ILLINOIS DEPARTMENT OF Healthcare and Family Services

Bruce Rauner, Governor
Felicia F. Norwood, Director

201 South Grand Avenue East, Springfield, IL 62763-0002 • (217) 782-1200 • (800) 526-5812 TTY

April 6, 2018

Nancy Wohlhart
VP, IL Medicaid Operations
Blue Cross Blue Shield of Illinois
300 East Randolph Street
Chicago, IL 60601

RE: Sanction of Blue Cross Blue Shield of Illinois due to non-compliance under the Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with State of Illinois Department of Healthcare and Family Services and Health Care Service Corporation

Dear Ms. Wohlhart:

This letter serves as notice to Blue Cross Blue Shield of Illinois (BCBS) of sanctions pursuant to the Three-way Contract ("contract") between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with State of Illinois Department of Healthcare and Family Services and Health Care Service Corporation for the Medicare-Medicaid Alignment Initiative (MMAI) program. The Department of Healthcare and Family Services ("Department") is issuing sanctions for multiple violations, outlined below.

Pursuant to Section 5.3.14.1.8 of the contract, BCBS is sanctioned $12,500, as the Department has determined that BCBS is in substantial noncompliance with the Quality Assurance Program requirements of the contract regarding implementation of remedial or corrective actions.

> Section 2.13.3.3 of the contract, Implementation of Remedial or Corrective Actions, states, *"The QAP shall include written procedures for taking appropriate remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished, including in the area of behavioral health, or services that should have been furnished were not. Quality Assurance actions that result in remedial or corrective actions shall be forwarded by the Contractor to CMS and the Department on a timely basis."*
>
> The BCBS Quality Improvement Committee (QIC), the designated accountable entity for implementation and oversight of the quality assurance program, failed to take appropriate remedial action for continued non-compliance with processing of grievances and appeals. The review of the grievance committee meeting minutes identified that grievance and appeals reports were not presented to the committee for several months. The QIC continued to request reports from the Grievance and Appeals Department,but did not implement remedial or corrective actions. The QIC only elevated that reports were not being submitted. As a result, the QIC failed to identify the continued noncompliance in processing grievances and appeals and take appropriate remedial or corrective action, as required under the contract.

Pursuant to Section 5.3.14.1.8 of the contract, BCBS is sanctioned $12,500, as the Department has determined that BCBS is in substantial noncompliance with the Quality Assurance Program requirements of the contract regarding effectiveness of corrective actions.

> Section 2.13.4 of the contract, Assessment of Effectiveness of Corrective Actions, states, *"The Contractor shall monitor and evaluate corrective actions taken to assure that appropriate changes have been made. The Contractor shall assure follow-up on identified issues to ensure that actions for improvement have been effective and provide documentation of the same."*
>
> The BCBS QIC, as the designated accountable entity for implementation and oversight of the quality assurance program, failed to monitor and evaluate corrective actions to assure that appropriate changes were implemented. BCBS was non-complaint with resolving and following-up on access related grievances in the 2016 Administrative Review. To remediate these findings, BCBS submitted a revised grievance and appeals policy and procedure document and staff training materials. Follow-up by HSAG during the 2017 Administrative Review identified that the remediation action was not implemented and/or monitored for compliance. The review of the grievance committee meeting minutes identified that grievance and appeals reports were not presented to the committee for several months, and the on-site 2017 Administrative Review did not validate compliance with grievance and appeal processing. BCBS management and operational staff could not accurately describe the grievance and appeals process during interview, and non-compliance was identified for timeliness of processing of grievances and appeals during the 2017 Administrative Review reporting period.

Pursuant to Section 5.3.14.1.13 of the contract, BCBS is sanctioned $12,500, as the Department has determined that BCBS is in substantial noncompliance with the internal grievance administration process requirements of the contract.

