DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SANTA ANA SECTION

REPORT ON THE MEDICAL AUDIT OF ANTHEM BLUE CROSS PARTNERSHIP PLAN, INC. FISCAL YEAR 2024-25

Contract Numbers: 03-76184, 04-36068, 07-65845,
10-87049, 13-90159, 23-30213, 23-30214, 23-30215, and 23-30340

Audit Period: November 1, 2023 — October 31, 2024

Dates of Audit: December 9, 2024 — December 20, 2024

Report Issued: June 11, 2025

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I. INTRODUCTION

Anthem Blue Cross Partnership Plan, Inc. (Plan) is a subsidiary of Anthem, Inc. The Plan provides medical Managed Care services to Medi-Cal members under the provisions of the California Welfare and Institutions Code section 14087.3. The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act.

The Plan is a full-scope Managed Care Plan serving the Medi-Cal, Medicare, and Seniors and Persons with Disabilities (SPD) population. The Plan delivers care to members under the Two-Plan, Geographic Managed Care (GMC), Rural Expansion, Commercial Plan, and Local Initiative models.

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

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

In 2023, the Plan had five contracts to provide services in 28 counties:

- Contract 03-76184, a Commercial contract, covers Alameda, Contra Costa, San Francisco, and Santa Clara Counties.
- Contract 04-36068 is a Local Initiative contract covering Tulare County.
- Contract 07-65845, a GMC contract, covers Sacramento County.
- Contract 10-87049, a Commercial contract, covers Fresno, Kings, and Madera Counties.
- Contract 13-90159, a GMC and Rural Expansion contract, covers Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba Counties.
- Contract 13-90163, a Regional contract covers San Benito.

Effective January 1, 2024, the Plan no longer served the following counties: Alameda, Butte, Colusa, Contra Costa, Glenn, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba.

In 2024, the Plan had four contracts to provide services in 15 counties:

- Contract 23-30213, a GMC contract covers Sacramento County.
- Contract 23-30214, a Two-Plan model contract covers Alpine, El Dorado, Fresno, Kern, Kings, Madera, San Francisco, and Santa Clara Counties.
- Contract 23-30215, a Regional model contract covers Amador, Calaveras, Inyo, Mono, and Tuolumne Counties
- Contract 23-30340, a Two-Plan model contract covers Tulare County.

As of October 31, 2024, the Plan served 804,661 Medi-Cal members in the following counties: Alpine (236), Amador (6,372), Calaveras (6,748), El Dorado (26,828), Fresno (149,106), Inyo (2,762), Kern (36,198), Kings (23,926), Madera (27,472), Mono (1,859), Sacramento (243,900), San Francisco (34,979), Santa Clara (92,030), Tulare (144,468), and Tuolumne (7,777).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of November 1, 2023, through October 31, 2024. The audit was conducted from December 9, 2024, through December 20, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on April 22, 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 May 7, 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 (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 for the period of October 1, 2022, through October 31, 2023, was issued on May 14, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year (2023), Corrective Action Plan (CAP).

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

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to ensure policies and procedures for authorization decisions are based on the medical necessity of a requested covered service and are consistent with the criteria or guidelines supported by sound clinical principles and evidence-based practice. The Plan did not ensure that prior authorization decisions were based on medical necessity of a requested service and were consistent with applicable written criteria.

The Plan must ensure that any written communication to a provider for a denial, delay, or modification of a request includes the name and telephone number of the Plan's health care professional responsible for the denial, delay, or modification. The Plan did

not include the name of the decision maker responsible for the denial, delay, or modification in the provider Notice of Action (NOA) letter.

The Plan is required to ensure that a member, a provider, or an authorized representative acting on behalf of the member, and with the member's written consent, may request an appeal. The Plan did not obtain written consent when an appeal was filed on the member's behalf.

The Plan is required to give the member written notice of the reason for extending the timeframe of an appeal and inform the member of their right to file a grievance if they disagree. The Plan did not inform the member in writing of the decision, nor did it provide written notification of the right to file a grievance after extending the timeframe of an expedited appeal request to a standard request.

The Plan is required to report to the DHCS Contract Manager any changes in the status of the Chief Medical Director within ten calendar days. The Plan did not report to the DHCS Contract Manager of the change in status of the Chief Medical Director within ten days.

Category 2 – Case Management and Coordination of Care

The Plan is required to begin care management assessments, within 30 days of identifying the member through Risk Stratification and Segmentation (RSS), referral, or other means, and completing an assessment within 60 days of the identification. The Plan did not ensure timely assessment of Long-Term Support Services (LTSS) needs within 60 days of identifying SPD members through an RSS process.

