

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

REPORT ON THE MEDICAL AUDIT OF

**ANTHEM BLUE CROSS
PARTNERSHIP PLAN**

2021

Contract Number: 03-76184, 04-36068,
07-65845, 10-87049
and 13-90159

Audit Period: October 1, 2019
Through
July 31, 2021

Report Issued: April 13, 2022

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I. INTRODUCTION

Anthem Blue Cross Partnership Plan, Inc. (Plan), is a subsidiary of Anthem, Inc. The Plan 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.

The Plan is a full-scope Managed Care plan that serves the Medi-Cal, Medicare, Seniors, Persons with Disabilities (SPD), and Rural Expansion population.

Mandatory enrollment of SPD into Managed Care began in June 2011. The California Department of Health Care Services (DHCS) received authorization (1115 Waiver) from the federal government to conduct mandatory enrollment of SPD into Managed Care to achieve care coordination, better manage chronic conditions, and improve health outcomes. In June 2011, DHCS awarded the Plan with the contract to provide Medicaid Managed Care benefits to beneficiaries under the State's SPD procurement.

On November 1, 2013, DHCS awarded the Plan the contract to provide Medicaid Managed Care benefits to beneficiaries under the State's Rural Expansion Procurement. The Plan is to deliver care to members in 18 additional counties under the Geographic Managed Care rural model.

At the local level, many of the services are provided through Regional Health Centers operated by the Plan. The Regional Health Centers provide members access to provider network physicians and community agencies.

The Plan has five contracts to provide services in twenty-seven counties: Contract 03-76184 (Commercial contract) covers Alameda, Contra Costa, San Francisco, and Santa Clara counties). Contract 04-36068 (Local Initiative contract) covers Tulare County. Contract 07-65845 (Geographic Managed Care contract) covers Sacramento County. Contract 10-87049 (Commercial contract) covers Fresno, Kings, and Madera Counties. Contract 13-90159 (Geographic Managed Care & Rural Expansion contract) covers Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba Counties.

As of July 2021, Anthem served approximately 851,419 Medi-Cal members in the following counties: Alameda 67,865, Alpine 162, Amador 5,524, Butte 23,590, Calaveras 5,596, Colusa 5,048, Contra Costa 32,483, El Dorado 12,055, Fresno 124,662, Glenn 2,774, Inyo 2,604, King 21,567, Madera 23,581, Mariposa 3,778, Mono 1,941, Nevada 13,391, Placer 33,753, Plumas 2,952, Sacramento 196,525, San Francisco 20,427, Santa Clara 74,158, Sierra 375, Sutter 33,851, Tehama 10,125, Tulare 108,080, Tuolumne 6,366 and Yuba 18,186.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical review audit for the review period of October 1, 2019 through July 31, 2021. The review was conducted from August 16, 2021 through August 27, 2021. The audit consisted of document review, verification studies, and interviews with the Plan personnel.

An Exit Conference with the Plan was held on March 1, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan did provide additional information after the Exit Conference in which DHCS reviewed.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the audit period of October 1, 2018 through September 30, 2019) was issued on January 30, 2020. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized its Corrective Action Plan (CAP).

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to ensure resolution of member appeals within 30 days of receipt. The Plan failed to resolve appeals within the contractually required timeframe.

Category 2 – Case Management and Coordination of Care

The Plan is required to provide blood lead screening tests to all child members at 12 and 24 months of age, and at 12 to 72 months of age for those that have no documented evidence of a prior blood lead screening. The Plan is also required to document and follow up on screening test results, and make reasonable attempts to ensure the screening is provided and to document attempts to provide the test.

The Plan did not ensure or instruct its network providers to provide verbal or written blood lead anticipatory guidance to the parent or guardian of a child member at each Periodic Health Assessment (PHA) starting at six months of age and continuing until 72 months of age.

Category 3 – Access and Availability of Care

The Plan did not develop or implement prompt and effective corrective action for repeated non-compliant providers to address identified timely access deficiencies within its network.

The Plan did not ensure Transportation Physician Certification Statement (PCS) Forms for authorization of Non-Emergency Medical Transportation (NEMT) services were completed by treating physicians as required by the Contract.

The Plan is required to ensure all contracted Non-Emergency Medical Transportation and Non-Medical Transportation (NMT) providers are enrolled in the Medi-Cal Program. The Plan did not ensure that all new and existing NEMT and NMT providers met the enrollment requirements.

Category 4 – Member's Rights

There were no findings in this category.

