DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SANTA ANA SECTION

# REPORT ON THE MEDICAL AUDIT OF BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 23-30216

Audit Period: April 1, 2024 — March 31, 2025

Dates of Audit: April 1, 2025 — April 11, 2025

Report Issued: November 19, 2025

# TABLE OF CONTENTS

# I. INTRODUCTION

Blue Shield of California Promise Health Plan (Plan), a wholly owned subsidiary of Blue Shield of California, is a nonprofit managed healthcare organization serving Medi-Cal members. The Plan provides Medi-Cal Managed Care services in San Diego and Los Angeles Counties. In Los Angeles County, the Plan is a fully delegated subcontractor to L.A. Care Health Plan.

In 2015, Blue Shield acquired Care 1st Health Plan, a provider-founded managed care company based in Los Angeles County. On January 1, 2019, Care 1st Health Plan changed its name to Blue Shield of California Promise Health Plan. The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since 1995.

As of January 2025, the Plan served 189,264 Medi-Cal members in San Diego County.

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of April 1, 2024, through March 31, 2025. The audit was conducted from April 1, 2025, through April 11, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on September 11, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On September 26, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Population Health Management and Coordination of Care, Network and Access to Care, Member's Rights, Quality Improvement and Health Equity Transformation, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of April 1, 2023, through March 31, 2024, was issued on September 17, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year, 2024 Corrective Action Plan (CAP).

The summary of the findings by category follows:

## Category 1 – Utilization Management

There were no findings noted for this category during the audit period.

## Category 2 – Population Health Management and Coordination of Care

The Plan must identify and assign a Complex Care Management (CCM) Care Manager for every member receiving CCM. Primary Care Providers (PCPs) may be assigned as CCM Care Managers when they are able to meet all the requirements specified in this subsection. When a CCM Care Manager other than the member's PCP is assigned, the Plan must provide the member's PCP with the identity of the member's assigned CCM Care Manager, and a copy of the member's Comprehensive Management Plan (CMP).

Finding 2.2.1: The Plan did not provide the member's PCP with a copy of the member's CMP.

The Plan must perform oversight of Enhanced Care Management (ECM) providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, All Plan Letters *(*APLs), and the Plan's Model of Care. Finding 2.6.1: The Plan did not perform oversight of ECM providers to ensure delivery of all seven core service components of ECM to members.

## Category 3 – Network and Access to Care

There were no findings noted for this category during the audit period.

## Category 4 – Member's Rights

The Plan must provide a notice of resolution to the member as quickly as the member's health condition requires, not to exceed 30 calendar days from the date the member makes an oral or written request to the Plan for a standard grievance or 72 hours for an expedited grievance. The Plan must notify the member with a written resolution of the grievance in the member's preferred language. Finding 4.1.1: The Plan did not provide grievance acknowledgment and resolution letters in threshold languages to members within the required timeframes.

The grievance and appeal requirements in the Contract allow the member, a provider, or authorized representative acting on behalf of a member and with the member's written consent, to file a grievance with the Plan either orally or in writing. Finding 4.1.2: The Plan did not obtain member written consent for grievances filed on behalf of a member.

The Plan must ensure that all member information is provided to members at a sixth grade reading level. Member information includes all mailings critical to obtaining services, including Notices of Action, grievances and appeals. Finding 4.1.3: The Plan did not ensure that grievance resolution letters sent to members were written at a sixth grade reading level.

The Plan must ensure that individuals making decisions take into account all comments, documents, records, and other information submitted by the member or the member's designated representative. Finding 4.1.4: The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters.

## Category 5 – Quality Improvement and Health Equity Transformation

The Plan must notify DHCS of any change in National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation status within 30 calendar days of receipt of the final NCQA report. Finding 5.1.1: The Plan did not notify DHCS within 30 days of receipt of its NCQA Health Equity Accreditation final report.

The Plan must develop, implement, maintain, and periodically update its Quality Improvement and Health Equity Transformation Program (QIHETP) policies and procedures to include mechanisms to continuously monitor, review, evaluate, and improve quality and health equity of clinical care services provided. Finding 5.1.2: The Plan did not periodically update its QIHETP policies and procedures to reflect current Quality Improvement (QI) processes.

The Plan must monitor, evaluate, and take timely action to address necessary improvements in the Quality of Care (QOC) delivered by all its providers, in any setting. Finding 5.1.3: The Plan did not evaluate its internal QOC review system and address deficiencies when Potential Quality Issues (PQIs) were leveled against itself.

