DEPARTMENT OF HEALTH CARE SERVICES
AUDIT AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SANTA ANA

REPORT ON THE MEDICAL AUDIT OF

Anthem Blue Cross
Partnership Plan

2023

Contract Number:	03-76184, 04-36068, 07-65845, 10-87049, and 13-90159
Audit Period:	October 1, 2022 through October 31, 2023
Dates of Audit:	November 27, 2023 through December 8, 2023
Report Issued:	May 14, 2024

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I. INTRODUCTION

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

Anthem 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), 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 beneficiaries under the State's SPD procurement.

On November 1, 2013, DHCS awarded the Plan 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 GMC rural model.

The Plan has five contracts to provide services in 27 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.

As of November 2023, the Plan served approximately 1,044,232 Medi-Cal members in the following counties: Alameda (87,775), Alpine (191), Amador (6,495), Butte (27,262), Calaveras (6,949), Colusa (5,550), Contra Costa (37,118), El Dorado (15,809), Fresno (152,908), Glenn (3,049), Inyo (3,106), Kings (25,075), Madera (29,339), Mariposa (4,280), Mono (2,012), Nevada (15,975), Placer (41,493), Plumas (3,066), Sacramento (233,095), San Benito (12,327), San Francisco (32,325), Santa Clara (93,291), Sierra (422), Sutter (26,079), Tehama (12,116), Tulare (137,496), Tuolumne (8,020), and Yuba (21,609).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of October 1, 2022, through October 31, 2023. The audit was conducted from November 27, 2023, through December 8, 2023. The audit consisted of document review, verification studies, and interviews with the Plan representatives.

An Exit Conference with the Plan was held on April 12, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the audit report findings. On April 26, 2024, the Plan submitted a response. The results of our evaluation 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, Members' Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of October 1, 2021, through September 30, 2022, was issued on June 19, 2023. This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of its pending prior year's Corrective Action Plan (CAP).

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan. The Plan did not track or monitor referrals to in-network specialists.

The Plan is required to ensure decisions are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. The Plan did not ensure prior authorization decisions were made in a timely manner while awaiting the confirmation of California Children's Services (CCS) eligibility.

The Plan is required to obtain written consent from the member when a provider files an appeal on behalf of the member. The Plan did not ensure the members' written consent was obtained when a provider filed an appeal on the members' behalf.

The Plan is required to ensure that the Grievance and Appeal System provides oral notice of the resolution of an expedited appeal within 72 hours. The Plan did not ensure the provision of oral notifications to members regarding the resolution of expedited appeals.

Category 2 – Case Management and Coordination of Care

There were no findings in this category.

Category 3 – Access and Availability of Care

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access. The Plan did not ensure corrective actions were implemented for providers who did not comply with appointment wait time standards.

The Plan is required to provide member appointments with a Primary Care Provider (PCP) within 10 business days of the request and a specialist within 15 business days of the request. The Plan did not ensure that its providers offered member appointments with a PCP within 10 business days of the request and a specialist within 15 business days of the request.

The Plan is required to use a DHCS-approved Physician Certification Statement (PCS) form on file to determine the appropriate level of service for Medi-Cal members. The Plan did not ensure PCS forms were on file to authorize Non-Emergency Medical Transportation (NEMT) services for all members.

Category 4 – Members' 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 completely resolve member grievances. The Plan sent member resolution letters without completely resolving the members' quality of service grievances.

The Plan is required to ensure timely resolution to the member as quickly as the members' health condition requires, within 30 calendar days from the date the Plan receives the grievance. The Plan did not resolve high severity quality of care grievances within 30 days of receipt of the grievance.

The Plan is required to ensure grievances related to medical quality of care issues shall be referred to a Medical Director. The Plan did not refer all quality of care grievances to the Medical Director for resolution.

Category 5 – Quality Management

There were no findings in this category.

Category 6 – Administrative and Organizational Capacity

There were no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division 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 State Contracts.