The Plan is required to provide and cover behavioral health treatment (BHT) services. BHT services must be provided, observed, and directed under a Plan-approved behavioral treatment plan. The provider of BHT services is required to review, revise, and/or modify no less than once every six months the behavioral treatment plan. If services are no longer medically necessary, then the behavioral treatment plan must be modified or discontinued. The Plan did not conduct subsequent BHT plan reviews at six months after initial authorization of BHT services, and discontinued BHT services without determining that the services are no longer medically necessary.

The Plan is required to complete each continuity of care (COC) request within the required timelines from the date the Plan received the request. The Plan did not document the determination of urgency levels to ensure timely completion of COC requests.

Category 3 – Access and Availability of Care

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

Category 4 – Member's Rights

The Plan is required to resolve grievances and send written resolutions to the member within 30 calendar days. The Plan did not send resolution letters for quality of service grievances within the required 30 calendar days.

The Plan is required to allow a member, a provider, or an authorized representative with the member's written consent, to file a grievance. The Plan did not obtain written consent from members for grievances filed on the members' behalf.

Category 5 – Quality Management

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

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 December 9, 2024, through December 20, 2024, for the audit period of November 1, 2023, through October 31, 2024. 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: Thirty-two medical and pharmacy prior authorization requests were reviewed for medical necessity, consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

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

Category 2 – Case Management and Coordination of Care

Health Risk Assessments (HRA)/LTSS: Eight medical records were reviewed for timeliness, completion, and compliance with HRA/LTSS provision requirements.

BHT: Thirteen medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.

COC: Four medical records were reviewed for completeness and timely completion.

Enhanced Care Management: Fifteen medical records were reviewed for eligibility, completeness, outreach program, and to determine compliance.

Category 3 – Access and Availability of Care

Transportation Access Standards: Fifteen Non-Medical Transportation (NMT) and 15 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.

Access and Availability of Care: Nineteen (CAPs) issued by the Plan were reviewed for follow-up of prior year corrective actions for non-compliant providers and availability of members' care. Twelve access related grievance cases were reviewed for follow-up of prior year appointment wait time grievances monitoring.

Category 4 – Member's Rights

Quality of Care Grievances: Nineteen quality of care grievance cases were reviewed for processing, clear and timely response, and appropriate level of review.

Quality of Service Grievances: Thirty-six quality of service grievance cases were reviewed for timeliness, investigation process, and appropriate resolution.

Category 5 – Quality Management

New Provider Training: Two samples were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Fourteen samples were reviewed for timely processing and reporting requirements.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Written Criteria or Guidelines for Medical Prior Authorizations

The Plan must ensure that covered services are provided to a member in an amount no less than what is offered in Medi-Cal Fee-For-Service, as defined in the most current Medi-Cal Provider Manual and consistent with current, evidence-based medical standards. *(Contract 2024, Exhibit A, Attachment III, 5.3.1 (A))*

The Plan will have policies and procedures for authorization decisions based on the medical necessity of a requested covered service and are consistent with criteria or guidelines supported by sound clinical principles and evidence-based practice. *(Contract 2024, Exhibit A, Attachment III, 2.3 (K) (1))*

The Plan will have written criteria or guidelines for UM that are developed with practicing health care providers. The written criteria or guidelines must be based on sound clinical practices and processes which are evaluated and updated, when necessary, at least annually, in accordance with California Health and Safety Code section 1363.5. *(Contract 2024, Exhibit A, Attachment III, 2.3.1 (D))*

The Plan policy, *CA_UMXX_041 Pre-service Authorization of Services* (revised 04/25/2024), states medically necessary services are determined in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors. When the nurse is unable to approve the services because they do not meet the medical necessity criteria, the case is routed to a Medical Director with sufficient expertise to evaluate the specific clinical issues involved in the health care services requested by the provider.

The Plan policy, *CA_UMXX_081 Application of Utilization Management Criteria – CA* (revised 07/26/2023), states the Plan staff reviewers uses criteria when making a medical necessity determination for all UM requests including prior authorization, retrospective, and concurrent reviews for in and out of network requests. When factors indicate the

UM guidelines are not appropriate for an individual, UM decision makers route the case to a Peer Clinical Reviewer for further review and a final determination.

Finding: The Plan did not ensure that prior authorization decisions were based on medical necessity of a requested service and were consistent with applicable written criteria.

