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

REPORT ON THE MEDICAL AUDIT OF

ANTHEM BLUE CROSS PARTNERSHIP PLAN

Contract Number:	03-76184, 04-36068, 07-65845, 10-87049 And 13-90159
Audit Period:	October 1, 2017 Through September 30, 2018
Report Issued:	June 12, 2019

TABLE OF CONTENTS

I. INTRODUCTION

Anthem Blue Cross Partnership Plan, Inc. (Anthem or the Plan), is a subsidiary of Anthem, Inc. Anthem provides medical managed care services to Medi-Cal beneficiaries under the provisions of Welfare and Institutions Code, Section 14087.3 and is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act.

Anthem is a full-scope managed care plan, which serves the Medi-Cal, Medicare, and Rural Expansion population. The Plan delivers care to members under the Two-Plan model in all counties with the exception of Sacramento County, which is a Geographic Managed Care (GMC) model. The Plan delivers care to members as a Commercial Plan in Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, and Santa Clara Counties. The Plan delivers care to members as a Local Initiative in Tulare County.

On November 1, 2013, California Department of Health Care Services awarded Anthem with the contract to provide Medicaid Managed Care benefits to beneficiaries under the State's Rural Expansion Procurement. The Plan is to deliver care to members in 18 additional counties under the Geographic Managed Care (GMC) rural model.

At the local level, many of Anthem's services are provided through Regional Health Centers operated by Anthem. The Regional Health Centers provide access to provider network physicians, members, and community agencies to Anthem's staff.

This report presents the findings of the medical audit of Anthem and its compliance and implementation of five contracts to provide services in twenty-seven counties: Contract 03-76184 (Commercial contract) covers Alameda, Contra Costa, San Francisco, and Santa Clara counties). Contract 04-36068 (Local Initiative contract) covers Tulare county. Contract 07-65845 (Geographic Managed Care contract) covers Sacramento county. Contract 10-87049 (Commercial contract) covers Fresno, Kings, and Madera counties. Contract 13-90159 (Geographic Managed Care & 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.

As of September 2018, Anthem served approximately 732,640 Medi-Cal members in the following counties: Alameda 59,533, Alpine 130, Amador 5,064, Butte 25,805, Calaveras 3,979, Colusa 4,744, Contra Costa 26,352, El Dorado 8,279, Fresno 108,164, Glenn 3,061, Inyo 1,921, King 19,745, Madera 19,409, Mariposa 3,022, Mono 1,602, Nevada 12,023, Placer 28,649, Plumas 2,461, Sacramento 176,767, San Francisco 18,943, Santa Clara 69,391, Sierra 365, Sutter 21,444, Tehama 8,642, Tulare 91,911, Tuolumne 4,973 and Yuba 6,261.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of October 1, 2017 through September 30, 2018. The onsite review was conducted from October 29, 2018 through November 9, 2018. The audit consisted of document review, verification studies, and interviews with the Plan personnel.

An exit conference was held on May 23, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report findings. The Plan did not provide additional information after the exit conference.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability of Care, Members' Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the audit period of November 1, 2016 through October 31, 2017) was issued August 28, 2018. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their corrective action plan (CAP).

A finding denoted as a repeat finding is an uncorrected deficiency substantially similar to that identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

The prior year audit report found that the Plan failed to develop and implement a specialty referral system including timeliness to track and monitor delegated entities. To correct the prior year audit finding, the Plan implemented tools to track and monitor the referral system. The Plan implemented quarterly out of network reports to track timeliness, turnover time, urgent and routine requests, and to monitor open and unused referrals.

There were no findings in this category.

Category 2 – Case Management and Coordination of Care

The Plan did not comply with Behavioral Health Treatment (BHT) requirements outlined in All Plan Letters (APL) 15-025 and 18-006. The Plan's policies and procedures outline all the required elements of the treatment plan. However, Plan medical records were missing the required transition plan and crisis plan.

Category 3 – Access and Availability of Care

There were no findings in this category.

Category 4 – Member's Rights

The Plan's medical director is required to resolve grievances related to medical quality of care. The Plan does not have an effective system to ensure that all grievances related to quality of care issues were reviewed by a medical director prior to sending resolution letters.

The contract requires specific timeframes and methods for reporting breaches of PHI and suspected security incidents. The Plan did not report all suspected security incidents to DHCS within 24 hours of discovery and investigation of breach within 72 hours of the discovery of the incidents.

