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

REPORT ON THE MEDICAL AUDIT OF

# Blue Shield of California
# Promise Health Plan

Contract Number: 09-86153

Audit Period: January 1, 2020
Through
December 31, 2020

Report Issued: June 22, 2021

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# I. INTRODUCTION

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

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

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

As of January 12, 2021, the Plan served 98,698 members through the following programs: 96,241 Medi-Cal and 2,457 Cal-MediConnect.

# II. EXECUTIVE SUMMARY

DHCS conducted an onsite audit of the Plan from February 22, 2021 through March 5, 2021. This report presents the results of the reduced scope medical audit for the audit period of January 1, 2020 through December 31, 2020.

An Exit Conference with the Plan was held on May 27, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in the report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

The audit evaluated five categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

The prior DHCS medical audit issued on June 3, 2020, for the audit period of January 1, 2019 through December 31, 2019, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP close-out letter dated November 5, 2020, documented that DHCS closed all previous findings.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

**Category 1 – Utilization Management**

Category 1 covers requirements and procedures for the UM program.

The Plan is required to ensure that the UM program includes the integration of the review of prior authorization and appeal reports into the Quality Improvement System (QIS). The Plan did not integrate UM activities into its QIS.

The Plan is required to ensure that the UM program includes an established Specialty Referral System to track and monitor referrals requiring prior authorization from the Plan. The Plan did not use its Specialty Referral Tracking System to ensure that members receive services within the required 15-business-days of request.

The Plan is required to maintain a Medical Director who shall actively participate in the Plan's grievance and appeal procedures and ensure that member grievances involving clinical issues were properly classified and reviewed by qualified medical personnel. The Plan's Medical Director did not actively participate in the Plan's grievance and appeal process and did not ensure that member grievances involving clinical issues were properly classified and reviewed by qualified medical personnel.

## Category 3 – Access and Availability of Care

Category 3 includes the requirements to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services.

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The Plan did not utilize the PCS forms to determine the appropriate level of service for NEMT.

The Plan is required to ensure that all NEMT services have prior authorization. The Plan did not consistently require prior authorization for NEMT services.

## Category 4 – Member's Rights

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

The Plan is required to submit the written record of grievances and appeals at least quarterly to its quality assurance committee for systematic aggregation and analysis for quality improvement. The Plan did not submit a written record of grievances and appeals at least quarterly to its quality assurance committee for systematic aggregation and analysis.

The Plan is required to have a procedure to ensure that it reports every grievance submitted to an appropriate level. The Plan did not refer Quality of Care (QOC) grievances to its Medical Director.

The Plan is required to resolve grievances to reach a conclusion with respect to the member's submitted grievance. The Plan did not fully resolve the members' submitted QOC grievances.

The Plan must complete multiple internal levels of grievance resolution within 30-calendar-days and refer grievances related to medical QOC issues to its Medical Director. The Plan's Grievance Coordinators did not immediately refer all QOC grievances to a Plan physician for determination within 30-calendar-days.

The Plan is required to provide fully translated written informing materials to its members. The Plan did not provide its members with translated grievance acknowledgement and resolution letter enclosures in their threshold languages.

## Category 5 – Quality Management

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

The Plan is required to ensure that all providers receive training regarding the Medi-Cal Managed Care program within ten-working-days after the Plan places a newly contracted provider on active status. The Plan did not ensure subcontractors trained new providers within the contractual timeframe.

# III. SCOPE/AUDIT PROCEDURES

## SCOPE

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

## PROCEDURE

The review was conducted from February 22, 2021 through March 5, 2021. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

### Category 1 – Utilization Management

Prior Authorization Requests: 24 medical, 20 pharmacy, and eight delegated prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 18 medical and two pharmacy appeals of denied prior authorizations were reviewed for appropriate and timely adjudication.

### Category 3 – Access and Availability of Care

NEMT and NMT: 30 records (15 NEMT and 15 NMT) were reviewed to confirm compliance with the NEMT and NMT requirements.

### Category 4 – Member's Rights

Grievance procedures: 21 QOC and 20 Quality of Service (QOS) grievances were reviewed for timely resolution, response to complainant, submission to the appropriate level for review, and translation in member's preferred language (if applicable).

