

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

REPORT ON THE MEDICAL AUDIT OF

**Blue Shield of California
Promise Health Plan**

Contract Number: 09-86153

Audit Period: January 1, 2019
Through
December 31, 2019

Report Issued: June 3, 2020

TABLE OF CONTENTS

- I. INTRODUCTION1
- II. EXECUTIVE SUMMARY2
- III. SCOPE/AUDIT PROCEDURES5
- IV. COMPLIANCE AUDIT FINDINGS
 - Category 1 – Utilization Management.....7
 - Category 2 – Case Management and Coordination of Care11
 - Category 4 – Member’s Rights16
 - Category 5 – Quality Management20

I. INTRODUCTION

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

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

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

As of January 31, 2020, the Plan served 80,404 members, which is comprised of 78,187 Medi-Cal members and 2,217 Cal-MediConnect members.

II. EXECUTIVE SUMMARY

DHCS conducted an onsite audit of the Plan from January 27, 2020 through February 6, 2020. This report presents the results of the limited scope medical audit for the audit period of January 1, 2019 through December 31, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on May 12, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in the report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

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

The prior DHCS medical audit issued on July 31, 2019 (for the audit period of January 1, 2018 through December 31, 2018) identified seven deficiencies, which were addressed in a Corrective Action Plan (CAP) dated September 3, 2019. As of January 7, 2020, one out of the seven deficiencies were closed. The remaining six deficiencies had projected implementation dates towards the end of the audit period. Therefore, this audit examined documentation to determine Contract compliance and the actions taken by the Plan to resolve the prior year audit findings.

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

Category 1 covers requirements and procedures for the UM program, including delegation of UM, prior authorization review, and the appeal process.

The Plan is required to collect and review their subcontractors' ownership and control disclosure information as set forth in Code of Federal Regulations (CFR), Title 42, section 455.104. The Plan did not verify the UM subcontractors submitted all of the required ownership and control information on the disclosure statements, such as social security numbers, owners' date of birth, and addresses.

The Plan is required to send a written acknowledgment within five-calendar-days of receipt of member appeals. The audit team reviewed 25 member appeals for adequate and timely resolution, medical appropriateness, and submission to the appropriate level of review. Five out of 25 acknowledgement letters were sent to members between six and 17-calendar-days after receipt of the appeal.

Category 2 – Case Management and Coordination of Care

Category 2 includes the requirements to provide Initial Health Assessment (IHA) to new members, Complex Case Management, and Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services.

The Plan must cover and ensure the provision of an IHA to each new member within timelines stipulated in the Contract. An IHA consists of a comprehensive history, physical examination, preventive services, and the individual health education behavioral assessment. The Plan did not ensure the provision of an IHA was timely and comprehensive.

The Plan and its subcontractors must use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of services for Medi-Cal members. The Plan did not utilize the PCS forms to determine the appropriate level of service.

Category 4 – Member’s Rights

Category 4 includes the requirements for the Plan’s grievance system, cultural and linguistic services.

The Plan is required to send members a written acknowledgment within five-calendar-days and a resolution letter within 30-calendar-days from receipt of the grievance. The audit team reviewed 40 grievances for adequate and timely resolution, response to complainant, and submission to the appropriate level of review. The Plan sent 14 acknowledgement letters between six and 140-calendar-days after receipt of the grievance. Eleven resolution letters were sent between 31 and 154-calendar-days after receipt of the grievance.

The Plan shall provide members fully translated written informing materials, including but not limited to grievance acknowledgement and resolution letters. The Plan did not provide translated grievance acknowledgement and/or resolution letters in the members’ threshold language.

Category 5 – Quality Management

Category 5 includes requirements to deliver adequate quality of care to members and take effective action to address quality of care improvements needed within the provider network.

The Plan is required to ensure all new providers receive training regarding the Medi-Cal Managed Care program and operate in full compliance with the Contract. The Plan did not ensure all newly contracted providers received training within ten-working-days of being placed on active status.

