DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION
LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN 2024

Contract Number: 23-30216

Audit Period: April 1, 2023 – March 31, 2024

Dates of Audit: April 23, 2024 – May 3, 2024

Report Issued: September 17, 2024

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I. INTRODUCTION

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

Formerly known as Care 1st Health Plan, 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 members in San Diego County.

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

As of January 2024, the Plan served 189,266 Medi-Cal members in San Diego County.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS medical audit for the period of April 1, 2023, through March 31, 2024. The review was conducted from April 23, 2024, through May 3, 2024. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on August 20, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On September 4, 2024, the Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of April 1, 2022, through March 31, 2023, was issued on August 3, 2023. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2023 Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

No findings were noted during the audit period.

Category 2 – Case Management and Coordination of Care

The Plan is required to provide acknowledgment of the Continuity of Care (COC) request within the specified timeframes, advising the member that the COC request has been received, the date of receipt, and the estimated timeframe for resolution. The Plan did not provide acknowledgment letters for COC requests to members.

Category 3 – Access and Availability of Care

All Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) providers must comply with the enrollment requirements set forth in

All Plan Letter (APL) 19-004, Provider Credentialing / Recredentialing and Screening / Enrollment. Medi-Cal transportation providers are required to enter into a provider enrollment agreement with the State as a condition of participating in the Medi-Cal program. The Plan did not ensure the transportation providers were enrolled in the Medi-Cal program.

Category 4 – Member's Rights

The Plan is required to send grievance resolution letters with a clear and concise explanation of the decision. The Plan's written resolution did not contain a clear explanation of the Plan's decision.

The Plan is required to ensure that every submitted grievance involving clinical issues is reported to qualified medical professionals with appropriate clinical expertise and is escalated to the Medical Director as needed, to ensure the grievance is properly handled. The Plan misclassified Quality of Care (QOC) grievances as Quality of Service (QOS) grievances.

The Plan is required to ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal. The Plan did not ensure that the person who made the final decision to resolve a grievance or appeal had not participated in any prior decisions.

Category 5 – Quality Management

No findings were noted during the audit period.

Category 6 – Administrative and Organizational Capacity

No findings were noted during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit was conducted from April 23, 2024, through May 3, 2024. The audit included a review of the Plan's Contract with DHCS, the 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

Service Requests: A total of 30 medical service requests (6 approved, 13 denied,

6 deferred, and 5 modified) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 20 appeals related to medical services were reviewed for appropriateness and timeliness of decision-making.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): Ten medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

COC: 15 medical records were reviewed to evaluate timeliness, appropriate determination, and notification of COC request.

Category 3 – Access and Availability of Care

NEMT: 17 records were reviewed to confirm compliance with NEMT requirements.

NMT: 20 records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: A total of 40 standard grievances (20 QOC and 20 QOS), 7 expedited grievances, 5 exempted grievances, and 3 call inquiries were reviewed for timely resolutions, response to the complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Potential Quality Issue (PQI): Six PQI cases were reviewed for appropriate evaluation, investigation, and effective action taken to address improvements and remediation.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse (FWA) Reporting: 15 cases were reviewed for proper reporting of any potential FWA to DHCS within the required time frames.

Encounter Data Review: 20 records were reviewed to verify the Plan's claims process.

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

COMPLIANCE AUDIT FINDINGS

Category 2 – Case Management and Coordination of Care

2.4 CONTINUITY OF CARE

2.4.1 Acknowledgment Letters

The Plan is required to ensure that members who have an established relationship with a network provider, and who want to continue their patient-provider relationship, are assigned to that provider without disruption in the member's care, if the member's existing relationship meets the requirements set forth in APL 22-032, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal Members Who Transition into a New Medi-Cal Managed Care Health Plan on or after January 1, 2023. (Contract, Exhibit A, Attachment III, 5.1.4(E))

The Plan is required to provide acknowledgment of the COC request within the specified timeframes, advising the member that the COC request has been received, the date of receipt, and the estimated timeframe for resolution. The Plan must notify the member by using the member's known preference of communication or by notifying the member using one of these methods in the following order: telephone call, text message, email, and then notice by mail. (*APL 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Medi-Cal Members Who Transition into a New Medi-Cal Managed Care Health Plan on or after January 1, 2023*)

Plan policy, *10.2.40 Continuity of Care for Medi-Cal Members* (effective date: 11/2022), stated that the Plan will provide acknowledgment of the COC request advising the member that the COC has been received, the date of the receipt, and the estimated timeframe for resolution. The Plan will use the member's known preference of communication or by notifying the member using one of these methods in the following order: telephone call, text message, e-mail, and then notice by mail.