### Category 5 – Quality Management

New provider training: 14 new provider training records were reviewed for timeliness.

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

| ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ |
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| **PLAN:** Blue Shield of California Promise Health Plan |
| **AUDIT PERIOD:** January 1, 2020 through December 31, 2020<br>**DATE OF AUDIT:** February 22, 2021 through March 5, 2021 |

## CATEGORY 1 - UTILIZATION MANAGEMENT

| 1.1 | UTILIZATION MANAGEMENT PROGRAM / REFERRAL TRACKING SYSTEM / MEDICAL DIRECTOR AND MEDICAL DECISIONS |
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### 1.1.1 Integration of Utilization Management with Quality Improvement

The Plan is required to ensure that the UM program includes the integration of UM activities into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. (Contract, Exhibit A, Attachment 5 (1)(G))

The Plan is required to compile the systematic aggregation and analysis of grievance and appeal data and use for Quality Improvement (QI). (Contract, Exhibit A, Attachment 14 (1)(J))

**Finding:** The Plan did not integrate review of prior authorization and appeal reports into its QIS.

The Quality Management Committee (QMC) did not review key UM reports, including reports containing prior authorization denials, deferrals and modifications, and the number and types of appeals. Instead, the QMC only reviewed timeliness of grievance and appeals acknowledgement and resolution letters. The QMC was not able to identify trends – such as in two appeal cases reviewed by the audit team containing overturned prior authorization denials for reconstructive surgery for its members with gender dysphoria.

During the interview, the Plan admitted that it was neither creating nor reviewing reports on numbers and types of prior authorizations and appeals. The only reports that contained this information were reports pulled from the Plan's data system at the request of the audit team. Without creating the reports, the Plan's QMC could not review them.

The Plan did not have policies and procedures in place to ensure that it integrated UM activities into its QIS. Plan policy 70.2.50, *UM Prior Authorization* (revised in January 2020) did not address creating and sending prior authorization and appeal reports to the QMC. Similarly, the Plan's UM Program Description listed several reports that it submitted to the QMC – including Specialty Referrals, turn-around-times, and appeals.

However, it did not specifically list the required number and types of appeals and prior authorization denials, deferrals, and modifications.

Without reviewing important UM functions, like the number and type of appeals and prior authorization denials, deferrals, and modifications, the Plan's QMC cannot adequately assess the level of quality the UM Department is providing its members. This lack of oversight impedes the QMC from detecting UM process failures, potentially leading to lower quality of life and worsening health and suffering for members.

**Recommendation:** Implement policies and procedures to integrate the review of prior authorization and appeal reports into the QIS.

### 1.1.2 Specialty Referrals Tracking System

The Plan is required to ensure that the UM program includes an established Specialty Referral System to track and monitor referrals requiring prior authorization from the Plan. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. (Contract, Exhibit A, Attachment 5 (1)(F))

Furthermore, the Plan shall offer members appointments with a specialist within 15-business-days of request. (Contract, Exhibit A, Attachment 9 (4)(B)(4))

**Finding:** The Plan did not use its Specialty Referral Tracking System to ensure that members receive services within the required 15-business-days of request.

The Plan's monthly specialty reports contained referrals with submission and approval dates. However, the reports contained a category "Days without a Claim" that included 16 or more days. The audit team requested the Plan to produce the reports cited in Plan policies 70.2.50, *UM Prior Authorization Review* (revised in January 2020), and 70.2.99, *Specialty Referral Tracking and Monitoring* (revised in March 2020). However, the Plan stated in an email that it does not have the Authorized Referral Report or the Specialty Tracking Report available for submission. Additionally, the Medical Services Committee and QMC meeting minutes for the entire audit period did not include review of the Specialty Referral Reports.

The Plan's policies and procedures did not require that its members had timely access to specialty services requiring prior authorization requests. Plan policy 70.2.7, *Specialty Care Referral Management* (revised in December 2018) stated that once the authorization is approved, members will be scheduled for an appointment within 30 days of the request. The Plan is in the process of updating this policy. Plan policy 70.2.99, *Specialty Referral Tracking and Monitoring* (revised in March 2020), stated, "A reminder letter will be sent to all the members who have prior authorization requests at

the 60 days, 90 days and 120 days." Both of the policies greatly exceed the required 15-business-day access timeline.