Category 5 – Quality Management

The Plan is required to ensure all providers receive training regarding the Medi-Cal Managed Care program. The Plan did not ensure all newly contracted providers received provider training within the ten working days of the Plan-Provider work relationship as required by the Contract.

Category 6 – Administrative and Organizational Capacity

There were no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The Department of Health Care Services (DHCS) Medical Review Branch conducted this audit to ascertain that the medical services provided to Plan members comply with Federal and State laws, Medi-Cal regulations and guidelines, and the State Contracts.

PROCEDURE

The onsite review was conducted from October 29, 2018 through November 9, 2018. The audit included a review of the Plan's contracts with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization: Eleven (11) medical and ten (10) pharmacy prior authorization requests were reviewed for medical necessity, consistent application of criteria, and timeliness. Of the sampled medical prior authorization requests, four (4) samples were Rural Expansion. Of the sampled pharmacy prior authorization request, four (4) samples were Rural Expansion.

Appeal Procedures: Eleven (11) prior authorization appeals were reviewed to ensure that required timeframes were met and appeals were appropriately routed and adjudicated. Of the sampled prior authorization appeals, four (4) samples were Rural Expansion.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment (IHA): Fifteen (15) medical records were reviewed for completeness and timely completion. Of the sampled Initial Health Assessments, two (2) samples were Rural Expansion.

Behavioral Health Treatment (BHT): Ten (10) medical records were reviewed for evidence of care coordination and collaboration between the provider of care and individual member. Of the sampled Behavioral Health Treatments, two (2) samples were Rural Expansion.

Category 3 – Access and Availability of Care

Appointment Procedures and Monitoring Wait Times: Fifteen (15) appointment wait time samples were reviewed to verify member wait times to obtain appointments for urgent care, routine care, routine specialty services, and initial prenatal care visits. Of the

sampled appointment procedures and monitoring wait times, three (3) samples were Rural Expansion.

Category 4 – Member's Rights

Grievance Procedures: Twenty (27) grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. Twelve (12) were quality of care and fifteen (15) were quality of service grievances. Of the sampled grievances, six (6) were Rural Expansion.

Confidentiality Rights Procedures: Twelve (12) Health Insurance Portability and Accountability Act (HIPAA) case samples were reviewed for timeliness and confidentiality.

Category 5 – Quality Management

New Provider Training: Fifteen (15) new provider training records were reviewed for timely Medi-Cal Managed care program training. Of the sampled new provider training, five (5) were Rural Expansion.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: ANTHEM BLUE CROSS PARTNERSHIP PLAN

AUDIT PERIOD: October 1, 2017 Through September 30, 2018
DATE OF AUDIT: October 29, 2018 Through November 9, 2018

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.3	BEHAVIORAL HEALTH TREATMENT

Services for Members under Twenty-One (21) Years of Age
Contractor shall ensure the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and EPSDT Supplemental Services for Members under 21 years of age, including those who have special health care needs. Contractor shall inform Members that EPSDT services are available for Members under 21 years of age, provide comprehensive screening and prevention services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, and lead toxicity screening), and provide treatment for all medically necessary services.
Two Plan Contract E.A.10.5

ALL PLAN LETTERS 15-025 and 18-006 Responsibilities for Behavioral Health Treatment Coverage for Members under the age of 21
The MCP is responsible for the provision of EPSDT supplemental services to include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions that develop or restore, to the maximum extent practicable, the functioning of a member with Autism Spectrum Disorder (ASD). The MCP must ensure all children, including children with ASD, receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening exam indicates the need for further evaluation of a child's health, the child must be referred for medically necessary diagnosis and treatment without delay. The MCP is required to:

1. Inform members that EPSDT services are available for members under 21 years of age
2. Provide access to comprehensive screening and prevention services, at designated intervals or at other intervals indicated as medically necessary, in accordance with the most current Bright Futures periodicity schedule
3. Provide access to medically necessary diagnostic and treatment services, including but not limited to , BHT services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist
4. Ensure appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the contract
5. Ensure coverage criteria for BHT are met.

MCP Approved Treatment Plan
MCPs must ensure that BHT services are medically necessary and are provided and supervised under an MCP-approved behavioral treatment plan developed by a contracted (or other form of agreement between the MCP and provider) and MCP-credentialed "qualified autism service provider," as defined by H&S Code Section 1374.73(c)(3) and the MCQMD ALL PLAN LETTERS 15-025 and 18-006, Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder.

