

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

REPORT ON THE MEDICAL AUDIT OF

**Blue Shield of California
Promise Health Plan**

2022

Contract Number: 09-86153

Audit Period: January 1, 2021
Through
December 31, 2021

Date of Audit: January 18, 2022
Through
January 27, 2022

Report Issued: July 13, 2022

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I. INTRODUCTION

Blue Shield of California Promise Health Plan (Plan) is a Health Maintenance Organization, wholly owned and operated by Blue Shield of California. The Plan provides Medi-Cal Managed Care services in San Diego County. Blue Shield of California is an independent member of the Blue Shield Association.

Formerly known as Care 1st Health Plan, Inc., the Plan has maintained a California full-service health plan license under the Knox-Keene Act since 1995. In June 2005, the Department of Health Care Services (DHCS) granted the Geographic Managed Care contract to the Plan to provide health care services to Medi-Cal beneficiaries in San Diego County.

In 2015, Blue Shield of California acquired Care 1st Health Plan. Effective January 1, 2019, the Plan's name was changed to Blue Shield of California Promise Health Plan.

As of February 2022, the Plan served 119,274 members through the following programs: Medi-Cal 116,577 and Cal MediConnect 2,697.

II. EXECUTIVE SUMMARY

This report presents the results of the full scope medical audit that includes the Seniors and Persons with Disabilities (SPD) population for the audit period of January 1, 2021 through December 31, 2021. DHCS conducted the audit of the Plan from January 18, 2022 through January 27, 2022. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on June 2, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in the report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

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

The prior DHCS medical audit issued on June 22, 2021, for the audit period of January 1, 2020 through December 31, 2020, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP close-out letter dated May 23, 2022, documented that DHCS closed all previous findings.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the current findings by category follows:

Category 1 – Utilization Management

Category 1 includes requirements and procedures for the UM program, including prior authorization (PA) review, the appeal process, Medical Director, and medical decisions.

The Plan is required to ensure that the UM program includes the integration of the review of PA and appeal reports into the Quality Improvement System (QIS). The Plan did not integrate review of PA and appeal reports into its QIS.

As part of PA review, the Plan must have a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. The Plan did not ensure medical criteria was consistently applied and used to adjudicate PA requests.

The Plan is required to maintain a Medical Director, pursuant to the California Code of Regulations (CCR), Title 22, section 53913.5, whose responsibilities shall include ensuring that qualified medical personnel render medical decisions. The Plan did not ensure that expedited appeals were reviewed by a health care professional with clinical expertise in treating the member's condition or disease.

The Plan is required to maintain a Medical Director who shall actively participate in the Plan's grievance procedures and ensure that member grievances involving clinical issues were properly classified and reviewed by qualified medical personnel. The Plan's Medical Director did not actively participate in the Plan's grievance procedures and did not ensure that member grievances involving clinical issues were properly classified and reviewed by qualified medical personnel.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements and procedures for Initial Health Assessment (IHA).

The Plan is required to cover and ensure the provision of an IHA to each new member. An IHA consists of a comprehensive history and physical examination, preventive services, and an Individual Health Education Behavioral Assessment (IHEBA). The Plan did not ensure the provision of complete and comprehensive IHAs.

Category 3 – Access and Availability of Care

Category 3 includes requirements and procedures to provide NEMT and NMT services for medically necessary services.

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The Plan did not utilize the PCS forms to determine the appropriate level of service for NEMT.

The Plan is required to ensure that all NEMT services have PA. The Plan did not consistently require PA for NEMT services.

The Plan must ensure its NMT and NEMT providers are enrolled in the Medi-Cal program. The Plan contracted with NEMT vendors not enrolled in the Medi-Cal program.

Category 4 – Member's Rights

Category 4 includes requirements and procedures to establish and maintain a grievance system, and to protect members' rights by properly reporting suspected or actual breaches or security incidents.

The Plan is required to refer grievances related to medical Quality of Care (QOC) issues to the Plan's Medical Director. The Plan did not refer all QOC grievances to its Medical Director.

The Plan is required to resolve grievances to reach a conclusion with respect to the member's submitted grievance. The Plan must complete multiple internal levels of grievance resolution within 30-calendar-days and refer grievances related to medical

QOC issues to its Medical Director. The Plan did not immediately refer all QOC grievances to a Plan physician for determination within 30-calendar-days.

The Plan is required to implement reasonable systems for the discovery and prompt reporting of a suspected or actual breach or security incident. The Plan did not notify the appropriate DHCS officers of breaches or security incidents within the required timeframes.

Category 5 – Quality Management

Category 5 includes requirements and procedures to monitor, evaluate, and take effective action to address needed improvements in the QOC delivered by providers.

The Plan is required to conduct training regarding the Medi-Cal Managed Care program for all new providers within ten-working-days after the Plan places a newly contracted provider on active status. The Plan did not provide training to and ensure subcontractors trained newly contracted providers within ten-working-days.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by 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 Contract.