Category 5 – Quality Management

There were no findings in this category.

Category 6 – Administrative and Organizational Capacity

The contract requires the Plan to report annually to DHCS on their recoveries of overpayments. The Plan did not report annual recoveries of overpayment to DHCS as required.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Medical Review Branch conducted this audit to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contracts.

PROCEDURE

The review was conducted from August 16, 2021 through August 27, 2021. 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 the Plan's administrators, a delegated entity, and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization: 43 medical and 26 pharmacy prior authorization requests were reviewed for medical necessity, consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Appeal Procedures: 25 prior authorization medical and pharmacy appeals were reviewed to ensure that required timeframes were met and appeals were appropriately routed and adjudicated.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment (IHA): 30 medical records and 30 blood lead screenings of young children were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Transportation Access Standards: 25 NMT and 20 NEMT records were reviewed to verify that the Plan's contracted NEMT and NMT providers are enrolled in the Medi-Cal Program.

Category 4 – Member's Rights

Grievance Procedures: 42 quality of care grievances, were reviewed for timely resolution, response to the complainant, and submission to the appropriate level for review.

54 quality of service grievances, were reviewed for timeliness and appropriate

resolution.

Category 5 – Quality Management

Potential Quality of Care Issues: 20 cases were reviewed for appropriate level of review and decision-making process.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Eight cases were reviewed for timely processing and reporting requirements.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.3

PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Timely Resolution of Appeal Requests

The Plan is required to resolve appeals requests within the established timeframe. The Plan is required to ensure timely member notice of resolution as quickly as the member's health requires, within 30 calendar days from receipt of the appeal request. (*Contract, Exhibit A, Attachment 14 (1)(B)*)

For standard appeal resolutions, the timeframe for resolving appeals is 30 calendar days and for expedited appeal requests, the Plan shall comply with the 72-hour timeframe in accordance with new federal regulations. *Managed Care All Plan Letter (APL) 17-006, Section IV Appeals (C)(2) and (D)*

The Plan specifies the required timeframe in its policies. Plan Policy, *GAMC 051 Member Appeals* (approved 6/22/21) states for standard appeals (pre-service and post-service), the Plan will resolve each appeal and provide notice as expeditiously as the member's health condition requires, within 30 calendar days from the date of the receipt of the appeal.

Plan Policies, *GAMC 053 Anthem Policy and GAXX 053 Provider Appeals* (approved on June 22, 2021), states the Grievance and Appeals (G&A) clinical associate will send a resolution letter to the provider within 30 calendar days with the determination and further appeal rights.

Finding: The Plan did not resolve appeals within the required timeframe.

The verification study identified ten appeal files that were resolved beyond the required 30 days. Nine appeals were delayed due to the appeals being misrouted. The nine misrouted files were reviewed with the G&A staff in interviews.

In the interviews, the G&A staff could not always identify which department had received the misrouted requests as the file only showed the receiving department name in code. Interviews and file notes indicated, that the Plan's late resolution of appeals was due to misrouting at the mailroom level and most often misrouted to the Claims Dispute Department.

The Plan has no consistent system to prevent or detect the noted delays. Occasionally,

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the delay was due to the provider submitting the appeal on the wrong form (i.e., the Provider Dispute form instead of the Appeal form). However, this cause was not described in the delayed member files. Sometimes, the appeal was not entered into their system at the G&A level or was delayed due to the G&A staff sending requests for information to the wrong medical group.

Failure to resolve appeals within the required timeframe may delay needed care and may increase member morbidity.

Recommendation: Develop and implement a process in the Plan policy to ensure that the Plan meets the contractual timeframe and notification when resolving appeal requests.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1 INITIAL HEALTH ASSESSMENT

2.1.1 Provision of Blood Lead Screening

The Plan shall document and appropriately follow up on blood lead screening test results. The Plan is also required to make reasonable attempts to ensure the blood lead screening is provided and document attempts to provide the test. If the member refuses the blood lead screen test, proof of voluntary refusal of the test shall be documented in the member's medical record. (*Contract, Exhibit A, Attachment 10 (5)(D)*)

The Plan is required to provide blood lead screening tests to all child members at 12 months and 24 months of age and when the network provider performing a PHA becomes aware that a child member who is 12 to 72 months of age has no documented evidence of a blood lead screening test taken. (*Managed Care APL 18-017 and 20-016, Blood Lead Screening of Young Children*)

Plan Policy, *Blood Lead Screening-Clinical Indications (last revised on December 10, 2020)* states the Plan requires primary care providers to screen for blood lead levels in children ages 12 months and 24 months as part of the Early and Periodic Screening. However, the policy does not include the procedure of performing blood lead screening tests on a child member who is 12 to 72 months of age and has no documented evidence of taking a blood lead screening test. In addition, the policy does not include the procedure of making reasonable attempts to ensure the blood lead screen test is provided and to document attempts to provide tests or the members' refusal of the test.