Finding: The Plan did not provide acknowledgment letters for COC requests to members.

A verification study identified 8 out of 15 COC requests did not have an acknowledgment letter sent to the member. Instead, the Plan sent a notice to the

members, but it did not include all the required elements such as advising the member that the request had been received, the date of receipt, and the estimated timeframe for resolution.

During the interview, the Plan stated that the system was able to auto-generate the acknowledgement letter, effective November 1, 2023. Furthermore, in a written statement, the Plan stated that the COC acknowledgement letter required verification and approval from the Internal Compliance Department and DHCS before it could be implemented.

Therefore, the Plan implemented a 'work-around' process. While awaiting approval, the Plan worked on timely decisions of COC requests within the acknowledgment timeframe to provide both members and providers, a determination without delay. Otherwise, when appropriate, a deferral letter was sent to inform members that additional information was required. However, the Plan did not send out any acknowledgment letters.

Without the acknowledgment letter, members may not be aware of the status of their COC request and plan of care.

Recommendation: Implement policies and procedures to provide acknowledgment letters for COC requests to the members.

COMPLIANCE AUDIT FINDINGS

Category 3 – Access and Availability of Care

3.8 NON-EMERGENCY MEDICAL TRANSPORTATION

NON-MEDICAL TRANSPORTATION

3.8.1 Transportation Provider Enrollment

All NEMT and NMT providers must comply with the enrollment requirements set forth in APL 19-004, Provider Credentialing / Recredentialing and Screening / Enrollment. The Plan is required to monitor and oversee the network providers, subcontractors, and the enrollment of NEMT or NMT providers as Medi-Cal providers. (APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)

Medi-Cal providers are required to enter into a provider enrollment agreement with the State as a condition of participating in the Medi-Cal program and provide the applicant with a written determination. (*APL 19-004 Provider Credentialing / Recredentialing and Screening / Enrollment*)

Plan policy, *10.31.3 Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) Medi-Cal Enrollment Monitoring* (effective: 8/3/2022), stated that NEMT providers must enroll in the Medi-Cal program following a California statewide set of enrollment standards. The Plan shall continuously monitor, evaluate, and approve the transportation broker's reporting to ensure the completeness and accuracy of subcontractor enrollment activities.

Finding: The Plan did not ensure transportation providers were enrolled in the Medi-Cal program.

A verification study identified 4 out of 17 NEMT trips that were assigned to a transportation subcontractor who was not enrolled in the Medi-Cal program as a NEMT provider. The subcontractor was enrolled in the Medi-Cal program as a NMT provider only.

The Plan's monitoring report for Medi-Cal program enrollment status inaccurately identified the subcontractor as having an approved enrollment status to provide both modes of transportation, NEMT and NMT. The Plan relied on the broker to report the subcontractor enrollment status including the mode of transportation. The Plan did not

ensure the mode of transportation that the subcontractor was enrolled to provide was accurate. The Plan did not follow policies and procedures to monitor, evaluate, and approve the transportation broker's reporting to ensure the completeness and accuracy of the subcontractor enrollment activities.

During the interview, the Plan stated that it monitored transportation subcontractor's enrollment status through weekly reporting from the transportation broker. The Plan reviews the enrollment report and validates whether the subcontractor is enrolled in the Medi-Cal program using the Enrolled Medi-Cal Fee-for-Service Providers list on the California Health and Human Services Open Data Portal. However, the Plan failed to ensure the provider was enrolled as a NEMT provider.

Medi-Cal members may be subject to inadequate and unsafe transportation conditions if unscreened transportation providers do not meet the Medi-Cal program requirements.