Although the Contract and Plan's policies and procedures require that requested pre-authorization are reviewed for medical necessity and supported with written evidence-based criteria, a verification study of 32 prior authorization samples identified four samples wherein the Plan did not apply the written criteria correctly to review medical necessity. The Plan failed to use the appropriate and applicable criteria in these cases. Therefore, the Plan failed to evaluate if endoscopy with botulinum toxin injection is appropriate evidence-based treatment for food pipe and stomach diseases which members were experiencing.

- Three samples pertaining to Esophagogastroduodenoscopy (endoscopy) with botulinum toxin injection were denied without applying the correct criteria. In all three samples, the criteria used did not pertain to the requested services. This led the Plan to incorrectly interpret the samples as experimental treatment and caused the samples to be inappropriately denied.
    - In the first sample, instead of applying criteria pertaining to achalasia (abnormal muscle tone of the food pipe), the Plan applied criteria Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia, and Gastroparesis which did not pertain to achalasia treatment.
    - In the second sample, instead of applying criteria pertaining to esophageal spasms, the Plan applied criteria Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia, and Gastroparesis, which did not pertain to or cover esophageal spasm treatment.
    - In the third sample, the Plan applied criteria that did not pertain to the requested service for treatment of gastroparesis.
- In the fourth sample, a hyperbaric oxygen treatment was denied despite the cited criteria showing support for medical necessity.

In review of the UM program overview, the Plan used proprietary evidence-based guidelines to review medical necessity decision making. The Plan's policy and procedures dictate that Registered Nurse (RN) reviewers locate and decide the most applicable criteria to be used for the service request.

During the interview, the Plan stated that RN reviewers choose criteria based on the requested service's International Classification of Diseases (ICD) or Current Procedural Terminology (CPT) codes. The Plan was asked why criteria or guidelines pertaining specifically to the requested service were not used for the above services. The Plan stated it is policy to use the criteria that closely matches the topic of the prior authorization service request, if no specific criteria is available. The Medical Directors were unable to answer why service requests were not reviewed on merit when an applicable criteria was not available. In effect, the Plan used incorrect or inapplicable guidelines and criteria to adjudicate denials. Additionally, Medical Directors did not review requested services to see if the criteria attached by RN reviewers were appropriately applicable to the service requested.

When members services requests are denied using inapplicable clinical guidelines or criteria, the member may not get medically necessary services to treat their conditions.

Recommendation: Revise and implement policies and procedures to ensure that prior authorization decisions are based on medical necessity of a requested service and consistent with applicable written criteria.

1.2.2 Documented Decision Maker

Any written communication to a provider for a denial, delay, or modification of a request must include the name and telephone number of the Plan's health care professional responsible for the denial, delay, or modification. *(Contract 2024, Exhibit A, Attachment III, 2.3.1 (E))*

For written notification to the provider, the name and direct telephone number or extension of the decision maker must be included. Decisions must be communicated to the member in writing. (*All Plan Letter (APL) 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan policy, *1.1.A1_CA_UMXX_013 Non-Authorization of Medical Services – CA* (revised 07/27/2023), states that for pre-service and continued stay reviews, when the Medical Director determines that a request is not medically necessary, a notification is given to the requesting provider. The requesting provider is offered an opportunity for a peer-to-peer discussion of the case. The Medical Director is available for peer-to-peer discussion of a decision and may be contacted through the UM Department.

The Plan policy, *CA_UMXX_117 Decision and Notification Timeframes – CA* (revised 02/08/2024), states written communications or NOA letters regarding decisions to the

member and provider will identify the specific health care service denied, deferred, or modified and will include the name of the health care professional responsible for the decision and the phone number to contact the physician reviewer or ask questions.

Finding: The Plan did not include the name of the decision maker responsible for the denial, delay, or modification in the provider NOA letter.

A verification study of 32 prior authorization request samples identified four samples where the correct decision maker responsible for the review of the prior authorization was not identified in the provider NOA letter. Instead, the NOA listed a doctor who was no longer employed with the Plan at time of prior authorization request.

In the interview, the Plan admitted it was unaware of the issue of NOA letters did not contain the name of the decision maker and that the internal quality review and audits had failed to detect the problem.

Providers may not be able to petition the Plan with the correct information when the decision maker responsible for a denial is not identified in the NOA letter. Additionally, if the decision maker is not correctly identified, it becomes unclear if the prior authorization was denied by qualified medical personnel. This makes the process of appealing prior authorization denials challenging for providers.

Recommendation: Implement policies and procedures to ensure the name of the decision maker responsible for the denial, delay, or modification is included in the provider NOA letter.