The Plan must ensure its delegated entities comply with all program requirements. The Plan's policies and procedures do not include training responsibilities of its subcontractors to ensure the new provider training requirement is met.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS, Medical Review Branch to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The onsite review was conducted from January 27, 2020 through February 6, 2020. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 20 medical and 25 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 25 pharmacy prior authorization appeals were reviewed for appropriate and timely adjudication.

Delegated prior authorization requests: Ten prior authorizations were reviewed for appropriate adjudication.

Category 2 – Case Management and Coordination of Care

Complex Case Management: Five medical records were reviewed for evidence of coordination of care between the Plan and the provider.

IHA requirements: 29 medical records were reviewed for timeliness and completeness of the IHA requirements.

NEMT: 18 records were reviewed to confirm compliance with the NEMT requirements.

NMT: Four records were reviewed to confirm compliance with NMT requirements.

Category 3 – Access and Availability of Care

Appointment availability verification: 15 providers of routine/urgent, specialty, and prenatal care from the Plan's directory were reviewed. The first available appointment was used to measure access to care.

Category 4 – Member's Rights

Grievance procedures: 20 quality of care and 20 quality of service grievances were reviewed for timely resolution, response to complainant, submission to the appropriate level for review, and translation in member's preferred language (if applicable).

Category 5 – Quality Management

New provider training: One new provider training record was reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and abuse: Five cases were reviewed for compliance of procedures to guard against fraud and abuse.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM REFERRAL TRACKING SYSTEM / DELEGATION OF UM MEDICAL DIRECTOR AND MEDICAL DECISIONS
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1.1.1 Ownership and Disclosure Information

The Plan is required to comply with CFR, Title 42, section 455.104 (Disclosure by providers: Information related to business transactions) (Contract, Exhibit E, Attachment 2(32)(B))

The Plan must require each disclosing entity to provide certain information, including the name, address, date of birth, and social security number of each person or other tax identification number of each person (individual or corporation) with an ownership or control interest in the disclosing entity. (CFR, Title 42, section 455.104)

The Plan is required to collect and review subcontractors' ownership and control disclosure information as set forth in CFR, Title 42, section 455.104. The Plan must make the subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. (*All Plan Letter (APL) 17-004, Subcontractual Relationships and Delegation*)

Plan policy 70.5.18.0, *Delegated Plan Subcontractors Complying with Terms and Conditions of the Contract between Plan, LA Care, DHCS, and CMS (effective date May 1, 2017)*, states that the Contracting Department will have the subcontractor complete a disclosure form. The subcontractor must include the names of the officers and owners of the subcontractor, stockholders owning more than ten percent of stock issued by the subcontractor, and major creditors holding more than five percent of the debt of the subcontractor.

Finding: The Plan did not collect all required information and did not review subcontractors' ownership and control disclosure forms for completeness.

Review of Plan subcontractor disclosure forms revealed the following deficiencies:

- Three disclosure forms did not contain social security numbers or tax identification numbers of all owners and individuals with control interest.
- One disclosure form did not contain dates of birth for all owners and individuals with control interest.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

- Two disclosure forms did not contain addresses for all owners and individuals with control interest.
- Three disclosure forms did not contain any ownership or control interest information.

The Plan has policies and procedures in place to obtain subcontractor disclosure forms; however, the policies and procedures do not specifically address a process to review the completeness of subcontractors' ownership and control disclosure information.

When the Plan does not collect and review the UM subcontractors' ownership and control disclosure information, it cannot ensure that the subcontractors' owners and individuals with controlling interest are eligible for program participation. There is also a risk that a conflict of interest exists.

In response to the audit finding, the Plan acknowledged the finding and stated it is currently developing a CAP to comprehensively address and remediate the deficiency and recommendations.

Recommendation: Revise and implement policy and procedures to ensure all required subcontractor disclosure information is collected and reviewed for completeness.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

1.3

PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeals Procedures

The Plan is required to send a written acknowledgement within five-calendar-days of receipt of the member's appeal. (Contract, Exhibit A, Attachment 14 (1) and *APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments*)

Plan Policy 10.19.5, *Grievance Management System (revision date November 18, 2019)*, states the Plan sends an acknowledgement letter within five-calendar-days upon receipt by the Appeals and Grievances Department (A&G). For appeals not involving a clinically urgent situation, a resolution letter will be mailed to the member within 30-calendar-days from receipt of the appeal.

