DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

BLUE CROSS OF CALIFORNIA
DBA ANTHEM BLUE CROSS

A FULL SERVICE HEALTH PLAN

JULY 8, 2019

Routine Survey Final Report
Blue Cross of California
DBA Anthem Blue Cross
A Full Service Health Plan

TABLE OF CONTENTS

EXECUTIVE SUMMARY

On July 18, 2016, the California Department of Managed Health Care (Department) notified Blue Cross of California DBA Anthem Blue Cross (Plan) of its scheduled Routine Survey to be conducted pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The survey team conducted the onsite survey February 6, 2017 through February 10, 2017 and September 18, 2017 through September 22, 2017.

The Department assessed the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Access to Emergency Services and Payment
Prescription (Rx) Drug Coverage
Language Assistance

The Department identified **fourteen** deficiencies during the Routine Survey. The 2016 Survey Deficiencies Table below notes the status of each deficiency.

2016 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	
	QUALITY ASSURANCE	
1	**The Plan does not adequately document that quality of care problems are being identified and that effective action is taken to improve care were deficiencies are identified.** Rule 1300.70(a)(1).	**Not Corrected**
2	**The Plan does not ensure appropriate licensed professional participation in quality assurance (QA) activities.** Rule 1300.70(b)(2)(E).	**Not Corrected**
	GRIEVANCES AND APPEALS	
3	**The Plan does not insert a correct version of the Section 1368.02(b) paragraph on every Plan contract, on every evidence of coverage, on copies of Plan grievance procedures, on Plan complaint forms, and on all written notices to enrollees required under the Plan's grievance process.** Section 1368.02(b).	**Not Corrected**

#	DEFICIENCY STATEMENT	
	GRIEVANCES AND APPEALS	
4	**The Plan's online grievance submission process does not allow the enrollee to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal.** Section 1368.015(c)(2).	**Corrected**
5	**The Plan's online grievance submission process does not include the correct quoted statement required by Section 1368.015.** Section 1368.015(c)(3).	**Not Corrected**
6	**The Plan's grievances and appeals policies and procedures are not in accordance with Department regulations and do not ensure adequate consideration of enrollee grievances.** Section 1368(a)(1); Rule 1300.68(a)(1).	**Not Corrected**
7	**The Plan does not adequately inform enrollees upon enrollment and annually thereafter of the procedure for processing and resolving grievances.** Section 1368(a)(2).	**Not Corrected**
8	**The Plan does not ensure that grievance forms, a description of the grievance procedure, and assistance in filing grievances are readily available at each contracting provider's office.** Section 1368(a)(3); Rule 1300.68(b)(6) and (7).	**Not Corrected**
9	**The Plan does not ensure adequate consideration and rectification of exempt grievances.** Section 1368(a)(1).	**Not Corrected**
10	**The Plan does not resolve all exempt grievances by the close of the next business day following receipt of the grievance.** Section 1368(a)(4)(B)(i); Rule 1300.68(a)(4); Rule 1300.68(d)(8).	**Not Corrected**
11	**The Department's TDD line is not bolded in the Plan's acknowledgment letters.** Section 1368.02(b); Rule 1300.68(d)(7).	**Not Corrected**

#	DEFICIENCY STATEMENT	
	GRIEVANCES AND APPEALS	
12	**The Plan's acknowledgment letters do not include a written notice of the availability of interpretation services in identified threshold languages.** Section 1367.04(b)(1)(B)(iv); Section 1367.04(b)(1)(C)(i).	**Not Corrected**
	ACCESS TO EMERGENCY SERVICES AND PAYMENT	
13	**The Plan improperly denies emergency services and care based on medical necessity by applying an incorrect standard and allowing non-clinicians to make the determination.** Section 1371.4(c); Section 1367.01(e).	**Not Corrected**
14	**The Plan's written communications to enrollees pertaining to denied emergency room (ER) claims do not include a clear and concise explanation for the Plan's decision, a description of the criteria or guidelines used, or the clinical reasons for the decisions.** Section 1367.01(h)(4).	**Not Corrected**

SURVEY OVERVIEW

At least once every three years the Department evaluates each licensed health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975[1] through a routine survey that covers major areas of the plan's health care delivery system. Surveys are conducted pursuant to Section 1380 and include a review of the overall performance of the plan in providing health care benefits and meeting the health care needs of enrollees in the following areas:

Quality Assurance – Each plan is required to have a quality assurance program directed by providers and designed to monitor and assess the quality of care provided to enrollees, and to take effective action to improve the quality of care when necessary. The quality assurance program must address service elements, including accessibility, availability and continuity of care and must monitor whether the provision and utilization of services meets professionally recognized standards of practice.

Grievances and Appeals – Each plan is required to have a grievance system that ensures a written record and adequate consideration of grievances, appropriate and timely processing and resolution, continuous review to identify any emergent patterns of grievances, and reporting procedures to improve plan policies and procedures.

Access and Availability of Services – Each plan is required to provide or arrange for the provision of access to health care services in a timely manner, appropriate for the enrollees condition and consistent with good professional practice.

Utilization Management – Plan and delegate utilization management functions must ensure that decisions based on medical necessity are consistent with clinical criteria/guidelines, that utilization review and oversight operations are performed by appropriate personnel and that enrollees and requesting providers receive timely and appropriate information concerning approvals, denials and modifications of requested services. Plans must also ensure that utilization functions satisfy access and quality requirements.

Continuity of Care – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Access to Emergency Services and Payment – Each plan is required to ensure that emergency medical and behavioral health services are accessible and available, and that reimbursement for these services are made as appropriate. Plans

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

must also have post-stabilization procedures to ensure timely authorization of care or transfer of enrollees who are stabilized following emergency care.

Prescription (Rx) Drug Coverage – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescription drugs, benefits and services, and ensure benefit coverage is communicated to enrollees.

Language Assistance – Each plan is required to implement a language assistance program to ensure interpretation and translation services are accessible and available to enrollees.

The Department issued the Preliminary Report to the Plan on February 19, 2019. The Plan had 45 days to file a written statement with the Director identifying each deficiency and describing the action taken to correct each deficiency and the results of such action.

This Final Report describes the deficiencies identified during the survey, the Plan's compliance efforts, the status of each deficiency at the time of the Department's receipt of the Plan's 45 day response and actions for outstanding deficiencies requiring more than 45 days which will be reassessed at a Follow-Up Survey.

PLAN BACKGROUND

In 1993, the California Department of Corporations, now the Department, granted the Plan a license to operate as a health care service plan under the Knox-Keene Act. The Plan restructured its operations and formed a holding company, WellPoint Health Networks Inc., which merged with, and is now a wholly owned subsidiary of WellPoint, Inc. The Plan headquarters is in Woodland Hills, California. As of December 31, 2016, the Plan's commercial enrollment totaled 2,054,594.