Without tracking Specialty Referrals requiring a prior authorization, the Plan risks delaying medically necessary care. This can potentially worsen member's health outcomes by delaying diagnosis and treatment of serious conditions, such as heart disease, and cancer.

**Recommendation**: Implement policies and procedures to track Specialty Referrals to identify any members not receiving services within the required 15-business-days of request.

### 1.1.3 Medical Director Involvement in the Grievance Process

The Plan is required to maintain a Medical Director, pursuant to California Code of Regulations (CCR), Title 22, section 53913.5, whose responsibilities shall include participating actively in the functioning of the Plan's grievance and appeal procedures. (Contract, Exhibit A, Attachment 1 (6)(A)(1))

**Finding:** The Plan's Medical Director did not actively participate in the Plan's grievance and appeal process.

The Plan's Chief Medical Officer (CMO) did not actively participate in reviewing and developing grievance and appeal policies and procedures. The CMO's participation in the grievance and appeal procedures was limited to reviewing percentage of turn-around time for grievance acknowledgement and resolution letters during the quarterly QMC meetings.

The Plan did not have policies and procedures to specify the CMO's involvement in the grievance system. The Plan's response to DHCS's Grievance Program Questionnaire identified the CMO as the Grievance Officer. Additionally, the Plan's CMO Job Description included "providing clinical guidance…in…grievances." However, the Plan's policies did not specify how the CMO was to provide clinical oversight in the grievance process nor address the responsibilities of the Grievance Officer. Plan policy 10.19.5, *Beneficiary Grievance Management System Policy* (revised in March 2020) the only submitted policy addressing the Grievance System - did not identify the CMO's involvement and responsibility in the Grievance Management System. As a result, the CMO (or Senior Medical Director) did not provide input into the Plan's grievance and appeals policies, procedures, and processes.

Without the Medical Director's active participation in the Plan's grievance and appeals process, the Plan cannot ensure the QOC provided to members.

**Recommendation:** Implement policies and procedures to include the Medical Director's active participation in the grievance and appeals system.

### 1.1.4 Medical Decisions in the Grievance Process

The Plan is required to maintain a Medical Director, pursuant to CCR, Title 22, section 53913.5, whose responsibilities shall include ensuring that qualified medical personnel render medical decisions as specified in Exhibit A, Attachment 14. (Contract, Exhibit A, Attachment 1 (6)(G))

The Plan is required to have a procedure to ensure that it reports every grievance submitted to an appropriate level, i.e., medical QOC versus health care delivery QOS. (Contract, Exhibit A, Attachment 14 (3))

The Plan is also required to refer grievances related to medical QOC issues to the Plan's Medical Director. (Contract, Exhibit A, Attachment 14 (4))

**Finding:** The Plan's Medical Director did not ensure that member grievances involving clinical issues were properly classified and reviewed by qualified medical personnel.

The CMO was not aware that the Plan did not resolve all clinical aspects of the QOC grievances and that two of the QOS grievance samples in the verification study contained clinical aspects that unlicensed, non-clinical Grievance Coordinators attempted to resolve. As a result, the Plan members did not receive timely and appropriate care as reflected in the grievance verification study.

The CMO delegated grievance responsibilities to the Senior Medical Director. During the interview, the Senior Medical Director stated that he did not periodically review random QOS grievance files to monitor that only the Plan's healthcare professionals reviewed and provided guidance on clinical aspects in member grievances.

Neither the CMO, the Senior Medical Director, nor any other licensed healthcare professional routinely reviewed the Grievance Coordinators' decisions on categorizing grievances or following through with clinical aspects of QOS grievances (e.g. members getting timely appointments to specialists). The Senior Medical Director only reviewed QOS grievances that the Grievance Coordinators brought to his attention.