Finding: The Plan did not send members their appeal acknowledgement letter within the required timeframe.

A verification study of 25 appeals were reviewed for adequate and timely resolution, medical appropriateness, and submission to the appropriate level of review. The study found the following notification delay:

- Five acknowledgement letters sent to the members exceeded five-calendar-days. The Plan sent member letters between six and 17-calendar-days after receipt of the appeal.

In an interview, the Plan attributed the delay to a system migration that occurred during the audit period. Beginning January 1, 2019, the Plan converted to new Customer Care and A&G computer software systems. On August 27, 2019, the A&G Department discovered that some of the grievances and appeals cases received by the Customer Care Department were not sent to the A&G Department. As a result of the system errors, the Plan identified 104 member grievances/appeals that were not acknowledged or resolved. The Plan's Information Technology (IT) Department corrected the issue and Customer Care worked with A&G to follow-up and resolve these appeals. The Plan began to implement quality controls to ensure this issue does not occur in the future.

Untimely acknowledgement letters may lead to delayed patient care and have an impact on clinical outcomes for members.

In response to the audit finding, the Plan acknowledged the finding and stated immediate action was taken when the issue was discovered in September 2019. Plan

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

also stated that it has sustained compliance since October 2019.

After review of the supporting documentation, DHCS stands by the audit finding, as the documentation showed action taken after the audit period.

Recommendation: Develop and implement procedures to ensure appeal acknowledgement letters are sent to members within contractual timeframes.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1 INITIAL HEALTH ASSESSMENT

2.1.1 Provision of an IHA

The Plan must cover and ensure the provision of an IHA to each new member within timelines stipulated in the contract. An IHA consists of a comprehensive history and physical examination, preventive services, and the individual health education behavioral assessment. (Contract, Exhibit A, Attachment 10 (3) and (3)(A))

The Plan must ensure the provision of an IHA within 120-calendar-days following the date of enrollment. (Contract, Exhibit A, Attachment 10 (5)(A)(1) and (6)(A)(1))

For members under the age of 21:

- The Plan must ensure that performance of the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment due for each Member at the time of enrollment is accomplished as part of the IHA. (Contract, Exhibit A, Attachment 10 (5)(A)(3))
- The Plan must provide preventative services as specified by the most recent American Academy of Pediatrics (AAP) Bright Future periodicity guidelines and schedule. (Contract, Exhibit A, Attachment 10 (5)(B)(1))

For members age 21 or older:

- The Plan must ensure that the latest edition of the Guide to Clinical Preventive Services published by U.S. Preventative Services Task Force (USPSTF) is used as a minimum guideline to determine the provision and frequency of clinical preventive services to asymptomatic, healthy adult members. All preventive services identified as USPSTF "A" and "B" recommendations must be provided and the status must be documented. (Contract, Exhibit A, Attachment 10 (6)(B)(1) and *Medi-Cal Managed Care Division, Policy Letter 08-003, Initial Comprehensive Health Assessment*)

The Plan must ensure that the Member's completed IHA is contained in the Member's Medical Record and available during subsequent health visits. (Contract, Exhibit A, Attachment 10 (3)(D))

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

Plan's policy 70.1.1.14, *Initial Health Assessment Oversight (Revision Date: 12/13/19)*, ensures all of the Plan's delegated entities and subcontractors promote timely access to an IHA within 120 days of enrollment for all members. Practitioners must complete an age appropriate Staying Healthy Assessment (SHA) form/Individual Health Education Behavioral Assessment (IHEBA) within the initial visit.

The policy includes,

- Cervical cancer screening (members age 21 and over).
- Blood lead level (BLL) screening (members under age 6).
- Hearing and vision screening, as appropriate (members under age 21).

The policy also states that the Plan conducts random medical record reviews on a monthly basis to assess the timeliness, quality, and completion of the IHA visit. The Plan's Facility Site Review (FSR) process also evaluates the timeliness of the IHA and the components of the IHA visit.