1.3 PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Written Consent for Appeals Made on Behalf of a Member

The member, a provider, or an authorized representative acting on behalf of the member and with the member's written consent, may request an appeal. *(Contract 2024, Exhibit A, Attachment III, 4.6.5, A.)*

Appeals filed by the provider on behalf of the member require written consent from the member. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan policy, *GAMC-051 Member Appeals* (revised 07/09/2024), states that appeals filed by the provider on behalf of the member require written consent from the member. The Plan will send an acknowledgement letter to the member, which includes a consent form, and request the member submit their written consent.

The Plan policy, *GBD Corporate Grievance and Appeals Department Desktop Process* (revised 06/03/2024), states the member's authorized representative or a provider acting on behalf of the member, and with the member's written consent, may appeal a Plan's adverse benefit determination. For expedited appeals, the Plan may bypass the requirement for member written consent and obtain member verbal consent. The member's verbal consent, and attempts to obtain verbal consent, shall be documented in the appeal record.

Finding: The Plan did not obtain written consent when an appeal was filed on the member's behalf.

A verification study of 14 appeal samples identified 10 routine appeal cases in which an appeal was submitted on the member's behalf. Ten of ten cases had no documentation of written consent from the member. This includes four expedited cases in which no documentation of the member's consent to process the appeal could be identified. Of note, three cases were identified in which member consent was not obtained after implementation of the revised policies and procedures and the Plan's *Desk Top Process (DTP)* as outlined in the Plan's 2024 CAP.

During the interview, the Plan confirmed that a member's written consent shall be obtained to process the appeal.

As a CAP to the prior year audit deficiency (1.3.1 - Written Consent for Appeals Made on Behalf of a Member) of the Plan not ensuring the members' written consent was obtained when a provider filed an appeal on the members' behalf, the Plan submitted a Desk Top Procedure (1.3.1_DTP - G&A Consent for Appeals_Evidence) which outlined a process to obtain consent for an appeal submitted on behalf of a member. In addition to the DTP, the Plan's Quality Team conducted monthly audits for September, October, and November 2024, which demonstrated a satisfactory appeal quality score. Despite the Plan's CAP for the member written consent, instances of non-compliance were identified during the audit period.

Failure to obtain written consent from a member may diminish the member's ability to be an active participant in their own health care. The member may be unaware of decisions that are made on their behalf that could affect their well-being and overall state of health.

This is a repeat of prior year finding 1.3.1 - Written Consent for Appeals Made on Behalf of a Member.

Recommendation: Implement policies and procedures to ensure the Plan obtains members' written consent when a provider or an authorized representative submits an appeal on behalf of a member.

1.3.2 Written Notification of Downgraded Appeals

The Plan is required to have an appeal process as required below to attempt to resolve member appeals pursuant to Code of Federal Regulations (CFR), Title 42, sections 438.228 and 438.400-424. *(Contract 2024, Exhibit A, Attachment III, 4.6.5)*

The Plan must have a policy and procedure to allow members to file a grievance to contest the Plan's unilateral decision to extend the timeframe for resolution of an appeal or expedited appeal. *(Contract 2024, Exhibit A, Attachment III, 4.6.2 B)*

If the Plan denies a request for an expedited resolution of an appeal, it shall follow the requirements in CFR, Title 42, section 438.408(c)(2). *(CFR, Title 42, section 438.410(c)(2))*

If the Plan extends the timeframe of an appeal, it shall give the member written notice of the reason for that decision and inform the member of their right to file a grievance if they disagree. *(CFR, Title 42, section 438.408(c)(2)(ii))*

The Plan policy, *GAMC 051 Member Appeals-CA* (revised 07/09/2024), states when the Grievance and Appeal clinical associate determines that applying the time period of a standard appeal for the medical care or treatment would not be detrimental to the member, the Grievance and Appeal Associate will:

a) Immediately notify the member by telephone, if possible, of the determination and that the request will be handled as a standard appeal. The member is also notified of the right to contact the Department of Managed Health Care (DMHC) regarding their appeal without participating in the Plan's Medi-Cal appeal process prior to applying to DMHC for review of an expedited appeal.

b) Documents the receipt of the appeal in the electronic information system

c) Assigns it to a Grievance and Appeals clinical associate

d) Immediately send an acknowledgement to the member, which indicates the receipt of the expedited appeal request, the date of the receipt, that the request was reviewed for urgency and will be handled as a standard appeal, and the member's right to immediately notify DMHC of the expedited

appeal. The acknowledgement letter includes the receipt date and the name and contact information of a representative who can be contacted.

