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

REPORT ON THE MEDICAL AUDIT OF

ANTHEM BLUE CROSS PARTNERSHIP PLAN

Contract Number: 03-76184, 04-36068, 07-65845, 10-87049 and 13-90159

Audit Period: October 1, 2018 Through September 30, 2019

Report Issued: January 30, 2020

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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 Welfare and Institutions Code, section 14087.3 and is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act.

Anthem is a full-scope Managed Care plan, which serves the Medi-Cal, Medicare, and 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.

The Plan has five contracts to provide services in 27 counties: Contract 03-76184,commercial contract, covers Alameda, Contra Costa, San Francisco, and Santa Clara Counties. Contract 04-36068, local initiative contract covers Tulare County. Contract 07-65845, GMC contract, covers Sacramento County. Contract 10-87049, commercial contract, covers Fresno, Kings, and Madera Counties. Contract 13-90159, 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.

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.

Anthem's services are provided through the Plan's regional health centers. The regional health centers provide access to provider network physicians, members, and community agencies.

As of July 1, 2019, the Plan served approximately 729,073 Medi-Cal members, which included 78,658 SPD members in the following counties: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Inyo, King, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Francisco, Santa Clara, Sierra, Sutter, Tehama, Tulare, Tuolumne, and Yuba.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical review audit for the review period of October 1, 2018 through September 30, 2019. The onsite review was conducted from September 30, 2019 through October 11, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on January 10, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management, and Administrative and Organizational Capacity. In addition, the Plan's SPD population were included in this review.

The prior DHCS medical audit,for the audit period of October 1, 2017 through September 30, 2018, was issued June 12, 2019. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

There were no findings in this category.

Category 2 – Case Management and Coordination of Care

The prior year audit found that the Plan did not comply with Behavioral Health Treatment requirements outlined in All Plan Letters 15-025 and 18-006. The prior audit found that the treatment plans did not clearly identify crisis plans and transition plans in the medical records. During this audit period, the sample medical records showed that all the required elements of the treatment plan were present.

There were no findings in this category for this audit period.

Category 3 – Access and Availability of Care

The Plan did not have procedures to follow up on missed appointments. In addition, the Plan was unable to provide any documentation regarding this as a process.

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 implement prompt and effective corrective action to address identified timely access deficiencies within its network.

The Plan is required to develop, implement, and maintain a procedure to monitor wait times for telephone calls. The Plan did not monitor wait times for providers to answer and return members' calls.

The Plan is required to develop, implement, and maintain a procedure to monitor wait times in the provider's offices. The Plan did not have a procedure to monitor wait times at providers' offices.

The Plan is required to ensure the accuracy of the information in the Plan's Provider Directory. The Plan did not ensure that its printed and online Provider Directories were accurate.

Category 4 – Member's Rights

The Plan did not correctly classify exempt and regular grievance cases. Exempt and quality of service grievances should have been classified as quality of care and/or coverage disputes.

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

PROCEDURE

The onsite review was conducted from September 30, 2019 through October 11, 2019. 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, staff, and the delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 25 medical prior authorization and 25 pharmacy prior authorization requests were reviewed for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Prior Authorization Appeals: 18 medical prior authorization appeals, including ten Medi-Cal and eight SPD prior authorization appeals, were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment: 16 medical records, which included six SPD files, were reviewed for completeness and timely completion.

Behavioral Health Treatment: Ten medical records were reviewed for evidence of care coordination and collaboration between the provider of care and individual member.

Category 3 – Access and Availability of Care

No verification studies were conducted.

Category 4 – Member's Rights

Quality of Care Grievances: 20 quality of care grievances, including five Medi-Cal and 15 SPD files, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Quality of Service Grievances: 35 quality of service grievances, including 15 Medi-Cal, ten SPD, five exempt Medi-Cal, and five exempt SPD grievance cases, were reviewed for timeliness and appropriate resolution.

Confidentiality Rights Procedures: Three Health Insurance Portability and Accountability Act case samples were reviewed for timeliness and reporting requirements.

Category 5 – Quality Management

New Provider Training: Nine new provider training records were reviewed for timely Medi-Cal Managed Care Program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Ten cases were reviewed for timely processing and reporting requirements.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: ANTHEM BLUE CROSS PARTNERSHIP PLAN

AUDIT PERIOD: October 1, 2018 through September 30, 2019
DATE OF AUDIT: September 30, 2019 through October 11, 2019

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM / REFERRAL TRACKING SYSTEM

1.1.1 Process to Follow Up on Missed Appointments

The Plan shall implement and maintain procedures for members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. The Plan shall also include procedures for follow-up on missed appointments.
(Contract, Exhibit A, Attachment 9(3)(A))

Finding: The Plan did not have procedures to follow up on missed appointments.