The Plan's policy 10.19.5, *Beneficiary Grievance Management System Policy* (revised in March 2020) – assigned the Plan's Grievance Coordinators (unlicensed non-healthcare individuals) responsible for classifying grievances into clinical (QOC) and non-clinical (QOS) categories. The policy did not address clinician oversight in this

process, causing the Plan to misclassify grievances with clinical aspects as QOS grievances. The policy also directed the Grievance Coordinators to close all QOC grievances by sending them to the QI Department as Potential Quality Issues (PQIs), delaying the Plan's clinicians up to 180 days before making a decision on the case as described in Plan policy 70.1.1.9, *Clinical Quality Review Potential PQI Process* (revised in January 2020). Findings related to grievances are covered in Category 4 of this report.

Without clinical oversight, non-clinical Plan staff may attempt to make complex decisions regarding medical services. Delays in medical care could result in poor medical outcomes for Plan members.

**Recommendation:** Revise policies and procedures to make certain the Plan's Medical Director ensures that member grievances involving clinical issues are properly classified and reviewed by qualified medical personnel.

## CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

| 3.8 | NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION |
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### 3.8.1 Physician Certification Statement

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

Pursuant to *All Plan Letter (APL) 17-010, Non-Emergency Medical and Non-Medical Transportation Services*, the Plan is required to use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. The Plan is responsible to ensure that members receive NEMT services when prescribed in writing by a provider, when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for obtaining medically necessary services.

The Plan's policy 10.3.21, *Non-Emergency Transportation* (revised in September 2020), states pursuant to APL 17-010, the Plan will utilize PCS forms to determine the appropriate level of service for Medi-Cal members.

**Finding:** The Plan did not utilize the required DHCS-approved PCS forms to determine the appropriate level of service for Medi-Cal members.

In a verification study, all 15 NEMT service requests revealed that the Plan did not utilize the PCS forms as prescribed by DHCS.

The Plan stated that a process gap between scheduling and prior authorization is the cause for the Plan not utilizing the PCS form. Two different departments perform these functions. Customer Service Representatives continued to schedule rides for members without verifying prior authorization, while the Plan's UM Department approved rides without requiring PCS forms.

Failure to use the PCS form may result in members unable to receive the transportation method that is necessary for their medical condition.

This is a repeat of prior year (2020) finding 2.4.1 – Physician Certification Statement, which was a repeat of the finding in the 2019 medical audit. (Section 2.4 became Section 3.8 for this audit year.)

**Recommendation:** Implement policies and procedures to ensure that providers use the DHCS-approved PCS forms for NEMT requests to determine the appropriate level of service for Medi-Cal members.

### 3.8.2 Treatment Authorization Request

The Plan is required to ensure that all NEMT services have prior authorization. (CCR, Title 22, section 51323)

Pursuant to *All Plan Letter (APL) 17-010, Non-Emergency Medical and Non-Medical Transportation Services*, prior authorization is required, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant Health and Safety Code, section 1250.

**Finding:** The Plan did not consistently require prior authorization for NEMT services.

A verification study revealed that in 15 NEMT requests requiring prior authorization, 11 did not have a Treatment Authorization Request (TAR). None of these 11 cases are exceptions as stated in APL 17-010.

In addition to the process gap discussed in Finding 3.8.1, the Plan stated that its policy 10.3.21, *Non-Emergency Transportation* (revised in September 2020), had a typographical error - the word “not” is missing when referring to the exceptions to instances when a TAR is required. However, the desk level procedure for call center agent contains the correct information and process for when NEMT transportation is requested for a member that is required to be transferred from an acute care hospital. The policy has been updated and submitted for publishing and approval.

If the Plan does not use TAR forms, it does not meet Contract requirements resulting in members unable to receive the transportation method that is necessary for their medical condition.

**Recommendation:** Implement policies and procedures to ensure prior authorization for NEMT services.

## CATEGORY 4 – MEMBER'S RIGHTS

| 4.1 | GRIEVANCE SYSTEM |
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### 4.1.1 Integration of Grievances into QI

The Plan is required to compile the systematic aggregation and analysis of grievance and appeal data and use for QI. (Contract, Exhibit A, Attachment 14 (1)(J))

The Plan is required to provide the following additional information on both grievances and appeals: the total number of grievances and appeals received, the average time it took to resolve, and general description of the reason for the grievance or appeal. (Contract, Exhibit A, Attachment 14 (3)(B)(2))

*APL 17-006 VII (G), Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments*, states, "The written record of grievances and appeals shall be submitted at least quarterly to the Managed Care Plan's Quality Assurance Committee for systematic aggregation and analysis for QI."