Finding: The Plan did not ensure new members received a timely and comprehensive IHA.

A verification study of 29 medical records showed 19 medical records did not contain the required components of an age-appropriate IHA and/or were not completed within a 120-calendar-day timeframe.

For eight medical records, the IHA was completed within required timeframes but lacked the documented evidence that the provider performed age-appropriate preventive services and SHA.

- For members under age six, two medical records lacked documentation of age-appropriate BLL screening as recommended by the AAP.
- For a 48 year-old female member, medical records did not contain documentation showing performance and/or attempts by the provider to offer age-appropriate cervical cancer screening.
- Five medical records lacked documentation of a completed age-appropriate SHA.

For 11 medical records, the IHA was not completed within 120-calendar-days from the members' enrollment date and the SHA and preventive services were not documented.

- Five medical records lacked documentation of a completed age-appropriate SHA.
- Two medical records lacked documentation of preventive services such as age-appropriate audio screening.
- Four medical records lacked documentation of preventive services such as age-

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

appropriate BLL screening.

The Plan monitors IHA timeliness and completion through medical record reviews and discusses the findings with the providers and within the Plan's committee meetings. In the Plan's Quality Management Committee meeting, the Plan discussed the IHA outreach and monitoring results for Q2 2019. The Plan noted that the provider's response rate for medical record requests was 45 percent, a decrease of four percent from the previous quarter. The Plan attributed the rate decrease to delays in their request to access the Federal Qualified Health Centers (FQHC) electronic medical record systems. The Plan also noted that two of the trending deficiencies were "SHA not completed and Pediatric Labs not done." The Plan's IHA completion rate for the Q2 2019 was 14%.

During the provider onsite visits, providers expressed concerns that the Plan did not provide sufficient training and guidance on IHA requirements and that the Plan did not adequately communicate its monitoring methods.

This is a repeat finding from the prior year audit. The Plan addressed the prior year's IHA finding by implementing a CAP with one local clinic on October 2019. As part of the CAP, the Plan began to establish a shared process with providers. The process includes outreach coordination between the Plan and the providers to assist with IHA scheduling. The process also includes provider education of the IHA requirements, member and provider incentives, IHA monitoring methods, and additional methods of member outreach such as sending members text messages. The data and analysis to evaluate the progress and effectiveness of the shared process is pending since this CAP is still in progress. Given the implementation date and the provider interview responses, the new process has not reached all of the clinics.

Without the provision of an IHA, providers cannot comprehensively assess the members' healthcare needs. This can lead to poor health outcomes, especially for at-risk members.

In response to the audit finding, the Plan acknowledged the finding and is currently developing a CAP to comprehensively address and remediate the deficiency and recommendations.

This is a repeat of prior year finding – 2.1.1 Initial Health Assessment.

Recommendation: Implement policies and procedures to ensure timely provision and documentation of all IHA components including BLL screenings and other age-appropriate preventive services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

2.4

NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICAL TRANSPORTATION

2.4.1 Physician Certification Statement

The Plan is required to cover NEMT services for members to obtain necessary medical care. (California Code of Regulations (CCR), Title 22, Section 51323 and *APL 17-010, Non-Emergency Medical and Non-Medical Transportation*)

NEMT means ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, rendered by licensed providers. (Contract, Exhibit E, Attachment 1(118))

All NEMT services require a physician's prescription and prior authorization. (CCR, Title 22, Section 51323)

Pursuant to *APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services*, the Plan and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members.

Plan policy 10.3.21, *Non-Emergency Transportation (revision date August 2019)*, states pursuant to *APL 17-010*, the Plan and its contracted vendors will utilize PCS forms to determine the appropriate level of service for Medi-Cal members.

Finding: The Plan did not utilize the PCS forms to determine the appropriate level of service.

In 24 of 24 NEMT cases reviewed, the Plan did not maintain the appropriate PCS forms as prescribed by DHCS.