PROCEDURE

The review was conducted from January 18, 2022 through January 27, 2022. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff. To ensure parity in services, the verification studies included both SPD and non-SPD members in the samples.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: 20 denied medical (15 Medi-Cal and five SPD) and 20 denied pharmacy (15 Medi-Cal and five SPD) PA requests were reviewed. All requests were evaluated for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Delegation of UM: Ten Medi-Cal PA requests from a delegated entity were reviewed for appropriate and timely adjudication.

Appeal Procedures: 27 PA appeals (13 Medi-Cal and 14 SPD) and five expedited PA appeals (three Medi-Cal and two SPD) were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services: Six medical records (four Medi-Cal and two SPD) were reviewed for completeness, timeliness, and evidence of coordination of care between the Plan and providers.

IHA: 23 medical records were reviewed for provision, completeness, and timeliness of IHAs.

Complex Case Management: Ten medical records were reviewed for coordination of care.

Behavioral Health Treatment: 15 medical records (11 Medi-Cal and four SPD) were

reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Continuity of Care: Eight medical records were reviewed for completeness and timeliness.

Category 3 – Access and Availability of Care

Claims: 20 emergency services (15 Medi-Cal and five SPD) and 20 family planning (18 Medi-Cal and two SPD) claims were reviewed for appropriate and timely adjudication.

NEMT and NMT: 15 NEMT (ten Medi-Cal and five SPD) and 15 NMT (ten Medi-Cal and five SPD) records were reviewed to confirm compliance with the transportation and appropriateness of services provided.

Category 4 – Member’s Rights

Grievance Procedures: 25 QOC (20 Medi-Cal and five SPD) and 33 quality of service (18 Medi-Cal and 15 SPD) standard grievances, seven expedited (five Medi-Cal and two SPD) grievances, ten Medi-Cal exempt grievances, and ten Medi-Cal call inquiries were reviewed. All grievances were reviewed for timely resolution, appropriate classification, response to complainant, submission to the appropriate level for review, and translation into the member’s preferred language (if applicable).

Confidentiality Rights: Nine security incidents were reviewed for processing and reporting requirements.

Category 5 – Quality Management

QIS System: Five Potential Quality Incident (PQI) cases were reviewed for timely evaluation and effective action taken to address needed improvement.

Provider Qualifications: 20 new provider training records were reviewed for timeliness of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 18 fraud and abuse cases were reviewed for 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

1.1	UTILIZATION MANAGEMENT PROGRAM / REFERRAL TRACKING SYSTEM
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1.1.1 Integration of Utilization Management with Quality Improvement

The Plan is required to ensure that the UM program includes the integration of UM activities into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. *(Contract, Exhibit A, Attachment 5 (1)(G))*

The Plan is required to compile the systematic aggregation and analysis of grievance and appeal data and use for Quality Improvement (QI). *(Contract, Exhibit A, Attachment 14 (1)(J))*

Plan policy 70.2.50, *UM Prior Auth Review* (revised July 2021), stated that the Medical Service Committee (MSC) performs quarterly reviews of UM reports to assure and improve QOC for Plan members. Quarterly reports reviewed by the MSC include PA denials, deferrals, and modifications, over- and under- utilization, continuum of care, as well as appeals and overturns. Report reviews and associated quarterly work plan updates are then reported to the Quality Management Committee (QMC) as part of the Plan's QI oversight.

Finding: The Plan did not integrate review of PA and appeal reports into its QIS.

Since the prior year audit, the Plan updated its policy 70.2.50, *UM Prior Auth Review*, to include the integration of UM activities into its QIS. However, the MSC meeting minutes did not document any review of PA and appeal data trends to report to the QMC, which the Plan confirmed were not collected or monitored. Therefore, the QMC did not review UM reports containing PA denials, deferrals and modifications, or the number and types of appeals. Instead, the QMC meeting minutes documented review of grievance and appeals data that involved administrative tasks such as number of grievances and appeals per 1,000 members per month, turnaround times, and appropriateness of acknowledgement letters.

Without reviewing important UM functions, such as the number and type of appeals and PA denials, deferrals, and modifications, the Plan's QMC cannot adequately assess the level of quality the UM Department is providing its members. This lack of oversight impedes the QMC from detecting UM process failures, potentially leading to lower quality of life and worsened health outcomes for members.

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This is a repeat finding of the prior year audit (2021) – 1.1.1 Integration of Utilization Management with Quality Improvement.

Recommendation: Implement policies and procedures to integrate the review of PA and appeal reports into the QIS.

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1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Prior Authorization Criteria

The Plan must have a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. (*Contract, Exhibit A, Attachment 5 (2)(D)*).

Plan policy 70.2.50, *UM Prior Auth Review* (revised July 2021), stated that the UM staff works within their scope of practice and in conjunction with the Chief Medical Officer (CMO) or physician designee to process authorizations appropriately. The CMO has substantial involvement in the authorization review and approval process. Decisions to approve, deny, delay, or modify will be based on medical necessity. These decisions will reflect appropriate application of Plan approved criteria/guidelines.