**Finding:** The Plan did not submit a written record of grievances and appeals at least quarterly to its Quality Assurance Committee for systematic aggregation and analysis.

The Plan's QMC minutes revealed that it mostly reviewed percentage of files compliant with acknowledgement and resolution letter timelines for grievances and appeals. During the interview, the Plan confirmed that these reports were the only reports that the QMC reviewed and that it did not review the grievance and appeals logs. Review of grievances and appeals, numbers, types, and providers involved creates a process for the Plan to detect trends and areas of improvement for both clinical and non-clinical aspects of services.

The Plan did not have policies and procedures to address the QMC reviewing its grievance and appeals log on a quarterly basis. Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised in March 2020), addressed contractual and regulatory requirements for creating a grievance and appeals log for its delegated members. However, the policy did not direct Plan staff to create and submit the reports for its non-delegated, direct Medi-Cal members to the QMC on a quarterly basis.

Without analysis of grievance and appeal data for PQIs, the Plan risks worsening its members' health and wellbeing.

**Recommendation:** Develop and implement policies and procedures to ensure the Plan submits the grievance and appeals log for all Medi-Cal members for QI review on a quarterly basis.

### 4.1.2 QOC Grievance Reviews

The Plan is required to have a procedure to ensure that it reports every grievance submitted to an appropriate level, i.e., medical QOC versus health care delivery QOS. (Contract, Exhibit A, Attachment 14 (3))

The Plan is also required to refer grievances related to medical QOC issues to the Plan's Medical Director. (Contract, Exhibit A, Attachment 14 (4))

**Finding:** The Plan did not refer QOC grievances to its Medical Director.

The QOS grievance verification study revealed three of 20 files reviewed had clinical issues that a physician did not make a final determination on the resolution of the grievance. In these files, the Plan's non-clinical Grievance Coordinators misclassified grievances with clinical components as QOS grievances, instead of categorizing these as QOC grievances. As a result, Grievance Coordinators – staff without qualifications to make medical decisions - resolved member grievances involving clinical issues. For example, in one of the misclassified QOS grievances, a member had not been able to obtain needed mental health services and was having problems tolerating the prescribed medications, yet the Plan did not inform or involve a Medical Director.

The Plan did not have policies and procedures to ensure that a physician reviewed and resolved all grievances related to QOC issues. The Plan's only grievance policy 10.19.5, *Beneficiary Grievance Management System* (revised in March 2020) did not assign qualified healthcare professionals to oversee the review and categorization of grievances. The policy only stated that, "All grievances received by the Plan will be referred to the Appeals and Grievance Department for review, investigation and/or allocation to another Plan service team." During the interview, the Plan acknowledged that the Grievance Coordinators who categorize the grievances were not licensed healthcare professionals.

Without having qualified licensed healthcare professionals oversee the review and categorization of grievances, the Plan may miss opportunities to address clinical issues by appropriately qualified staff.

**Recommendation:** Develop and implement policies and procedures that require the Plan to submit every grievance involving medical issues to the Medical Director for review.

### 4.1.3 Resolution of Grievances

The Plan is required to implement and have in place a Member Grievance System in accordance with CCR, Title 28, section 1300.68. This shall include a procedure to ensure notification of grievance acknowledgement and resolution to the complainant. (Contract, Exhibit A, Attachment 14 (1) and (2) (a))

In accordance with CCR, Title 28, section 1300.68 (4), "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance."

**Finding:** The Plan did not fully resolve the members' submitted QOC grievances.

A verification study revealed a grievance processing deficiency in two QOC cases that the Plan did not address and resolve members' original grievance. In one grievance case, the member was dissatisfied about not receiving timely prenatal services because she was waiting for the Plan to approve them. The Grievance Coordinator did not document understanding that prenatal services do not require authorization approval and that the member's physician should have directly referred the member. The UM Coordinator involved did not understand this as well. As a result, the Grievance Coordinator closed the grievance without fully resolving it and without assisting the member and the member's Primary Care Physician to schedule an immediate appointment. In another grievance case, the member's optometrist did not know that eyeglasses are part of the member's benefits, resulting in the optometrist billing the member for a covered service. The Grievance Coordinator did not resolve the grievance by informing the member's optometrist about the benefit. Instead, the Grievance Coordinator initiated a process to attempt to reimburse the member for paying for a covered service.

