additionally, several grievances had multiple issues and the responses did not address all the issues. Several quality of care cases were given severity scores of 0 where delays in care were noted and were not reviewed by a Medical Director.
COMPLIANCE AUDIT FINDINGS (CAF)

PLAN: Anthem Blue Cross Partnership Plan

AUDIT PERIOD: September 1, 2012 through August 31, 2013

DATE OF AUDIT: November 12 thru 22, 2013

RECOMMENDATIONS:

- Ensure that all Quality of Care cases are reviewed by a Medical Director.

- Ensure that medical records for pertinent dates of service relevant to the grievance be obtained to ensure a complete medical review. Emergency room records along with office records should be requested if applicable.

- Ensure that resolution letters be sent out after a complete evaluation and review by the Medical Director. If additional time is needed, issue an extension letter to the Member and/or Provider.

- Ensure that resolution letters be fully translated into the identified threshold language.

- Ensure that all the issues raised in the grievances are addressed in the resolution letter.

- Ensure that grievance data is incorporated into the QI Process as potential quality improvement projects or forwarded to peer review.
## MEMBERS’ RIGHT TO CONFIDENTIALITY
Contractor shall implement and maintain policies and procedures to ensure the Members’ right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.

2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member’s consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

### HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RESPONSIBILITIES:
Contractor agrees:

B. Safeguards—To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract.

H. Notification of Breach—During the term of this Agreement:
1) Discovery of Breach. To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract...

2) Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer...

I. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit...

### SUMMARY OF FINDINGS:
The Plan’s policy, Safeguards (CPP 208) states that WellPoint has implemented Administrative, Technical and Physical safeguards in order to protect confidential and proprietary information including Protected Health Information (PHI) from unauthorized Use or Disclosure. Anthem associates are required to safeguard both paper and electronic forms of PHI, confidential and proprietary information.

The Plan’s policy, Privacy and Security Incident Response and Reporting (CPP 1201) states that its WellPoint’s obligation to identify, investigate, mitigate, and respond to suspected and actual incidents involving the suspected non-permitted use or disclosure of Member Confidential Information.

The Plan’s policy, Reporting Disclosures to Department of Health Care Services (CA_PRXX_127) stipulates that breaches of security are notified to the Department of Health Care Services Privacy Officer by email or phone and the DHCS Contract Manager within twenty-four (24) hours during a work week of discovery by Anthem. In addition, the policy states that a written report of the investigation of a breach of PHI will be provided to DHCS MMCD Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer within 10 working days of the discovery.

The Compliance Officer is responsible for overseeing the reporting and investigation of the privacy breaches. The Plan provides HIPAA Compliance annual training for new hires at the Plan facility.

Through the Member Handbook, the Plan’s Notice of Privacy Practices (NPP) is given to new Members upon
enrollment and distributed annually to all Members. Members' rights and responsibilities are stated in the Member handbook. They are also posted on the Plan's website.

The Provider Operations Manual includes information about security, storage and maintenance, and availability of medical records to illustrate the importance of safeguarding protected health information.

Eight (8) HIPAA cases were received for the audit. Based on the review of eight cases, the Initial Notification of Breach was only sent to the Department of Health Care Services (DHCS) Privacy Officer and not submitted to the DHCS Medi-Cal Managed Care Division (MMCD) Contract Manager and the DHCS Information Security Officer as required by the contracts. In addition, breach notification for five (5) of the eight (8) HIPAA cases was not submitted within the required 24-hour time frame.

RECOMMENDATIONS:

- Ensure that actual and suspected breaches are reported to the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer.

- Ensure that the initial notification of PHI breach is submitted to the required DHCS personnel within the required timeframe as stipulated in the DHCS contracts.
**COMPLIANCE AUDIT FINDINGS (CAF)**

**PLAN:** Anthem Blue Cross Partnership Plan

**AUDIT PERIOD:** September 1, 2012 through August 31, 2013

**DATE OF AUDIT:** November 12 thru 22, 2013

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**CATEGORY 5 – QUALITY MANAGEMENT**

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<tr>
<th>5.5</th>
<th>MEDICAL RECORDS</th>
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**Medical Records**

