CONTRACT AND ENROLLMENT REVIEW DIVISION
SANTA ANA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Anthem Blue Cross
Partnership Plan

2022

Contract Number:	03-76184, 04-36068, 07-65845, 10-87049 13-90159 and 13-90163
Audit Period:	October 1, 2021 Through September 30, 2022
Dates of Audit:	October 24, 2022 Through November 4, 2022
Report Issued:	June 20, 2023

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I. INTRODUCTION

Anthem Blue Cross Partnership Plan, Inc. (Plan) is a subsidiary of Anthem, Inc. 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 Managed Care plan serving the Medi-Cal, Medicare, and Seniors and Persons with Disabilities (SPD) population. The Plan delivers care to members under the Two-Plan, Geographic Managed Care (GMC), Commercial Plan, and Local Initiative models.

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 GMC rural model.

The Plan has six contracts to provide services in 28 counties: Contract 03-76184, a commercial contract, covers Alameda, Contra Costa, San Francisco, and Santa Clara Counties. Contract 04-36068, a local initiative contract covers Tulare County. Contract 07-65845, a GMC contract, covers Sacramento County. Contract 10-87049, a commercial contract, covers Fresno, Kings, and Madera Counties. Contract 13-90159, a GMC and 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. Contract 13-90163 a San Benito contract, covers San Benito County.

Anthem's services are provided through the Plan's regional health centers. The regional health centers provide access to provider network physicians, members, and community agencies.

As of December 1, 2022, the Plan served approximately 729,073 Medi-Cal members, which included 78,658 SPD members in the following counties: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Inyo, King,

Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Francisco, Santa Clara, Sierra, Sutter, Tehama, Tulare, Tuolumne, and Yuba.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical review audit for the review period of October 1, 2021 through September 30, 2022. The review was conducted from October 24, 2022 through November 4, 2022. The audit consisted of document review, verification studies, and interviews with the Plan personnel.

An Exit Conference with the Plan was held on May 16, 2023. 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.

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, 2019 through July 31, 2021) was issued on April 13, 2022. This audit examined documentation for compliance.

The summary of the findings by category follows:

Category 1 – Utilization Management

There were no findings in this category for this audit period.

Category 2 – Case Management and Coordination of Care

There were no findings in this category.

Category 3 – Access and Availability of Care

The Plan is required to monitor and oversee their transportation brokers and providers for compliance with Contract requirements. The Plan did not have detailed procedures to impose corrective action for identified non-compliant transportation brokers and providers.

Category 4 – Member's Rights

The Plan is required to implement and maintain procedures for grievances and ensure timely acknowledgment of the grievance. The Plan did not send members notification of acknowledgment letters within the required five calendar days, resolution letters within the required 30 days, written notification, and estimated date of the resolution of the grievances.

Category 5 – Quality Management

There were no findings in this category.

Category 6 – Administrative and Organizational Capacity

There were no findings in this category for this audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Contract and Enrollment Review Division 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 State Contracts.

PROCEDURE

The review was conducted from October 24, 2022 through November 4, 2022. 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 Authorizations: 20 medical and 16 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: 20 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: 20 medical records and ten blood lead screenings of young children. Complex Case Management: 20 medical records.

Behavioral Health Treatment: 20 Medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Transportation Access Standards: 27 Non-Medical Transportation (NMT) and 42 Non-Emergency Medical Transportation (NEMT) records were reviewed to verify that the Plan's contracted NEMT and NMT providers were enrolled in the Medi-Cal Program.

Category 4 – Member's Rights

Grievance Procedures: 20 quality of care and 38 quality of service grievances were reviewed for a timely resolution, response to the complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

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

Category 6 – Administrative and Organizational Capacity

No verification studies were conducted.