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the QOC delivered by all providers rendering services on its behalf, in any setting. Finding 5.1.4: The Plan did not conduct oversight of all aspects of the Plan's service delivery system applying the principles of Continuous Quality Improvement (CQI).

## Category 6 – Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

# III. SCOPE/AUDIT PROCEDURES

## SCOPE

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

## PROCEDURE

DHCS conducted an audit of the Plan from April 1, 2025, through April 11, 2025, for the audit period of April 1, 2024, through March 31, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

## Category 1 – Utilization Management

Prior Authorization (PA) Requests: Twenty-six medical samples were reviewed for medical necessity, consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Appeal Process: Twenty-six  PA medical appeal samples were reviewed to ensure that required timeframes were met and appeals were appropriately routed and adjudicated.

Delegated PA Requests: Twenty-five PA medical samples were reviewed for appropriate and timely adjudication.

Post-Stabilization Authorization (PSA): Ten PSA samples were reviewed for medical necessity and timely adjudication.

## Category 2 – Population Health Management and Coordination of Care

CCM: Ten medical record samples were reviewed for timeliness, completion, and compliance with CCM provision requirements.

Coordination of Care: Eighteen medical record samples were reviewed for completeness and timely completion.

ECM: Fourteen medical record samples were reviewed for eligibility, completeness, outreach program, and to determine compliance.

## Category 3 – Network and Access to Care

Transportation Access Standards: Twenty-five Non-Medical Transportation (NMT) and 25 Non-Emergency Medical Transportation (NEMT) samples 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

QOC Grievances: Twenty-six QOC grievance samples (20 standard QOC, and 6 expedited QOC) were reviewed for processing, clear and timely response, and appropriate level of review.

Quality of Service (QOS) Grievances: Twenty-five QOS grievance samples were reviewed for timeliness, investigation process, and appropriate resolution.

## Category 5 – Quality Management and Health Equity Transformation

PQI: Twelve samples were reviewed for monitoring, evaluating, and taking effective action to address needed improvements in the QOC.

## Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Thirty-nine samples were reviewed for proper reporting of suspected fraud, waste, and abuse to DHCS within the required timeframe.

Encounter Data: Ten samples were reviewed for completeness and timeliness.

# COMPLIANCE AUDIT FINDINGS

## Category 2 – Population Health Management and Coordination of Care

### 2.2 Complex Care Management

#### 2.2.1 Comprehensive Management Plan

The Plan must identify and assign a CCM Care Manager for every member receiving CCM. PCPs may be assigned as CCM Care Managers when they are able to meet all the requirements specified in this subsection. When a CCM Care Manager other than the member's PCP is assigned, the Plan must provide the member's PCP with the identity of the member's assigned CCM Care Manager, and a copy of the member's CMP. *(Contract Exhibit A, Attachment III, 4.3.7(B)(1)(b))*

Plan policy, *10.27.02 Complex Case Management Process* (revised 02/07/2025), described the Plan's CCM program that lists the duties of CCM Case Managers. CCM Case Manager duties include providing the member's PCP with a copy of the CMP.

**Finding**: The Plan did not provide the member's PCP with a copy of the member's CMP. In a verification study, eight of ten medical record samples of which the CCM Care Manager is not the member's PCP, revealed that the Plan's CCM Care Manager did not provide the member's PCP with a copy of the member's CMP. Additionally, the care plans and case management notes lacked any reference to this communication. During the interviews, the Plan described its documentation process which includes the expectation for case managers to document the provision of CMP copies to PCPs. However, this was not reflected in the eight medical record samples reviewed. The Plan's oversight documents, including the monthly population health management reviews and Medi-Cal Performance and Operations Driver meetings, did not identify or address CCM-related deficiencies nor did it have a procedure to verify that members' PCPs were provided with a CMP. Furthermore, the Plan submitted a description of its CCM training. However, the training materials did not include guidance on the requirement to provide a copy of the CMP to the members' PCP.

If the Plan does not provide the member's PCP with a copy of the member's CMP, it can negatively impact facilitation of communication and collaboration among different healthcare professionals and support workers. This failure to coordinate care may result

in fragmented service delivery, duplication of services, and diminished member outcomes, and is inconsistent with DHCS requirements for care coordination.