During the onsite audit interview, the Plan indicated that it does not have any formal mechanism or policy to track and follow up on missed appointments. In addition, the Plan was unable to provide any documentation regarding this process.

The identification of members with missed appointments would ensure follow up on members that may need medically necessary services.

Recommendation: Establish a policy and procedure to monitor and follow up on missed appointments.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Corrective Action for Non-Compliant Providers Regarding Routine Appointment Wait Time

The Plan shall 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 these standards. *(Contract, Exhibit A, Attachment 9(3))*

The Plan shall have a documented system for monitoring and evaluating 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 1300.67.2.1)*

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))*

Finding: The Plan did not implement prompt and effective corrective action to address identified timely access deficiencies within its network.

Plan Policy CA_PNXX_033, Access to Care Standard, stated that providers who remained non-compliant with appointment wait time standards may be required to submit a corrective action plan.

The Plan provided documentation of the actions taken for a sample of providers who were found to be non-compliant with the appointment wait time standards during the audit period based on the Access to Care Survey. The Plan sent letters to non-compliant providers informing them of the nature of the non-compliance.

For instances of repeated non-compliance, the Plan sent another letter to the provider informing them of the repeated non-compliance. If provider did not respond to the letter,

a Provider Relations Representative would contact the provider to discuss the potential contractual violations. The representative asked providers whether they were aware of their non-compliance, what steps had provider taken to remain in compliance, and going forward whether provider intended to remain in compliance.

The Plan did not develop or implement prompt investigation and corrective actions for repeated non-compliant providers who were not sufficient to ensure timely access. No specific or documented corrective actions were requested from the non-compliant providers.

Without implementing effective corrective action, the Plan will continue to have non-compliant providers that could delay needed medical services to its members.

Recommendation: Ensure implementation of effective corrective actions for non-compliant providers to comply with established access and availability standards.

3.1.2 Telephone Wait Time

The Plan shall establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times for telephone calls. *(Contract, Exhibit A, Attachment, 9(3)(C))*

Finding: The Plan did not monitor wait times for providers to answer and return members' calls.

Plan Policy CA_PNXX_033, Access to Care Standard, required that provider offices return a member's call within 30 minutes. The policy indicated that the Plan monitors office call back times through surveys of provider offices.

However, the review of Plan surveys did not identify any monitoring for telephone wait times. In interviews, the Plan was unable to clarify its monitoring method of telephone wait times. In addition, the access section of the *Quality Management Committee Meeting Minutes* did not have any discussions or analysis of telephone wait times monitoring. Likewise, the Plan did not submit any documentation to support that telephone wait times were monitored.

Telecommunication is essential for members to contact providers for issues, concerns, and treatments. Without monitoring the wait time of telephone calls, Plan members may not have timely access and information for treatment.

Recommendation: Develop and implement procedures to monitor telephone wait times for member's call to the provider's offices, including answering and returning calls.

3.1.3 Wait Times at Provider Offices

The Plan shall establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2.1. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices. *(Contract, Exhibit A, Attachment 9(3)(C))*

Finding: The Plan did not have a procedure to monitor wait times at providers' offices.

Plan *Policy CA_PNXX_033, Access to Care Standard,* did not have any procedures to monitor wait times at providers' offices. In interviews, the Plan confirmed that it does not have a policy and procedure to monitor wait times at providers' office. The access section of the *Quality Management Committee Meeting Minutes* did not identify any discussions or analysis of office wait times monitoring.

In order to render quality medical service, improvement of office wait time is essential. Without monitoring provider office wait times, the Plan is unable to determine compliance with access standards or identify how long members have to wait.

Recommendation: Develop and implement policy and procedure to monitor office wait times at providers' offices.

3.1.4 Provider Directories

The Plan is required to distribute a Provider Directory. The Provider Directory should include following information: The name, provider number, and telephone number of each service location. In the case of a medical group/foundation or independent practice

association, the medical group name, provider number, address, and telephone number shall appear for each physician provider. *(Contract, Exhibit A, Attachment 13(4)(D)(4))*

The Plan is required to ensure the accuracy of the information in the Plan's Provider Directory and shall, at least annually, review and update the entire Provider Directory. *(Health and Safety Code, Section 1367.27)*

Finding: The Plan did not ensure its printed and online Provider Directories were accurate.

The Plan has a process to update its online Provider Directory on a weekly basis and to update its printed Provider Directory on a monthly basis. The Plan indicated that its Provider Data Management is responsible for the accuracy, validity, and availability of this data.