The Plan did not provide any documents containing procedures regarding the use of the required PCS forms. The Plan's Provider Manual did not contain information regarding the PCS form requirement. The meeting minutes from the Plan's Transportation Taskforce Committee, a committee specifically created to address members' transportation issues, did not document any discussions related to the PCS forms. The Plan's desktop procedures for handling transportation calls does not include instructions to ask members if a PCS form has been filled out by their provider.

During the interview, the Plan confirmed that it did not obtain the PCS forms from the

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

providers prior to scheduling the transportation services for the members. Instead, the Plan relied on the member's verbal request to determine the mode of transportation service required.

One of the deficiencies addressed in the prior year audit finding (2.4.1 Non-Emergency Medical and Non-Medical Transportation Services) was that the Plan did not use the PCS form. In response to the CAP, the Plan stated that copies of the approved PCS forms for NEMT services would be shared and controls added to policies to confirm utilization of the PCS form. The CAP showed an implementation date of September 30, 2019. The verification samples were from dates of service before and after the implementation date. However, none of the NEMT verification study samples had the PCS forms within the members' files. Therefore, the Plan's CAP response did not correct the prior year's deficiency regarding PCS forms.

Without the PCS forms, members may not be able to receive the proper mode of transportation to safely obtain Medi-Cal services.

In response to the audit finding, the Plan acknowledged the finding and took action to remediate the issue. Documentation submitted showed the Plan's corrective action steps occurred after the audit period.

This is a partial repeat of prior year finding 2.4.1 – Non-Emergency Medical and Non-Medical Transportation Services.

Recommendation: Implement policies and procedures to ensure the DHCS approved PCS forms are used to determine the appropriate level of service for Medi-Cal members.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

CATEGORY 4 – MEMBER’S RIGHTS

4.1 GRIEVANCE SYSTEM

4.1.1 Grievance Acknowledgment and Resolutions

The Plan is required to send a written acknowledgment within five-calendar-days of receipt of a grievance. The Plan is required to resolve each grievance and provide notice to the member as quickly as the member’s health condition requires, within 30-calendar-days from receipt of the grievance. (Contract, Exhibit A, Attachment 14 (1) and APL 17-006)

According to the Plan’s Policy 10.19.5, *Grievance Management System* (revision date November 18, 2019), the Plan sends an acknowledgement letter within five days upon receipt by A&G. A resolution letter will be mailed to the member or representative within 30-calendar-days of the receipt of the grievance.

Finding: The Plan did not provide acknowledgement letters within five-calendar-days and resolution letters within 30-calendar-days to members after receipt of the grievance.

The audit team conducted a verification study and reviewed 20 quality of care and 20 quality of service grievances for adequate and timely resolution, response to complainant, and submission to the appropriate level of review. The verification study found the following notification delays:

- Quality of Care Grievances
 - Nine acknowledgement letters sent to the members exceeded five-calendar-days. The Plan sent member acknowledgement letters between six and 140-calendar-days after receipt of the grievance.
 - Eight resolution letters sent to the members exceeded 30-calendar-days. The Plan sent member resolution letters between 31 and 154-calendar-days after receipt of the grievance.
- Quality of Service Grievances
 - Five acknowledgement letters sent to the members exceeded five-calendar-days. The Plan sent member letters between six and 125-calendar-days after receipt of the grievance.
 - Three resolution letters sent to the members exceed 30-calendar-days. The Plan sent member resolution letters between 35 and 132-calendar-days after receipt of the grievance.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

In an interview, the Plan attributed the delay to a system migration that occurred during the audit period. Beginning January 1, 2019, the Plan converted to new Customer Care and A&G computer software systems. On August 27, 2019, the A&G department discovered that some of the grievances and appeals cases received by the Customer Care department were not sent to the A&G department. As a result of the system errors, the Plan identified 104 member grievances/appeals that were not acknowledged or resolved. The Plan's Information Technology Department corrected the issue and Customer Care worked with A&G to follow-up and resolve these grievances. The Plan began to implement quality controls to ensure this issue does not occur in the future.

Untimely grievance letters may lead to delayed patient care and have an impact on clinical outcomes for members.