Recommendation: Implement policies and procedures to ensure transportation providers are enrolled in the Medi-Cal program and approved to provide services for the mode of transportation.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 GRIEVANCE SYSTEM

4.1.1 Grievance Resolution Letter

The Plan is required to have in place a member grievance and appeal system that complies with Code of Federal Regulations (CFR), Title 42, sections 438.228 and 438.400 – 424, California Code of Regulations (CCR), Title 28, sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858 for covered services including the Plan's selected Community Supports under CFR, Title 42, section 438.3(e)(2). The Plan must follow grievance and appeal requirements set forth in, and use all notice templates included in, APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates. (*Contract, Exhibit A, Attachment III, 4.6.4*)

The Plan's grievance procedure shall at minimum provide for a description of the action taken by the Plan or provider to investigate and resolve the grievance and the proposed resolution by the Plan or provider. (*CCR, Title 22, section 53858 (a))*

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

Plan policy, *10.19.5 Beneficiary Grievance Management System* (effective: 2/13/2023), stated that the resolution letter includes what actions were taken to resolve the issue and upon request, the member may have access to, and copies of, all documents relevant to the member's grievance, including the benefit provision, guideline, protocol, or other similar criterion on which the grievance decision was based.

Finding: The Plan's written resolution did not contain a clear explanation of the Plan's decision.

A verification study identified a QOS grievance resolution where the Plan did not provide a clear and concise explanation of the Plan's decision to the member. Instead, the resolution letter included the following templated statement "We are unable to share the details of our review due to federal law."

During the interview, the Plan explained that due to the state laws, H&S Code 1370 and California Evidence Code 1157, the Plan's PQI investigations are protected and cannot

be released to the member, even though the cases were not referred to PQI investigations.

The Plan believed that the California H&S Code section 1370 citation in resolution letters was approved by DHCS in 2022, within the member notice templates and the standard QOC grievance resolution letter. However, the DHCS Contract Oversight Branch only approved the templates based on review findings that did not include the citation. Furthermore, Plan policy 10.19.5 did not include the requirement to provide written resolution letter with a clear and concise explanation of the Plan's decision.

When the Plan does not provide a clear and concise written explanation of the Plan's decision, it may lead to confusion and misunderstanding among members regarding their health care.

Recommendation: Revise and implement policies and procedures to ensure that grievance resolution letters include a clear and concise explanation of the Plan's decision.

4.1.2 Grievance Classification and Processing

The Plan is required to ensure that every submitted grievance involving clinical issues is reported to qualified medical professionals with appropriate clinical expertise and is escalated to the Medical Director as needed, to ensure the grievance is properly handled. (*Contract, Exhibit A, Attachment III, 4.6.2(C)*)

QOC means the degree to which health services for members increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge. (*Contract, Exhibit A, Attachment I*)

The member grievance procedures shall at a minimum, provide for the immediate submittal of all medical QOC grievances to the Medical Director for action. (*CCR, Title 28, section 53858 (e)(2))*

Plan policy, *10.19.5 Beneficiary Grievance Management System* (effective: 2/13/2023), stated that a QOC grievance is an oral or written expression of dissatisfaction about the QOC received or not received that adversely impacted or had the potential to adversely impact the member's health. Conversely, QOS is an oral or written expression of dissatisfaction with the Plan, provider, vendor, or medical group, that does not have a clinical aspect and does not impact the member's health care and does not fall under the definition of a QOC/PQI.

Plan procedure, *Blue Shield Promise Medi-Cal Standard Grievances MedHOK* (effective 1/26/2024), stated an example of a QOC grievance is any instance where a member infers or states they believe they received, or did not receive, care that adversely impacted or had the potential to adversely impact their health. Furthermore, any deviation of an expected provider QOC that includes access to care and referral or authorization issues may be a PQI.

Finding: The Plan misclassified QOC grievances as QOS.

A verification study identified 3 out of 20 QOS grievances were misclassified as access, QOS, when they should have been classified as QOC. The cases included:

- A member filed a grievance for delayed prior authorization and went without receiving any care services for three weeks while waiting for cancer treatment. It was revealed that the member experienced multiple delays in care during the last month of her life, while in a critical health condition.
- A member filed a grievance because of delay in modification to an authorization. The grievance was reported as access instead of QOC in the grievance log. The Plan misclassified the grievance, and the final correct determination was not properly reclassified.
- A member claimed to have ongoing suicidal thoughts when filing a grievance, complaining about the difficulty in accessing the Intensive Outpatient Program. The Medical Director took five days to determine that the grievance was categorized as QOS, not QOC.