PROCEDURE

The review was conducted from October 1, 2022, through October 31, 2023. 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, a delegated entity, and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 30 medical prior authorization records were reviewed for timely decision making, consistent application of criteria, and appropriate review.

Appeals: 20 medical appeal records were reviewed for appropriateness and timely adjudication.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment (BHT): 15 medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.

Category 3 – Access and Availability of Care

NEMT: 25 records were reviewed for timeliness and compliance with NEMT requirements.

Non-Medical Transportation (NMT): 15 records were reviewed for timeliness and compliance with NMT requirements.

Category 4 – Members' Rights

Quality of Care Grievances: 20 quality of care grievance cases were reviewed for processing, clear and timely response, and appropriate level of review.

Quality of Service Grievances: 40 quality of service grievance cases were reviewed for timeliness, investigation process, and appropriate resolution.

Category 5 – Quality Management

PQI: Ten cases were reviewed for timely evaluation, and effective action taken to address improvements.

Category 6- Administrative and Organizational Capacity

No verification studies were conducted.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Anthem Blue Cross Partnership Plan

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CATEGORY 1 – UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Referral Tracking for In-Network Providers

The Plan is responsible to ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan. *(Contract, Exhibit A, Attachment 5(1)(F))*

The Plan shall ensure that policies and procedures for authorization decisions are based on the medical necessity of a requested health care service and are consistent with criteria or guidelines supported by sound clinical principles. *(Contract, Exhibit A, Attachment 5(1)(J))*

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. *(Contract, Exhibit A, Attachment 4(1))*

The Plan's, *UM Program Description,* lists the goals of the UM Program as "(1) to ensure the adequacy of service availability and accessibility to eligible members; (2) to maximize appropriate medical and behavioral health care; and (3) to minimize/eliminate over- and/or under-utilization of medical and behavioral health services".

Finding: The Plan did not track or monitor referrals to in-network specialists.

Plan Policy, *UMXX-003 Access to Specialty Care (revised date 07/23/2023),* states, "No authorization is required by the Plan to see an in-network specialist." If a member needs to see a specialist regarding their health, the PCP will refer the member to an in-network specialist. If the PCP cannot find an in-network specialist, they can reach out to the Plan for assistance.

During the interview, the Plan confirmed that because prior authorization is not required, they do not track referrals made to in-network specialists.

If the Plan does not track and monitor referrals to in-network specialists, it increases the risk of fraud, waste, and abuse. This could lead to a lack of access for members and ultimately result in substandard care and poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure referrals are appropriately tracked and monitored.

1.2.2 Prior Authorization in Potential California Children's Services (CCS) Eligible Conditions

The Plan shall develop and implement written policies and procedures for identifying and referring children with CCS eligible conditions to the local CCS program. The policies and procedures shall ensure that the Plan continues to provide all medically necessary covered services to the member until CCS eligibility is confirmed. *(Contract, Exhibit A, Attachment 11(9)(4))*

The Plan shall ensure that its prior authorization procedures meet the requirement that decisions are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. *(Contract, Exhibit A, Attachment 5(2)(G))*

Decisions to approve, modify, or deny, based on medical necessity shall be made in a timely fashion, not to exceed five business days from the Plan's receipt of the information reasonably necessary to make the determination. *(Health and Safety Code, section 1367.01(h)(1))*

Plan Policy, *UMXX-117 Decision and Notification Timeframes (revised date 07/26/2023),* states "the decision to approve, modify, or deny requested non-urgent pre-service requests, are made within 5 business days from the receipt of the request, but no longer than 14 calendar days from the receipt of the request."

Finding: The Plan did not ensure prior authorization decisions were made in a timely manner while awaiting the confirmation of CCS eligibility.

Plan Policy, *UMXX-004 CCS Referral and Coordination of Care (revised date 05/31/2023),* outlines the procedure to create a case, request further information, and "advise the requesting provider to defer the case to the members' county CCS office."

During the interview, the Plan confirmed that the process is to advise the requesting provider to refer to CCS. If CCS does not accept the member, the Plan will furnish medically necessary services.