In response to the audit finding, the Plan acknowledged the finding and stated immediate action was taken when the issue was discovered in September 2019. Plan also stated that it has sustained compliance since October 2019.

After review of the supporting documentation, DHCS stands by the audit finding, as the documentation showed action taken after the audit period.

Recommendation: Develop and implement a process to ensure grievance letters are sent to members and resolutions are resolved within contractual timeframes.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

4.2

CULTURAL AND LINGUISTIC SERVICES

4.2.1 Linguistic Services

The Plan shall provide, at minimum, the following linguistic services at no cost to Medi-Cal members or potential members:...Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or Limited English Proficiency members that speak the identified threshold or concentration standard languages. (Contract Exhibit A, Attachment 9(14)(C)(2))

The Plan's policy 70.15.3.0, *Translation of Written Member-Informing and Health Education Materials (revision date November 2019)*, states all written translations of materials are culturally and linguistically sensitive and appropriate in the threshold languages determined by the DHCS.

Finding: The Plan did not provide members with translated grievance acknowledgement and resolution letters in their threshold languages.

Nine out of 40 grievances sampled in the verification study required the acknowledgement and resolution letters to be translated. Of the nine grievances, the Plan did not submit translated letters for nine acknowledgement letters and six resolution letters.

The Plan did not have an effective process in place to ensure the grievances that required translations were processed. During the onsite, the Plan stated that they identified a need for additional internal monitoring controls. The Plan's inventory reporting tool did not contain the member's preferred language. Therefore, the Plan did not identify and email the grievance cases that required translated acknowledgement and resolution letters to the Plan's A&G translation mailbox for processing.

This finding was also in the prior year audit, in which the cause was due to a delayed approval process. As part of the corrective actions, the Plan stated that they would standardized the turnaround time and pricing with the vendor. However, the grievances sampled continued to have deficiencies with the translation letters. Therefore, the Plan's corrective actions were ineffective and did not address the deficiencies.

Without translated materials, members who require these translation services may not know how to access the proper care and know how to resolve issues when they arise.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

In response to the audit finding, the Plan acknowledged the finding and took steps to remediate the issue. Documentation submitted showed the Plan's corrective action steps occurred after the audit period.

This is a repeat of prior year finding 4.2.1 – Linguistic Services.

Recommendation: Develop and implement a process to ensure the timely translation of all grievance letters into the members' preferred language and implement the Plan policy.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

CATEGORY 5 – QUALITY MANAGEMENT

5.2 PROVIDER QUALIFICATIONS

5.2.1 New Provider Training

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

Plan's policy 70.5.1.2, *Provider Orientation and Education (revision date November 2019)*, states that the Plan will train and educate its providers on its policies and procedures, requirements, and Managed Care and regulatory requirements. Furthermore, the Plan will conduct an orientation and in-service for providers within ten-business-days of placing a provider on active status with all lines of business.

Finding: The Plan did not train new providers within the contractual timeframe.

The Plan only placed one provider group on active status during the audit period. The provider group received training 121 days after being placed on active status.

This was a finding in the prior year audit. As part of the CAP, the Plan stated that the Provider Relations Representatives will review the contracting provider log at a minimum on a weekly basis and conduct outreach to new providers to schedule their in-service orientation. The Plan policies and procedures went through several revisions throughout the audit period. On November 15, 2019, the Plan revised its policy 70.5.1.2, *Provider Orientation and Education*, which states the Plan will conduct a daily review of the Contracting provider log to schedule an in-person orientation. However, the Plan did not add any new providers to its network after the policy change. Therefore, it cannot be determined if the Plan's new provider training process was fully implemented and is effective.

The lack of timely provider training may result in substandard quality of services or poor coordination of care.

In response to the audit finding, the Plan acknowledged the finding and stated it completed remediation efforts in November 2019. Plan also stated that it has sustained compliance since November 2019.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

After review of the supporting documentation, DHCS stands by the audit finding, as the documentation showed compliance of the requirement occurred after the audit period.

This is a repeat of prior year finding 5.2.1 – Provider Training.

