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: 13-90495
Cal MediConnect Three-Way Contract

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

Report Issued: January 30, 2020

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I. INTRODUCTION

The Department of Health Care Services (DHCS) received authorization from the federal government to conduct a Duals Demonstration Project to coordinate the delivery of health and long term care services to beneficiaries within California who are eligible for benefits under both Medicare and Medicaid. Starting in April 2014, DHCS began enrollment of Cal MediConnect (CMC) beneficiaries in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara Counties.

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.

In collaboration with the Centers for Medicare and Medicaid Services (CMS), DHCS operates a program to integrate care for beneficiaries who are eligible for both the Medicare and Medi-Cal Programs. The program is an alternative effort under the Coordinated Care Initiative. The goal of the CMC program is to provide enrolled beneficiaries with a more coordinated, person-centered care experience, along with access to new services.

The CMC contract is a three-way contract between CMS, DHCS, and Medicare-Medicaid health plans to coordinate the delivery of care for covered Medicare and Medicaid services for CMC members. The covered services include medical, behavioral health, long-term institutional, and home-and-community based services.

As of July 1, 2019, the Plan’s enrollment totals for its CMC line of business was 5,852 members across two counties: 3,312 members in Los Angeles and 2,540 members in Santa Clara counties.

II. EXECUTIVE SUMMARY

This report presents the audit findings of 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 the 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 audit evaluated three categories of performance: Utilization Management, Continuity of Care, and Members' Rights.

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

There were no findings in this category.

Category 4 – Member's Rights

The Plan did not send an acknowledgement letter to members when there was a delay in receiving the grievance from its Customer Service Department. In this case, only the resolution letter is sent to the member.

The Plan did not resolve the grievances within 30 days**.** The delay in resolving these grievances were due to the Customer Service Department not being able to forward these cases timely to the Grievance Department.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

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 and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: Ten medical prior authorization requests were reviewed for compliance with contractual requirements, including medical necessity, consistent application of criteria, and timeliness.

Category 2 – Case Management and Coordination of Care

Health Risk Assessment: Ten medical records were reviewed for completeness and timely completion.

Category 4 – Member's Rights

Quality of Care Grievances: One quality of care grievance was reviewed for proper categorization, timely resolution, and response to complainant.

Quality of Service Grievances: 12 quality of service grievances including seven quality of service, three call inquiries, and two exempt grievance cases were reviewed to verify the reporting timeframes and investigation process.

❖ 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 Acknowledgement letters

The Grievance System must meet the following standards: Timely acknowledgement of receipt of each enrollee grievance. *(Three way contract, 2.14.2.1.2.1)*

The Plan shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, consistent with the Knox-Keene Act, and the regulations promulgated there under, Welfare and Institutions Code section 14450 and California Code of Regulations, Title 22, section 53260. *(Three way contract 2.14.2.1.1.)*

Every plan shall provide a written acknowledgment within five calendar days of the receipt of a grievance. *(Knox-Keene Act, § 1368, (4)(a))*

Finding: The Plan did not send acknowledgement letter for grievances.

Plan Policy # CHS-AG-MMP-01, MMP Medi-Cal Grievances, stated that grievances not resolved by the next business day are subject to the acknowledgement and written response requirement.

The Plan did not follow *Policy # CHS-AG-MMP-01*. The Plan did not send the acknowledgement letters for two of seven grievance files reviewed.

During the interviews, the Plan stated that the Grievance Department did not send an acknowledgement letter when there was a delay in receiving the grievance from the Customer Service Department. In this case, only the resolution letter was sent to the member.

Members not informed of the grievance status can potentially lead to delay in resolving the grievance and create additional dissatisfaction.

Recommendation: Implement procedures to ensure that an acknowledgment letter is sent to members for all grievances within the required timeframe.

4.1.2 Grievance Resolution

The Plan shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, consistent with the Knox-Keene Act. *(Three way contract 2.14.2.1.1.)*

The Grievance System shall require the Plan to resolve grievances within 30 days. *(Knox-Keene Act, § 1368.01)*.

Finding: The Plan did not resolve the grievances within 30 days**.**

Plan *Policy # CHS-AG-MMP-01, MMP Medi-Cal Grievances,* stated if the Plan has multiple internal levels of grievance resolutions or appeals, all levels must be completed within 30 calendar days of the Plan's receipt of the grievance.

The Plan did not send the resolution letters within 30 days for three of seven grievance files reviewed. For example;

- A member filed a grievance on May 7, 2019 with the Customer Service Department. After 33 days, on June 10, 2019, the Customer Service Department forwarded the case to the Grievance Department. The Grievance Department completed their investigation and sent the resolution letter to the member on June 28, 2019, 51 days after the grievance was originally received by the Plan.
- A member filed a grievance on May 22, 2019 with the Customer Service Department. After 36 days, on June 28, 2019, the Customer Service Department forwarded this case to the Grievance Department. The Grievance Department completed their investigation and sent the resolution letter to the member on July 9, 2019, 47 days after the grievance was originally received by the Plan.

During the interviews, the Plan stated the delay in resolving these grievances were due to the Customer Service Department not being able to forward these cases timely to the Grievance Department.
Delay in resolving the grievance could have potential impact on member treatments and the Plan's quality improvement process.

Recommendation: Develop and implement a process to ensure that grievances are resolved within the contractually required timelines.