A verification study revealed that in all three requests for prior authorization, the Plan delayed evaluation until CCS eligibility was denied as follows:

- One case involved evaluation by a hematologist-oncologist (cancer doctor) of a chest mass in a five-year-old with a family history of neurologic tumors. The Plan deferred decision making for 21 days.
- Another case involved testing for unexplained syncope (loss of consciousness) in a 16-year-old where the Plan deferred decision making for 29 days.
- In the last case, involving a hospital stay, the Plan deferred decision making for 34 days.

For these cases, the Plan did not document any other reason for delay, such as the need for further information.

The Plan's procedures do not require the Plan to provide medically necessary services until CCS eligibility is confirmed.

If requested services are not determined in a timely fashion, this may delay the provision of medically necessary care and ultimately result in poor health outcomes.

Recommendation: Develop policies and procedures to ensure prior authorization decisions are made in a timely manner for the provision of medically necessary services and not unduly delayed for the confirmation of CCS eligibility.

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Written Consent for Appeals Made on Behalf of a Member

The member, or a provider acting on behalf of a member and with the member' S' written consent, may request an appeal. *(Contract, Exhibit A, Attachment 14 (5)(A))*

Appeals filed by the provider on behalf of the member require written consent from the member. *(All Plan Letter (APL) 21-011, Grievance and Appeal Requirements)*

Plan Policy*, GAMC-051 Member Appeals (revised date 05/17/2023),* states "Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary. The Plan will send an acknowledgment letter to the member, which includes a consent form, and request the member submit their written consent."

Finding: The Plan did not ensure the members' written consent was obtained when a provider filed an appeal on the members' behalf.

A verification study of provider-initiated appeals revealed that five out of eight appeals did not have the members' written consent.

During the interview, the Plan confirmed that although it sends a consent form along with the appeal acknowledgment letter to the member, it lacks a process to ensure that the members' written consent is sent back to the Plan.

The written consent to a provider-initiated appeal furnishes members with necessary information about their medical care needs. Without this written consent, members are not able to provide input into their own healthcare decisions.

Recommendation: Revise and implement policies and procedures to ensure a members' written consent is obtained when a provider requests an appeal on behalf of a member.

1.3.2 Oral Notification of Resolution for Expedited Appeals

The Plan shall ensure that the Grievance and Appeal System provides oral notice of the resolution of an expedited appeal within 72 hours. *(Contract, Exhibit A, Attachment 14(1)(H))*

The Plans are required to make reasonable efforts to provide the member with oral notice of the expedited appeal resolution. *(APL 21-011, Grievance and Appeal Requirements)*

Plan Policy*, GAMC-051 Member Appeals (revised date 05/17/2023),* states that the Plan makes reasonable efforts to provide oral notices to members of expedited appeal resolutions. In addition, the Plan also utilizes an appeals checklist with instructions for the Grievance and Appeal associate to "review that one oral attempt was made to notify the member of the resolution, and there is a documented note in the case."

Finding: The Plan did not ensure the provision of oral notifications to members regarding the resolution of expedited appeals.

A verification study showed two out of six expedited appeals did not have a documented attempt to provide oral notification to the member.

During the interview, the Plan stated that for expedited appeal resolutions, if a call is made to the member the attempt is documented in the chart. For some members, like in-patient members, a call may not be made.

Because expedited appeals involve decisions that could seriously jeopardize the members' health, it is imperative to provide the decision as soon as possible. In addition, when the Plan does not notify the member, it may affect the quality of their care.

Recommendation: Fully implement policies and procedures to ensure that a reasonable attempt is made to provide oral notice to members regarding expedited appeal resolutions.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	ACCESS AND AVAILABILITY OF CARE

3.1.1 Corrective Actions for Timely Access Deficiencies

The Plan is required to establish acceptable accessibility standards in accordance with California Code of Regulations (CCR), Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. *(Contract, Exhibit A, Attachment 9(3)(C))*

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access, which includes but is not limited to taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies and to bring its network into compliance. *(CCR, Title 28, section 1300.67.2.2 (d)(3))*

Plan Policy*, CA_PNXX_033 Access to Care Standards – CA (revised date 04/28/2023),* indicated that provider CAPs: providers who are found to be out of compliance will be required to submit a CAP to the Plan for monitoring.