BHT services must be provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider. The behavioral treatment plan must be reviewed, revised and/or modified no less than once every six months by a qualified autism service provider.

Continuity of Care (APL'S 15-025 and 18-006)
MCPs must ensure continuity of care in accordance with existing contract requirements, ALL PLAN LETTER 15-025 and 18-006, and Health & Safety Code Section 1373.96 for the provision of BHT services.

Delegation Oversight (APL'S 15-025 and 18-006)
The MCP must ensure that delegates comply with all applicable state and federal laws and regulations, contract requirements, and DHCS guidance, including APLs for the provision of BHT services

SUMMARY OF FINDING:

2.3.1 Behavioral Health Treatment Plan Criteria

Behavioral Health Treatment (BHT) services must be based upon a treatment plan that is reviewed no less than every six (6) months by a qualified autism service provider and by the federally approved State Plan. The Plan shall provide medically necessary BHT services as stated in the treatment plan (Contract, Exhibit A, Attachment 10.5.F).

All Plan Letters (APL) 15-025 and 18-006 require the Plan to provide guidance regarding the provision of medically necessary Behavioral Health Treatment (BHT) services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment.

All Plan Letters 15-025 and 18-006 state Behavioral Health Treatment coverage for children diagnosed with Autism Spectrum Disorder requires that the Behavioral

Treatment Plan must clearly identify the service type, number of hours of direct services, observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.

Plan Policy CA_BHXX_004, Applied Behavioral Analysis identified the required elements of a treatment plan and the requirements for Applied Behavioral Analysis (ABA) services as specified in All Plan Letters 15-025 and 18-006. The policy states that treatment plan shall clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.

The Plan did not follow their policies and procedures to comply with the requirements of the provision of BHT services.

In the interview, Plan personnel stated that BHT covered services were delivered in accordance with the member's approved behavioral treatment plan. Although the Plan of Treatments may vary by different agencies, all the required elements listed under All Plan Letters 15-025 and 18-006 should be present.

Ten (10) medical records were reviewed for the verification study. Two medical records did not contain treatment plans from the ABA providers. Two other medical records lacked the required elements of a crisis plan, transition plan, and discharge plan in the member's treatment plans.

Although, there were written elements of the treatment plan under the Plan's policies and procedures, not all the required elements of the treatment plan were documented in the medical records.

The prior audit found that the treatment plans did not clearly identify crisis plan and transition plan in the medical records. This is a repeat finding.

A treatment plan without the required elements or criteria may delay the member's transitioning to the next level of care or can result in the treatment goals not being met.

RECOMMENDATION:

2.3.1 Implement policies and procedures to meet the current contract and All Plan Letter requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: ANTHEM BLUE CROSS PARTNERSHIP PLAN

AUDIT PERIOD: October 1, 2017 Through September 30, 2018
DATE OF AUDIT: October 29, 2018 Through November 9, 2018

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).
GMC Contract A.14.1

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's Grievance system and the expedited review of grievances required under 28 CCR 1300.68 and 1300.68.01 and 22 CCR 53858….(as required by Contract)
GMC Contract A.14.2

Contractor shall implement and maintain procedures…to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858….(as required by Contract)
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance, logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
GMC/2-Plan Contract A.14.3.A

SUMMARY OF FINDING:

4.1.1 Review of Quality of Care Grievances by the Medical Director

The Plan's medical director is required to resolve grievances related to medical quality of care. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there were no pending enrollee appeals within the Plan's grievance system, including entities with delegated authority. If the

Plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the Plan's receipt of the grievance required under Title 28, CCR 1300.68, 1300.68 (a) (4) (A), 1300.68.01 and Title 22 CCR 53858. (Contract, Exhibit A, Attachment 14.2)

Plan *Policy CA_GAMC_015 Grievance Process* complied with APL 17-006. The policy mandates all grievance and appeals related to medical quality of care issues be immediately submitted to Anthem's medical director for action. Furthermore, the policy states that all clinical grievances were to be assigned to clinical associates for review and appropriate action.

The Plan's process omitted medical director review of quality of care grievances prior to sending resolution letters.