**Recommendation**: Implement policies and procedures to ensure that a copy of the CMP is given to the member's PCP.

## 2.6 Enhanced Care Management

### 2.6.1 Enhanced Care Management Core Service Components

The Plan must ensure all members receive all the following seven ECM core service components, as further defined in APLs:

- Outreach and engagement
- Comprehensive assessment and Care Management Plan
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family supports
- Coordination of and referral to community and social support services

*(Contract, Exhibit A Attachment III, 4.4.11)*

The Plan must perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contract, DHCS policies and guidance, APLs, and the Plan's Model of Care. *(Contract, Exhibit A, Attachment III, 4.4.13)*

The Plan must administer ECM and provide the seven core ECM services to eligible members in applicable ECM Populations of Focus. The requirements under the core service components are described below, which must include, but is not limited to:

Health Promotion

- Providing services to encourage and support the member to make lifestyle choices based on healthy behavior, with the goal of supporting the member's ability to successfully monitor and manage their health.
- Supporting the member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing

other chronic conditions.

Comprehensive Transitional Care

- Providing the member services to reduce avoidable admissions and readmissions by evaluating the member's medical care needs, developing a treatment plan, and coordinating any support services to facilitate safe and appropriate transitions to, from, and among treatment facilities, including admissions and discharges.
- Supporting members by tracking admissions and discharges to or from an emergency department, hospital inpatient facility, skilled nursing facility, or other treatment center and communicating with the appropriate care team members to include coordinating medication review and reconciliation; as well as providing adherence support and referral to the appropriate services.
- Coordinating medication review and reconciliation.
- Providing adherence support and referral to appropriate services.

*(APL 23-032, Enhanced Care Management Requirements)*

Plan policy, *10.27.1.5 CalAIM Enhanced Care Management* (approved 12/10/2024), stated that the Plan's Population Health Management Social Services Department ECM Program Management team will work closely with contracted ECM providers to ensure delivery of all core ECM services to each provider's assigned membership. The Plan's ECM Program Management team will conduct oversight of ECM providers' participation in ECM to ensure the quality of ECM services and ongoing compliance with ECM requirements, which may include audits and/or corrective actions. Monthly audits of each provider will be completed.

**Finding:** The Plan did not perform oversight of ECM providers to ensure delivery of all seven core service components of ECM to members.

In a verification study, 6 of 14 medical record samples revealed that all seven core service components were not provided to members. There was no documentation that health promotion and/or comprehensive transitional care were provided to members. For example:

- In one sample, the admission, discharge, and transfer data showed that a member was admitted on 12/01/2024 and discharged on 12/03/2024; however, the Plan did not provide transitional care services for the member, such as ensuring discharge risk assessment and discharge planning was created with

appropriate parties, and planning timely scheduling of follow-up appointments with recommended outpatient providers.

- In another sample, a member had over ten emergency department visits and called 911 over 20 times for diverticulitis within the last six months. However, during the comprehensive assessment the lead care manager did not assess any emergency department visits during the interactions with the member. The lead care manager did not develop strategies to reduce avoidable member admission and readmission, such as developing and regularly updating discharge planning documents for the member.

During the interview, the Plan stated that they did not perform oversight of the ECM providers such as medical record reviews to ensure that all ECM core service components are provided to members who are enrolled in the ECM program. The Plan's policy stated that the ECM Program Management team will conduct oversight of ECM providers which includes monthly audits of each ECM provider. However, the Plan acknowledged that they did not conduct monthly audits of each ECM provider.

If all the ECM core service components are not provided to members, it can lead to inconsistent care management and a decline in the member's health with highly complex needs.

**Recommendation:** Develop and implement policies and procedures to conduct oversight of ECM providers to ensure delivery of all core service components of ECM to members.

# COMPLIANCE AUDIT FINDINGS

## Category 4 – Member's Rights

### 4.1 Grievance System

#### 4.1.1 Translated Letters Mailed Within Required Timeframes

The Plan is required to implement and maintain a member grievance system in accordance with the California Code of Regulations (CCR), Title 22, section 53858 and CCR, Title 28, section 1300.68. *(Contract, Exhibit A, Attachment III, 4.6.1)*

The grievance process requires the Plan to provide written acknowledgement to the member within five calendar days of receipt of the grievance. *(Contract, Exhibit A, Attachment III, 4.6.2(E))*

The Plan must provide a notice of resolution to the member as quickly as the member's health condition requires, not to exceed 30 calendar days from the date the member makes an oral or written request to the Plan for a standard grievance, or 72 hours for an expedited grievance. The Plan must notify the member with a written resolution of the grievance in the member's preferred language as required by the Code of Federal Regulations (CFR), Title 42, sections 438.10 and 438.404, Welfare and Institutions Code (W&I) section 14029.91, and CCR, Title 22, section 53876. *(Contract, Exhibit A, Attachment III, 4.6.1(B))*

The Plan is required to provide translation of written materials to members in their preferred threshold language. *(Contract, Exhibit A, 5.1.1(A)(1)(h))*

Plan policy, *10.19.5 Beneficiary Grievance Management System* (revised 10/10/2024), stated that the Plan notifies the member with a written resolution of the grievance in the member's preferred language as required by CFR, Title 42, sections 438.10 and 438.404, W&I Code section 14029.91, and CCR, Title 22, section 53876. The Plan's grievance system addresses the linguistic and cultural needs of its members, and ensures all members have access to and can fully participate in the grievance system by assisting those with Limited English Proficiency . Such assistance will include translations of grievance procedures, forms, and the Plan's responses to grievances.