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

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	**NON-EMERGENCY MEDICAL TRANSPORTATION** **NON-MEDICALTRANSPORTATION**

3.8.1 Corrective Action Plan Process

All Policy and All Plan Letters (APL) issued by Medi-Cal Managed Care Division subsequent to the effective date of the Contract shall provide clarification of the Plan's obligations pursuant to this Contract and may include instructions to the Plan regarding implementation of mandated obligations pursuant to changes in state or federal statutes or regulations, or pursuant to judicial interpretation. (*Contract, Exhibit E, Attachment 2 (1)(D))*

Plans are responsible for monitoring and overseeing their transportation brokers to ensure they comply with the requirements in this APL. Plans must conduct monitoring activities no less than quarterly. Further, Plans must have a process in place to impose corrective action on their transportation brokers and network providers if non-compliance with this APL is identified through any monitoring or oversight activities(*APL 22-008 NEMT and NMT Services and Related Travel Expenses)*

The Plan's policy, *Transportation Benefits – CA* (Revised on 7/29/2022), stated that transportation brokers must make at least two attempts to obtain the PCS form. After the two attempts, the non-responsive provider will be added to the weekly Pending PCS Form Report. The Plan's staff will conduct follow up calls to providers to obtain the required PCS forms. Continued non-compliance will result in a Corrective Action Plan (CAP).

Finding: The Plan does not have detailed policies and procedures to impose corrective action on identified non-compliant providers with outstanding PCS forms.

In the verification study, 20 out of 37 samples did not have PCS forms available for review. There were no CAPs issued for those non-compliant providers.

During the interview, the Plan stated that the non-responsive healthcare providers would be reached out to secure the PCS forms based on the transportation broker's weekly outstanding PCS form reports. Moreover, the CAP would only be issued to truly non-responsive providers unwilling to move forward with the PCS form. Although the Plan's Provider Performance Management staff monitored and identified non-compliance, the Plan still lacked criteria to base identification of those who required CAPs. Additionally, the Plan acknowledged that it did not have approved policies and

procedures to oversee the CAP process for non-compliant transportation brokers and in-network providers.

The Plan is required to ensure its contracted providers complies with the NEMT standards. Without detailed policies and procedure to effectively impose and monitor CAP, the Plan cannot ensure that providers complies with all applicable federal and state laws, regulations, and Contract requirements, which may lead to inadequate assistance, inappropriate transportation methods, and compromised safety.

Recommendation: Develop and implement the new detailed policies and procedures in processing and monitoring effective correction actions for on identified non-compliant providers to ensure PCS form are completed and maintained on Medi-Cal member's record.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Acknowledgement Letters

The Plan is required to implement and maintain procedures for grievances and the expedited review of grievances required under California Code of Regulations (CCR), Title 28, sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858. The Contract also highlights that the Plan shall ensure timely acknowledgment for grievance in accordance with CCR, Title 28, section 1300.68 and 1300.68.01, CCR, Title 22, section 53858 *(Contract, Exhibit A, Attachment 14, (1)(2))*

The Plan is required to provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the grievance. The acknowledgment letter must advise the member that the grievance has been received and the date of receipt. It must also provide the representative's name, telephone number, and address who may be contacted about the grievance. *(APL 21-011, Grievance and Appeal (G&A) Requirements, Notice and "Your Rights" Templates)*

Plan Policy – Grievance Process (review date 5/17/2022), states that "the Plan's Medi-Cal G&A associate sends a written acknowledgment of the member's grievance that is dated and postmarked within five calendar days of the date stamped as the received date for the grievance."

Finding: The Plan did not send grievance acknowledgement letters for quality of service grievances within the required five calendar days.

In a verification study of quality of services grievance cases, the written grievance acknowledgment letters for 13 of 38 cases were sent past the five calendar day timeframe. Written acknowledgment letters were sent between 5 to 57 days.

In an interview, the Plan attributed the failure to provide members with timely written acknowledgment letters to the shortage of staff in their A&G Department, lack of proper

training provided to staff, and failure to effectively monitor the A&G Department to ensure notification letter timeliness.

Delays in resolving grievances could negatively impact member medical care and the Plan's quality of service.