Plan policy 10.2.100.30, *Coverage of Transgender Services* (revised September 2021), stated that the Plan uses nationally recognized clinical guidelines in reviewing PA requests for services from transgender beneficiaries and shall apply those standards consistently across the population. The primary source of clinical guidance for the treatment of gender dysphoria is found in the most current “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People,” published by the World Professional Association for Transgender Health.

The Plan’s *Utilization Management Program Description* (revised January 2021), stated that the CMO is responsible for reviewing the consistency of UM decision criteria and implementing corrective actions when needed. The CMO is also responsible for providing directions and oversight of the professional UM staff to assure compliance with written policies and procedures.

Finding: The Plan did not ensure medical criteria was consistently applied and used to adjudicate PA requests.

The verification study found six of 20 medical PA requests were denied for the following reasons:

- Four PA requests were denied for electrolysis in transgender members as a non-covered benefit. However, this was a covered service which was medically necessary.
- Two PA requests were denied for enteral feedings for a member under 21 years of age using adult medical criteria instead of children’s medical criteria.

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The Plan did not have a process to review actual denied PA requests for medical necessity to ensure decisions were appropriately made using Plan approved medical criteria. The Plan acknowledged these requests were inappropriately denied. Although the PA cases were adjudicated by the Medical Directors, the annual review was overseen by a Plan Registered Nurse (RN) who only ensured successful completion of PA administrative tasks, such as notice of action reading levels and case turnaround times.

Additionally, the Plan's MSC and QMC meeting minutes did not document the classification or etiology, or report any trends of medical PA denials. The Plan confirmed it did not track and trend denied PA overturned appeals to identify reoccurring issues.

If the Plan does not ensure correct criteria is used to adjudicate PAs, members may experience denials and delays in receiving medically necessary services or may not receive the care they need.

Recommendation: Develop and implement policy and procedures to ensure the Plan utilizes correct medical criteria to adjudicate PA requests.

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1.3

PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Medical Decisions in the Expedited Appeal Process

The Plan is required to maintain a Medical Director, pursuant to CCR, Title 22, section 53913.5, whose responsibilities shall include ensuring that medical decisions are rendered by qualified medical personnel. *(Contract, Exhibit A, Attachment 1 (6))*

The Plan shall ensure that the person making the final decision for the proposed resolution of grievances and appeals has clinical expertise in treating a member's condition or disease if deciding an appeal of a denial based on lack of medical necessity, a grievance regarding denial of an expedited resolution of an appeal, and any grievance or appeal involving clinical issues. *(Contract, Exhibit A, Attachment 14 (1)(D))*

The Plan shall implement and maintain procedures to resolve expedited appeals. The Plan shall follow the expedited appeal process when it determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. *(Contract, Exhibit A, Attachment 14(6))*

Managed Care Health Plans (MCPs) must comply with all existing state regulations pertaining to expedited appeal handling in accordance with state law. The decision-maker must be a health care professional with clinical expertise in treating a member's condition or disease on any grievance or appeal involving clinical issues. *(All Plan Letter (APL) 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates, issued August 31, 2021)*

Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised October 2021), stated as part of the Plan's formal appeal system, the decision-maker shall be a health care professional with clinical expertise in treating the member's condition or disease if the following applied:

- An appeal of an Adverse Benefit Determination that is based on lack of medical necessity.
- A grievance regarding denial of an expedited resolution of an appeal.
- Any grievance or appeal involving clinical issues.

Plan policy 10.19.5, further stated if the appeal is for a clinically urgent situation, the appeals and grievance Coordinator will immediately forward the case to the assigned RN or Licensed Vocational Nurse (LVN) for review. The assigned nurse will then request an immediate review by the Medical Director for a clinical review.

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Finding: The Plan did not ensure that expedited appeals were reviewed by a health care professional with clinical expertise in treating the member's condition or disease.

The verification study found three expedited appeal cases were downgraded to standard appeal by a LVN without documented involvement of a Medical Director.

In addition to Plan policy 10.19.5, *Beneficiary Grievance Management System*, the Plan implemented Desktop Procedure, *Blue Shield Promise_Medi-Cal and CMC Grievance and Appeals* (effective December 2020), which stated a member may request to file an expedited/immediate appeal should the member believe their request/case is urgent. When a member requests to file an expedited/immediate appeal, the Customer Care Representative will inform the member that the Medical Director will review the case to determine if it meets the expedited/immediate criteria. However, the Plan confirmed nurses downgraded expedited appeals without a Medical Director review.

If the Plan does not ensure expedited appeals are reviewed by health care professionals with clinical expertise in treating the member's condition or disease, members may not receive necessary services timely, which could jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Recommendation: Implement policies and procedures to ensure that expedited appeals are reviewed by a health care professional with clinical expertise in treating the member's condition or disease.