The Plan contracts with participating medical groups (PMGs) to provide health care services (such as primary care, specialty care and some ancillary services) and compensates them on a capitated basis. The Plan also contracts with hospitals to provide hospital services on a capitated, per diem, case rate, or other basis. The Plan contracts with a number of skilled nursing facilities, home health agencies, and freestanding ambulatory surgical centers. Specialty care is provided by the PMGs through contracted specialists. The Plan also contracts with physicians statewide to provide services to its preferred provider organization enrollees.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On February 19, 2019, the Department issued the Plan a Preliminary Report that described each deficiency, as well as the legal and factual basis for each deficient finding. In that report, the Department instructed the Plan to within 45 days of issuance of the Preliminary Report:

(a) Develop and implement a corrective action plan for each deficiency, and
(b) Provide the Department with evidence of the Plan's completion of, or progress toward, implementing those corrective actions.

The following describes the Department's preliminary findings, the Plan's corrective actions, and the status of the deficiency following the Department's review of the Plan's compliance efforts.

DEFICIENCIES

QUALITY ASSURANCE

Deficiency #1: The Plan does not adequately document that quality of care problems are being identified and that effective action is taken to improve care were deficiencies are identified.

Statutory/Regulatory Reference(s): Rule 1300.70(a)(1).

Assessment: Based on a review of the Plan's policies and procedures, interviews with Plan staff, and review of potential quality issue (PQI) files, the Department determined the Plan fails to consistently identify quality issues and take appropriate action to improve care.

The Plan's training document regarding handling quality of care (QOC) and quality of service (QOS) grievances and PQIs, *Is it a QOC/Is it a PQI? Is it a PAE? Is it a QOS? Quality Circle*, defines a QOC issue as "a formal expression of dissatisfaction of medical care not based on an adverse benefit determination."[2] QOS issues are defined as "administrative issues that do not impact care" and "[do] not involve a clinical care issue."[3]

The first page of the Plan's grievances and appeals (G&A) policy states:

> The Health Plan is required by law to establish and maintain procedures for continuously monitoring the quality of care and performance of participating providers. Whereas [Quality of Care (QOC)] grievances are submitted by members, PQIs are issues that are identified by internal associates or external providers and must be investigated and tracked. No communication is sent to the member upon receipt of a PQI. The scope of

[2] Is it a QOC/Is it a PQI? Is it a PAE? Is it a QOS? Quality Circle.
[3] *Ibid*.

> the PQI review process may be concurrent or retrospective in nature. G&A will conduct an immediate investigation of a PQI regardless as to whether or not the patient is in the hospital or still under care.[4]

A few pages later, the policy states that QOC grievances must be "appropriately researched by requesting the necessary medical records/response within the first 30 calendar days of the Health Plan receipt date."[5] Although the policy sets forth circumstances where the timeframe for investigating QOC grievances may be extended to 60 days, the initial timeframe for investigation is 30 days.

The Department conducted two separate file reviews. The first set of files consisted of 75 randomly selected QOC and QOS files with severity levels of C-0 to C-2 and S-0 to S-2. Out of these 75 files, 45 files were neither QOC or QOS issues and were eliminated from the sample.[6] The second set of files consisted of 25 files selected because the Plan assigned severity levels of C-3[7] and higher and S-3[8] and higher. Out of these 25 files, seven files were neither QOC or QOS issues and were eliminated from the sample.[9] These 52 discarded files consisted of billing and claims issues, insurance broker issues, and requests to change effective date, which calls into question the Plan's ability to accurately identify QOC and QOS issues.

In 13 out of 29 files (45%) that were assigned lower severity levels,[10] records were requested by the Plan outside of the 30-calendar day timeframe set forth in the Plan's policy.[11] For example, in File #11, the enrollee complained on March 1, 2016 that the doctor gave her a CT scan she did not need or want. The Plan did not request records until November 11, 2016, 255 calendar days after the enrollee contacted the Plan.

In six out of 16 files (38%) that were assigned higher severity levels,[12] records were requested outside of the 30-calendar day timeframe.[13] For example, in File #12, the enrollee scheduled an appointment with the doctor because she was in pain. An ultrasound was performed and the office had not called back with the results. The enrollee called the Plan on January 12, 2016 and the Plan did not request records until June 4, 2016, 144 calendar days after the enrollee contacted the Plan.

---

[4] Anthem Enterprise G&A Policy, Title: Member Grievance, PQI and PAE Processes, page 1.
[5] *Id*. at 5.
[6] File #1; File #2; File #3; File #4; File #5; File #7; File #9; File #10; File #13; File #15; File #19; File #22; File #23; File #24; File #26; File #27; File #29; File #30; File #31; File #32; File #33; File #34; File #35; File #39; File #42; File #44; File #45; File #48; File #49; File #52; File #53; File #54; File #55; File #58; File #59; File #61; File #62; File #64; File #66; File #69; File #70; File #71; File #72; File #73; File #74.
[7] Failure of a practitioner/provider to respond to a member grievance regarding a clinical issue despite two requests per internal guidelines (Anthem Enterprise G&A Policy, Title: Member Grievance, PQI and PAE Processes, page 11).
[8] Failure of a practitioner/provider to respond to a member grievance despite two requests per internal guidelines (Anthem Enterprise G&A Policy, Title: Member Grievance, PQI and PAE Processes, page 11).
[9] File #3; File #6; File #13; File #14; File #17; File #18; File #23.
[10] File #28 was not included in the review as the Plan did not request additional records.
[11] File #6; File #11; File #12; File #14; File #18; File #25; File #36; File #37; File #40; File #41; File #50; File #57; File #65.
[12] File #7 and File #24 were not included in the review as the Plan did not request additional records.
[13] File #4; File #10; File #11; File #12; File #20; File #22.

Section 1300.70(a)(1) requires the Plan to document that QOC problems are identified and effective action is taken to improve care where deficiencies are identified. The Department requested 100 PQI files, but 52 files were immediately eliminated as they contained neither QOC nor QOS issues. It is concerning to the Department that Plan staff cannot identify grievances with care or service elements. In addition, the Plan's failure to investigate cases in a timely manner and in accordance with the timeframes set forth in the Plan's G&A policy, causes quality issues to remain unidentified and unresolved. As the Plan fails to consistently identify these issues and take appropriate action to improve care, the Department finds the Plan in violation of this regulatory requirement.

TABLE 1
Identification of PQIs

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
PQI (C-0 to C-2 and S-0 to S-2)	29	PQIs investigated in a timely manner	16 (55%)	13 (45%)
PQI (C-3, S-3, and above)	16	PQIs investigated in a timely manner	10 (63%)	6 (37%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it conducted training sessions to coach its G&A clinical team to evaluate quality issues. The Plan provided information to its Utilization Management (UM) teams on how to refer quality issues to the G&A team. The Plan also revised its policies to include actions it would take when providers do not submit or comply with corrective action plans or when providers do not respond to the Plan's requests for information. The Plan's "audit of these processes will begin April 15, 2019."