> Section 2.11.2.1 of the contract states, *"The system must meet the following standards: 2.11.2.1.1 Timely acknowledgement of receipt of each Enrollee Grievance; 2.11.2.1.2 Timely review of each Enrollee Grievance; 2.11.2.1.3 Informal attempt by Contractor to resolve all Grievances; 2.11.2.1.4 Establishing a Grievance Committee, which shall have at least one (1) member who is an Enrollee and, at the Department's option, a representative of the Department, to hear Grievances that are not appropriate for informal review, were denied at the informal review, or are not appropriate for the procedures established by 215 ILCS 134/45; ...2.11.2.1.6 Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the Grievance..."*
>
> BCBS did not respond to grievances within the required timeframes. During the 2017 Administrative Review, a review of grievance reports for the review period identified non-compliance with timely resolution of grievances. An HSAG interview with grievance and appeals management and operational staff identified a lack of understanding of Illinois MMAI grievance and appeals contract requirements. HSAG conducted a follow-up Focused File Review of a sample of grievances based on the findings of the 2017 Administrative Review, which further identified non-compliance. A review of the six sample grievances indicated overall compliance for the intake and

processing of grievances was 31 percent. Acknowledgment letters were sent in three of the six cases. BCBSIL resolved one of the six grievances within the contractually required timeframe. A review of the case notes associated with the sample grievances and interviews with BCBS staff raise concern about BCBS's overall process for addressing grievances. The grievance file review identified the following findings: two of six sample files did not address nor provide resolution for all elements of the grievance; the average length of time to send acknowledgment letters was 28 days after receipt of the grievance (range of eight days to 42 days); the average length of time to resolve the six grievances was 81 days; BCBS reported the grievance receipt date as the date that the grievance is entered into the health plan's database, Enterprise Appeal Application (EAA), as opposed to the date that the health plan or its delegate received the grievance; and resolution letters to the enrollee are not appropriately personalized with letters including cut-and-paste responses from the individual investigating the grievance. Resolution letters to the enrollee were not reviewed to determine appropriate reading level prior to being sent to the enrollee. Grievances handled by Cognizant/TMG the delegated member and provider call center, were not forwarded to the BCBS Grievance and Appeals Department, and the grievances processed by Cognizant/TMG were not included in the BCBS grievance reporting to HFS. Additionally, a review of grievance committee meeting minutes and interview with plan staff identified that BCBS did not have representation of at least one enrollee on the Grievance Committee, as required by the contract.

Pursuant to Section 5.3.14.1.13 of the contract, BCBS is sanctioned $12,500, as the Department has determined that BCBS is in substantial noncompliance with the standard appeals requirements of the contract.

Medicare A & B Service Appeals, Section 2.12.3.2.1 of the contract, states, *"Unless an Enrollee requests an expedited Appeal, for Level One Appeals filed with the Contractor, the Contractor shall render its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. The Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension or if the Contractor desires additional information and/or documents and is able to establish that the delay is in the interest of the Enrollee."*

Medicaid Appeals, Section 2.12.4.2.1 of the contract states, *"For Level One Appeals filed with the Contractor, if the Enrollee does not request an expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor may require the Enrollee to follow an oral Appeal with a written, signed Appeal. The Contractor shall render its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. In the case of oral appeals, the Contractor shall render its decision on the Appeal within fifteen (15) Business Days after the receipt of the oral appeal. The Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor demonstrates to the satisfaction of the appropriate State agency's Hearing Office that there is a need for additional information and the delay is in the Enrollee's interest."*

Medicare A & B/Medicaid Appeals (Overlap Services and Items), Section 2.12.5.2.1 of the contract states, *"For Level One Appeals filed with the Contractor, if the Enrollee does not request an expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor shall*

render its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. The Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor demonstrates to the satisfaction of the appropriate State agency's Hearing Office that there is a need for additional information and the delay is in the Enrollee's interest."

During the on-site 2017 Administrative Review, a review of service level reports for the review period identified non-compliance with timely resolution of appeals. An HSAG interview with grievance and appeals management and operational staff identified a lack of understanding of Illinois MMAI grievance and appeals contract requirements. HSAG conducted a follow-up Focused File Review of a sample of appeal files based on the findings of the 2017 Administrative Review, which further identified non-compliance. A review of eight sample appeal files indicated overall compliance for the intake and processing of appeals was 57%. Two of three standard reviews did not meet the 15-business day requirement. A review of the case notes associated with the sample appeal files and interviews with BCBS staff raise concern about BCBS's overall process for processing of appeals. The appeal file review identified a lack of use of a consistent appeal template letter and a lack of compliance with enrollee notification of appeal decisions. Additionally, under the delegation agreement, EviCore was responsible for processing denial decisions and BCBS retained responsibility for generation and distribution of appeal decisions to enrollees. Relaying appeal decisions was established via secure email. During review of appeal files processed by EviCore, documentation of appeal decisions and notification to BCBS was verified, however, the file review identified no evidence of enrollee notification of the appeal decisions. The file review identified no evidence of attempts to follow-up with the enrollees or remediate the cause of non-compliance with enrollee notification requirements.