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1.4

MEDICAL DIRECTOR AND MEDICAL DECISIONS

1.4.1 Medical Director Involvement in the Grievance Process

The Plan is required to maintain a full time physician as Medical Director, pursuant to 22 CCR 53913.5, whose responsibilities shall include, but not be limited to, resolve grievances related to medical QOC, and actively participate in the functioning of the Plan's grievance and appeal procedures as specified in Exhibit A, Attachment 14. (*Contract, Exhibit A, Attachment 1 (6)*)

Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised October 2021), stated the CMO, who is an officer of the Plan, shall be designated as the primary responsibility for the Plan's grievance system. The CMO may delegate responsibility to a Plan Medical Director to provide clinical oversight and actively participate in the grievance process. The Plan Medical Director will provide support in addressing the responsibilities of the Grievance Officer by reporting any findings to the CMO on a regular monthly cadence. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances.

Finding: The Plan's Medical Director did not actively participate in the Plan's grievance procedures.

Since the prior year audit, the Plan updated its policy 10.19.5, *Beneficiary Grievance Management System*, to include responsibilities of oversight by the CMO and Medical Director in the grievance process. However, the CMO and Medical Director did not actively participate in the grievance process beyond reviewing a portion of QOC grievance administrative procedures (i.e., percentage of turnaround time for grievance acknowledgement and resolution letters) during the quarterly QMC meetings. The QMC meeting minutes did not indicate that the Plan was aware of quality performance issues affecting the grievance process. Further, the Plan stated the CMO and Medical Director only reviewed a selection of QOC grievances that were referred to them by the clinical grievance RN reviewer.

Without the Medical Director's active participation in the Plan's grievance process, the Plan cannot ensure the QOC provided to members.

This is a repeat finding of the prior year audit (2021) – 1.1.3 Medical Director Involvement in the Grievance Process.

Recommendation: Implement policies and procedures to ensure the Medical Director's active participation in the grievance system.

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1.4.2 Medical Decisions in the Grievance Process

The Plan is required to maintain a full time physician as a Medical Director, pursuant to 22 CCR 53913.5, whose responsibilities shall include ensuring that medical decisions are rendered by qualified medical personnel. (*Contract, Exhibit A, Attachment 1 (6)(A)(1)*)

Grievances related to medical QOC issues shall be referred to the Plan's Medical Director. (*Contract, Exhibit A, Attachment 14 (4)*)

All grievances related to medical QOC issues must be immediately submitted to the MCP's Medical Director for action. (*APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates, issued August 31, 2021*)

Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised October 2021), stated the Plan's CMO or designated Medical Director will work closely with the Plan's Appeals and Grievances RN Manager to ensure that member grievances involving clinical issues are properly classified and reviewed by qualified medical personnel. The Plan's Medical Director will focus on the following when conducting the audit of the monthly grievance log:

- Appropriate case categorization, i.e., whether the grievance was non-clinical, clinical and if a potential quality component existed.
- Appropriate resolution, i.e., did the resolution address the members' specific concerns, were clinical grievances forwarded to a Medical Director.
- Results of the quarterly grievance log submission are shared with the CMO, (if it is the designated Medical Director that conducts the review instead of the CMO).

Finding: The Plan's Medical Director did not ensure that member grievances involving clinical issues were properly classified and reviewed by qualified medical personnel.

Since the prior year audit, the Plan updated its policy 10.19.5, *Beneficiary Grievance Management System*, to address clinician oversight and Medical Director involvement. The Plan also implemented Desktop Procedure, *Blue Shield Promise_Medi-Cal and CMC Grievance and Appeals* (effective December 2020), which instructed Customer Care Representatives to classify grievances and appeals appropriately using the Plan's *Appeals and Grievances Codes Job Aid*. Further, the Plan stated that the Customer Care Representatives were trained when hired, and pre- and post-closure audits were randomly performed monthly for quality review. However, no clinical oversight by a qualified licensed healthcare professional was provided at the intake level to ensure that member grievances involving QOC were appropriately classified. The Plan confirmed grievances were classified at the intake level.

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Without clinical oversight, non-clinician Plan staff may attempt to make complex decisions regarding medical services. Delays in medical care could result in poor health outcomes for members.

This is a repeat finding of the prior year audit (2021) – 1.1.4 Medical Decisions in the Grievance Process.

Recommendation: Implement policy and procedures to ascertain the Plan’s Medical Director ensures that member grievances involving clinical issues are properly classified and reviewed by qualified medical personnel.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1 INITIAL HEALTH ASSESSMENT

2.1.1 IHA Completion

An IHA consists of a comprehensive history and physical examination, preventive services, and an IHEBA that enables a provider of primary care services to comprehensively assess the member's current acute, chronic and preventive health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this Contract. (*Contract, Exhibit A, Attachment 10 (3)*)

The Plan shall provide preventive services for all members under 21 years of age as specified by the most recent American Academy of Pediatrics guidelines and periodicity schedule (Bright Futures guidelines). (*Contract, Exhibit A, Attachment 10 (5)(B)(1)*)

The Plan shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult member age 21 or older. (*Contract, Exhibit A, Attachment 10 (6)(B)(1)*)

Plan policy 70.1.1.14, *Initial Health Assessment Oversight* (revised December 2021), stated that an IHA consists of a comprehensive health history, assessment of health education needs, completed physical assessment, completion of the Staying Healthy Assessment Form in accordance to the member's age group, specific evaluations, tests, Advisory Committee on Immunization Practice recommended immunization, counseling follow-up, and treatments. The Plans QI Department conducts a random medical record review on at least a monthly basis to assess the quality and completion of the IHA visit. The IHA Medical Record Review results and findings are provided to the physician/clinic and or the IPA, along with resources and guidelines that will assist the provider to meet IHA requirements. CAPs may be required to address noncompliance or other findings.