Supporting Documentation:

- Is it a QOC? Is it a PQI? Is it a PAE? Is it a QOS? Quality Circle (August 9, 2018)
- Commercial/Senior Business Member Grievance Complaint Referral/Form (revised September 5, 2017)
- Member Quality of Care ("QOC")/Quality of Service ("QOS") Investigations
- Member Grievance, PQI and PAE Processes, v 1.19 (last review date February 19, 2019)

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that the Plan has taken steps to correct this deficiency by training its G&A clinical and utilization management (UM) teams and revising its policies. However, although the Plan added provisions in its policies to include actions it will take

against noncompliant providers, the Plan's CAP failed to address how it will ensure Plan staff will request additional information in a timely manner. In addition, the Plan states that it will audit "these processes" beginning April 15, 2019, but it is unknown what the Plan will be auditing.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of the Plan's QOC and QOS files. Since the Plan will be auditing "these processes" starting mid-April 2019, the Department will also review the Plan's audit tools and audit results to assess whether Plan staff are accurately identifying quality concerns and taking action in a timely manner. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #2: The Plan does not ensure appropriate licensed professional participation in quality assurance (QA) activities.

Statutory/Regulatory Reference(s): Rule 1300.70(b)(2)(E).

Assessment: Based on a review of the Plan's policies and procedures, interviews with Plan staff, and review of PQI files, the Department determined the Plan does not consistently involve appropriately licensed professionals in performing required QA activities.

The Plan's grievances and appeals policy states:

> **I. Procedure for Intake and Screening of Member Grievances**
> 1. The grievance process begins upon the date the grievance is received by the Health Plan.
>
> 2. Quality of care grievances are assigned to a G&A clinical associate who coordinates the review until completion,
>
> 3. Quality of service grievances are assigned to a G&A Analyst who coordinates the review until completion …[14]

In addition:

> C. First Level Review of a Member Grievance or PQI (Non-Behavioral Health)
>
> 1. Quality of service and administrative (non-clinical) grievances are investigated and resolved by G&A Analysts …
>
> 5. Quality of care grievances and PQIs are processed by G&A clinical associates.[15] If the clinical associate determines the case is a non-issue

[14] Anthem Enterprise G&A Policy, Title: Member Grievance, PQI and PAE Processes, page 6.
[15] G&A Clinical Associates include licensed nurses and behavioral health clinicians, who coordinate the review and investigation of member clinical grievances, PQIs, and PAEs until resolution (Anthem Enterprise G&A Policy, Title: Member Grievance, PQI and PAE Processes, page 2).

> with no identifiable quality issue, the clinical associate may assign a level C-0. The clinical associate may also assign level C-1 for a known or predictable complication/outcome. LVN's must have sign-off from an RN when assigning a level C-0 and level C-1.
>
> 6. For all other cases, the G&A clinical associate will collect the medical records, request a response from the involved practitioner, facility or PMG, and will send a case summary to the Medical Director for review, upon receipt of the medical information …[16]

The Department reviewed the same two sets of PQI files referenced in Deficiency #1. During file review, the Department identified cases involving clinical issues that impacted care that were incorrectly classified as QOS and managed totally by non-clinical staff. In 11 out of 30 randomly selected files (37%)[17] and nine out of 18 files (50%)[18] that were assigned higher severity levels (C-3, S-3, and above), the cases involved clinical issues, but there was no indication that any clinical staff were involved. The cases came to the Plan as grievances and were handled only by non-clinical G&A specialists. For example:

- **File #38:** The enrollee complained that her neurologist told her to go off her seizure medication and said it would be good for her to have a seizure. The G&A specialist requested and reviewed treatment information from the doctor and determined there was no quality issue. This case should have been forwarded to clinical staff to determine whether the neurologist provided inappropriate care.

- **File #60:** The enrollee complained that the doctor kept asking for unnecessary tests (e.g., x-rays and MRIs). The G&A specialist classified this as a QOS case. The specialist spoke with someone from the provider's office and determined that the services were appropriate. This case should have been classified as a QOC case. In addition, medical records should have been obtained and evaluated by clinical personnel to determine if the care provided was appropriate.

- **File #24:** The enrollee's wife complained about the physician getting angry and scolding the enrollee for not following the medicine's exact prescription. The doctor did not listen to the enrollee's complaints and subjected the enrollee to confusing and varying doses of pain medication. When the enrollee had problems, they could not get in touch with the doctor. The doctor was moody and aggressive, threatened to let the enrollee go if he did not do what the doctor wanted, and eventually dropped the enrollee as a patient.

  A G&A specialist reviewed the case and without requesting additional information or clinical review, identified this case as a QOS issue and assigned a severity level of S-4 for "confirmed discrimination." Since the complaint contained charges that the pain medication was confusing and had varying dosages, the Plan should have investigated how the doctor was treating the pain issues, what

[16] Anthem Enterprise G&A Policy, Title: Member Grievance, PQI and PAE Processes, page 8.
[17] File #8; File #16; File #21; File #28; File #38; File #43; File #51; File #56; File #60; File #68; File #75.
[18] File #1; File #7; File #8; File #9; File #15; File #16; File #21; File #24; File #25.

medications were prescribed, and how the doctor responded to the patient's concerns. The appropriate way to conduct this investigation would have been to have a clinician manage the case, request medical records, and have a medical doctor review the case. Because these steps were not taken, the Plan was not able to determine if there was a QOC issue and whether follow-up could have improved subsequent care.

During onsite interviews, Plan staff stated that there is a tool for G&A staff to determine if grievances contain QOC issues, but the Plan was unable to produce the tool. Management staff in the G&A unit stated cases are audited to determine whether QOC issues were correctly identified and forwarded for clinical review. However, the G&A team did not provide the Department with the audit tool or a policy and procedure that described the process.

When asked about oversight of the handling of QOC and QOS cases, the Medical Director stated that he does not review grievances with only QOS issues so he was unaware of any issues related to the categorization of cases. He stated that the only reports he sees on how grievances are handled pertain to the timeliness of resolution. In addition, the Manager of Clinical G&A said that she does not review whether G&A staff appropriately classifies cases.

The Plan's quality assurance (QA) process is further complicated because the Plan has two separate routes for QOC and QOS grievances with no clinical oversight. Plan staff do not know where to route the cases, and non-clinicians end up reviewing QOC cases. Notably, on the behavioral health side, all grievances with QOC or QOS issues are reviewed by licensed clinicians, which makes it more likely that appropriate clinical review will occur.

Rule 1300.70(b)(2)(E) requires licensed professional participation in QA activity to be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. Since the Plan's PQIs with QOC issues are reviewed by non-clinical staff with little to no oversight from clinicians, the Department finds the Plan in violation of this regulatory requirement.