**Finding:** The Plan did not provide grievance acknowledgment and resolution letters in threshold languages to members within the required timeframes.

The verification study revealed that 12 of 51 grievances were filed by members speaking threshold languages. In these 12 grievance samples, none of the grievance acknowledgment and resolution letters in threshold languages were sent to members within the required timeframes. The following deficiencies were found:

- Seven QOC standard grievances did not have acknowledgment letters in threshold languages mailed within 5 calendar days, and/or resolution letters in threshold languages mailed within 30 calendar days. The translated acknowledgment letters were mailed between 12 and 34 days, and/or the translated resolution letters were mailed between 49 and 326 days after receipt of the grievance.
- Three QOC expedited grievances did not have resolution letters in threshold languages mailed within 72 hours. The translated resolution letters were mailed between 14 days and 21 days after receipt of the expedited grievance.
- Two QOS standard grievances did not have acknowledgment letters in threshold languages mailed within 5 five calendar days, and/or resolution letters in threshold languages mailed within 30 calendar days. The translated acknowledgment letters were mailed between 29 and 64 days, and/or the translated resolution letters were mailed between 64 and 143 days after receipt of the grievance.

Therefore, the Plan is not adherent to the Contract requirements and its policies and procedures on timeframes for translated grievance status letters.

During the interview, the Plan stated that letters requiring translation were sent to their translation vendor, and a subsequent entry in the system of record, MedHok was made when the translated letters were mailed. However, the clerical supervisor confirmed that the "acknowledgment date mailed" and "resolution date mailed" entered in the case history section of MedHok (dates used for tracking and reporting) were the dates the English letters were done, even for Limited English Proficiency members. Hence, the Plan lacks a mechanism to ensure translated letters are sent timely.

When the Plan does not provide written timely notification of grievance status to members in their threshold language, the Plan is not providing equitable service across its membership. The delay in notifications could negatively impact the medical treatment and wellbeing of members who speak threshold languages.

**Recommendation:** Develop and implement policies and procedures to ensure translated grievance acknowledgment and resolution letters in threshold languages are mailed to members within the required timeframes.

### 4.1.2 Member Written Consent

The Plan is required to implement and maintain a member grievance system in accordance with the CCR, Title 22, section 53858 and CCR, Title 28, section 1300.68. *(Contract, Exhibit A, Attachment III, 4.6.1)*

The grievance and appeal requirements in the Contract allow the member, a provider, or authorized representative acting on behalf of a member and with the member's written consent, to file a grievance with the Plan either orally or in writing. (*Contract, Exhibit A, Attachment III, 4.6.1(A))*

If state law permits and with the written consent of the member, a provider or an authorized representative may request an appeal or file a grievance on behalf of a member. *(CFR, Title 42, section 438.402(c)(1)(ii))*

Plan policy, *10.19.5 Beneficiary Grievance Management System* (revised 10/10/2024), allows members, providers or authorized representatives with the member's written consent, to file a grievance or request an appeal either orally or in writing.

**Finding:** The Plan did not obtain member written consent for grievances filed on behalf of a member.

The verification study revealed that 4 of 45 standard (QOC and QOS) grievance samples were filed on behalf of a member. None of these four grievance samples included member written consent. The Plan mailed an Appointment of Representative form along with the acknowledgment letter in only three of the four cases. The completed form was not found in any of the four samples.

During the interview, the Plan stated that it does not require written member consent to process grievances filed on a member's behalf. The Plan confirmed that there was no authorized representative documentation on file for the two QOC grievance samples filed on behalf of a member. The Plan stated that it is protocol to mail an Appointment of Representative form when a grievance is filed on a member's behalf in case the member prefers to have the resolution letter mailed to the person filing the grievance, not because it is required to process the grievance.

Hence, the Plan is not adherent with the Contract requirements and its policies and procedures on obtaining written member consent for grievances filed on a member's behalf.