Plan Policy, *Service for Members Under 21 (last revised on January 28, 2021)*, does not include the procedure of making reasonable attempts to ensure the blood lead screen test is provided or to document the attempts to provide the test.

Plan Policy, *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Corporate Outreach and Monitoring (last revised on March 22, 2021)*, states corporate EPSDT contact/outreach is conducted by mail, text messages, or emails. However, the policy does not indicate the requirement of making reasonable attempts to ensure the blood lead screen test is provided or to document the attempts to provide the test.

Finding: The Plan did not ensure the provision of a blood lead screening test to members at 12 months and 24 months of age and members 12 to 72 months of age who have no documented evidence of a blood lead screening test taken. In addition, the

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Plan did not make reasonable attempts to ensure the blood lead screening was provided and did not document attempts to provide the test or the members' refusal of the test.

The *March 2020 and March 2021 Quality Management Committee (QMC) Meeting Minutes* indicated the Lead Screening in Children (LSC) measure was omitted and was not included in the 2019 analysis of the Healthcare Effectiveness Data and Information Set (HEDIS) measures. There were no HEDIS measures on LSC for 2020.

The *2020 Provider Manual* described the requirement of blood lead screening tests for children at one and two years of age and three to six years of age who have not been tested. However, the manual does not include the requirement of making reasonable attempts to ensure the blood lead screen test is provided and documentation of the attempts to provide the test.

The *2020 Initial Health Assessment Presentation* for provider training does not include blood lead screening tests for young children as one of the IHA components.

The verification study identified 12 child members who did not have blood lead screening tests performed. In addition, there was no documentation of the Plan making reasonable attempts to provide the test or the member's refusal of the test.

During the interview, the Plan acknowledged that it has not implemented requirements from APL 18-017 requiring blood lead screening tests for young children is a new requirement. Therefore, the Plan is still working on it. However, the APL became effective on October 22, 2018. Eleven of the 12 files samples had enrollment dates between October 2019 and July 2020, over a year since the APL became effective. In addition, the Centers for Medicare and Medicaid Services released an informational bulletin in November 2016, that provided an overview of blood lead screening requirements for children enrolled in Medicaid.

The blood lead screening test assists primary care physicians in identifying and tracking young children's high-risk lead exposure. Children can be exposed to lead from sources such as paint, plumbing fixtures, and consumer products. Even low levels of lead in the blood can affect IQ, the ability to pay attention, and the academic achievement of a child, and consequently, the child's lifelong good health may be compromised.

Recommendation: Update and implement policies and procedures to ensure compliance and the provision of the Plan's contracted providers to perform blood lead screening test to young children.

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2.1.2 Provision of Lead Poisoning Anticipatory Guidance

The Plan is required to comply with all existing final Policy Letters and APL issued by DHCS. (*Contract, Exhibit E, Attachment 2*)

The Plan is required to ensure their network providers give verbal or written anticipatory guidance to the parent or guardian of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. The parent or guardian must be provided this anticipatory guidance at each PHA, starting at six months of age and continuing until 72 months. (*Managed Care APL 18-017 and 20-016, Blood Lead Screening of Young Children*)

Plan Policy, *Blood Lead Screening-Clinical Indications (last revised on December 10, 2020)* does not include the procedure for the Plan's network providers to provide verbal or written blood lead anticipatory guidance to the parent or guardian of a child member at each PHA.

Finding: The Plan did not ensure their network providers delivered verbal or written blood lead anticipatory guidance to the parent or guardian of a child member at each PHA starting at six months of age and continuing until 72 months of age.

In the *2020 and 2021 quarterly Quality Management Committee (QMC) Meeting Minutes*, there is no documentation of the Plan monitoring or effective action to ensure their network providers provide blood lead anticipatory guidance to the parent/guardian of a child member.

The *2020 Provider Manual* described the requirement of blood lead screening tests for children at one and two years of age and three to six years of age who have not been tested. However, the manual does not include the requirement of having the Plan's network providers provide blood lead anticipatory guidance to the parent/guardian of a child member at each PHA.