<table>
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<tr>
<th>A. General Requirement</th>
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<tr>
<td>Contractor shall ensure that appropriate Medical Records for Members, pursuant to 28 CCR 1300.80(b)(4) and 42 USC 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each Encounter in accordance with 28 CCR 1300.67.1(c).</td>
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<tr>
<th>B. Medical Records</th>
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<tr>
<td>Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records...</td>
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<tr>
<th>C. On-Site Medical Records</th>
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<td>Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.</td>
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<tr>
<th>D. Member Medical Record</th>
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<tr>
<td>Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services... (as required by Contract)</td>
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**SUMMARY OF FINDINGS:**

The Plan's policy, **Quality Management - Medical Record Documentation and Confidentiality Standards (CA_QMXX_045)** communicates the procedures for medical record documentation and confidentiality standards, including storage and access. The policy communicates standards for the administration and maintenance of medical records by individual practitioners to facilitate communication, coordination and continuity of care, and to promote efficient and effective care. The policy also contains procedures to ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care.

The Plan performs Medical Record Reviews (MRRs) using the most current medical record review survey tool issued by the Department of Health Care Services (DHCS) to assure primary care practitioners (PCP) and OB/GYNs acting as PCPs are in compliance with the medical record documentation.

The Plan has developed procedures to maintain patient medical records and to safeguard the confidentiality of medical records and information. This was verified during the onsite visits. Facilities visited had properly secured medical records and had a designated person responsible for securing and maintaining medical records.
## COMPLIANCE AUDIT FINDINGS (CAF)

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In a verification study, 122 medical records were received according to the Contract requirements, including documentation review of medical services and coordination of care. Eighty of 122 medical records reviewed did not document a complete record of immunizations, health maintenance, or preventive services rendered. (Contract Reference: 2-Plan Exhibit A, Attachment 4.13.D.6/GMC Exhibit A, Attachment 4.13.D.7)

**RECOMMENDATIONS:**

- Ensure that a complete medical record is maintained for each Member.
- Continue to monitor provider compliance with Facility Site Reviews including medical record reviews.
**COMPLIANCE AUDIT FINDINGS (CAF)**

**PLAN:** Anthem Blue Cross Partnership Plan  
**AUDIT PERIOD:** September 1, 2012 through August 31, 2013  
**DATE OF AUDIT:** November 12 thru 22, 2013

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<tr>
<th>5.6</th>
<th>INFORMED CONSENT</th>
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| **Informed Consent** | Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services, and at a minimum includes: ...All informed consent documentation, including the human sterilization consent procedures required by 22 CCR Sections 51305.1 through 51305.6, if applicable.  
GMC Contract A.4.13.D.7 |
| | Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes: ...All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.  
2-Plan Contract A.4.13.D.6 |
| | Contractor shall ensure that Members are informed of the full array of covered contraceptive methods and that informed consent is obtained Members for sterilization, consistent with requirements of 22 CCR 51305.1 and 51305.3.  
GMC Contract A.9.9.A.1 |
| | Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.  
2-Plan Contract A.9.9.A.1 |

**SUMMARY OF FINDINGS:**

The Plan’s policy, *Family Planning Services* (CA_UMXX_132) indicates that Members have access to family planning services through any family planning provider without prior authorization. The policy indicates that Members of childbearing age may access services from out-of-plan family planning providers to temporarily or permanently prevent or delay pregnancy.

The policy includes the criteria for eligibility for sterilization procedures. In addition, the policy states that the Plan’s contracted providers will be required to obtain a sterilization consent form for the designated procedures prior to performing such procedures. The Plan has specific instructions for the completion of the Sterilization Consent Form (PM 330).

The Member Handbook informs Members of the family planning services available from any participating PCPs and OB/GYNs, both in and out-of-network, without prior authorization.

Through the Provider Manual, Providers are informed about the guidelines and regulations to follow for each Member seeking family planning and sterilization services.