When the Plan does not obtain members' written consent prior to processing grievances filed on their behalf, members risk being uninformed and not involved in decisions about their care.

**Recommendation:** Revise and implement policies and procedures to obtain member written consent for grievances filed on behalf of a member.

### 4.1.3 Resolution Letters at Sixth Grade Level

The Plan is required to implement and maintain a member grievance system in accordance with CCR, Title 22, section 53858 and CCR, Title 28, section 1300.68. *(Contract, Exhibit A, Attachment III, 4.6.1)*

The Plan must ensure that all member information is provided to members at a sixth grade reading level. Member information must inform members on the Plan's processes and the member's right to make informed health decisions. (*Contract, Exhibit A, Attachment III, 5.1.3(F))*

Member information includes, but is not limited to, the Member Handbook, Provider Directory, and all mailings and notices critical to obtaining services, including letters, Notices of Action, Notices of Adverse Benefit Determination, grievances or appeals. (*Contract, Exhibit A, Attachment III, 5.1.3(D))*

**Finding:** The Plan did not ensure that grievance resolution letters sent to members were written at a sixth grade reading level.

In a verification study, all of 20 standard QOC grievance resolution letters sent to members were lengthy (two to three pages) and often contained grammatical errors and/or medical terminology, such as, "Due to your left elbow lateral epicondylitis ER diagnosis, a referral for you to see an orthopedic specialist was submitted."

Plan policy, *10.19.5 Beneficiary Grievance Management System* (revised 10/10/2024), did not include requirements that grievance letters be written at the sixth grade reading level.

Therefore, as part of the verification study, the Flesch-Kincaid computer application was used to calculate the readability portion of the resolution letter drafted by the grievance coordinator in 6 of 20 standard QOC grievance samples. The results showed:

- Flesch-Kincaid Grade Level ranged from 9.4 to 14.2
- Flesch-Kincaid Readability Test was at the college level (challenging for most adults)

During the interview, the Plan stated that the Flesch-Kincaid tool is used to assess the reading level of the Medical Doctor verbiage in the resolution letters. However, the Plan acknowledged that the rest of the letter written by grievance coordinators is not assessed for reading level and that the coordinators do not use a tool for readability.

Grievance resolution letters not written at the required sixth grade reading level may lead to member confusion and misunderstanding of health plan processes and ultimately cause members to make poor health care decisions.

**Recommendation:** Develop and implement policies and procedures to ensure all grievance letters are written at the required sixth grade reading level.

### 4.1.4 Complete Resolution of Grievances

The Plan must ensure that its grievance and appeal system considers all comments, documents, records, and other information submitted by the member, provider, or authorized representative. *(Contract, Exhibit A, Attachment III, 4.6.1(E))*

The Plan must have a policy and procedure to ensure that Plan's staff monitor grievances to identify issues that require corrective action. (*Contract, Exhibit A, Attachment III, 4.6.2(D))*

The Plan is required to implement and maintain a member grievance system in accordance with CCR, Title 22, section 53858 and CCR, Title 28, section 1300.68. The Plan must follow grievance and appeal requirements set forth in and use all notice templates included in *APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*. *(Contract, Exhibit A, Attachment III, 4.6.1)*

The Plan must establish, implement, maintain, and oversee a grievance and appeal system to ensure the receipt, review, and resolution of grievances and appeals. The Plan must ensure that individuals making decisions take into account all comments, documents, records, and other information submitted by the member or member's designated representative. The Plan must ensure adequate consideration of grievances and appeals and rectification when appropriate. "Resolved" means that the Plan has reached a final conclusion with respect to the member's submitted grievance. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, 10.19.5 *Beneficiary Grievance Management System* (revised 10/10/2024), stated that the Appeals and Grievances Department (AGD) Intake Coordinator receives all grievances for review, investigation and/or allocation to another Plan service team. The Plan's grievance system ensures all comments, documents, records, and other information submitted by members, providers, or authorized representatives will be considered. Corrective actions are imposed to remedy all identified deficiencies.

**Finding:** The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters.

The verification study revealed that 4 of 26 QOC grievance samples were inadequately reviewed prior to resolution. The following are examples of the deficiencies:

- An expedited grievance was filed for a delay in receiving wound care supplies after a hospital discharge was downgraded by the Plan. The true root cause (delay in authorizing discharge supplies by the delegate) was not identified by the Plan. The member waited nine days post-discharge for wound vacuum supplies and medically necessary wound care. The Plan did not follow up with the delegate.
- A grievance was filed with DHCS by a hospital case manager against the Plan for the inability to find home health agencies to accept Plan members for home Physical Therapy (PT) and Occupational Therapy (OT). The case manager used In-Lieu-Of program funds to arrange a safe discharge plan with home PT and OT. The Plan processed this grievance. The Plan's grievance coordinator did not follow instructions from the Clinical Oversight Team to "call vendors to see if they are able to accept this member for PT/OT services." Instead, the grievance was hastily resolved in 24 hours with a finding against the hospital case manager. There was no investigation into the availability of the Plan's contracted home health agencies to accept new referrals.