Finding: The Plan did not inform the member in writing of the decision, nor did it provide written notification of the right to file a grievance after extending the timeframe of an expedited appeal request to a standard request.

A verification study of 14 appeal samples identified 6 expedited appeal samples. Two of six expedited requests were downgraded to standard priority. In both cases, the appeal log notes state an "Acknowledgment letter will be mailed to members containing written notice of DMHC Grievance and Appeal Rights." However, no written notification was sent to the members informing them of the Plan's decision to unilaterally downgrade the appeal request or of their right to file a grievance because of the extended timeframe for resolution.

During the interview, the Plan stated that the acknowledgment includes notice of the downgrade of an appeal request from expedited to standard and the right to file a grievance against the decision. However, this was missing when reviewing the acknowledgement letters. The Plan agreed that this was not found in the acknowledgment letters reviewed during the audit.

The Plan stated that the member receives verbal notification as soon as the clinical decision to downgrade the appeal is made and that the letter is mailed the same day. In the two cases, there is documentation in the appeal log notes that verbal notification was unsuccessful. The Plan confirmed that there was no subsequent written notification to the member regarding the downgrade or the right to file a grievance in these cases.

The Plan did not follow the written policies and procedures for expedited appeals. Additionally, the Plan did not follow contractual requirements to inform the member in writing of the decision and of their right to file a grievance when the timeframe for the resolution of an expedited appeal request is extended.

A unilateral decision to extend the timeframe of an expedited appeal request, without informing the member the right to file a grievance, hinders the only recourse for the member to petition the Plan's decision. This may seriously jeopardize the member's health and delay urgently requested health services.

Recommendation: Revise and implement policies and procedures to ensure members are given written notice of the expedited appeal downgrade decision, reason for the decision, and the members' right to file a grievance therein.

1.4 MEDICAL DIRECTOR AND MEDICAL DECISIONS

1.4.1 Department of Health Care Service Notification of Changes in Status of the Medical Director

The Plan must report to the DHCS Contract Manager any changes in the status of Chief Medical Director within ten calendar days. *(Contract 2024, Exhibit A, Attachment III, 1.1.8)* The Plan must appoint a physician as a full-time Medical Director pursuant to California Code of Regulations, Title 22, section 53857, whose responsibilities includes, but should not be limited to, the following:

a) Ensuring that medical and other health services decisions are rendered by qualified medical personnel, and not influenced by fiscal or administrative management considerations

b) Ensuring that the medical and other health care provided meets acceptable standards of care

c) Ensuring that the Plan's medical personnel follow medical protocols and rules of conduct

d) Developing and implementing medical policy consistent with applicable standards of care

e) Resolving Grievances related to Quality of Care

f) Participating directly in the implementation of Quality Improvement and Health Equity activities

(Contract 2024, Exhibit A, Attachment III, 1.1.6)

Finding: The Plan did not report the change in status of the Chief Medical Director to the DHCS within ten calendar days.

During the interview, the Plan stated that the previous Chief Medical Director, also referred to as the Managing Medical Director, left the Plan in December 2023. The Plan did not provide the exact date of the previous Chief Medical Director's exit. The Plan stated another staff member took on the duties as the Interim Chief Medical Director. The Plan stated a new person was hired into the Chief Medical Director role in March 2024. However, the Plan did not provide the exact date of when new person was hired. The Plan did not provide any notification to DHCS of the new person being hired as a Chief Medical Director or of the one that left in December 2023. Additionally, the Plan stated that although the new person was hired in March 2024, the notification to the

DHCS was in July 2024, with a financial disclosure form dated July 8, 2024, which does not meet the notification requirement within ten calendar days.

The Chief Medical Director's duties are broad and essential to the proper functioning of the Plan's service. When there is no Chief Medical Director, there is a loss of oversight to UM, medical staff, and processes like grievances and appeals. Additionally, if there is no notification of the change, the DHCS cannot provide oversight and may not be aware of the Plan's responsible personnel.

Recommendation: Develop and implement policies and procedures to ensure that the Plan reports to DHCS any changes in the status of the Chief Medical Director within ten calendar days.