Finding: The Plan did not ensure the provision of complete and comprehensive IHAs.

The verification study found 20 of 23 medical records did not have a complete IHA and age appropriate IHEBA. Medical records did not include preventive screening (i.e. blood lead screening, immunization status, fall prevention, alcohol screening, and cervical cancer screening).

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Although the Plan conducts monthly IHA Medical Record Reviews to ensure provision of comprehensive IHAs and IHEBAs as outlined in Plan policy 70.1.1.14, *Initial Health Assessment Oversight*, the Plan stated that only a sample of providers were reviewed. Therefore, providers who completed IHAs as part of the verification study may not have been part of the monthly reviews.

If the Plan does not ensure the provision of complete and comprehensive IHAs, it may lead to members not receiving necessary medical care due to lack of identification of health risks, medical treatment, or referrals for coordination of care.

Recommendation: Implement policies and procedures to ensure completion of comprehensive IHAs.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8

NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION

3.8.1 Physician Certification Statement

The Plan shall cover transportation services as required in the Contract and directed in APL 17-010 to ensure members have access to all medically necessary services. *(Contract Amendment A20, Exhibit A, Attachment 10(8)(H))*

NEMT services are subject to PA and the Plan is required to use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. Authorizations may be for a maximum of 12 months. *(APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services, revised September 8, 2020)*

Plan policy 70.2.100, *Non-Emergency Medical Transportation Services* (revised November 2021), stated that a Request for NEMT – PCS form must be completed and submitted before NEMT services can be authorized and provided to the member. The PCS form certifies the medical necessity to determine the type of transportation being requested. The Plan’s NEMT oversight team is responsible for monitoring the monthly compliance of authorizations issued and rides occurring with the *Request for NEMT – PCS* forms.

Finding: The Plan did not utilize the required DHCS-approved PCS forms to determine the appropriate level of service for Medi-Cal members.

The verification study found that eight of 15 sample records did not utilize a PCS form.

The Plan confirmed their UM team did not ensure that PCS forms and Treatment Authorization Requests (TAR) were received before issuing authorizations. The Plan stated to address these deficiencies and simplify the authorization process, the PCS and TAR have been consolidated into a one page form. However, the form was not approved until September 2021. The verification study sample covered the time period of January through October 2021.

If the Plan does not utilize PCS forms, members may not receive the appropriate level of service necessary for their medical condition.

This is a repeat finding of the prior year audits (2020 and 2021) – 3.8.1 Physician Certification Statement.

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Recommendation: Implement policies and procedures to ensure that all NEMT requests include a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members.

3.8.2 Treatment Authorization Request

The Plan is required to ensure that all NEMT services have PA. (*CCR, Title 22, section 51323*)

NEMT services are subject to a PA, except when a member is transferred from an acute level of care, to a skilled nursing facility or intermediate care facility licensed pursuant to Health and Safety Code, Section 1250. (*APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services, revised September 8, 2020*)

Plan policy 10.3.21, *Non-Emergency Transportation* (revised February 2021), stated that NEMT requests require a TAR and PCS.

Finding: The Plan did not consistently require PA for NEMT services.

The verification study found that 11 of 15 sample records did not include a TAR, none of which were exceptions as stated in APL 17-010.

The Plan confirmed their UM team did not ensure that PCS forms and TARs were received before issuing authorizations. The Plan stated to address these deficiencies and simplify the authorization process, the PCS and TAR have been consolidated into a one page form. However, the form was not approved until September 2021. The verification study sample covered the time period of January through October 2021.

If the Plan does not utilize a TAR, members may not receive the transportation method necessary for their medical condition.

This is a repeat finding of prior year audit (2021) – 3.8.2 Treatment Authorization Request.

Recommendation: Implement policies and procedures to ensure that all NEMT requests include PA.

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3.8.3 Non-Enrolled NEMT Transportation Providers

The Plan must ensure that all network providers and subcontractors are enrolled in the Medi-Cal program. (*Code of Federal Regulations (CFR), Title 42, section 438.602(b)*)

MCP shall evaluate the prospective subcontractor's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 438.230(b)(3), (4) and 22 CCR section 53250, as well as those specified in this Contract. (*Contract, Exhibit A, Attachment 6(14)*)

All MCP network providers must enroll in the Medi-Cal program. MCPs 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 DHCS. (*APL 19-004, Provider Credentialing / Recredentialing and Screening / Enrollment, issued June 12, 2019*)

The Plan is required to ensure all network providers are enrolled in the Medi-Cal program. MCP will remain contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the subcontracted functions. (*APL 19-004*)

Finding: The Plan did not ensure contracted NEMT providers were enrolled in the Medi-Cal program.