TABLE 2
Licensed Professional Engaging in QA Activities

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
PQI (C-0 to C-2 and S-0 to S-2)	30	Licensed professional participation in QA activity	19 (63%)	11 (37%)
PQI (C-3, S-3, and above)	18	Licensed professional participation in QA activity	9 (50%)	9 (50%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated coding errors existed because staff were "inappropriately working [QOS] in [QOC] modules due to a system change in the medical management system." The Plan claims that this "error" has since been resolved with the April 1, 2019 implementation of a new system called PEGA NextGen. The Plan also provided the Department with a policy that outlines the assignment of QOS and QOC cases, and a tool used by G&A staff to determine whether grievances contain QOC issues.

Supporting Documentation:

- Member Quality of Care ("QOC")/Quality of Service ("QOS") Investigations
- Member Grievance, PQI and PAE Processes, v 1.19 (last review date February 19, 2019)
- Standard Tool LEGEND (Excel Spreadsheet)

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that the Plan has taken steps to correct this deficiency by using a new system, implementing policies and procedures, and using a tool to identify quality issues in grievances. However, the Department must verify the Plan's CAP has effectively corrected this deficiency.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of QOC and QOS files. The Department may also conduct interviews and review any other documents deemed relevant.

GRIEVANCES AND APPEALS

Deficiency #3: **The Plan does not insert a correct version of the Section 1368.02(b) paragraph on every Plan contract, on every evidence of coverage, on copies of Plan grievance procedures, on Plan complaint forms, and on all written notices to enrollees required under the Plan's grievance process.**

Statutory/Regulatory Reference(s): Section 1368.02(b).

Assessment: The Department reviewed several of the Plan's template communications to enrollees and discovered that the Plan is using incorrect versions of the Section 1368.02(b) paragraph. In five documents,[19] the Plan used the following paragraph:

[19] (1) Member Grievance Form; (2) 2016 Annual Distribution to Existing Members; (3) QOC – Member Decision Letter Template; (4) QOC or QOS Member Acknowledgment Letter Template; (5) QOS – Member Decision Letter Template.

> The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **800-365-0609**, or at the TDD line **866-333-4823**, before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free number **(888-HMO-2219)** and a TDD line **(877-688-9891)** for the hearing and speech impaired. The department's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online. You may also contact the department by writing to the following address: 980 9th Street, Suite 500, Sacramento, CA 95814 or by e-mail at **helpline@dmhc.ca.gov**.

Comparing the paragraph above to the Section 1368.02(b) paragraph, there is extra punctuation and missing language in the second sentence of the Plan's paragraph. In addition, the Plan added a sentence to the end of the paragraph. In the sixth document reviewed,[20] there is an extra sentence added to the end of the Plan's paragraph.

Section 1368.02(b) requires certain plan documents to contain a quoted paragraph with specific formatting requirements. Since the Plan did not insert the paragraph verbatim in the six documents reviewed, the Department finds the Plan in violation of this regulatory requirement.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated that its G&A Program Director revised the Section 1368.02(b) paragraph and distributed the updated version "to all of the Plan's impacted business areas on March 5, 2019 with instructions to use 12 point boldface font per the regulation." In addition, the Member Grievance Form was updated on September 5, 2018. Letter templates were reviewed, and "[c]orrections to systematically create Member Acknowledgment and QOS/QOC letters have been submitted and are expected to be completed by April 30, 2019."

Supporting Documentation:

- Updated Section 1368.02(b) paragraph
- Member Grievance Form

Final Report Deficiency Status: Not Corrected

[20] Acknowledgment Letter Template.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

The Plan provided the Department with a revised Section 1368.02(b) paragraph, but other than an updated Member Grievance Form, the Plan did not provide evidence to demonstrate that the impacted business areas amended the various contracts, procedures, forms, and notices to contain this required paragraph.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through the review of the six documents enumerated in Footnotes 19 and 20. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #4: The Plan's online grievance submission process does not allow the enrollee to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal.

Statutory/Regulatory Reference(s): Section 1368.015(c)(2).

Assessment: The Plan's online grievance submission process does not allow enrollees to edit and preview complaints prior to submission. The Plan provided a website demonstration to the Department during the onsite portion of the survey, but the Department was unable to verify this requirement. In addition to the website demonstration, the Department requested screenshots of the online process to verify compliance.

The top half of the online grievance form asks for information such as preferred method of contact, claim number, doctor's name, date of service, etc. The bottom half of the online grievance form is a text box that allows enrollees to provide additional details about the grievance or appeal. An explanation added to the Plan's fourth screenshot states the member "can edit any and all fields before hitting 'send'"; however, enrollees can only edit information in the text box as they complete the form.

Section 1368.015(c)(2) requires that the Plan's online grievance submission process shall allow the subscriber or enrollee to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal. As the Plan's online process does not allow enrollees to preview and edit information entered before finalizing the complaint, the Department finds the Plan in violation of this regulatory requirement.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it understands that "the Department is requesting the enrollee be able to view the grievance form in its entirety on one screen." The Plan is in the process of developing a preview and edit function that will "allow the enrollee to edit any content as needed before submitting the form." The function is targeted for release on April 12, 2019.

Final Report Deficiency Status: Corrected

On May 23, 2019, the Plan arranged a WebEx teleconference with the Department to demonstrate its new preview and edit function. Plan staff logged into a test account and clicked on a link titled “GRIEVANCE FORM.” After filling out the online grievance form, Plan staff scrolled to the bottom of the page, where there were two buttons – “Preview and Send” and “Cancel.” Clicking on the “Preview and Send” button takes the user to a second page where all of the information filled out is displayed. At the bottom of the second page, there are two buttons – “Edit” and “Send.” Users who select the “Edit” button are taken back to the first page and will be able to make any corrections to the grievance form prior to submission.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been corrected.

Deficiency #5: The Plan’s online grievance submission process does not include the correct quoted statement required by Section 1368.015.

Statutory/Regulatory Reference(s): Section 1368.015(c)(3).

Assessment: The Plan’s online grievance submission process includes the following statement:

> The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the toll free telephone number listed on your ID card and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you might call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s Internet website has complaint forms, IMR application forms and instructions online.

Comparing the paragraph above to the Section 1368.015(c)(3) paragraph, the Plan’s telephone number is not inserted in the second sentence. Also, the last sentence in the paragraph is supposed to include the Department’s website address. However, instead of writing out the Department’s website address, the Plan made “Internet website” (last

sentence of the paragraph) a hyperlink that is supposed to take enrollees to the Department's website.[21]

Section 1368.015(c)(3) requires the Plan's online grievance submission process to contain a quoted paragraph. As the Plan did not insert the paragraph verbatim in its website, the Department finds the Plan in violation of this regulatory requirement.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it turned "internet website" into a hyperlink instead of writing out the Department's website address "to ensure compliance with Section 508[22] that requires all website content to be accessible to people with disabilities." Nevertheless, the Plan corrected its online submission process to include the paragraph required by Section 1368.015(c)(3), and changes were implemented on April 2, 2019.