The verification study identified 22 files that did not have documentation of verbal or written anticipatory guidance provided to the parent or guardian of a child member at each PHA from six months to 72 months of age.

During the interview, the Plan acknowledged that it has not implemented requirements from APL 18-017. The 22 samples were enrolled between October 2019 and October 2020, over a year since the APL became effective.

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Regular anticipatory guidance concerning childhood lead poisoning and lead exposure helps to educate members' parents/guardians in understanding and preventing their child from lead poisoning and exposure. If the anticipatory guidance is not provided to parents/guardians regularly at each PHA, the child member's health can be seriously harmed, including damage to the brain and nervous system, slowing growth and development, learning and behavior problems, and hearing and speech problems.

RECOMMENDATION: Update and implement policies and procedures to ensure compliance and the provision of anticipatory guidance concerning childhood lead poisoning and lead exposure to members' parents/guardians regularly at each PHA.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1 APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Corrective Action for Timely Access Deficiencies

The Plan is required to establish acceptable accessibility standards in accordance with California Code of Regulations (CCR), Title 28, section 1300.67.2.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. *(Contract, Exhibit A, Attachment 9 (3))*

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access, which includes but is not limited to taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies and to bring its network into compliance *(CCR, Title 28, section 1300.67.2.2 (d)(3))*

The Plan must also have policies and procedures for imposing corrective action on network providers upon discovering non-compliance. *(Managed Care APL 17-004, Subcontractual Relationships and Delegation)*

Plan Policy, #CA_PNXX_003 - *Access to Care Standards (Revised on May 13, 2021)*, states providers who remain out of compliance over two years will be required to submit a CAP to the Plan for monitoring. Providers that fail to remediate non-compliant survey results will be reviewed for potential contractual action, such as a block of new members.

Finding: The Plan does not have procedures to impose prompt CAP to bring non-compliant providers in compliance in a timely manner with access standards. The Plan does not impose CAPs until a provider is out of compliance for over two years.

Without prompt investigation regarding causes of non-compliance, the Plan cannot ensure that providers comply with all applicable federal and state laws, regulations, and Contract requirements. The risk of prolonged non-compliance can lead to delays in obtaining necessary medical services for members.

Recommendation: Develop and implement procedures to ensure prompt investigation and effective corrective actions to bring non-compliant providers into compliance in a timely manner with access and availability standards.

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3.8

**NON-EMERGENCY MEDICAL TRANSPORTATION
NON-MEDICAL TRANSPORTATION**

3.8.1 Transportation Physician Certification Statement Forms

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. (*Contract, Exhibit E, Attachment 2*)

The Plan must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the Plan cannot modify the authorization. Each Plan must have a mechanism to capture and submit data from the PCS form to DHCS. (*APL 17-10, Non-Emergency Medical and Non-Medical Transportation Services*)

Plan Policy, *Transportation Benefits – CA (revised 9/25/2020)*, states NEMT for new riders requires a PCS form completed by the member's physician. A completed and approved PCS forms may not be modified and are valid for up to 12 months and are re-evaluated and re-authorized every 12 months by the contractor. The PCS is required for all non-urgent, routine trips. Upon receipt of a trip request, the contractor submits the form to the member's physician or physician extender. In providing this service, the Plan or the contractor may require that transportation be prior authorized, specify the mode of transportation, have a general expectation that a recipient uses a personal vehicle or public transit system for transportation to and from the source of medical care, specify the date and time of the transportation, or require that transportation assistance be requested a minimum of seven-ten working days in advance.

Finding: The Plan did not ensure PCS forms for NEMT services were utilized.

During the interview, the Plan stated it was standard practice for its transportation contractor to make three follow-up attempts with physicians for the PCS form. If the contractor could not reach the physician, the transportation services would still be provided without a PCS form and physician certification.

The verification study found 17 samples where a PCS form was not completed at the time of the trip.

Medi-Cal members' medical transportation needs may be compromised without the PCS form, subject to inadequate assistance and transportation methods, and unsafe transportation dues to the member's condition.

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RECOMMENDATION: Implement policies and procedures to ensure that the completed PCS form is received from providers before transportation.