For the verification study, twenty-five (25) sterilization claims were reviewed: 23 paid claims and 2 denied claims. Claims were reviewed for compliance with standards. Of the 23 paid claims reviewed, 14 sterilization claims lacked the Informed Consent form PM 330.
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**RECOMMENDATIONS:**

- Educate Providers and the Plan's claims department on the proper completion of the PM 330.
- Develop a system to monitor for compliance in the completion of Informed Consent forms.
- Ensure that the Plan obtains a completed Informed Consent form (PM 330) submitted with claims.
COMPLIANCE AUDIT FINDINGS (CAF)

PLAN: Anthem Blue Cross Partnership Plan

AUDIT PERIOD: September 1, 2012 through August 31, 2013

DATE OF AUDIT: November 12 thru 22, 2013

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3 HEALTH EDUCATION PROGRAM

Health Education:
- Contractor shall implement and maintain a health education system that provides the organized programs, services, functions, and resources necessary to deliver health education, health promotion and patient education to assist Members improve their health and manage illness.
- Contractor shall ensure administrative oversight, direction, management, and supervision of the health education system by a qualified full-time health education director or manager possessing a master of public health degree (MPH)...
- Contractor shall ensure the organized delivery of health education programs and services, at no charge for Members... (as required by Contract)
- Contractor shall provide health education programs and services directly and/or through subcontractors that have expertise in delivery of health education programs and services....(as required by Contract)

GMC Contract A.10.8.A

- Contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members.
- Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator.
- Contractor shall ensure the organized delivery of health education programs... (as required by Contract)
- Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements....(as required by Contract)

2-Plan Contract A.10.8.A

SUMMARY OF FINDINGS:

The Plan has policies and procedures that guide it in implementing and maintaining a health education system that includes programs, services, functions and resources to provide health education, health promotion, and patient education for all Members.

The Plan has developed policies and procedures that state that the Plan provide accessible, no cost, health education programs, services, training and resources to their Members.

Methods are measured by Plan staff to evaluate that the materials are written at sixth grade level, age and gender appropriate, culturally and linguistically appropriate. The Plan has developed policies and procedures to ensure that Members receive point of service education that provides educational interventions as part of the preventative and primary health care visits.

Anthem educates its primary care physician’s network on the importance of providing health education services through the provider operations manual, newsletters, targeted mailings, fax blasts and training sessions. Twice a year Provider newsletters are used as vehicles to inform Providers regarding changes and updates to Medicaid programs and activities, new legislative, regulatory issues, provider educational opportunities, and training.

The Plan’s contracts state that the Plan shall ensure administrative oversight of the health education system by a qualified full-time health educator. (Contract Reference: Exhibit A, Attachment 8.A.2)

Pursuant to GMC Contract, Contractor shall ensure administrative oversight, direction, management and supervision
of the health education system by a qualified, full-time education director or manager possessing a masters of public health degree (MPH) with an emphasis in health education. (Contract Reference: Exhibit A, Attachment 8.A.2)

According to the Plan personnel, the Plan has never had a full-time health educator dedicated to the health education department. There is no staff member that is dedicated to the health and education department on a full-time basis.

The Anthem staff Member that oversees the Health Education Program possesses a Masters in health education.

**RECOMMENDATION:**

Maintain a full-time qualified health educator to head the health education department. Pursuant to GMC Contract, management of The Health Education Department shall possess a masters of public health degree (MPH) with an emphasis in health education.
**COMPLIANCE AUDIT FINDINGS (CAF)**

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### 6.4 PROVIDER TRAINING

**Medi-Cal Managed Care Provider Training:**
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status.

GMC/2-Plan Contract A.7.5

**SUMMARY OF FINDINGS:**

The Plan’s policy, *Provider Training* (CA_PTXX_001) states that provider training regarding Medi-Cal Managed Care will be conducted for providers within ten days after the Plan has placed a newly contracted provider on active status.

The Plan’s policy, *Provider Education* (CA_PTXX_002) states that the Provider Operations Manual is designed as a “how to” guide for specific policies and procedures. The Plan ensures that all providers are properly trained and informed about Anthem Blue Cross’ services, policies and process for the state’s Medi-Cal Managed Care. The Manual is available to all contracted providers, via the Anthem Blue Cross website. Anthem Blue Cross conducts training with existing providers on an as-needed basis, as operations, services, and policies and procedures change.

Plan personnel confirmed that the Plan mails a “Welcome Letter” to new providers. The new provider can access the Provider Operations Manual (POM), the POM Acknowledgement Form online. The form must be signed and faxed to the Plan’s Provider Data Operations upon completion.

Review of five (5) new Provider samples were selected for the verification study. Three (3) of the 5 new Providers sampled did not include the Provider Operations Manual Acknowledgement forms. The Plan failed to submit complete records to document that Provider Training was conducted. The dates could not be confirmed due to lack of documentation. (Contract Reference: Exhibit A, Attachment 7.5)

**RECOMMENDATION:**

Ensure that all new providers receive training within 10 working days after the Plan places a newly contracted provider on active status which includes complete records to document that provider training was conducted.
FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse....