Supporting Documentation:

- Plan Website Screenshot

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that the last sentence of the paragraph on the Plan's website still does not match the Section 1368.015(c)(3) paragraph. Specifically, the Plan's paragraph uses "Internet website," and the statutorily required language is "Internet Web site." In addition, the Plan should note that Section 1368.015(c)(3) also requires the statement be in a "legible font that is clearly distinguishable from other content on the page."

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency during another website demonstration. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #6: The Plan's grievances and appeals policies and procedures are not in accordance with Department regulations and do not ensure adequate consideration of enrollee grievances.

Statutory/Regulatory Reference(s): Section 1368(a)(1); Rule 1300.68(a)(1).

Assessment: The Department reviewed several policies and procedures as part of the Plan's grievance system. Plan policies contained the following definitions:

[21] Since the Plan provided a screenshot, the Department was unable to confirm whether the hyperlink is functional.
[22] The Rehabilitation Act of 1973.

- Appeal is a *formal* request for reconsideration or reversal of an adverse determination made by the health plan or by a contracting entity, e.g. a commercial HMO medical group (emphasis added).[23]

- Appeal: A *formal* request for a review of a prospective, concurrent and/or retrospective adverse benefit determination. Member appeals may be initiated by the member or the member's authorized representative, including a provider acting on the member's behalf (emphasis added).[24]

- Appeal: A *formal* request for review of an Adverse Benefit Determination. An appeal should always be documented in writing. It should be required to be submitted in writing by the member or the member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., urgent care), applicable state or federal law (e.g., California, Georgia, Medicare Advantage and it's [sic] prescription drug plan, MAPD) or applicable accreditation guidelines. This request is considered to be regulated and must be reported within company's G&A metrics (emphasis added).[25]

These definitions are problematic for several reasons. First, each of the definitions indicate that an appeal is a "formal" request, but the policies do not define what makes a request "formal," or whether there is an informal request process.[26] Second, the Plan's policy states, "G&A uses the term 'appeal' throughout this policy, but recognized that it is a form of grievance based on the DMHC's definition."[27] The Plan's definitions are inconsistent with Rule 1300.68(a)(1). Rule 1300.68(a)(1) does not require enrollees to "request" a grievance to be filed. Rather, the grievance process must be initiated as soon as it is determined that the enrollee or the enrollee's representative is expressing dissatisfaction, which includes complaints, disputes, and requests for reconsideration or appeal.

Furthermore, the Plan's California-specific Glossary of Terms provided to customer service representatives (CSRs) contains the requirement that appeals must be "submitted in writing by the member or the member's representative," and sets forth confusing exceptions. For example, one of the exceptions is "applicable state or federal law (e.g., California, Georgia, Medicare Advantage, and it's [sic] prescription drug plan, MAPD) or applicable accreditation guidelines…" No state or federal laws are cited, and no explanation is offered. This glossary is supposed to aid CSRs in the processing of

[23] West Region G&A Policy: Member Appeal Process for Standard and Expedited Appeals, Policy #G&A 1, page 4.
[24] Enterprise G&A Policy: Member Grievance, PQI and PAE Processes, page 3.
[25] CA Glossary of Terms Grievance & Appeals, page 1.
[26] During interviews, Plan staff confirmed that CSRs ask enrollees whether they wish to file a formal grievance. If the enrollee answers no, then the grievance will be neither filed nor documented.
[27] West Region G&A Policy: Member Appeal Process for Standard and Expedited Appeals, Policy #G&A 1, page 4.

G&A, but the confusing manner in which the exception is phrased may lead CSRs to believe that appeals cannot be orally filed.

Section 1368(a)(1) requires the Plan to establish and maintain a grievance system that provides reasonable procedures in accordance with Department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate. Rule 1300.68(a)(1) defines a grievance as "a written or oral expression of dissatisfaction regarding the plan and/or provider…and shall include a complaint, dispute, request for reconsideration or appeal…" Review of the Plan's policies and reference materials revealed erroneous or confusing language that may lead to CSRs inconsistently processing expressions of dissatisfaction as grievances. Moreover, asking enrollees to file a "formal" grievance and defining an appeal as a "formal" request is contrary to the regulatory requirement to treat all expressions of dissatisfaction, complaints, disputes, and requests for reconsideration or appeal as grievances. Therefore, the Department finds the Plan in violation of these regulatory requirements. Notably, this is a repeat deficiency from the Plan's last routine medical survey.[28]

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated, "[b]ased on discussions with Department, the Plan's response to this deficiency will be submitted at a later date."

Final Report Deficiency Status: Not Corrected

On June 5, 2019, the Department and the Plan entered into a settlement agreement resolving Enforcement Matter Number 15-268, which included uncorrected grievance system deficiencies from the 2013 Routine Survey.[29] In Exhibit B of the settlement agreement, the Plan agreed to implement various corrective actions such as enhancing training for its CSRs, auditing and monitoring CSR compliance, and incorporating process improvements to improve the handling of grievances. The Plan agreed to implement these corrective actions by July 31, 2019, and to provide the Department with periodic status and results of the corrective actions through April 2020.

To give the Plan adequate time and opportunity to implement these corrective actions, the Department will assess this finding at the Plan's next routine medical survey.

Deficiency #7: The Plan does not adequately inform enrollees upon enrollment and annually thereafter of the procedure for processing and resolving grievances.

Statutory/Regulatory Reference(s): Section 1368(a)(2).

Assessment: Upon enrollment and annually thereafter, enrollees receive a Welcome Kit and information sheet in the mail. The kit includes information on how to access personalized benefit information on the Plan's website, required notices and rights, and

[28] Routine Survey Final Report issued March 24, 2015 and Routine Survey Follow-Up Report issued December 16, 2016 (see Deficiency #1).
[29] Enforcement Matter Number 15-268 Stipulated Settlement Agreement.

how to access the evidence of coverage (EOC). As the Plan does not send EOCs to enrollees, enrollees can obtain a copy of the EOC by either requesting a copy from the Plan or by accessing it on the Plan's website. Neither the Welcome Kit nor the information sheet contain information on how the Plan processes and resolves grievances.