In the interview, Plan personnel stated that the grievance process has been changed as of March 2018. The Plan hired a new medical director in the spring of 2018. In addition, the Plan also hired a new grievance and appeals director to reorganize clinical review teams, monitor initial clinical review, revise tracking of grievances, add detail to resolution letters, train review teams. Furthermore, the Plan established and developed a system to track and monitor the grievance process and made changes in writing resolution letters.

Although, the Plan initiated changes in handling the grievances, a review of sampled quality of care grievances did not reflect these changes.

Twelve (12) quality of care grievances were reviewed for the verification study. The verification study showed that a medical director did not document review of all twelve sampled quality of care grievances. Resolution letters were sent to the member without documentation of medical director review on the quality of care grievances.

The prior audit identified that resolution letters were sent to the member without a medical director review on the quality of care grievances. This is a repeat finding.

If a medical director does not evaluate quality of care grievances in a timely manner, the Plan risks a potential quality of care issue, which could delay needed services or be detrimental to the members' health and well-being.

RECOMMENDATION:

4.1.1 Implement a system to ensure that a medical director reviews all quality of care grievances prior to sending resolution letters.

4.3	CONFIDENTIALITY RIGHTS

Members' Right to Confidentiality
Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information….
2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Business Associate agrees:

> Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316….

GMC/2-Plan Contract G.III.C.2.

Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS**. (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement….
2. **Investigation and Investigation Report**. To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. **Complete Report**. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

GMC/2-Plan Contract G.III.J

SUMMARY OF FINDING:

4.3.1 Breach Notification Procedures

The Plan is required to identify, investigate, mitigate, and respond to suspected and actual incidents involving the non-permitted use or disclosure of Member Confidential Information or Provider/Broker Confidential Information. The Plan is also required to notify members, regulators, and other parties of any confirmed Incident and/or Breach as required by federal and state law or regulations and contractual obligations (i.e. Business Associate Agreements) or as otherwise deemed appropriate by the Plan. *(Contract, Exhibit G, Attachment III.J)*

Discovery of Breach: The Plan is required to notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of the Contract, or potential loss of confidential data affecting the Contract. *(Contract, Exhibit G, Attachment III.H)*

Investigation of Breach: The Plan is required to immediately, investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer. *(Contract, Exhibit G, Attachment III.H)*

Plan *Policy CPP 1201, Privacy and Security Incident Response and Reporting* does not identify the required timeframes for reporting privacy breaches/suspected breaches and does not identify DHCS personnel contact information. However, the Plan developed an internal desktop procedure to track the required timeframes and DHCS contact personnel.

The Plan does not have internal controls to monitor the required timeframes for reporting the Discovery of Breaches and the Investigation of Breaches.

During the interview, Plan personnel stated that the delay is coming from their Medicaid Business unit. The Medicaid Business is actually the staff who receive the breach, most of them were from customer service department. The Medicaid Business associate does not report to the compliance department in timely manner, they usually hold it for couple of days.

Ten (10) HIPAA breach notifications were reviewed for the verification study.

DHCS was not notified within 24 hours by e-mail or fax. All ten (10) samples exceeded the 24-hour timeframe requirement to report discovery of suspected breaches. These were reported to DHCS seven to eleven days after it was discovered by the Plan. The Plan was notifying DHCS with an incorrect date (i.e. The Plan notified DHCS regarding discovery of breach when their Medicaid Business Associate was notified), not when the Plan actually discovered the issue.

The Plan exceeded the 72-hour timeframe for the investigation of suspected breaches. All ten (10) exceeded the 72-hour timeframe. The amount of time an investigation is open is well over the 72 hours.

The prior year audit found that the Plan lacked internal controls to monitor and track the timeframe requirements to report the suspected breaches. This is a repeat finding.

The Plan lacks internal control to monitor and track the timeframe of the privacy breaches and security incidents, which leads to loss of oversight and enforcement of the contract terms. If the Plan does not report potential breaches timely, member confidential information may be jeopardized. By ensuring that the Plan consistently reports all suspected security incidents within the required timeframes, the Plan will meet its contractual and regulatory requirements in safeguarding the privacy of members' protected health information.