Finding: The Plan did not ensure that corrective actions were implemented for providers who did not comply with appointment wait time standards.

A verification study of 19 CAPs (Corrective Action Plan), based on the 2022 Provider Appointment Availability Survey (PAAS), showed that the Plan lacked an effective process to monitor for CAP implementation to meet access standards. It was noted that the Plan provided network notification and correspondence informing a provider group of individual providers who were non-compliant with access standards. In response, the provider group sent the Plan a CAP response letter. However, the provider group did not identify the individual non-compliant providers, the nature of each provider's non-compliance, and the specific corrective actions that were implemented at the provider level. Therefore, the Plan could not monitor and ascertain CAP implementation and compliance with access standards.

During the interview, the Plan stated that it required non-compliant providers, who did not meet the access timeframe requirements in the PAAS survey to submit a CAP to the Plan. However, the Plan confirmed they did not determine if any corrective actions at the provider level were submitted or implemented as specified in Plan Policy*, CA_PNXX_033*.

Without implementing corrective actions for non-compliant providers, the Plan will continue to experience non-compliance with appointment wait times that could result in members not receiving timely care access.

Recommendation: Revise and carry out policies and procedures to ensure the Plan implements corrective actions for providers who do not comply with appointment wait time standards.

3.1.2 Appointment Waits Time Grievances Monitoring

The Plan shall ensure the provision of acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2.2 as specified: members must be offered an appointment with a PCP within ten business days of the request and a specialist within 15 business days of the request. *(Contract, Exhibit A, Attachment 9(*3))

Each health care service plan shall have a documented system for monitoring and evaluating the accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. *(CCR, Title 28, section 1300.67.2(f))*

Plan Policy*, CA_PNXX_033 Access to Care Standards – CA (revised date 04/28/2023)* indicated that all contracted providers must not exceed the specified intervals between a members' request for service and the date/time an appointment is offered for the member to receive requested medical services (PCP within 10 business days of the request, and a specialist within 15 business days of the request).

Finding: The Plan did not ensure that its providers offered member appointments with a PCP (Primary Care Physician) within ten business days of the request, and a specialist within 15 business days of the request.

A verification study of access-related grievances showed that for six of nine cases, the Plan did not offer a PCP appointment within the required 10 business days, or a specialist appointment within the required 15 days. For example:

- On 10/24/2022, a member filed a grievance stating that a PCP did not have an appointment until January 2023. The Plan confirmed with the PCP office that they don't have available appointments until January 2023. On 11/23/2022, the Plan sent a resolution letter to the member indicating a change of PCP; however, the Plan did not ensure that the member is offered a PCP appointment within ten business days.
- On 10/17/2022, a member filed a grievance stating that a specialist did not have an appointment until January 2023. The Plan confirmed with the

specialist office that appointments are unavailable until January 2023. On 11/21/2022, the Plan sent a resolution letter to member indicating that the member should contact the PCP to request another Neurologist; however, the Plan did not ensure that the member is offered a specialist appointment within 15 business days.

During the interview, the Plan stated that it continuously monitors appointment wait times through grievances but did not ensure providers offer member appointments with a PCP within 10 business days of the request and a specialist within 15 business days of the request as specified in the Plan Policy*, CA_PNXX_033*.

The Plan cannot ensure providers meet the timely appointment requirements if it does not ensure or review appointments received by members. Non-compliance in access to timely appointments with a PCP within 10 business days of the request and a specialist within 15 business days can result in compromised health or preventable complications.

Recommendation: Implement procedures to ensure providers offer member appointments with a PCP within 10 business days and a specialist within 15 business days of the request.