The EOC contains a section titled "How to Make a Complaint,"[30] which includes the Plan's post office box address where grievances may be submitted,[31] as well as the Section 1368.02(b) paragraph, which contains the Department's toll-free telephone number, TDD line, and website address.[32] The EOC instructs enrollees to call the customer service number on the member identification card, and does not provide the Plan's telephone number.[33]

Upon enrollment and annually thereafter, Section 1368(a)(2) requires the Plan to inform enrollees of its procedure for processing and resolving grievances as well as the location and telephone number where grievances may be submitted. The Plan's documents mailed to enrollees each year refer enrollees to the EOC for more information, but contain no references to the Plan's grievance process. Enrollees must request a copy of the EOC or find a copy of it online, and comb through a lengthy document to find the information. In addition, the EOC does not contain the Plan's telephone number for enrollees to call to file a grievance. Therefore, the Department finds the Plan in violation of this regulatory requirement.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it "corrected legal inserts to fully explain Anthem's process for filing grievances and how grievances are resolved by Anthem…" The inserts were revised to include information on how grievances can be submitted to the Plan, and the Section 1368.02(b) paragraph.

As of March 23, 2019, the CA Individual Welcome Kits will include the updated "universal insert." The insert will be included in Individual and Small Group Welcome Kits starting in July-August 2019. The insert will be mailed to Large Group enrollees beginning mid-April 2019. Starting June 2019, the Plan will send the insert to all fully insured members each June. On April 1, 2019, this information was posted on the Plan's website.

The Plan's Small Group and Large Group EOCs were revised to include the Plan's telephone number and TDD line. The changes will take place July through August 2019, and will be reflected in the Plan's annual benefit change submissions for 2020.

Supporting Documentation:

- DMHC Insert Draft 2
- Important information for you inside (Legal Notice)

[30] EOC pages 124 to135.
[31] *Id*. at 125.
[32] *Id*. at 133.
[33] *Id*. at 125 and 132.

- How to file a grievance or appeal a decision (https://info-ca.anthem.com/article/how-file-grievance-or-appeal-decision-1)

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that the Plan has taken steps to inform enrollees of the Plan's procedure for processing and resolving grievances. However, while the Plan provided a PDF of the revised insert, there is no evidence that the updated insert has been included in Welcome Kits, EOCs, and sent to enrollees.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through the review of Welcome Kits, EOCs, and mailings. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #8: The Plan does not ensure that grievance forms, a description of the grievance procedure, and assistance in filing grievances are readily available at each contracting provider's office.

Statutory/Regulatory Reference(s): Section 1368(a)(3); Rule 1300.68(b)(6) and (7).

Assessment: On August 26, 2016, the Plan emailed its medical groups' medical directors, quality management (QM) directors, and utilization management (UM) directors regarding member grievances. The email stated:

> …As you may be aware, the DMHC's routine medical survey will now include evaluation of a Health Plan's compliance with CA Health and Safety Code section 1368(a)(2); 28 CCR 1300.68(b)(2) and (9). These regulations require Health Plans to ensure that grievance forms, a description of grievance procedures, and assistance in filing grievances are readily available at each contracting provider's office, contracting facility, or Plan facility.
>
> We ask that you please review and distribute the attached Anthem Blue Cross grievance form to provider offices. Please implement a process to ensure that the attached grievance form is provided to an Anthem Blue Cross member upon request.

The statutory and regulatory provisions cited in the first paragraph of the Plan's email are incorrect, as the requirements to ensure grievance forms, descriptions of grievance procedures, and assistance in filing grievances are readily available at each contracting provider's office, contracting facility, or Plan facility are found in Rules 1300.68(b)(6) and (7).

During interviews, the Plan stated that it informs its medical groups of its grievance process by issuing the Plan HMO Manual to its providers. The Department asked the Plan how it audits the medical groups to ensure providers comply with the Plan's G&A process. The Plan responded that since medical groups are not delegated to perform G&A functions, the Plan does not perform audits to ensure that grievance forms, a description of the grievance procedure, and assistance in filing grievances are readily available at each contracting provider's office. The Plan's assertion that it does not need to oversee its medical groups to ensure compliance with Rules 1300.68(b)(6) and (7) is inaccurate because the regulations pertain to enrollees obtaining grievance forms and assistance, not to the processing of grievances.

Section 1368(a)(3) requires the Plan to provide grievance forms to enrollees. Rule 1300.68(b)(6) requires the Plan to ensure that assistance in filing grievances is provided at each location where grievances may be submitted. Rule 1300.68(b)(7) requires grievance forms and a description of the grievance procedure to be readily available at each Plan facility, and from each contracting provider's office or facility. The Plan instructed its medical groups to implement processes to provide grievance forms, procedures, and assistance to enrollees. However, since the Plan does not ensure the implementation of these processes, the Department finds the Plan in violation of these regulatory requirements.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it:

> [Instructs] its medical groups to implement processes to provide grievance forms, procedures and assistance to enrollees via email blasts. The Plan ensures the implementation of these processes with each delegated medical group by requiring an Anthem HMO coordinator to serve as a liaison to both the medical group and Anthem Covered Individuals. The coordinator responsibilities includes assisting enrollees with grievances[.]

The Plan also provided an excerpt from its HMO Manual, and highlighted a portion of its PMG/IPA Responsibilities section that describes the responsibilities of the Plan's HMO Provider Group Coordinator.[34]

On March 29, 2019, the Plan sent an email blast to its medical directors, QM directors, and UM directors citing Rule 1300.68(b)(6) and (7) instead of Rule 1300.68(b)(2) and (9). Each year, the Plan will send two email blasts to remind its commercial contracted providers that grievance forms, a description of the grievance procedure, and assistance in filing grievances must be readily available in the providers' offices. The first email blast is scheduled to go out on April 8, 2019.

The Plan will post the grievance form on the provider portal by April 30, 2019, and articles about this requirement will be included twice a year in the provider newsletter, beginning with the May 2019 provider newsletter. In addition, beginning August 2019, an annual survey will be distributed to commercially contracted providers via the provider portal "to confirm provider offices have implemented processes to provide

[34] HMO Manual page 12.

grievance forms and assistance to enrollees." The Plan will also provide ongoing educational webinars regarding this requirement to providers.

Supporting Documentation:

- Anthem Blue Cross HMO Manual: PMG/IPA Responsibilities (February 2016)
- Plan Email: Process for Submitting Member Grievances to Anthem Blue Cross (March 29, 2019)

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that that the Plan has taken steps to correct this deficiency by educating providers through email blasts, provider newsletters and webinars. However, the Department must verify the Plan's corrective actions have effectively corrected this deficiency.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through the review of various educational materials, provider contacts, and survey results. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #9: The Plan does not ensure adequate consideration and rectification of exempt grievances.

Statutory/Regulatory Reference(s): Section 1368(a)(1).

Assessment: The Department assessed 69 randomly selected exempt grievance files.[35] In 32 out of 69 files (46%), the Plan failed to adequately consider and rectify the grievance.[36] For example:

- **File #28:** The enrollee called the Plan to follow up on the status of a MRI authorization for her lower back. The CSR called the imaging company and verified that the request is pending for additional review. The enrollee also asked if authorization is needed for physical therapy, and the CSR said that only a prescription is needed. The enrollee then complained that her doctor's office waited too long to submit her request.