RECOMMENDATION:

4.3.1 Implement notification process to meet the required timeframes for reporting Discovery of Breach and Investigation of Breach. Develop internal controls to monitor and track when incidents are reported.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: ANTHEM BLUE CROSS PARTNERSHIP PLAN

AUDIT PERIOD: October 1, 2017 Through September 30, 2018
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CATEGORY 5 - QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.
Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
GMC/2-Plan Contract A.4.12

Standards:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
GMC/2-Plan Contract A.4.12.A

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies, or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status….
GMC/2-Plan Contract A.7.*5*

Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities…
GMC/2-Plan Contract A.4.12.B

5.2	PROVIDER QUALIFICATIONS

Disciplinary Actions:
Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
GMC/2-Plan Contract A.4.12.D

Medi-Cal and Medicare Provider Status:
The Contractor will verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider List. Terminated providers in either Medicare or Medi-Cal or on the Suspended and Ineligible Provider List cannot participate in the Contractor's provider network.
GMC/2-Plan Contract A.4.12.E

SUMMARY OF FINDING:

5.2.1 New Provider Training Time Frames

Plan shall ensure that all providers receive training on the Medi-Cal Managed Care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations. Plan shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures, and any modifications to existing services, policies, or procedures. Training shall include methods for sharing information between the Plan, provider, member, and/or healthcare professionals. The Plan shall conduct training for all providers within ten (10) working days after the Plan places a newly contracted provider on active status (*Contract, Exhibit A, Attachment 7.5*).

Plan Policy CA NRXX 013 Provider Training does not contain any specific provisions that monitors and tracks the results for the timely completion of new provider training. The Plan's Provider Manual does not contain new provider training information.

In the interview, the Plan acknowledged staffing issues that accounted for the training compliance difficulty. The Plan stated that they were making changes and hiring more staff to ensure that the new providers receive training in a timely manner.

Fourteen (14) new provider trainings were reviewed for the verification study. The verification study showed 13 trainings were out of compliance with the ten-day

timeframe. The average time for receiving new provider training from the provider's effective date was 111 days. This exceeds the 10 days requirement.

The prior year audit found deficiencies that the Plan did not accurately monitor newly contracted providers to ensure that new providers were trained within the ten working days of the Plan-Provider work relationship as required by the Contract. This is a repeat finding.

The Plan's noncompliance with the time requirement may cause missed opportunities for newly contracted providers to offer the services and benefits to Medi-Cal members on a timely basis. The purpose of the training is to ensure that new providers have the necessary minimum knowledge to administer optimal care to the Medi-Cal population.

RECOMMENDATION:

5.2.1 Develop effective monitoring and tracking methodology that direct and support the contractual time requirement for new provider training.

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

REPORT ON THE MEDICAL AUDIT OF

ANTHEM BLUE CROSS PARTNERSHIP PLAN

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

Audit Period: October 1, 2017 Through September 30, 2018

Report Issued: June 12, 2019

TABLE OF CONTENTS

I. INTRODUCTION

The audit report presents the findings of the contract compliance audit of Anthem Blue Cross Partnership Plan and its implementation of the State Supported Services Contract Nos. 03-75795, 04-36079, 07-65846, 10-87053 and 13-90160 with the State of California. The State Supported Services Contract covers abortion services for Anthem Blue Cross Partnership Plan.

The onsite audit of the Plan was conducted from October 29, 2018 through November 9, 2018. The audit covered the review period from October 1, 2017 through September 30, 2018 and consisted of a document review of materials provided by the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Anthem Blue Cross Partnership Plan

AUDIT PERIOD: October 1, 2017 through September 30, 2018
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STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes*: 59840 through 59857
HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*
State Supported Services Contract Exhibit A.1

SUMMARY OF FINDING(S):

Policy CA_UMXX_067, Abortion Services, states that members may access and obtain abortion services. Abortions are required to be provided in accordance with State and Federal law and are considered by the California Department of Health Care Services to be a "sensitive service." Abortion is considered a self-referable service. Anthem reimburses both network and out-of-network providers for abortion procedures. Members are encouraged to remain in-network for these procedures; however, the services will be covered for non-network providers, if necessary.

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

Members have the right to choose and access qualified family planning services including abortion service/pregnancy termination without prior authorization. Members may self-refer to a contracted or non-contracted provider. The *Member Handbook* informs members that minors do not need an adult's consent or referral to access pregnancy termination services. The *Provider Manual* informs providers of the rights of members to receive timely access to care for abortion services.

The Plan is in compliance with contractual requirements.

RECOMMENDATION:

None