During the interview, the Plan confirmed that the sample files should have been thoroughly reviewed prior to sending resolution letters.

Inadequate investigation and resolution of member grievances can lead to immediate and future member harm, and to missed opportunities for the Plan to improve its health care delivery system.

**Recommendation:** Develop and implement policies and procedures to ensure the Plan thoroughly investigates and adequately resolves grievances before sending member resolution letters.

# COMPLIANCE AUDIT FINDINGS

## Category 5 – Quality Improvement and Health Equity Transformation

### 5.1 Quality Improvement System

#### 5.1.1 National Committee for Quality Assurance Health Equity Accreditation - Department of Health Care Services Notification

The Plan must have full NCQA (HPA) and NCQA Health Equity Accreditation no later than January 1, 2026. The Plan must maintain full NCQA HPA and NCQA Health Equity Accreditation throughout the term of the Contract and submit NCQA HPA and Health Equity Accreditation results every three years. *(Contract, Exhibit A, Attachment III, 2.2.8(A))*

The Plan must notify DHCS of any change in NCQA HPA and NCQA Health Equity Accreditation status within 30 calendar days of receipt of the final NCQA report. *(Contract, Exhibit A, Attachment III, 2.2.8(E))*

Plan policy, *HEQ-001 Quality Improvement and Health Equity Transformation Program* (revised 09/19/2024), stated that the Plan ensures reporting of accreditation activities, and provides copies of reports from independent private accrediting agencies, such as the NCQA.

- Provides accreditation status, survey type, level.
- Provides accreditation agency results and recommended actions/improvements, CAPs, and summaries.
- Denotes accreditation expiration date.

**Finding:** The Plan did not notify DHCS within 30 days of receipt of its NCQA Health Equity Accreditation final report.

During the interview, the Plan reported it received its NCQA Health Equity Accreditation with NCQA's final report on 01/29/2025. The Plan was asked to provide documentation of DHCS notification. Documentation provided by the Plan post-interview showed that the Plan did not notify DHCS within 30 days of receipt of its NCQA Health Equity Accreditation final report.

The Plan did not follow contractual requirements after receiving NCQA Health Equity Accreditation.

NCQA accreditation status validates the Plan's adherence to national standards. When the Plan does not report changes in NCQA accreditation status to DHCS, it may adversely reflect on the Plan's commitment to quality and meeting standards that can affect overall member health outcomes.

**Recommendation:** Revise and implement policies and procedures to notify DHCS of changes in NCQA accreditation status within 30 days of receipt of NCQA Health Equity Accreditation final report.

### 5.1.2 Updating Policies and Procedures to Support Continuous Quality Improvement

The Plan must implement a QIHETP that includes, at a minimum, the standards set forth in CFR, Title 42, sections 438.330 and 438.340, and CCR, Title 28, section 1300.70. *(Contract, Exhibit A, Attachment III, 2.2)*

The Plan must develop, implement, maintain, and periodically update its QIHETP policies and procedures to include mechanisms to continuously monitor, review, evaluate, and improve quality and health equity of clinical care services provided. *(Contract, Exhibit A, Attachment III, 2.2.6(O))*

The Plan must have a policy and procedure to ensure its staff monitor grievances to identify issues that require corrective action. *(Contract, Exhibit A, Attachment III, 4.6.2(D))*

The Plan must follow grievance and appeal requirements set forth in *APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*. *(Contract, Exhibit A, Attachment III, 4.6.1)*

The Plan must operate in accordance with its written procedures for grievance and appeals. The grievance and appeal system must include reporting procedures in order to improve the Plan's policies and procedures. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *PHPCQR-1 Potential Quality Issue (PQI) Review Process* (revised 8/2024), stated the following procedures:

1. Member grievances received by the AGD that are clinical in nature are screened by a clinical quality review nurse to determine if a QOC review is indicated. If so, the case is referred to the Clinical Quality Review (CQR) Department for QOC

review.

2. Member grievances related to QOS may also be screened and will be reviewed as a PQI if the service issue impacted or could have impacted care.