  The CSR did not address the enrollee's complaint about her doctor's office waiting too long to submit a MRI authorization. Taking too long to submit

[35] File #3 was removed because the Plan's internal system had problems, so file notes were limited. File #17, File #54, and File #55 were removed because the Department lacked jurisdiction to review those files.
[36] File #5; File #7; File #9; File #12; File #15; File #20; File #23; File #24; File #25; File #28; File #29; File #30; File #31; File #33; File #34; File #35; File #37; File #38; File #39; File #40; File #41; File #42; File #52; File #56; File #60; File #61; File #63; File #65; File #67; File #71; File #72; File #73.

paperwork may be a QOS issue for the Plan to address with the provider group or provider. In addition, if the enrollee has a serious lower back issue, the delay of the submission of the authorization may lead to a QOC issue. Either way, as there are no notes in the system, the CSR did not adequately consider or rectify this issue.

- **File #38:** The CSR's notes state, "[Member] upset the Neurologist MD was not [in network]. There are other Neurologists [in network] within 30 miles so we can't do a referral."

  The request to see an out of network provider was not adequately considered because the CSR failed to take into account that there could be a clinical reason as to why the enrollee needed to see that particular provider. Since CSRs do not have clinical training, it would have been more appropriate to elevate this case for clinical review to determine if a referral to this out of network neurologist is medically necessary for the enrollee's condition.

- **File #52:** The CSR's notes state, "[Member] has [a prescription] for oxycotin and morphine and having an issue getting it refilled until 8/26/16."[37] The CSR advised the member that he could file a grievance.

  Similar to the file above, the request for an earlier refill was not adequately considered because the CSR failed to take into account that there could be a clinical reason as to why the enrollee requested a refill a few days before the scheduled date. Since this could potentially be a clinical issue, the CSR should have elevated this case for clinical review instead of rejecting the enrollee's request merely based on refill dates. Furthermore, the CSR should not be advising the enrollee that the enrollee can file a grievance. If there is any expression of dissatisfaction regarding the Plan and/or provider, including complaints, disputes, or a request for reconsideration or appeal, the CSR should automatically file a grievance.[38]

The exempt grievance files the Plan provided to the Department for review contain screenshots of the Plan's internal system. In addition to the screenshots, the Plan inserted an additional sheet of paper in each file that contained an "analysis summary." The analysis summary for this case states, "…The CSR advised [member] they could file a grievance and the [member] declined. [Member] issue was resolved. An exempt grievance was filed due to [member] dissatisfaction with the Rx refill cycle prescribed by his doctor." The Department notes that the Plan is presenting additional facts that are not documented in the Plan's system, as the screenshots did not show that the enrollee rejected the filing of a grievance.

Section 1368(a)(1) requires the Plan to ensure adequate consideration of enrollee grievances and rectification when appropriate. Since 32 out of 69 (46%) exempt grievance files did not show that CSRs adequately considered or rectified the enrollees'

[37] The prescriptions were last refilled on 07/25/16. The next refill was scheduled for 08/26/16, and the enrollee called the Plan on 08/22/16.
[38] Please see Rule 1300.68(a)(1).

issues, the Department finds the Plan in violation of this regulatory requirement. Notably, this is a repeat deficiency from the Plan's last routine medical survey.[39]

TABLE 3
Adequate Consideration and Rectification of Grievances

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt G&A	69	Grievances must be adequately considered and rectified	37 (54%)	32 (46%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated, "[b]ased on discussions with Department, the Plan's response to this deficiency will be submitted at a later date."

Final Report Deficiency Status: Not Corrected

On June 5, 2019, the Department and the Plan entered into a settlement agreement resolving Enforcement Matter Number 15-268, which included uncorrected grievance system deficiencies from the 2013 Routine Survey.[40] In Exhibit B of the settlement agreement, the Plan agreed to implement various corrective actions such as enhancing training for its CSRs, auditing and monitoring CSR compliance, and incorporating process improvements to improve the handling of grievances. The Plan agreed to implement these corrective actions by July 31, 2019, and to provide the Department with periodic status and results of the corrective actions through April 2020.

To give the Plan adequate time and opportunity to implement these corrective actions, the Department will assess this finding at the Plan's next routine medical survey.

Deficiency #10: The Plan does not resolve all exempt grievances by the close of the next business day following receipt of the grievance.

Statutory/Regulatory Reference(s): Section 1368(a)(4)(B)(i), Rule 1300.68(a)(4), Rule 1300.68(d)(8).

[39] Routine Survey Final Report issued March 24, 2015 and Routine Survey Follow-Up Report issued December 16, 2016 (see Deficiency #4).
[40] Enforcement Matter Number 15-268 Stipulated Settlement Agreement.

Assessment: The Department assessed 69 randomly selected exempt grievance files.[41] In 32 out of 69 files (46%), the Plan failed to resolve the exempt grievance by the close of the next business day following receipt of the grievance.[42] For example:

- **File #15:** The enrollee called about his bill and was "also upset with refund issued." The CSR documented his explanation with regard to the enrollee's bill, but failed to address the enrollee's refund issue.

- **File #20:** The CSR's notes stated, "[Received Evidence of Benefits] for wife_[date of service] 102016 [advised] on claim reprocess_gave # to tech support and [transferred.]"

  The screenshots of the Plan's internal system showed that the enrollee's issues were not clearly documented. In addition, the file did not include a resolution. The Plan's analysis summary stated:

  Member contacted for claims adjustment and EOB for wife. Claims were properly tagged sent for processing. Member was advised that claims were processed on 11/16 and Member had not received adjusted EOB. All claims were adjusted and Member issue resolved. Member was provided phone for tech support and transferred. Exempt grievance was correctly filed due to technical support issues.

  The Department notes that the Plan is presenting additional facts that were not documented in the Plan's system. These analysis summaries are created by Plan staff; however, the source of the information is unknown.

- **File #33:** The CSR's notes stated, "[Member] called to verify that her doctor was changed as she was assigned to the wrong doctor…[Advised] that yes and fax over letter to [phone number]. [Attention (woman's name)] per [member] request."

  It is unclear why the CSR said yes. The CSR could be confirming that the enrollee's doctor changed, or agreeing that the enrollee was assigned to the wrong doctor. Either way, the reason why the enrollee called is unclear. Presumably, the enrollee wants to switch to a different doctor, but the CSR's actions were also unclear, as it is unknown what was faxed and who the woman is. Ultimately, the Department finds this case unresolved because it is unknown whether the enrollee was able to change her doctor.

  The Plan's analysis summary stated:

[41] File #3 was removed because the Plan's internal system had problems, so file notes were limited. File #17, File #54 and File #55 were removed because the Department lacked jurisdiction to review those files.
[42] File #5; File #7; File #9; File #12; File #15; File #20; File #23; File #24; File #25; File #28; File #29; File #30; File #31; File #33; File #34; File #35; File #37; File #38; File #39; File #40; File #41; File #42; File #52; File #56; File #57; File #60; File #61; File #65; File #67; File #71; File #72; File #73.