In interviews, the Plan stated they sent out notices to ask providers to update their information weekly, but if the providers did not report the updated information to the Plan, then it would not be reflected correctly in the Provider Directories. The Plan relied on the providers to self-report and update their information as changes occur, but the Plan did not actively determine if the Provider Directories at any given time were accurate.

Information for providers listed on the Plan's printed and online Provider Directories were reviewed to determine its accuracy. For the printed Provider Directory, five providers did not have accurate information. For the online version Provider Directory, four providers did not have accurate information.

Without an accurate printed or online Provider Directory, members might have difficulty in finding needed medical services and this may lead to the delay of necessary treatment.

Recommendation: Develop procedures to ensure both printed and online Provider Directories are accurate.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: ANTHEM BLUE CROSS PARTNERSHIP PLAN
AUDIT PERIOD: October 1, 2018 through September 30, 2019 **DATE OF AUDIT: September 30, 2019 through October 11, 2019**

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance classification

Grievances related to medical quality of care issues shall be referred to the Plan's Medical Director. *(Contract, Exhibit A, Attachment 14(2)(E))*

The Plan shall implement and maintain a Member Grievance System in accordance with CCR, Title 28, sections 1300.68 and 53858. *(Contract, Exhibit A, Attachment 14(1))*

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, experimental, or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgement and response. *(CCR, Title 28, section 1300.68(d)(8))*

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

Finding: The Plan did not correctly classify exempt and regular grievance cases. Exempt and quality of service grievances should have been classified as quality of care and/or coverage disputes.

Plan Policy CA_GAMC_015, Grievance Process Members, required that all grievances be routed to its Grievance and Appeals Department (G&A) except those received over the phone that are not determined to be disputes involving medical necessity, experimental, or investigational treatment and can be resolved by the close of the next business day. The policy also stated that clinical grievances were assigned to G&A clinical associates for review and that those with quality concerns were to be reported to the Medical Director.

During the interview, the Plan stated that the Customer Service Department misunderstood the Contract and Plan policy language, thus the exempt grievances were misclassified. The Plan also stated that the newer G&A staff did not properly classify

and investigated the grievances that involved quality of care issues. The misclassification occurred due to the lack of training and experience of new staff.

In the verification study of 15 exempt grievances, the Plan misclassified 11 exempt grievances. Seven exempt grievances should have been classified as regular coverage dispute grievances and four should have been quality of care grievances. In addition, two quality of service grievance should have been classified as quality of care.

For example:

- A member filed a grievance stating her provider is unfamiliar with her dental infections. She informed her primary care physician over a year ago about the infections, but she complained they did not listen to her.
- A member filed a grievance stating that after three appointments with the provider, she still had not received any treatment for her severe lower-back and mid-back pain. She also complained that the provider simply gave her prescriptions without looking at her body.

The Plan classified and investigated both of these cases as quality of service instead of quality of care grievances.

Misclassification of grievances may lead to improper investigations and missed opportunities for healthcare quality improvements.

Recommendation: Ensure that staff receives training to properly classify grievances.

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

REPORT ON THE MEDICAL AUDIT OF

ANTHEM BLUE CROSS PARTNERSHIP PLAN

Contract Numbers:	03-75795, 04-36079, 07-65846, 10-87053 and 13-90160 (State Supported Services)
Audit Period:	October 1, 2018 Through September 30, 2019
Report Issued:	January 30, 2020

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II. COMPLIANCE AUDIT FINDINGS 2

INTRODUCTION

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

The on-site audit of the Plan was conducted from September 30, 2019 through October 11, 2019 and the audit covered the review period from October 1, 2018 through September 30, 2019. The audit consisted of a document review of materials provided by the Plan and interviews with staff.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

Anthem Blue Cross Partnership Plan

AUDIT PERIOD: October 1, 2018 – September 30, 2019
DATE OF AUDIT: September 30, 2019 – October 11, 2019

STATE SUPPORTED SERVICES

SUMMARY OF FINDINGS:

The Plan's policies and procedures, Medi-Cal Provider Guide, Provider Manual, and Member Handbook were reviewed for the provision of State Supported Services.

The Plan had policies and procedures in place to provide abortion and abortion-related procedures to members. The services were included in the Member Handbook. The Plan informed providers of their responsibilities to provide abortion and abortion-related procedures without prior authorization through their Provider Manual.

A verification study of State Supported Services claims were conducted to determine appropriate and timely adjudication of claims. The verification study did not identify any material issues of non-compliance.

There were no deficiencies noted during this audit period.

RECOMMENDATION:

None.