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICAL TRANSPORTATION

3.8.1 Physician Certification Statement (PCS) Form for NEMT Services

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

The Plan is required to use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. The member must have an approved PCS form authorizing NEMT by the provider. The Plan is required to provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months and the Plan cannot modify the authorization. The Plan must ensure that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*

Plan Policy*, CA_OPXX_003 – Transportation Benefits – CA (revised date: 04/12/2023)*, stated the PCS is required for all non-urgent, routine trips. Upon receipt of a trip request, ModivCare submits the form (via fax) to the members' physician or physician extender. ModivCare will make two attempts to obtain the PCS form. After the two attempts the non-responsive provider is added to the weekly Pending PCS Form Report. The Plan will then engage the non-responsive provider or delegated group the member is assigned to request that the PCS form be returned. Effective May 1, 2023, ModivCare will deny all non-urgent NEMT requests if a valid PCS form is not on file.

Finding: The Plan did not ensure PCS forms were on file to authorize NEMT services for all members.

In a verification study, 5 of 25 NEMT trips did not have the required PCS forms on file for the service trip date.

Plan Policy*, CA_OPXX_003*, indicated the Plan's transportation vendor ModivCare is initially required to obtain the PCS forms from the providers. ModivCare will attempt two calls to providers to obtain the PCS forms. If unsuccessful, the non-responsive provider will be added to the weekly Pending PCS Form Report that is then submitted to the Plan for further PCS requests. During the interview, the Plan confirmed that ModivCare needed to add members without PCS forms to the weekly Pending PCS Report. However, ModivCare actually did not include the non-responsive providers in the weekly Pending PCS Report for the following examples:

- For a physical therapy trip provided on 08/24/2023, there was no PCS form on file. The first attempt to request the PCS form was made on 08/11/2023, and the second request on 08/24/2023.
- For a pain management trip provided on 07/07/2023, there was no PCS form on file. Of note, the first and second attempts to request the PCS form were made on 02/01/2023.
- For a Methadone treatment trip provided on 07/17/2023, there was no PCS form on file. The first attempt to request the PCS form was made on 03/02/2022, and the second request on 08/16/2022.

Without obtaining PCS forms for NEMT trips, the Plan is unable to determine the appropriate level of service for Medi-Cal members.

Recommendation: Revise and implement policies and procedures to ensure PCS forms are on file to authorize NEMT services for all members.

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CATEGORY 4 – MEMBERS' RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Resolution Letters

The Plan is required to implement and maintain a Member Grievance System in accordance with the CCR, Title 22, section 53858 and CCR, Title 28, section 1300.68. *(Contract, Exhibit A, Attachment 14(1))*

Timeframes for resolving grievances and sending written resolution to the member are delineated in federal and state law. The State's established timeframe is 30 calendar days. Managed Care Plans must comply with the state's established timeframe of 30 calendar days for grievance resolution. (*APL 21-011, Grievance and Appeal Requirements)*

Plan Policy*, CA_GAMC_015 Grievance Process: Member - CA (revised date: 08/28/2023),* stated that the Plan has designated who will send grievance resolution letters to its Medi-Cal members 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 days.

In a verification study of quality of service grievance cases, the resolution letters for 39 of 40 cases were not sent within the required 30 calendar days timeframe. The grievance resolution letters were sent between 38 to 61 days.

During the interview, the Plan stated that it monitors the timeliness of the grievance cases daily and monthly through its turnaround time dashboard. The dashboard captures the daily and monthly percentages of grievance cases as a whole that are completed timely or not. However, even with this form of monitoring, the Plan still did not ensure all grievance cases were resolved within the required timeframe.

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

This is a repeat of prior year finding 4.1.2 - Grievance Resolution Letters.

Recommendation: Develop and implement a process to ensure quality of service grievance resolution letters are sent to members within required timeframes.