COMPLIANCE AUDIT FINDINGS

Category 2 – Case Management and Coordination of Care

2.1 BASIC CASE MANAGEMENT

2.1.1 Long Term Support Services Assessments

The Plan must comply with all DHCS guidance, including but not limited, to APLs, Policy Letters, the California Medicaid State Plan (Title XIX), and the Medi-Cal Provider Manual. *(Contract 2024, Exhibit E, 1.1.2)*

The Plan is required to follow the policy related to changes to SPD HRA requirements as outlined in the Population Health Management Policy Guide. *(APL 22-024, Population Health Management Policy Guide)*

The DHCS simplified the expected timeline for assessment of those with LTSS needs to align with National Committee for Quality Assurance's requirement for care management assessments, which include beginning to assess within 30 days of identifying the member through RSS, referral, or other means, and completing assessment within 60 days of identification. *(Population Health Management Policy Guide, page 34)*

The Plan policy, *CA_CAXX_107 Seniors and Persons with Disabilities – Case Management and Coordination of Care - CA* (revised 03/14/2024), states that the Plan will complete SPD assessments through the use of HRA forms that include questions to determine LTSS needs. The Plan will conduct outreach for HRA completion by calling members at least two times and through correspondence. Furthermore, this policy refers to complying with the Population Health Management Policy Guide instructions as it relates to SPDs.

Finding: The Plan did not ensure timely assessment of LTSS needs within 60 days of identifying SPD members through the RSS process.

A verification study of eight medical record samples identified three medical records with non-timely completion of the HRA/LTSS questionnaire forms with delays ranging between 65 and 239 days. Therefore, the Plan did not complete the LTSS assessments within 60 days of identifying high-risk SPD members.

Although the Plan policy *CA_CAXX _107* states that the Plan will complete the HRA/LTSS questionnaire for SPDs, this policy does not state that the HRA is to be completed within

60 days of identifying high-risk SPD members. Since the HRA form contains the LTSS questionnaire for SPDs, non-timely completion of the HRA form leads to noncompliance with timeliness requirements for completing the LTSS needs assessments.

In an interview, the Plan confirmed tracking for timely completion of the HRA/LTSS referral questions form. Review of the Plan's HRA outreach tracking report demonstrated that the Plan tracks for letters sent out to members. However, the Plan did not track telephonic outreach attempts for timely HRS completion.

Non-timely completion of the HRA/LTSS referral questions form can result in failure to ensure the provision of appropriate referrals to necessary care services based on the specific needs of the Plan's high-risk SPD members.

Recommendation: Revise and implement policies and procedures to ensure timely assessment of LTSS needs within 60 days of identifying SPD members through the Plan's RSS process.

2.3 BEHAVIORAL HEALTH TREATMENT

2.3.1 Behavioral Health Treatment Plan and Medical Necessity Determination

The member's behavioral health treatment plan may be modified or discontinued only if it is determined that the services are no longer medically necessary under the EPSDT medical necessity standard. *(Contract 2024, Exhibit A, Attachment III(F)(2))*

Plans are required to provide and cover, or arrange as appropriate, all medically necessary EPSDT services, including BHT services. BHT services must be provided, observed, and directed under a Plan-approved behavioral treatment plan. The provider of BHT services must review, revise, and/or modify no less than once every six months the behavioral treatment plan. If services are no longer medically necessary under the EPSDT medical necessity standard, then the behavioral treatment plan must be modified or discontinued. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary. *(APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21)*

The Plan policy, *UM 014.12 CA Authorization Procedures for BHT – Medi-Cal* (revised 05/28/2024), states that if services are no longer medically necessary under the EPSDT medical necessity standard, then the behavioral treatment plan must be modified or discontinued. Initial service authorization is granted for a six-month period. At the end

of this period a reassessment is completed. Continued authorization is provided if the patient continues to meet criteria for continued treatment, or there is appearance of new problems or symptoms that meet admission criteria.

Finding: The Plan did not conduct subsequent BHT plan reviews at six months after initial authorization of BHT services, and discontinued BHT services without determining that the services are no longer medically necessary.

In a verification study, three of 13 BHT samples showed that the Plan did not conduct subsequent BHT plan reviews at six months after the initial authorization of BHT services. Based on documentation reviewed, members received no further BHT services. However, there was no progress report to show a determination that services were no longer medically necessary under the EPSDT medical necessity standard.

Review of member treatment plans showed that the Plan's BHT provider noted in the transition and exit plan that discharge from BHT services may be recommended if the client achieves all treatment goals, demonstrates a lack of meaningful progress for successive authorization periods, the client no longer meets diagnostic criteria for autism spectrum disorder/related disorder, the family is interested in discontinuing services, and the family and provider are not able to reconcile important issues in treatment planning and delivery. However, records did not document that transition and exit criteria were met and that a determination of medical necessity was conducted by the Plan's BHT provider. Additionally, BHT case management or COC were not documented in all three verification study samples.