3.8.2 Medi-Cal Enrollment of Transportation Providers

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. (*Contract, Exhibit E, Attachment 2*)

Plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. Plans have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through a state-level enrollment pathway. If a Plan chooses to enroll a provider type into their network that does not have an enrollment pathway through the Provider Enrollment Division, DHCS will recognize all other state-level enrollment pathways. (*APL 17-019, Provider Credentialing/Recredentialing and Screening/Enrollment*)

Plans may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, Plans may also rely on the enrollment and screening results conducted by DHCS or other Plans. Plans can access the California Health and Human Services Open Data Port to obtain a currently enrolled Medi-Cal Fee-For-Service providers list. Plans are required to issue network providers a "verification of enrollment" that Plans can rely on to prevent enrollment duplication. Plans may collaborate to share provider screening and enrollment results. (*APL 19-004, Provider Credentialing / Recredentialing and Screening / Enrollment*)

Finding: The Plan did not have a process in place to ensure that contracted NEMT and NMT providers were enrolled in the Medi-Cal program.

The verification study found 15 transportation providers were not enrolled in the Medi-Cal program.

The Plan does not have a policy or procedure for ensuring its providers are enrolled in the Medi-Cal program.

During the interview, the Plan confirmed it did not have a monitoring process to ensure that every NEMT and NMT provider is enrolled in the Medi-Cal program.

NEMT and NMT provider enrollment in the Medi-Cal program requires verification of vans, drivers, and business operations meet regulatory requirements. Without an enrollment process, Medi-Cal members may be subject to inadequate and unsafe transportation conditions.

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Recommendation: Develop and implement policies and procedures to ensure that new and existing NEMT and NMT providers meet Medi-Cal enrollment requirements.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2 FRAUD AND ABUSE

6.2.1 Annual Overpayment Reporting

In accordance with Title 42 of the Code of Federal Regulations (CFR), section 438.608(d)(4), DHCS shall use the results of the information and documentation collected by the Plan for setting actuarially sound capitation rates for the Plan consistent with the requirements in CFR, Title 42, section 438.4. (*Contract Exhibit E, Attachment 2 (34)(D)*)

The Plan is required to report annually to DHCS on their recoveries of overpayments, including those made to a network provider that was otherwise excluded from participation in the Medicaid program and those made to a network provider due to fraud, waste, or abuse. These reports shall be submitted through the existing rate setting process in a manner specified by DHCS. (*APL 17-003 Treatment of Recoveries made by the Managed Care Health Plan of Overpayments to Providers.*)

The Plan's, *Government Business Division Overpayment Policy* (last revised on August 21, 2021), did not have any language stating that the Plan will annually report to DHCS their recoveries of overpayments.

Finding: The Plan did not report annual recoveries of overpayments to DHCS.

During the interview, the Plan confirmed they do not have policies and procedures for collecting overpayments and do not report overpayments to DHCS. The Plan stated that they did not believe it was a reporting requirement in the State of California.

The Plan identified overpayments from 30 different county providers during the audit period. However, the Plan did not annually report their recoveries of overpayments to DHCS.

If the Plan does not report annually overpayment recoveries, overpayments cannot be monitored, and the data cannot be analyzed to help identify possible trends or issues.

Recommendation: Develop and implement procedures to ensure an annual reporting of overpayment recoveries to DHCS.

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

REPORT ON THE MEDICAL AUDIT OF

**ANTHEM BLUE CROSS
PARTNERSHIP PLAN**

2021

Contract Numbers: 03-75795, 04-36079,
07-65846, 10-87053
and 13-90160
(State Supported Services)

Audit Period: October 1, 2019
Through
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INTRODUCTION

The audit report presents the findings of the contract compliance audit of Anthem Blue Cross Partnership Plan (Plan) and its implementation of the State Supported Services contract Nos. 03-75795, 04-36079, 07-65846, 10-87053 and 13-90160 with the State of California. The State Supported Services contract covers abortion services for the Plan.

The audit due to Covid-19 restrictions was conducted via video conference of the Plan from August 16, 2021 through August 27, 2021 and the audit covered the review period from October 1, 2019 through July 31, 2021. The audit consisted of a document review of materials provided by the Plan and interviews with staff.

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Anthem Blue Cross Partnership Plan

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STATE SUPPORTED SERVICES

FINDINGS: The Plan's policies and procedures, Medi-Cal Provider Guide, Provider Manual, and Member Handbook were reviewed for the provision of State Supported Services.

The Plan had policies and procedures in place to provide abortion and abortion-related procedures to members. The services were included in the Member Handbook. The Plan informed providers of their responsibilities to provide abortion and abortion-related procedures without prior authorization through their Provider Manual.

A verification study of State Supported Services claims were conducted to determine appropriate and timely adjudication of claims. The verification study did not identify any material issues of non-compliance.

There were no deficiencies noted during this audit period.

RECOMMENDATION: None.