4.1.2 Plan's Resolution of Quality of Service Grievances

The Plan is required to implement and maintain a Member Grievance System in accordance with CCR, Title 22, section 53858 and CCR, Title 28, Section 1300.68. *(Contract, Exhibit A, Attachment 14(1))*

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances. *(CCR, Title 28, section 53858(a))*

"Resolved" means that the grievance has reached a final conclusion with respect to the members' submitted grievance, and there are no pending member appeals within the Plan's grievance system, including entities with delegated authority. *(CCR, Title 28, section 1300.68(a)(4))*

Plan Policy*, CA_GAMC_015 Grievance Process: Member – CA (revised date: 08/28/2023),* stated that the Plan 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*. Members have the right to communicate dissatisfaction with any aspect of the Plan's Medi-Cal services for investigation and resolution in writing.

Finding: The Plan sent member resolution letters without completely resolving the members' quality of service grievances.

A quality of service grievance verification study revealed that in 6 of 25 cases the Plan did not fully address and resolve all issues in members' grievances.

During the interview, the Plan stated that its Grievance Analysts are responsible for addressing and fully resolving the grievances. The Grievance Analyst sends up to three requests for a response from the provider in order to render a written resolution to address and resolve the members' grievances. However, the Plan could not substantiate that all issues in members' grievances were completely resolved. The Plan lacked the procedures to adequately address all grievances for the member. For example:

- In one case, the member filed a grievance because the earliest appointment available was three months later. During the investigation process, the analyst tried to help the member get an earlier appointment, but the steps taken were not documented in the file. The resolution letter stated that the Plan confirmed with the provider that there was no appointment sooner than three months. The Plan did not ensure or document whether the member was able to have a timely appointment.

- In another case, the member filed a grievance in November 2022, because she could not get a doctor's visit until January 2023. The Plan confirmed with the provider that no appointment was available until January 2023. The resolution letter stated that a PCP change was made for the member, and the Plan urged member to call the new PCP for any appointment. The Plan did not ensure that the member was able to make a timely appointment.

Incomplete resolution of member grievances may result in missed opportunities for improved health care delivery and poor health outcomes for members.

Recommendation: Revise and implement policy and procedure to ensure member grievances are completely resolved.

4.1.3 Plan's Resolution of Quality of Care Grievances

The Plan shall provide a notice of grievance resolution to the member as quickly as the members' health condition requires, within 30 calendar days from the date Plan receives the grievance*. (Contract, Exhibit A, Attachment 14(1)(B))*

The Plan shall implement and have in place a Member Grievance System in accordance with CCR, Title 28, section 1300.68 *(Contract, Exhibit A, Attachment 14(1))*

"Resolved" means that the grievance has reached a final conclusion with respect to the members' submitted grievance. If the Plan has multiple internal levels of grievance resolution, all levels must be completed within 30 calendar days of the Plan's receipt of the grievance. *(CCR, Title 28, section 1300.68 (4a))*

The Plan's written resolution must contain a clear and concise explanation of the Plan's decision. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan Policy*, CA_GAMC_015 Grievance Process: Member - CA (revised date: 08/28/2023*), stated all clinical grievances are assigned to Grievance and Appeal Clinical Associates for review and appropriate action. If the clinical situation is not urgent, the grievance or problem is resolved within 30 calendar days of receipt of the grievance.

Finding: The Plan did not resolve quality of care grievances within 30 days of receipt of the grievance.

In a verification study, two quality of care grievances did not have grievance resolution within the required 30-day time frame. These two grievances were eventually classified as high severity PQI cases.

Although the grievance resolution letters in these two cases were sent within 30 days, the letters did not provide the members with any specific information on the status of the Plan's decision on the validity of the grievance. For example:

- One sample involved a four month delay in needed pain management for an urgent radiologically proven injury. The grievance resolution letter was sent within 30 days but did not provide the member with any specific information on the status of the Plan's decision on the validity of the grievance.
- The second sample involved a two and a half month delay in the required physical therapy post-knee surgery to optimize patient outcomes. The grievance resolution letter was sent within 30 days but again did not provide the member with any specific information on the status of the Plan's decision on the validity of the grievance.