The Plan utilizes a subcontracted vendor to assist in providing ground transportation services to members. The Plan did not have a process in place to ensure its subcontracted transportation vendor complied with Medi-Cal enrollment requirements during the review period.

The verification study found that four of 19 transportation providers were not enrolled in the Medi-Cal program.

The broker delegated the NEMT services to their subcontractors. The Plan's agreement with its transportation broker stated the broker's scope of work includes subcontractor credentialing, as well as ensuring all delegated entities and subcontractors meet requirements set forth by the Plan and DHCS where applicable.

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The Plan stated subcontractor information was annually requested to verify enrollment in the Medi-Cal program. The audit team reviewed the Plan's monitoring report, dated October 2021, and found the Plan did not completely and accurately ensure subcontractors were enrolled. The report identified one non-enrolled subcontractor as enrolled and one enrolled subcontractor as not enrolled in Medi-Cal.

If the Plan contracts with transportation providers not enrolled in the Medi-Cal program, it cannot ensure that members receive adequate and safe transportation services.

Recommendation: Implement policies and procedures to ensure contracted NEMT providers are enrolled in the Medi-Cal program.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1	GRIEVANCE SYSTEM
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4.1.1 QOC Grievance Reviews

The Plan is required to implement and maintain procedures for grievances and the expedited review of grievances required under 42 CFR 438.402, 406, and 408, 28 CCR 1300.68 and 1300.68.01, and 22 CCR 53858. The Plan is required to ensure that every grievance submitted is reported to an appropriate level, i.e., QOC versus Quality of Service (QOS). Grievances related to medical QOC issues shall be referred to the Plan’s Medical Director. (*Contract, Exhibit A, Attachment 14 (2)(B)*)

All grievances related to medical QOC issues must be immediately submitted to the Plan’s Medical Director for action. The Plan must ensure the person making the final decision for the proposed resolution of a grievance is a health care professional with clinical expertise in treating a member’s condition or disease on any grievance involving clinical issues. (*APL 21-011, Grievance and Appeal Requirements, Notice and “Your Rights” Templates, revised August 31, 2021*)

Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised October 2021), stated all medical QOC grievances will be submitted to the Appeals and Grievance Department clinical team for clinical oversight. The Plan’s CMO or designated Medical Director will work closely with the Plan’s Appeals and Grievances RN Manager to ensure that member grievances involving clinical issues are reviewed by qualified medical personnel. Since the prior year audit, the Plan updated its policy 10.19.5, to reflect this process.

Further, the policy stated upon receipt of a request for an expedited grievance, the Customer Care Representative will forward the request to the Grievance Department. The appeals and grievance Coordinator will immediately have the expedited grievance request reviewed by the Medical Director. The Medical Director will determine if the expedited grievance request qualifies as expedited. Expedited criteria include grievances involving an imminent and serious threat to the health of the beneficiary, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, or as requested by a physician.

Finding: The Plan did not refer QOC grievances to its Medical Director.

The verification study found two of seven QOC expedited grievances and 11 of 25

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standard QOC grievances were not elevated to the appropriate level of review. Further, six standard QOS grievances were misclassified as QOS although QOC issues were present. None of the documentation received showed these grievances were reviewed for QOC issues by the Medical Director.

In addition to Plan policy 10.19.5, *Beneficiary Grievance Management System*, the Plan's Desktop Procedure, *Blue Shield Promise_Medi-Cal and CMC Grievance and Appeals* (reviewed December 2020), instructed Customer Care Representatives to present the request for an expedited grievance to the Medical Director for determination. However, the Plan did not refer all expedited grievance requests to the Medical Director. The expedited requests were reviewed by the Plan's clinical team of nurses, who determined whether to reduce a member's request from an expedited grievance to a standard grievance. The Plan confirmed that nurses reduced expedited requests to a standard grievance without a Medical Director's review.

Further, the Plan stated the Medical Director reviewed only the QOC grievances that were selected by the Appeals and Grievances Department clinical team. This was done on a monthly basis after the grievances were closed. The Medical Director did not immediately review QOC grievances as they were received.

When QOC issues are not referred to the Medical Director, there may be the potential for health care delivery problems. The Plan may miss QI opportunities and as a result, the Plan may not fully address member's health care concerns.

This is a repeat finding of prior year audit (2021) – 4.1.2 QOC Grievance Reviews.

Recommendation: Implement policies and procedures to ensure all QOC grievances are referred to the Medical Director for review.