In addition, based on the review of the grievance log for the audit period, the Plan grouped 219 grievances (9 percent of all standard cases) into subcategories that include "Timely Access", "Timely Authorization", and "Timely Response to Authorization/Appeal Request" under the "Access" category and processed the grievances as QOS rather than QOC.

According to Plan policy 10.19.5 and internal training materials, delays in service or authorization grievances should be categorized as QOC and must be submitted to the Medical Director for action. However, the Plan failed to follow the policies and procedures for classification and processing of QOC grievances.

The misclassification of grievances may result in unresolved member complaints thereby potentially jeopardizing the member's health.

Recommendation: Implement the policies and procedures, including relevant systems, to ensure the correct classification when processing grievances.

4.1.3 Clinical Grievance Decision Maker

The Plan is required to ensure that the person making the final decision for the proposed resolution of a grievance or appeal has neither participated in any prior decisions related to the grievance or appeal, nor is a subordinate of someone who has participated in the prior decision. (Contract, Exhibit A, Attachment III, 4.6.1 (D))

The Plan is required to ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal. (*APL 21-011 Grievance and Appeals Requirements, VII (M)*)

Plan policy, *10.19.5 Beneficiary Grievance Management System* (effective: 2/13/2023), stated that the person making the final decision for the proposed resolution of a grievance or appeal has neither participated in any prior decisions related to the grievance or appeal, nor is a subordinate of someone who has participated in the prior decision.

Finding: The Plan did not ensure that the person who made the final decision to resolve a grievance or appeal had not participated in any prior decisions.

A verification study identified two cases where the same Medical Director made the decision that denied a service request, for the same member, on both the grievance and appeal.

During the interviews, the Plan stated a decision about the appeal, and a related decision about a grievance, could be provided by the same Medical Director because the Plan considers the grievance process to incorporate both a grievance and appeal for the same situation, and that prior decisions only relate to prior authorization.

When the same decision maker resolves a clinical grievance related to a previous case, members may not receive an objective decision about their complaint.

Recommendation: Implement the policies and procedures to ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN 2024

Contract Number: 23-30248 (State Supported Services)

Audit Period: April 1, 2023 – March 31, 2024

Dates of Audit: April 23, 2024 – May 3, 2024

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I. INTRODUCTION

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

The audit was conducted from April 23, 2024, through May 3, 2024. The audit covered the audit period from April 1, 2023, through March 31, 2024. It consisted of document reviews and interviews with the Plan's staff.

An Exit Conference with the Plan was held on August 20, 2024. There were no deficiencies found for the audit period of the Plan's State Supported Services.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes 59840 through 59857 and Health Care Financing Administration (HCFA) 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 electronic transaction and code sets provisions. *(State Supported Services Contract, Exhibit A, (1))*

Plan policy, *CLM-11 Abortion Services* (revised: 1/13/2023), stated that the Plan agrees to provide, or arrange to provide, to eligible members all applicable State Supported Sensitive Services in the Current Procedural Coding System Codes and HCFA Coding System Codes.

Plan policy, *10.3.6 Family Planning* (effective: 2/09/2023), stated that members may self-refer to a qualified family planning provider with the Plan or self-refer to an out-of-network family planning provider without prior authorization. Upon enrollment, members are informed about their rights to access family planning services. Members are provided information through the Member Handbook, newsletter, and member services contracts, to make informed choices regarding the types of family planning services available, and their right to access these services in a timely manner.

The Plan's 2024 Medi-Cal Member Handbook, Evidence of Coverage, informed members that they may choose to go to any doctor or clinic for outpatient abortion services. Additionally, the Medi-Cal Member Handbook provided information on the type of sensitive care services that are accessible to minors without parent or guardian's consent.

The verification study revealed the Plan appropriately processed abortion claims for payment and did not demonstrate any deficiencies related to State Supported Services. Based on the review of the Plan's documents, there were no deficiencies noted for the audit period.

RECOMMENDATION:

None.