Although the Plan policy *UM 014.12 CA* states that the Plan will conduct a reassessment at the end of the initial six-month BHT authorization, this policy does not state how the Plan will monitor compliance with the reassessment requirement to ensure that for all members receiving BHT, determinations are made to continue or discontinue BHT based on medical necessity.

In an interview, the Plan stated that if the BHT provider does not submit the six month reassessment and BHT reauthorization request, the Plan does not currently coordinate care to ensure a medical necessity determination was made by the BHT provider whether to continue or discontinue BHT.

If the Plan does not ensure that member's discontinued behavioral treatment plans are no longer medically necessary, this can lead to delayed progress in BHT goals related to behaviors that are helpful, such as communication, social skills, and self-care.

Recommendation: Revise and implement policies and procedures to ensure the provision of BHT services, and ensure the required periodic reviews of the BHT plans, no less than once every six months, including the documentation of the medical necessity determination.

2.4 CONTINUITY OF CARE

2.4.1 Continuity of Care Completion Timelines

The Plan must comply with all DHCS guidance, including but not limited to APLs, Policy Letters, the California Medicaid State Plan, and the Medi-Cal Provider Manual. *(Contract 2024, Exhibit E, 1.1.2)*

The Plan must begin to process non-urgent requests within five working days following the receipt of the COC request. Additionally, each COC request must be completed within the following timelines from the date the Plan received the request:

a) Thirty calendar days for non-urgent requests

b) Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs

c) As soon as possible, but no longer than three calendar days for urgent requests (i.e. there is identified risk of harm to the member)

(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023)

The Plan must provide acknowledgment of the Continuity of Care request within the following specified timeframes:

- For non-urgent requests, within seven calendar days of the decision.
- For urgent requests, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three calendar days of the decision.

A Continuity of Care request is considered complete when the Plan notifies the Member of the Plan's decision.

(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023)

The Plan policy, *CA_CAXX_029 Continuity of Care/Transition Assistance - CA* (revised 03/14/2024), states that the Plan will complete COC requests in accordance with APL 23-022 timelines such that from the date of receipt, non-urgent requests are completed within 30 calendar days, cases requiring immediate action are completed within 15 calendar days, and urgent requests are processed as soon as possible, but no longer than 3 calendar days for urgent requests (i.e. there is identified risk of harm to the member).

Finding: The Plan did not document the determination of urgency levels to ensure timely completion of COC requests.

In a verification study, all four samples were completed within 30 calendar days and member denial notifications were sent within seven calendar days of the decision. The Plan would have demonstrated COC timeframe compliance if all four samples were documented as non-urgent requests. However, for all four medical records, the Plan did not document the COC urgency level to identify non-urgent, immediate action, and urgent COC requests. Completion of COC processing and notification of COC decisions are based on the urgency level determination. Therefore, it could not be confirmed if the verification samples met timeframe requirements based on their urgency level.

Review of Plan documents submitted showed that the Plan lacked a process for tracking the following: urgency level of COC request, approval or denial date, and subsequent notification of the Plan's decision regarding the COC request. If the urgency level is not documented, the Plan cannot track for timeliness of COC completion as follows: non-urgent requests are completed in 30 calendar days; immediate action requests are completed in 15 calendar days, and urgent requests are completed as soon as possible, but no longer than three calendar days.

Although the Plan policy *CA_CAXX_029* states the Plan will comply with COC completion timelines in accordance with APL 23-022, this policy does not state who is responsible for determining the urgency level for COC requests and how this is documented.

In an interview, the Plan explained a clinician/case manager stratifies COC requests but there is no established process to document this stratification. In a written narrative, the Plan acknowledged that it did not document the level of urgency in the medical records of samples from the verification study.

If the Plan does not stratify COC requests, it cannot ensure timely completion of non-urgent, immediate action, and urgent COC requests. This can delay access to medically necessary care for members.

Recommendation: Revise and implement policies and procedures to document and complete non-urgent, immediate action, and urgent COC requests within the required timeframes.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 GRIEVANCE SYSTEM

4.1.1 Grievance Resolution Letter Timeframe

The Plan is required to have in place a member grievance and appeals system that ensures timely written acknowledgement of each grievance and provides 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 a verbal or written request to the Plan for a standard grievance or appeal. *(Contract 2024, Exhibit A, Attachment III, 4.6.1)*

Timeframes for resolving grievances and sending written resolution to the member are delineated in both federal and state law. The Plan must comply with the State's established timeframe of 30 calendar days for grievance resolutions.

"Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in state regulations. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan policy, *GAMC_015 Grievance Process: Members* (revised 08/28/2023), states that the Plan's Medi-Cal policy has established, implemented, maintains, and oversees a grievance and appeal system to ensure receipt, review, and resolution of grievances and appeals, in accordance with the requirements in APL 21-011, Grievance and Appeal Requirements. The Plan designated staff will send a written resolution letter to the member within 30 calendar days of the receipt of the grievance.

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

A verification study of 36 quality of service grievance samples identified 34 samples where the Plan did not resolve the grievances within 30 calendar days. The grievance resolution letters were sent between 33 to 62 days.

During the interview, the Plan attributed the failure to provide members with timely notification of written resolution to the shortage of staff in their Appeals and Grievances Department.

As a CAP to the prior year audit deficiency (4.1.1 Grievance Resolution Letters) of not sending resolutions letters within the required 30 calendar days, the Plan used daily activity logs to monitor the timeliness of case deadlines. There was also a process in place for individual analysts to monitor and prioritize workload by displaying case age and upcoming due dates. However, the verification study samples identified grievances that were processed late which the Plan attributed to staff shortage.

The failure to resolve grievances within the required timeframe may restrict the members from receiving timely medical services.

This is a repeat of prior year finding 4.1.1 - Grievance Resolution Letters.

Recommendation: Implement policies and procedures to ensure the grievance is resolved and the resolution letter is sent within the required 30 calendar day timeframe.

4.1.2 Grievance Written Consent

The grievance and appeal requirements allow the member, a provider, or authorized representative with the member's written consent, to file a grievance. *(Contract 2024, 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, or request a state Fair Hearing, on behalf of a member. *(CFR, Title 42, section 438.402 (C)(1)(ii)))*

The Plan policy, *4.1.1_CA_GAMC_015_Grievance Process Members-CA* (revised 07/22/2024), states if a representative submits the grievance on behalf of the member, the member must sign a Designation of Representation (DOR) form, or the member may give verbal authorization. The representative or member, as appropriate, is contacted and sent a DOR form, which must be signed by the member. If the member gives verbal authorization, it is documented in the member's file, and a follow-up letter is sent to the member confirming the verbal authorization to designate a representative.

Finding: The Plan did not obtain written consent for grievances filed on member's behalf.

A verification study of 19 quality of care grievance samples identified four grievances filed on an adult member's behalf. All four samples did not have member's written consent for authorized representation.

During the interview, the Plan admitted that it does not collect written consent, and that verbal consent only is collected. The Plan's policy states that a member must sign a DOR

form or give verbal authorization. If the member gives verbal consent, then a follow up letter is sent to the member confirming the verbal consent. No DOR forms indicating written consent were present in the verification studies. The Plan stated it does not attempt to obtain written consent if verbal consent is obtained. The Plan's policy and procedure do not meet contractual requirements of obtaining written consent.

When the Plan does not obtain a member's written consent prior to the filing of a grievance on their behalf, a member's Protected Health Information may be compromised, unauthorized decisions may be made concerning healthcare and notice of the outcome may not be received.

Recommendation: Revise policies and procedures to ensure the Plan obtains a member's written consent for authorized representation prior to a representative filing a grievance on behalf of the member.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SANTA ANA SECTION

REPORT ON THE MEDICAL AUDIT OF ANTHEM BLUE CROSS PARTNERSHIP PLAN, INC. FISCAL YEAR 24-25

Contract Numbers: 22-20469, 22-20474, 22-20475, 22-20479, 22-20487, 23-30245, 23-30246, 23-30247, and 23-30341

Contract Type: State Supported Services

Audit Period: November 1, 2023 — October 31, 2024

Dates of Audit: December 9, 2024 — December 20, 2024

Report Issued: June 11, 2025

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I. INTRODUCTION

This report presents the results of the audit of Anthem Blue Cross Partnership Plan's, Inc. (Plan) compliance and implementation of the State Supported Services contract numbers 22-20469, 22-20474, 22-20475, 22-20479, 22-20487, 23-30245, 23-30246, 23- 30247, and 23-30341 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of November 1, 2023, through October 31, 2024. The audit was conducted from December 9, 2024, through December 20, 2024, 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 April 22, 2025. No deficiencies were noted during the review of the State Supported Services Contracts.

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 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 of health of the pregnant individual.

The Plan's policies and procedures, Provider Manual, and Member Handbook were reviewed for the provision of State Supported Services. The Plan had policies and procedures in place to provide abortion and abortion-related procedures to members. The services were included in the Member Handbook. The Plan informed providers of their responsibilities to provide abortion and abortion-related procedures without prior authorization through the Provider Manual.

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

Recommendation: None.