Pursuant to Section 5.3.14.1.13 of the contract, BCBS is sanctioned $12,500, as the Department has determined that BCBS is in substantial noncompliance with the expedited appeals requirements of the contract.

Medicare A & B Service Appeals, Section 2.12.3.2.1 of the contract states, *"If an Enrollee requests an expedited Appeal, the Contractor shall notify the Enrollee, within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that the Contractor requires to evaluate the expedited Appeal. The Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information."*

Medicaid Appeals, Section 2.12.4.2.2 of the contract states, *"If an Enrollee requests an expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor shall notify the Enrollee, within 24 hours after the submission of the Appeal, of all information from the Enrollee that the Contractor requires to evaluate the expedited Appeal. The Contractor shall also inform the Enrollee of the limited time available for the Enrollee to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information and shall make reasonable efforts to provide oral notice. If the Contractor denies the expedited Appeal, the Contractor shall ensure that it complies with the procedures in 42 C.F.R. § 438.410(c). The Contractor may extend this*

timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor demonstrates to the satisfaction of the appropriate State agency's Hearing Office that there is a need for additional information and the delay is in the Enrollee's interest. The Contractor must ensure that no punitive action is taken against a Provider that either requests an expedited Appeal or that supports an Enrollee's expedited Appeal. If the Enrollee does not request an expedited Appeal, the Contractor shall render a decision within fifteen (15) business days after receipt of the Appeal and shall provide the Enrollee with written notice of the resolution pursuant to 42 CFR § 438.408."

Medicare A & B/Medicaid Appeals (Overlap Services and Items), Section 2.12.5.2.2 of the contract states, *"If an Enrollee requests an expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor shall notify the Enrollee, within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that the Contractor requires to evaluate the expedited Appeal. The Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. If the Enrollee does not request an expedited Appeal, the Contractor shall render a decision within fifteen (15) business days after receipt of the Appeal and shall provide the Enrollee with written notice of the resolution pursuant to 42 CFR § 438.408."*

During the on-site 2017 Administrative Review, a review of service level reports for the review period identified non-compliance with timely resolution of appeals. An HSAG interview with grievance and appeals management and operational staff identified a lack of understanding of Illinois MMAI grievance and appeals contract requirements. HSAG conducted a follow-up Focused File Review of a sample of appeal files based on the findings of the 2017 Administrative Review, which further identified non-compliance. A review of eight sample appeal files indicated overall compliance for the intake and processing of appeals was 57%. Four of the five expedited reviews did not meet the 24-hour requirement. A review of the case notes associated with the sample appeal files and interviews with BCBS staff raise concern about BCBS's overall process for processing of appeals. The appeal file review identified a lack of use of a consistent appeal template letter and a lack of compliance with enrollee notification of appeal decisions. Additionally, under the delegation agreement, EviCore was responsible for processing denial decisions and BCBS retained responsibility for generation and distribution of appeal decisions to enrollees. Relaying appeal decisions was established via secure email. During review of appeal files processed by EviCore, documentation of appeal decisions and notification to BCBS was verified, however, the file review identified no evidence of enrollee notification of the appeal decisions. The file review identified no evidence of attempts to follow-up with the enrollees or remediate the cause of non-compliance with enrollee notification requirements.

Pursuant to Section 5.3.14.1.13 of the contract, BCBS is sanctioned $12,500, as the Department has determined that BCBS is in substantial noncompliance with the subcontracting requirements of the contract.

Section 2.7.2.2 of the contract, Subcontracting Requirements, states, *"2.7.2.2.1 The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. The Contractor shall require each First Tier, Downstream or*

Related Entity to meet all terms and requirements of the Contract that are applicable to such First Tier, Downstream or Related Entity. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract. 2.7.2.2.2 The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the Contractor."

