CONTRACT AND ENROLLMENT REVIEW DIVISION
SAN DIEGO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

2023

Contract Number:	09-86153
Audit Period:	April 1, 2022 Through March 31, 2023
Date of Audit:	April 17, 2023 Through April 27, 2023
Report Issued:	August 3, 2023

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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 March 2023, the Plan served 148,048 members through its Medi-Cal line of business.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS medical audit of the Plan for the period of April 1, 2022 through March 31, 2023. The audit was conducted from April 17, 2023 through April 27, 2023. The audit consisted of document review, verification studies, and interviews with Plan personnel.

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.

An Exit Conference with the Plan was held on July 13, 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 submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

DHCS issued a Corrective Action Plan (CAP) for the 2022 DHCS medical audit. The Plan was required to respond to audit findings through the CAP and identify steps to resolve compliance issues. During the 2023 medical audit process, DHCS reviewed the CAP while it remained open through March 3, 2023. The audit found that the Plan implemented eight of the 13 recommendations thus far.

The Plan continuously remediated compliance issues during the CAP process. The 2023 audit found that the Plan made improvements in its processes. This was primarily attributed to the onboarding of the Plan's new Senior Medical Director in January 2023. The Plan designated the Senior Medical Director to actively participate in and oversee its UM, grievance, and appeal processes. The verification study results demonstrated the Plan's efforts with the direct participation and oversight by the new Senior Medical Director.

The section below presents a summary of the current finding:

Category 1 – Utilization Management

Audit of Category 1 yielded no findings.

Category 2 – Case Management and Coordination of Care

Audit of Category 2 yielded no findings.

Category 3 – Access and Availability of Care

Audit of Category 3 yielded no findings.

Category 4 – Member's Rights

Audit of Category 4 yielded no findings.

Category 5 – Quality Management

Audit of Category 5 yielded no findings.

Category 6 – Administrative and Organizational Capacity

The Plan is required to promptly report, within ten-working-days to DHCS, all overpayments due to potential fraud; when the Plan receives information about changes in a member's circumstances and when the Plan receives information about a change in a network provider's circumstances. The Plan did not promptly report all potential fraud overpayments nor changes in member's and network provider's circumstances within ten-working-days to DHCS.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS, Contract and Enrollment Review Division 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 April 17, 2023 through April 27, 2023. 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.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization (PA) Requests: 26 (nine approved and 17 denied) medical requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeal Procedures: 16 PA appeals and 19 expedited PA appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Appointment (IHA): Ten medical records were reviewed for provision, completeness, and timeliness of IHAs.

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): 15 NEMT and 15 NMT records were reviewed to confirm compliance with the transportation and appropriateness of services provided.

Category 4 – Member's Rights

Grievance Procedures: 29 Quality of Care (QOC) and 20 Quality of Service (QOS) standard grievances, 24 expedited grievances (14 QOC and ten QOS), ten exempt grievances, and ten call inquiries were reviewed. All grievances were reviewed for timely resolution, appropriate classification, response to the complainant, submission to the appropriate level for review, and translation into the member's preferred language (if

applicable).

Confidentiality Rights: 14 security incidents were reviewed for processing and reporting requirements.

Category 5 – Quality Management

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: Ten fraud and abuse cases were reviewed for processing and reporting requirements.

Encounter Data: Five encounter data records were reviewed for complete, accurate, reasonable, and timely encounter data submissions.

A description of the finding is contained in the following section.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: April 1, 2022 through March 31, 2023
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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	Fraud and Abuse

6.2.1 Timely Notification

The Plan is required to promptly report, within ten-working-days to DHCS of all overpayments due to potential fraud, and changes in a member's and provider's circumstances.
(Contract Amendment A32, Exhibit E, Attachment 2, Provision 26, Subprovision B)

Finding: The Plan did not promptly report all identified or recovered overpayments nor provide prompt notification of changes in member's and network provider's circumstances within ten-working-days to DHCS.

The Plan's policy, *Overpayment Recoupment Process* (revised December 2021), stated that the Plan would report to DHCS annually on 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.

A review of the Plan's DHCS submission logs and correspondence found that the Plan reported two recovered overpayments within 30 and 44 days of receiving issued checks. Further, the Plan notified DHCS of changes in members' circumstances on a monthly basis and network provider's circumstances on a quarterly basis.

The Plan stated in an interview that it reports to or notifies DHCS within ten-working-days, in accordance with the amended contract, and that the requirements are included in its policy. However, the Plan was unaware that its policy did not include the reporting requirement within ten-working-days to DHCS and therefore did not have a monitoring mechanism in place. Following the interview, the Plan drafted an update to its policy to include those requirements.

If the Plan does not promptly report all overpayments and changes in member's and network provider's circumstances to DHCS, it may compromise the integrity of the Plan and the Medi-Cal program.

Recommendation: Revise and implement policies and procedures to ensure the reporting of all overpayments and the prompt notification of changes in member and network provider's circumstances within ten-working-days to DHCS.

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REPORT ON THE MEDICAL AUDIT OF

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

2023

Contract Number:	09-86154 and 22-20483 State Supported Services
Audit Period:	April 1, 2022 Through March 31, 2023
Date of Audit:	April 17, 2023 Through April 27, 2023
Report Issued:	August 3, 2023

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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 Nos. 09-86154 and 22-20483. The State Supported Services Contracts cover abortion services for the Plan.

The review was conducted from April 17, 2023 through April 27, 2023 for the audit period of April 1, 2022 through March 31, 2023. The audit consisted of a document review, verification study, and interviews with Plan staff.

The audit reviewed 16 service claims for appropriate and timely adjudication.

An Exit Conference with the Plan was held on June 20, 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 submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: April 1, 2022 through March 31, 2023
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STATE SUPPORTED SERVICES

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology codes 59840 through 59857 and Health Care Financing Administration Common Procedure Coding System codes X1516, X1518, X7724, X7726, and Z0336.
(*State Supported Services Contracts, Exhibit A*)

The Plan policy 10.2.35, *Abortion Services* (revised January 2023), stated that members could 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. Minors who wish to receive abortion services may do so without parental consent under the Medi-Cal Minor Consent Program.

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 are also informed that referrals are not needed from the primary care provider for abortion and abortion-related services.

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 to the contractual requirements.

Recommendation: None