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.

2) Contractor shall provide effective training and education for the compliance officer and all employees.

3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.

4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity....

5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs....

SUMMARY OF FINDINGS:

According to Plan policies, Member Fraud Investigation and Involuntary Disenrollment (CA_FAXX_001) and Provider Fraud Investigations (CA_FAXX_006) state that the Plan will report to the Program Integrity Unit at Department of Health Care Services (DHCS) all cases of suspected fraud, waste and/or abuse, where there is reason to believe that an incident of fraud, waste and/or abuse has occurred, within ten (10) working days of the date when the Plan first becomes aware of or is on notice of such activity. The Plan shall notify DHCS prior to conducting any investigations.

In the Plan's policy, Excluded and Debarred Providers (US_PNXX_309) it contains procedures related to the monthly tracking of suspended and ineligible providers as required by the contracts to ensure its Providers are in good standing with Medicare and Medi-Cal.

The Plan provides annual fraud, waste, and abuse training to its employees.

The Plan informs Members on fraud and abuse through the Member Handbook, its website, and Member newsletters.

The Plan informs Providers on fraud and abuse through the Provider Manual, its website, and Provider newsletters.

Eleven Fraud and Abuse cases were selected for review from those submitted by the Plan. Based on the review, the Plan failed to report one (1) suspected fraud and abuse case to DHCS within the timeframe of ten (10) working days to comply with the contractual requirements. (Contract Reference: 2-Plan Exhibit E, Attachment 2.26.B/GMC Exhibit E, Attachment 2.25.B)
RECOMMENDATION:

Ensure that all cases of suspected fraud and abuse are reported to Department of Health Care Services within the 10 working day limit.
MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

ANTHEM BLUE CROSS PARTNERSHIP PLAN

Contract Numbers: 03-75795
04-36079
07-65846
10-87053
State Supported Services

Audit Period: September 1, 2012
Through
August 31, 2013

Report Issued: September 4, 2014
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II. COMPLIANCE AUDIT FINDINGS................................................... 2
INTRODUCTION

The audit report presents findings of the contract compliance audit of Anthem Blue Cross Partnership Plan and its implementation of the State Supported Services contracts with the State of California. The State Supported Services contracts cover abortion services for Anthem Blue Cross.

The onsite audit was conducted from November 12, 2013 through November 22, 2013. The audit covered the review period from September 1, 2012 through August 31, 2013 and consisted of document review of materials supplied by the Plan.

An Exit Conference was held on June 18, 2014 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report finding. No additional information was submitted following the Exit Conference.
COMPLIANCE AUDIT FINDINGS

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes: 59840 through 59857
HCFA Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336
State Supported Services Contract Exhibit A.1

SUMMARY OF FINDINGS:

Policy CA_UUMXX_067, Abortion Services states that Members may access and obtain abortion services. Abortions are required to be provided in accordance with State and Federal law and are considered by the California Department of Health Care Services to be a “sensitive service”. Abortion is considered a self-referable service. Anthem reimburses both in-network and out-of-network providers for abortion services. Members are encouraged to remain in-network for these procedures; however, the services will be covered for non-network providers, if necessary.

Policy CA_IMXX_067 does not include Current Procedural Terminology (CPT) Codes 59840 through 59857, 59853 and HCPCS codes X1516, X1518, X7724, X7726, Z0336 as billable pregnancy termination services according to contractual requirement. Based on a discussion with Medi-Cal Managed Care Division (MMCD), the billing codes change frequently and is not considered a contact violation.

Members have the right to choose and access qualified family planning services including abortion service/pregnancy termination without prior authorization. Members may self-refer to a contracted or non-contracted Provider. The Member Handbook informs Members that minors do not need an adult’s consent or referral to access pregnancy termination services.

According to Plan personnel, billing procedure codes are excluded in its policy. The Plan personnel indicated that the Plan’s billing codes are included in the Plan’s billing code system. The Plan has guidelines to provide instructions for the billing of abortion services for participating Providers and for claims processors when paying or denying a claim with updated billing codes. The Plan is in compliance with the contractual requirement.