4.1.2 Resolution of Grievances Involving Clinical Issues

The Plan is required to have in place a system in accordance with 28 CCR, 1300.68. (*Contract, Exhibit A, Attachment 14 (1)*)

Grievances related to medical QOC issues shall be referred to the Plan's Medical Director. (*Contract, Exhibit A, Attachment 14 (2)(B)(4)*)

"Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. If the Plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30-calendar-days of the Plan's receipt of the grievance. (*CCR, Title 28, section 1300.68 (a)*)

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The MCPs written resolution must contain a clear and concise explanation of the MCP's decision. In the event that resolution of a standard grievance is not reached within 30-calendar-days as required, the MCP must notify the member in writing of the status of the grievance and the estimated date of resolution. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates, issued August 31, 2021*)

Finding: The Plan did not immediately refer all QOC grievances to the Plan's Medical Director for resolution within the contractual timeframe.

The verification study found that 11 of 20 QOC grievances were not immediately referred to the Plan's Medical Director for clinical review. Instead, the Plan classified grievances with both clinical and non-clinical components as PQIs, resolved the non-clinical components, closed the case, and sent resolution letters to the members within 30-calendar-days. As a result, the Medical Director did not participate in all clinical aspects of the members' original grievances and no final resolution of the grievances was reached within the contractual timeframe.

Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised October 2021), stated all medical QOC grievances will be submitted to the Appeals and Grievance Department clinical team for clinical oversight. The Grievance Department staff refers all QOC issues or grievances to the QI Department when they are received and upon closing the case. The Plan did not have policies and procedures to ensure a final conclusion was reached and that the Medical Director reviewed and rendered decisions on QOC grievances within the required timeframe. In addition, if there is a QOC issue, the resolution letter will inform the member that the matter has been forwarded to QM for further evaluation and investigation.

The processes for resolving grievances and investigating PQIs are separate and distinct with different timeframes. The Plan's process of closing all QOC grievance cases by sending them to the QI Department for PQI severity determination prevented the Plan's Medical Director from reviewing the cases within the required 30-calendar-day timeframe. In addition, members' grievances never reached a final conclusion with respect to the original grievance. Initiating a PQI, which can take up to 180 days to investigate, should not preclude, delay, or impact the grievance processing and resolution within the required timeframe.

If QOC grievances are not fully resolved, members' rights are circumvented. The Plan puts its members' health at risk when its physicians do not review grievances with clinical issues in a timely manner. Members' health conditions can rapidly deteriorate if a physician does not promptly address their medical needs.

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Recommendation: Develop and implement policies and procedures to ensure all QOC grievances are immediately referred to the Medical Director for resolution within the contractual timeframe.

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4.3

CONFIDENTIALITY RIGHTS

4.3.1 Privacy Breach and Notifying Required Entities

The Plan is required to notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion, or unauthorized access, use, or disclosure of Protected Health Information (PHI) or Personal Information (PI), or potential loss of confidential data. Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer. (*Contract, Exhibit G(III)(J)(1)*)

Within 72 hours of discovery, the Plan shall submit an updated DHCS Privacy Incident Report (PIR) containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer. (*Contract, Exhibit G(III)(J)(2)*)

Within ten-working-days of the discovery, the Plan shall submit a complete report of the investigation to the DHCS Program Contract Manager, DHCS Privacy Officer, and the DHCS Information Security Officer. (*Contract, Exhibit G(III)(J)(3)*)

Plan policy PO-004, *Breach of Security Protocol* (revised July 29, 2021), stated that upon determining a breach of security has occurred, the Plan's Privacy Office in consultation with legal counsel, will identify applicable notification requirements and, in accordance with its standard operating procedures, the Privacy Office will issue notifications to impacted individuals, members, clients, business associates, regulators, enforcement agencies, the media, and/or others as necessary and appropriate.

Finding: The Plan did not provide notifications and DHCS PIRs to DHCS entities within the required timeframes.

The verification study of nine cases reviewed found the following:

- For five cases, PIRs were submitted to DHCS beyond the 72-hour timeframe.
- For two cases, no PIRs were submitted to DHCS within the 72-hour timeframe.
- One case did not provide a 24-hour notification to the DHCS Program Contract Manager.
- Another case submitted a complete report beyond the required ten-working-days.

Plan policy PO-004, *Breach of Security Protocol*, did not reflect DHCS reporting procedures and timeframes. The Plan stated the Privacy Team utilized an internal job aid that detailed the DHCS reporting requirements. However, the internal job aid did not

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specify that the DHCS Program Contract Manager and the DHCS Information Security Officer must be included when submitting the PIR during the required 72-hour and ten-working-day timeframes.

Upon discovery of a breach or security incident, it is important that the Plan promptly investigates and reports the breach to prevent or mitigate the access, use, or disclosure of PHI or PI by an unauthorized person. If the Plan fails to promptly investigate and report these incidences, a member's PHI or PI may be compromised.

Recommendation: Revise and implement policies and procedures to ensure notifications and DHCS PIRs are submitted to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within the required timeframes.