Recommendation: Implement a process to conduct training within ten-working-days from the date a new provider is placed on active status.

5.2.2 Delegation of Provider Training

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

The Plan may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. In doing so, the Plan shall meet the subcontracting requirements as stated in CFR, Title 42, section 438.230 (b)(1), (c)(1)(i)-(iii), (c)(2), (c)(3), CCR, Title 22, Section 53250, *APL 17-004*, and the Contract. (Contract, Exhibit A, Attachment 6 (14))

All subcontracts shall be in writing and in accordance with the requirements of the Knox-Keene Health Care Services Plan Act of 1975. A subcontract means a written agreement entered into by the Plan with a provider of health care services who agrees to furnish covered services to members. (Contract, Exhibit E, Attachment 1 (171))

APL 17-004 states, if a Plan delegates any activity or obligation to a subcontractor, whether directly or indirectly, the subcontract or written agreement shall specify any and all delegated activities, obligations, and related reporting responsibilities. Plans are ultimately responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; Contract requirements; reporting requirements; and other DHCS guidance including, but not limited to, APLs.

Plan policy 70.5.1.2, *Provider Orientation and Education (revision date November 15, 2019)*, states the Plan will conduct an orientation and in-service within ten-business-days of placing a provider on active status.

Finding: The Plan's policies and procedures do not include provider training procedure responsibilities of its subcontractors.

In the delegation agreements, the Plan delegates "education and training" to its subcontractors. However, the agreements do not specify new provider training and does

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

DATE OF AUDIT: January 27, 2020 through February 6, 2020

not specify the contractual timeframes to complete the training.

In an interview, the Plan stated that they do not conduct oversight audits of the new provider training given by subcontractors to their newly contracted providers. The Plan only obtains new provider's demographic information to include it on their provider network directory.

Without policies and procedures that specify training responsibilities, the Plan cannot ensure its subcontractors meet the contractual requirements for new provider training.

In response to the audit finding, the Plan acknowledged the finding and began developing a process to ensure compliance of all requirements.

Recommendation: Develop and implement policies and procedures to include provider training procedure responsibilities of the Plan's subcontractors.

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

REPORT ON THE MEDICAL AUDIT OF

**Blue Shield of California
Promise Health Plan**

Contract Number: 09-86154
State Supported Services

Audit Period: January 1, 2019
Through
December 31, 2019

Report Issued: June 3, 2020

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

I. INTRODUCTION

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

The onsite audit was conducted from January 27, 2020 through February 6, 2020. The audit period is January 1, 2019 through December 31, 2019, and consisted of document review of materials supplied by the Plan.

An Exit Conference with the Plan was held on May 12, 2020.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Blue Shield of California Promise Health Plan

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DATE OF AUDIT: January 27, 2020 through February 6, 2020

State Supported Services

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

The Plan's policy, 10.2.35 *Abortion Services (revision date December 2018)*, states that members can access abortion services in- or out-of-network without prior authorization. The Plan defines abortion services as a "sensitive service" and assures that confidentiality and accessibility are maintained. Inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures, in accordance with California Code of Regulations, Title 22, section 51327.

The Plan's policy, 10.2.16 *Sensitive Services (revision date December 2018)*, states that parental consent is not required for abortions. The Plan's policy, 10.3.6 *Family Planning (revision date May 2019)*, reinforces the Plan's policy on abortion services and states that abortions are part of family planning services. The Plan's policy, 10.9.4 *Automatic Payment Criteria (revision date November 2015)*, states that services that do not require prior authorization, such as abortion, are automatically paid within regulatory required timelines.

The Plan's abortion billing code sheet includes CPT codes 59840 through 59857 and Healthcare Common Procedure Coding System codes A4649-U1, A4649-U2, S0190, S0191, and S0199 (formerly known as X1516, X1518, X7724, X7726, and Z0336) as billable pregnancy termination services as required by the Contract.

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

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

❖ **COMPLIANCE AUDIT FINDINGS (CAF)** ❖

PLAN: Blue Shield of California Promise Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2019

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The audit found no discrepancies in this section.

Recommendation: None