Recommendation: Implement Plan procedures to monitor the grievance acknowledgment letters and to ensure the letters are sent within the mandated five calendar days.

4.1.2 Grievance Resolution Letters

The Plan is required to implement and maintain procedures for grievances and the expedited review of grievances required under CCR, Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858. The Contract also highlights that the Plan shall have procedures to ensure a notice of the resolution is provided to the member as quickly as the member's health condition requires, within 30 calendar days form the date the Plan receives the grievance or request for an appeal. (Contract, Exhibit A, Attachment 14, (1)(2))

The Plan is required to have timeframes for acknowledging receipt of and resolving grievances and sending a written resolution to the beneficiary that are required under federal and state law. The State's established timeframes is 30 calendar days for grievance resolution. (APL 21-011, G&A Requirements, Notice and "Your Rights" Templates)

Plan Policy – Grievance Process (review date 5/17/2022), states that "the Plan's designated staff sends a written resolution letter to the member within 30 calendar days of receipt of the grievance."

Finding: The Plan did not send grievance resolution letters for quality of service grievances within the required 30 calendar days.

In a verification study of quality of service grievance cases, the resolution letters for 31 of 38 cases were not sent past the 30 calendar day timeframe. Grievance resolution letters were sent between 30 to 49 days.

In an interview, the Plan attributed the failure to provide members with timely grievance resolution letters to the shortage of staff in their A&G Department, lack of proper training provided to staff, and failure to effectively monitor the A&G Department to ensure resolution letter timeliness.

Delays in resolving grievances could potentially impact member treatments and the Plan's quality of service.

Recommendation: Implement Plan procedures to closely monitor the grievance resolution process and to ensure grievance resolution letters are sent within the required 30 calendar days.

4.1.3 Grievance Status and Estimated Date of Resolution

The Plan is required to implement and maintain procedures for grievances and the expedited review of grievances required under CCR, Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858. The Plan shall have procedures to ensure timely acknowledgment, resolution, and feedback to the complainant. *(Contract, Exhibit A, Attachment 14, (1)(2))*

In the event that the resolution of a standard grievance is not reached within 30 calendar days as required, the Plan shall notify the member in writing that it needs more information to process the claim or approve it. *(APL 21-011, G&A Requirements, Notice and "Your Rights" Templates)*

Plan Policy – Grievance Process (review date 5/17/2022), states that in the event that a resolution is not reached within 30 calendar days, the member is notified in writing of the status of the grievance and provided with an estimated completion date of resolution, which shall not exceed 14 calendar days.

Finding: The Plan did not send written notification of the status of grievance and estimated resolution dates.

The Plan attributed the failure to provide members with written notifications to the shortage of staff in their A&G Department, lack of proper training provided to staff, and failure to effectively monitor the A&G Department to ensure notification letters were sent.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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In a verification study of quality of service grievances, the notification of their grievance status, and estimated resolution date for 30 of 38 cases were not sent to the members.

Delays in member notification of grievance status and estimated resolution date could negatively impact the medical care of members and Plan's quality of service.

Recommendation: Implement policies and procedures to monitor the grievance resolution and notification process to ensure timely grievance resolution and notification.

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REPORT ON THE MEDICAL AUDIT OF

ANTHEM BLUE CROSS PARTNERSHIP PLAN

2022

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

Audit Period: October 1, 2021 Through September 30, 2022

Report Issued: June 19, 2023

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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 October 24, 2022 through November 4, 2022 and the audit covered the review period from October 1, 2021 through September 30, 2022. The audit consisted of a document review of materials provided by the Plan and interviews with staff.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

Anthem Blue Cross Partnership Plan

AUDIT PERIOD: October 1, 2021 – September 30, 2022
DATE OF AUDIT: October 24, 2022 – November 4, 2022

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.

Policy CMPR_004, Abortion Services, includes all Current Procedural Terminology Codes as billable pregnancy termination services according to contractual requirement.

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.

The *Provider Manual* informs providers of the rights of members to receive timely access to care for abortion services.

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.