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CATEGORY 5 – QUALITY MANAGEMENT

5.3 PROVIDER QUALIFICATIONS

5.3.1 New Provider Training

The Plan is required to 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. The Plan shall conduct training for all network providers within ten-working-days after the Plan places a newly contracted network provider on active status. (*Contract, Exhibit A, Attachment 7(5)(A)*)

Plan policy 70.5.1.2, *Provider Orientation and Education* (revised November 2019), stated that the Plan will train and educate its providers on its policies and procedures, requirements, Managed Care, and regulatory requirements. The Plan will conduct an orientation and an in-service for providers within ten-business-days of placing a provider on active status with all lines of business. All training is documented and monitored by the Plan's Provider Relations Manager to ensure adequate training is provided to direct providers and participating provider groups in the network.

Plan policy 10.30.4, *Oversight of Delegated Entity's Contracted Provider Orientation and Education (New and Ongoing)* (revised July 2021), stated that the Plan will perform quarterly audits to ensure delegated entities are following the regulatory requirement of DHCS as identified in Exhibit A, Attachment 7, Section 5.

Finding: The Plan did not ensure that all providers received training from the Plan or its delegated entities within ten-working-days after the Plan placed a newly contracted provider on active status.

The verification study found 12 of 20 new providers did not receive training within ten-working-days. Selected cases for review was reflective of the entire audit period.

- Five providers received training from the Plan 34 to 1,139 days after becoming active with the Plan.
- Seven providers received training from the delegated entities 22 to 197 days after becoming active with the Plan.

The Plan acknowledged that training was conducted outside of the ten-working-day requirement and has taken action to address training across the board to correct the prior year audit finding.

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In addition to Plan policy 70.5.1.2, *Provider Orientation and Education*, the Plan implemented a desktop procedure, *Medi-Cal Eligibility Research*, to monitor new provider orientation. However, the Plan did not implement this process during the audit period.

Further, the Plan implemented newly contracted provider training CAP remediation on all delegated entities. Subsequently, the Plan launched quality assurance activities to validate the effectiveness of the remediation implemented. However, CAP remediation and quality assurance activities on the delegated entities were not effective until September 1, 2021 and delegates who were identified as being out of compliance were given until December 31, 2021 to term providers who had still not received training.

Without timely new provider training, the Plan cannot ensure providers operate in full compliance with the Contract and all applicable federal, state, and local regulations and may ultimately result in substandard care provided to members.

This is a repeat finding of prior year audit (2021) – 5.2.1 New Provider Training, however, prior year finding pertained only to delegated entity training.

Recommendation: Implement policies and procedures to ensure that all providers receive training from the Plan or from its delegated entities within ten-working-days after the Plan places a newly contracted provider on active status.

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

REPORT ON THE MEDICAL AUDIT OF

**Blue Shield of California
Promise Health Plan**

2022

Contract Number: 09-86154
State Supported Services

Audit Period: January 1, 2021
Through
December 31, 2021

Date of Audit: January 18, 2022
Through
January 27, 2022

Report Issued: July 13, 2022

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I. INTRODUCTION

This report presents the audit findings of Blue Shield of California Promise Health Plan (Plan) State Supported Services Contract No. 09-86154. The State Supported Services Contract covers contracted abortion services with the Plan.

The review was conducted from January 18, 2022 through January 27, 2022 for the audit period of January 1, 2021 through December 31, 2021. The audit consisted of document review, verification study, and interviews with Plan staff.

The audit reviewed 21 service claims for appropriate and timely adjudication.

There were no deficiencies found for the review period on the Plan's State Supported Services.

An Exit Conference with the Plan was held on June 2, 2022.

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STATE SUPPORTED SERVICES

The Hyde Contract requires the Plan to provide, or arrange to provide, to eligible members State Supported Services, which include the Current Procedural Terminology (CPT) codes 59840 through 59857 and Health Care Financing Administration Common Procedure Coding System codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services' implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract. (*State Supported Services Contract Exhibit A.1*)

The Plan is required to reimburse complete claims within 45-working-days after the date of receipt, unless the complete claim or portion thereof is contested or denied. (*California Code of Regulations (CCR), Title 28, section 1300.71(g)*)

Plan policy 10.2.35, *Abortion Services* (revised November 2020) stated that members can access abortion services in- or out-of-network without prior authorization. The Plan defines abortion services as a "sensitive service" and assures confidentiality and accessibility are maintained. Inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures, in accordance with CCR, Title 22, section 51327.

Plan policy 10.3.6, *Family Planning* (revised November 2020) stated that abortions are part of family planning services and parental consent is not required for abortions.

The Plan's Claims Processing Guidelines for abortion include CPT codes 59840 through 59857 and Healthcare Common Procedure Coding System codes A4649-U1, A4649-U2, S0190, S0191, and S0199 (formerly known as X1516, X1518, X7724, X7726, and Z0336) as billable pregnancy termination services.

The Member Handbook/Evidence of Coverage informs members that some providers have a moral objection to abortion and have a right not to offer this service. However, Members can contact the Plan's Member Services Call Center for assistance with abortion services. Members do not need a referral from the Primary Care Provider for abortion and abortion-related procedures.

The Provider Manual informs providers of the members' freedom of choice in obtaining sensitive services, such as abortion services, without prior authorization.

The audit found no exceptions with the contractual requirements.

Recommendation: None