During the on-site 2017 Administrative Review interviews, follow-up Focused File Review interview and review of denial and appeal sample files, and a review of reporting for the 2016-2017 review period by HSAG, it was identified that delegates responsible for processing denials and appeals were not using the required notice determinations. The delegated vendor EviCore did not consistently use the Department-approved denial letter template for decision notices and its denial notice letterheads included delegated vendor EviCore, BCBS with a Texas address, and BCBS a New Mexico address, instead of BCBS of Illinois. A review of the case notes associated with the sample denial files and interviews with BCBS staff raise concerns about BCBS's overall process for oversight of delegated functions related to denials. Also, grievances were not reported to the Grievance and Appeals Department by the delegated vendor Cognizant/TMG customer service representatives, and Cognizant/TMG also had noncompliance in the areas of call center service level metrics, timely distribution of welcome packet by the fulfillment vendor, and timely processing of claims. BCBS is not compliant with timely processing of provider complaints through the Managed Care Provider Complaints Portal. The delegated vendor Cognizant/TMG is responsible for processing claims, which BCBS cited as impacting their ability to respond timely to provider complaints that come through the Managed Care Provider Complaints Portal. In addition, review of the delegated vendor DentaQuest's online dental directory identified that the directory did not have the required fields updated in the directory (*e.g.,* credentials, telephone number, address, and hours of operation). BCBS did not appropriately identify and establish corrective action for the noncompliance of these delegated vendors.

Pursuant to Section 5.3.14.1.13 of the contract, BCBS is sanctioned $12,500, as the Department has determined that BCBS is in substantial noncompliance with the authorization of services requirements of the contract.

Section 5.15.5 of the contract, Authorization of Services states, *"If Contractor declines to authorize Covered Services that are requested by a Provider or authorizes one or more services in an amount, scope, or duration that are less than that requested, Contractor shall notify the Provider orally or in writing and shall furnish the Enrollee with written notice of such decision. Such notice shall meet the requirements set forth in 42 CFR 438.404."*

Section 2.9.4.5 of the contract states, *"The Contractor must notify the requesting Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Section 2.4, and must: 2.9.4.5.1 Be produced in a manner, format, and language that can be easily understood."*

HSAG conducted a follow-up Focused File Review of denial notices based on the findings of the 2017 Administrative Review. A review of six sample denial files indicated overall compliance for the intake and processing of denials was 83 percent. One expedited review did not meet the 72-hour requirement. A review of the case notes associated with the sample denial files and interviews with BCBS staff raised concern about BCBS's overall process for oversight of denial notices, including delegated functions related to denials. Multiple denial letter templates were used. One delegated entity, EviCore, did not consistently use the Department-approved denial letter template for decision notices; its template letterheads included delegated vendor EviCore, BCBS with a Texas address, and BCBS with a New Mexico address, instead of BCBS of Illinois. There also was a lack of review of denial decision letters developed by BCBS to verify compliance with reading level requirements prior to distribution to enrollees.

Pursuant to Section 5.3.14.4 of the contract, this notice services as the timely written notice that explains the basis and nature of the sanctions. The Department is disallowing an opportunity for BCBS to cure the non-compliance of the requirements above prior to sanction as the non-compliance is egregious, persistent, and incapable of being cured retroactively. Therefore, the Department is sanctioning BCBS in the amount of $87,500. BCBS is required to remit a check to the Department within 30 days of receipt of this letter. Payment should be sent to:

HFS Bureau of Fiscal Operations
Attn: Matthew Duff
2200 Churchill Road
Building A2
Springfield, IL, 62702

Attached is an MMAI Corrective Action Plan (CAP) that, if followed, should remediate the non-compliance actions above going forward. The CAP is a follow-up to the 2017 Administrative Review HSAG conducted at BCBS's office on December 6 and December 7, 2017 and a Focused File Review HSAG conducted at BCBS's office on December 21, 2017. The CAP includes required actions to address substantial noncompliance issues going forward, including those noted above.

The Department will monitor BCBS's remediation in accordance with HSAG's CAP to determine whether BCBS satisfactorily addresses the actions needed to correct the deficiencies. Furthermore, pursuant to Section 5.3.13 of the contract, *"CMS and the Department may require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan, and demonstrate to CMS and the Department that the implementation of the plan was successful in correcting the problem. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by CMS and the Department or other intermediate sanctions as described in Section 5.3.14."*

Please let your Account Manager know if you have any questions.

Sincerely,

Robert Mendonsa
Deputy Administrator, Division of Medical Programs
Illinois Department of Healthcare and Family Services

cc:

Michelle Maher
Laura Ray
Laura Phelan
Sylvia Riperton-Lewis
Matthew Seliger
Tobey Oliver
Naphatarra Pankey
Chad Johnson
Cynthia Garraway