13. Physician Inter-rater reliability audits are conducted on a semi-annual basis to ensure consistency in QOC reviews and severity level assignments. The audit is conducted using an "8 and 30" file sampling procedure for each physician reviewer as follows:

    - A sampling of 30 cases assigned a severity level by each physician reviewer are selected.
    - Eight of the 30 cases are reviewed by an appointed physician auditor. If the auditor agrees with the determination for all eight cases, no further action is needed. If the auditor disagrees with one or more of the original eight, the additional cases are also reviewed.
    - The audit finding and feedback is provided to the physician reviewer and re-education occurs for any inconsistent reviews or leveling patterns as identified.

Plan Policy *10.19.5, Beneficiary Grievance Management System* (revised 10/10/2024), stated that a grievance log review and analysis is conducted monthly by the Medical Director and AGD leadership to identify emerging trends and opportunities for improvement. The Medical Director selects 30 cases for the monthly grievance log review.

**Finding:** The Plan did not periodically update its policies and procedures to reflect current QI processes.

During the interview, the Plan agreed that Procedures 1, 2, and 13 in Plan policy *PHPCQR-1, Potential Quality Issue (PQI) Review Process* (revised 8/2024), have not been updated to reflect the current processes.

- Grievances are screened by the Clinical Oversight Team in the AGD, not by the CQR nurse.
- The CQR Medical Director is the only physician reviewer of PQI cases in the CQR Department; therefore, Inter-rater reliability audits are not occurring.

Additionally, the Plan confirmed that monthly grievance log review in Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised 10/10/2024), had been

discontinued effective February 2024. As of November 2024, the grievance log process is now structured as a weekly e-mail review of the closed cases by the Chief Medical Officer.

The Plan agreed the language for the above procedures needs to be updated to reflect current QI processes.

The contract requires periodic updates to its QI policies and procedures. When the Plan's policies and procedures do not reflect current practice, there is a lack of standardization and decreased accountability which may lead to negative outcomes for members.

**Recommendation:** Revise and implement policies and procedures to reflect current QI processes.

### 5.1.3 Evaluation of Internal Potential Quality Issues

The Plan must implement a QIHETP that includes, at a minimum, the standards set forth in CFR, Title 42, sections 438.330 and 438.340, and CCR, Title 28, section 1300.70. The Plan must monitor, evaluate, and take timely action to address necessary improvements in the QOC delivered by all its providers in any setting. *(Contract, Exhibit A, Attachment III, 2.2)*

The Plan must develop, implement, maintain, and periodically update its QIHETP policies and procedures to include mechanisms to continuously monitor, review, evaluate, and improve quality and health equity of clinical care services provided. *(Contract, Exhibit A, Attachment III, 2.2.6(O))*

The intent and regulatory purpose of the Quality Assurance (QA) program is that it must document that the QOC provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. *(CCR, Title 28, section 1300.70(a)(1))*

QA reports to the Plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic QOC issues. *(CCR, Title 28, section 1300.70(b)(2)(C))*

In addition to the internal QOC review system, a Plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of

the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department. *(CCR, Title 28, section 1300.70(c))*

Plan policy *HEQ-001Quality Improvement Health Equity Transformation Program* (revised 9/19/2024), stated that the Plan will monitor, evaluate, and take timely action to address necessary improvements in the QOC delivered by all its providers in any setting.

Plan policy *PHPCQR-2 Severity Leveling of Potential Quality Issue (PQI) Cases* (revised 8/2024), stated that follow up actions that occur for a closed QOC issue/PQI may include issuing a CAP request, sending an educational letter to convey opportunities for improvement, or forwarding a referral to the credentialing committee for consideration of termination of the contracted provider from the Plan network.

**Finding:** The Plan did not evaluate its internal QOC review system and address deficiencies when PQIs are leveled against itself.

In a verification study, 4 of 12 PQI samples were leveled against the Plan. Two of the four samples did not evaluate and hold the Plan accountable. For example:

- In one sample, a hospital case manager filed a grievance against the Plan for inability to find a home health agency to accept the member for home PT and OT. The case manager used In-Lieu-Of program funds to arrange a safe discharge plan with home PT and OT. Yet in the end, the PQI was leveled C-2 moderate/serious quality of care issue (requires peer review committee review) against the hospital despite documentation from the hospital that home PT and OT had been arranged by the case manager for safe hospital discharge. The Plan did not assess for available access within its home health provider network.
- In another sample, a six-month delay in a speech therapy appointment resulted from an administrative error related to a Letter of Agreement (LOA) by the Plan's Contracting Department. The Plan responded that the LOA requires manual data entry, and they are working to automate the process. The Plan did not provide interim countermeasures.