The Plan's grievance resolution letters did not clearly and concisely explain the grievance decision as required by APL 21-011.
If the Plan does not provide timely grievance resolution for quality of care grievances, it can lead to delayed resolution and missed services, resulting in poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure that all quality of care grievances are resolved timely.

4.1.4 Medical Director Review of Quality of Care Grievance

The Plan shall maintain a Medical Director whose responsibilities shall include resolving grievances related to the medical quality of care. *(Contract, Exhibit A, Attachment 1(6)(E))*

The Plan shall implement and maintain procedures to ensure every grievance submitted is reported to the appropriate level and participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to a Medical Director. *(Contract, Exhibit A, Attachment 14(2)(C)(D))*

Plan Policy*, GAMC 15 Grievance Process Members (revised date 08/28/2023),* states that "all grievances related to the medical quality of care issues are immediately submitted to the Plan's Medical Director for action." It outlines the process: "Clinical grievances are assigned to Grievance and Appeals Clinical Associates for review and appropriate action. If there is evidence of a quality of care concern, the Grievance and Appeals Clinical Associate will create a PQI and send it to the Medical Director."

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Anthem Blue Cross Partnership Plan

AUDIT PERIOD: October 1, 2022, through October 31, 2023
DATE OF AUDIT: November 27, 2023, through December 8, 2023

Finding: The Plan did not refer all quality of care grievances to the Medical Director for resolution.

In verification study samples, all 13 quality of care grievances, rated zero or one, did not have documented Medical Director review prior to resolution. Notably, all the resolution letters were signed by nurses who reviewed the quality of care grievance.

During the interview, the Plan explained that a nurse initially reviews the quality of care grievances and will recommend a severity level before sending it to a Medical Director for final review. If the recommended severity level is two or higher, a PQI will be opened. However, the Plan could not substantiate that a Medical Director reviewed or took action on the grievances.

The Plan's policy requires but does not ensure that the Medical Director reviews all quality of care grievances.

If a Medical Director does not adjudicate quality of care grievances, important clinical issues may be missed, ultimately affecting health care, and resulting in poor outcomes.

Recommendation: Revise and implement policies and procedures that ensure all quality of care grievances are referred to a Medical Director for resolution.

DEPARTMENT OF HEALTH CARE SERVICES
AUDIT AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SANTA ANA

REPORT ON THE MEDICAL AUDIT OF

Anthem Blue Cross
Partnership Plan

2023

Contract Number:	03-76184, 04-36068, 07-65845, 10-87049, and 13-90159 (State Supported Services)
Audit Period:	October 1, 2022 through October 31, 2023
Dates of Audit:	November 27, 2023 through December 8, 2023
Report Issued:	May 14, 2024

TABLE OF CONTENTS

I. INTRODUCTION

The report presents the audit findings of Anthem Blue Cross Partnership Plan (Plan)compliance and implementation of the State Supported Services Contract Nos. 03-76184, 04-36068, 04-35797, 07-65845, 10-87049, 13-90159 and 13-90163. The State Supported Services Contract covers abortion services for the Plan.

The audit was conducted from November 27, 2023 through December 8, 2023 and covered the audit period from October 1, 2022 through October 31, 2023. The audit consisted of a document review of materials provided by the Plan and interviews with Plan staff.

An Exit Conference with the Plan was held on April 12, 2024. There were no deficiencies found for the audit period.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Anthem Blue Cross Partnership Plan

AUDIT PERIOD: October 1, 2022 through October 31, 2023
DATES OF AUDIT: November 27, 2023 through December 8, 2023

State Supported Services

The Plan's policies and procedures, provider manual and member handbook indicated that abortion service was covered, and prior authorization is not required for this service. Members may go to any Medi-Cal provider of their choice for abortion services, at any time for any reason, regardless of network affiliation.

A verification study of 21 State Supported Service claims were conducted to determine appropriate and timely adjudication of claims. There were no compliance issues identified during the audit period.

RECOMMENDATION:

None