The Plan did not have policies and procedures in place to ensure that the Grievance Department resolved all aspects of QOC grievances. Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised in March 2020), did not instruct Grievance Staff to resolve the members' original grievances. Instead, it merely instructed staff, "Depending on the nature of the grievance/inquiry, the Grievance Unit will determine the Department to which the grievance/inquiry will be forwarded for assistance in the resolution…QOC Issues - Quality Management Department." The Grievance and Appeals Desktop Procedures did not address how to resolve grievances completely or

how to determine member benefits. Furthermore, the Plan's written response acknowledged that it had not trained its Grievance Department on member benefits.

Without policies and procedures, including training, to ensure all grievances are resolved, the Plan risks denying its members of needed services. This can result in the Plan denying and delaying medically necessary care, which can contribute to poor member health outcomes.

**Recommendation:** Revise and implement policies and procedures to ensure that every grievance submitted is fully resolved.

### 4.1.4 Timely Resolution of Grievances Involving Clinical Issues

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

In accordance with CCR, Title 28, section 1300.68 (4)(A), "If the Plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30-calendar-days."

The Plan is also required to refer grievances related to medical QOC issues to the Plan's Medical Director. (Contract, Exhibit A, Attachment 14 (4))

**Finding:** The Plan's Grievance Coordinators did not immediately refer all QOC grievances to the Plan's Medical Director for resolution within the contractual timeframe.

Instead, the Grievance Coordinators categorized all QOC grievances as PQIs, closed the QOC grievance cases, and referred the PQIs to the QI Department. The QI Department's Medical Director reviewed the PQIs for severity level and determined follow-up only. The QI Medical Director did not participate in all clinical aspects of members' original grievances.

The processes for resolving grievances and for investigating PQIs are separate and distinct with different timeframes. The Plan's process of closing all QOC grievance cases by sending them to the QI Department for PQI severity determination prevented the Plan's Medical Director from reviewing the cases within the required 30-calendar-day timeframe. Initiating a PQI, which can take up to 180 days to investigate, should not preclude, delay, or impact the grievance processing and resolution within the required timeframe. The PQI verification study revealed that, on average, the QI Medical Director took three to four months to review most PQIs that started as QOC grievances. As a

result, both QOS and QOC verification study files included cases where the Plan denied members timely care (Refer to cases discussed in Finding 4.1.2).

The Plan did not have policies and procedures to ensure the Medical Director reviewed and rendered decisions on QOC grievances within the required timeframe. Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised in March 2020), stated, "All medical QOC grievances will be submitted to the QI Department." The policy further stated, "Depending on the nature of the grievance/inquiry, the Grievance Unit will determine the department to which the grievance/inquiry will be forwarded for assistance in the resolution." For QOC issues, the policy instructs Grievance Coordinators to forward to the Quality Management Department.

The Plan's policy 70.1.1.9, *Clinical Quality Review Potential Quality Issue (PQI) Process* revised in January 2020) , stated, "Grievance(s) related to a member's care are opened by Clinical Quality Review as a PQI' and "All PQI cases will be leveled within 180 days."

The Plan puts its members' health at risk when its physicians do not review grievances with clinical issues in a timely manner. Members' health conditions can rapidly deteriorate if a physician does not promptly address their medical needs.

**Recommendation:** Develop and implement policies and procedures to resolve all grievances, including those involving medical issues, within the contractual timeframe.

## 4.2 CULTURAL AND LINGUISTIC SERVICES

### 4.2.1 Linguistic Services

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

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

**Finding:** The Plan did not provide its members with translated Grievance Acknowledgement and Resolution letter enclosures in their threshold languages.

Seven of 41 grievances sampled in the verification study required translation of the Acknowledgement and Resolution letters along with enclosures in the member's preferred language. All seven grievances had translations of the Acknowledgement and Resolution letters in the member's preferred language. However, six of the seven grievances did not include translation of the Grievance Acknowledgement and Resolution letter enclosures in the member's preferred language.