During the interview, the Plan stated that issuing educational letters or CAPs to itself was not particularly effective. The Plan now meets with the department where the problem occurred for education. The Plan acknowledged there is no policy and procedure documenting how the Plan evaluates and takes action on PQIs leveled against itself in lieu of a CAP. The Plan stated that most of these issues will go to the Quality Oversight Committee and Quality Management Committee. However, no specific mention of PQI against the Plan were found in review of committee minutes.

Hence, the Plan is not adhering to the standards of the contract underpinned by CCR, Title 28, section 1300.70.

Without a documented standard procedure for evaluation of PQIs leveled against itself, the Plan is holding itself to a lower standard than it holds its providers thereby increasing the potential for further incidents with adverse outcomes.

**Recommendation:** The Plan develop and implement policies and procedures to evaluate its internal QOC review system and address deficiencies when PQIs are leveled against itself.

### 5.1.4 Oversight in Continuous Quality Improvement

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the QOC delivered by all providers rendering services on its behalf, in any setting. *(Contract, Exhibit A, Attachment III, 2.2)*

The Plan must apply the principles of CQI to all aspects of the Plan's service delivery system through analysis, evaluation, and systematic enhancements. *(Contract, Exhibit A, Attachment III, 2.2(B))*

Plan policy HEQ-001 stated that the Plan will have mechanisms to continuously monitor, review, evaluate, and improve quality and health equity of the clinical care services provided. The Plan applies the principles of CQI to all aspects of service delivery through analysis, evaluation, and systemic enhancements.

**Finding:** The Plan did not conduct oversight of all aspects of the Plan's service delivery system thereby incompletely applying the principles of CQI.

In a verification study, 3 of 12 PQI samples contained administrative errors within the CQR Department and the departments supporting CQR. The following are examples of the deficiencies:

- A grievance information request form for the wrong member was included in the file by a grievance coordinator. Neither the grievance department nor the CQR department detected the error.
- The root cause of the PQI was determined to be an administrative error related to data entry in the Contracting Department that resulted in significant delay of care.
- CQR staff faxed personal health information to the wrong durable medical

equipment provider.

During the interview, the Plan agreed that all three samples were administrative errors. The Plan was asked to provide a policy and procedure or desk level procedure for monitoring and oversight of clerical staff. However, the Plan provided a PowerPoint presentation on an audit training tool used to assess data entry accuracy and completion by the registered nurses, and not the clerical staff.

Oversight and monitoring are key to CQI. When the Plan does not have standard processes for monitoring staff within departments, it is not applying the principles of CQI to its service delivery system, which may lead to member harm and missed opportunities for addressing underlying problems.

**Recommendation:** Develop and implement policies and procedures to provide oversight of all aspects of the Plan's service delivery system thereby applying the principles of CQI.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SANTA ANA SECTION

# REPORT ON THE MEDICAL AUDIT OF BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 23-30248

Contract Type: State Supported Services

Audit Period: April 1, 2024 — March 31, 2025

Dates of Audit: April 1, 2025 — April 11, 2025

Report Issued: November 19, 2025

# TABLE OF CONTENTS

# I. INTRODUCTION

This report presents the results of the audit of Blue Shield of California Promise Health Plan's (Plan) compliance and implementation of the State Supported Services contract number 23-30248 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of April 1, 2024, through March 31, 2025. The audit was conducted from April 1, 2025, through April 11, 2025, which consisted of a document review and verification study with the Plan's administration and staff.

An Exit Conference with the Plan was held on September 11, 2025. No deficiencies were noted during the review of the State Supported Services Contract.

# COMPLIANCE AUDIT FINDINGS

## State Supported Services

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

The 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.

The Reproductive Privacy Act provides that the State, and thus managed care plans may not deny or interfere with a person's right to choose or obtain an abortion prior to viability of the fetus or when an abortion is necessary to protect the life and health of the pregnant individual.

Plan policy, *CLM-011 Abortion Services* (revised 5/25/2024), stated that members may go to any Medi-Cal Provider of their choice for abortion service, at any time for any reason, regardless of network affiliation without prior authorization. Members are provided with abortion information through the Plan's Member Handbook. The Plan informed providers of their responsibilities to provide abortion and abortion-related procedures without prior authorization through the Plan's Provider Manual.

The verification study revealed that the Plan appropriately processed abortion claims for payment and timely adjudication of claims.

**Finding:** There were no deficiencies noted during this audit period.

**Recommendation:** None.