The Plan did not have an effective process in place to ensure all Grievance Acknowledgement and Resolution letter enclosures were translated in the member's preferred language. During the interview, the Plan admitted it became aware that not all members were receiving translated Grievance Acknowledgement and Resolution letter enclosures in their threshold languages due to newly implemented internal audit processes that were part of the CAP for the previous audit finding.

Without translated materials, members who require these translated documents may not know how to access care or know how to resolve issues when they arise.

This is a repeat of prior year (2020) finding 4.2.1 – Linguistic Services, which was a repeat of the finding in the 2019 medical audit. Though the findings in the last two

consecutive medical audits refer to the letters and this finding refers to the letter enclosures, essentially the issue is the translation of member-informing materials.

**Recommendation:** Revise and implement policies and procedures to ensure translation of all Grievance Acknowledgement and Resolution letter enclosures into members' preferred languages.

## CATEGORY 5 – QUALITY MANAGEMENT

| 5.2 | PROVIDER QUALIFICATIONS |
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### 5.2.1 New Provider Training

The Plan is required to ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. The Plan shall conduct training for all network providers within ten-working-days after the Plan places a newly contracted provider on active status. (Contract, Exhibit A, Attachment 7(5)(A))

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

The Plan's policy 10.30.1.1, *Oversight of Delegated Entity's Contracted Provider Orientation and Education (New and Ongoing)* (revised in July 2020), states that the Plan will perform quarterly audits for all newly contracted providers on all in-services and orientation to ensure adequate training is being provided by the delegated entities within ten-working-days after the newly contracted provider is on active status.

**Finding:** The Plan did not ensure subcontractors trained new providers within the contractual timeframe.

The Plan did not ensure that its delegated entities conducted training for newly contracted providers within ten-working-days of placing them on active status. This finding was also in the prior year audit; however, it pertained to both in-house and delegated entity training.

The Plan did complete in August 2020 a Delegation Oversight Audit as stated in the prior audit's CAP. This audit resulted in the Plan placing their delegated entities on their own CAPs. The Plan stated it continues to work with delegated entities to bring them into compliance.

Each CAP that the Plan has with a delegated entity lists why the delegated entity failed to conduct new provider training within the required timeframe. Two common trends are

pandemic-related virtual classroom transition lags and delegated entities unaware of the DHCS timeframe requirement.

Failure to ensure provision of new provider training within ten-working-days of active status designation may result in the following: delays in providing quality service to members, poor coordination of care, and ineffective monitoring resulting in the inefficiency of operations and compliance with applicable statutes and regulations

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

**Recommendation:** Implement policies and procedures to ensure delegated entities conduct training within ten-working-days of placing newly contracted providers on active status.

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

REPORT ON THE MEDICAL AUDIT OF

# Blue Shield of California
# Promise Health Plan

| | |
|---|---|
| Contract Number: | 09-86154<br>State Supported Services |
| Audit Period: | January 1, 2020<br>Through<br>December 31, 2020 |
| Report Issued: | June 22, 2021 |

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# I. INTRODUCTION

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

The audit period is January 1, 2020 through December 31, 2020. The review was conducted from February 22, 2021 through March 5, 2021, and consisted of document review of materials provided by the Plan and interviews with Plan's administration and staff.

An Exit Conference with the Plan was held on May 27, 2021.

# ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** Blue Shield of California Promise Health Plan

**AUDIT PERIOD:** January 1, 2020 through December 31, 2020
**DATE OF AUDIT:** February 22, 2021 through March 5, 2021

## STATE SUPPORTED SERVICES

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

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

The Plan's policy 10.2.16, *Sensitive Services* (revised in December 2018), states that parental consent is not required for abortions. Plan policy 10.3.6, *Family Planning* (revised in May 2019), reinforces the Plan's policy on abortion services and states that abortions are part of family planning services. Plan policy 10.9.4, *Automatic Payment Criteria* (revised in February 2020), states that the Plan automatically pays for services that do not require prior authorization, such as abortion, within regulatory required timelines.

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

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

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** Blue Shield of California Promise Health Plan

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

The audit found no exceptions with the contractual requirements.

**Recommendation:** None.