> Member contacted Anthem called because she was auto assigned to the wrong doctor and was calling to verify that a PCP change had been made in the system. The CSR reviewed member's account and confirmed that she had been re-assigned to a new PCP. CSR resolved issue by faxing a new eligibility letter to the new PCP's office. An exempt grievance was correctly filed due to an incorrect doctor being assigned to the member.
>
> Again, the Department notes that the Plan is presenting additional facts that were not documented in the Plan's system and the source of the information is unknown.

Due to the CSRs' sparse documentation, many of the 32 deficient exempt grievance files did not include evidence that the enrollee's grievance was resolved. In addition, when enrollees contact the Plan with multiple issues, CSRs frequently do not resolve all of the issues. There were also files that were resolved, but the resolution took multiple days, so the grievance should have been handled through the Plan's standard grievance process.

Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8) require exempt grievances to be resolved by the close of the next business day upon receipt of the grievance. Rule 1300.68(a)(4) defines "resolved" to mean that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, with no pending enrollee appeals within the Plan's grievance system. The Plan's attempt to demonstrate compliance by inserting additional, unsubstantiated information such as the analysis summary is concerning to the Department, as the Plan is unable to provide valid evidence that exempt grievances are processed in accordance with the law. Therefore, the Department finds the Plan in violation of these regulatory requirements. Notably, this is a repeat deficiency from the Plan's last routine medical survey.[43]

TABLE 4
Resolution of Exempt Grievances

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt G&A	69	Exempt grievances must be resolved by the close of the next business day	37 (54%)	32 (46%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated, "[b]ased on discussions with Department, the Plan's response to this deficiency will be submitted at a later date."

[43] Routine Survey Final Report issued March 24, 2015 and Routine Survey Follow-Up Report issued December 16, 2016 (see Deficiency #3).

Final Report Deficiency Status: Not Corrected

On June 5, 2019, the Department and the Plan entered into a settlement agreement resolving Enforcement Matter Number 15-268, which included uncorrected grievance system deficiencies from the 2013 Routine Survey.[44] In Exhibit B of the settlement agreement, the Plan agreed to implement various corrective actions such as enhancing training for its CSRs, auditing and monitoring CSR compliance, and incorporating process improvements to improve the handling of grievances. The settlement agreement also contained specific provisions regarding the Plan's handling and resolving of exempt grievances. The Plan agreed to implement these corrective actions by July 31, 2019, and to provide the Department with periodic status and results of the corrective actions through April 2020.

To give the Plan adequate time and opportunity to implement these corrective actions, the Department will assess this finding at the Plan's next routine medical survey.

Deficiency #11: The Department's TDD line is not bolded in the Plan's acknowledgment letters.

Statutory/Regulatory Reference(s): Section 1368.02(b), Rule 1300.68(d)(7).

Assessment: Section 1368.02(b) and Rule 1300.68(d)(7) require the Plan's standard G&A acknowledgment letters to contain the Department's TDD number in 12 point boldface type. The Department reviewed 70 standard G&A files. The acknowledgment letters in 16 out of 70 files (23%)[45] did not contain the Department's TDD number in boldface type.[46] Therefore, the Department finds the Plan in violation of these regulatory requirements.

TABLE 5
Section 1368.02(b) Paragraph in Acknowledgment Letters

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard G&A	70	Acknowledgment letters include Section 1368.02(b) paragraph with the Department's TDD number in boldface type	54 (77%)	16 (23%)

[44] Enforcement Matter Number 15-268 Stipulated Settlement Agreement.
[45] File #1; File #2; File #5; File #7; File #9; File #12; File #28; File #38; File #39; File #42; File #53; File #56; File #59; File #63; File #65; File #68.
[46] File #28 and File #53 did not contain acknowledgment letters. The acknowledgment letters in File #42 and File #68 did not contain Section 1368.02(b) paragraphs.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it identified a system issue that was corrected on October 14, 2016. The system change "fixed the boldface type of the TDD line in the acknowledgment letters" and "provided for an annual validation of system letters in the quality program to avoid such issues in the future." Letters are being changed in the system and are targeted for release by April 30, 2019.

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that that the Plan has taken steps to correct this deficiency by making system changes. However, the Department must verify the Plan's corrective actions have effectively corrected this deficiency.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of standard grievance and appeal files. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #12: The Plan's acknowledgment letters do not include a written notice of the availability of interpretation services in identified threshold languages.

Statutory/Regulatory Reference(s): Section 1367.04(b)(1)(B)(iv), Section 1367.04(b)(1)(C)(i).

Assessment: The Plan's Notice of Language Assistance Services (NOLA) that it sends along with its vital documents informs enrollees that they are entitled to:

- Free interpreter services 24 hours a day, 7 days a week, including sign language interpreters;
- Free written translation services;
- Language assistance with the G&A process.[47]

In addition, vital documents not translated up-front will contain a NOLA informing enrollees of the availability of interpretation and translation services.[48]

Section 1367.04(b)(1)(B)(iv) and Section 1367.04(b)(1)(C)(i) require Plans to include a written notice of the availability of interpretation services with grievance acknowledgment letters. The Department reviewed 70 standard G&A files. The acknowledgment letters in 15 out of 70 files (21%)[49] did not contain a NOLA.[50] Instead,

[47] Anthem Blue Cross California Language Assistance Program, page 4.
[48] *Id*. at 6.
[49] File #11; File #18; File #19; File #21; File #25; File #28; File #37; File #46; File #48; File #50; File #51; File #53; File #57; File #69; File #70.
[50] File #28 and File #53 did not contain acknowledgment letters.

there was a statement in English asking Spanish-speaking enrollees to contact the Plan. Therefore, the Department finds the Plan in violation of these regulatory requirements.

TABLE 6
Inclusion of NOLAs with Acknowledgment Letters

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard G&A	70	Acknowledgment letters include a NOLA	55 (79%)	15 (21%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated that all acknowledgment letter templates reviewed in March 2019 include a NOLA. Letters have been audited and tested, and once system changes are implemented and available on April 30, 2019, the Plan will send a copy of the acknowledgment letter with the appropriate NOLA attachment.

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that that the Plan has taken steps to correct this deficiency by making system changes. However, the Department must verify the Plan's corrective actions have effectively corrected this deficiency. As of the issuance date of this Final Report, the Department has not received a copy of the acknowledgment letter with a NOLA statement attached.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of acknowledgment letter templates and standard grievance and appeal files. The Department may also conduct interviews and review any other documents deemed relevant.

Grievance System Recommendations

The Department's 2013 Routine Survey Follow-Up Report provided a brief historical summary of the Plan's systemic violations in its G&A operations spanning a 13 year period.[51] Notably, deficiency numbers six, nine, and ten in this routine medical survey, set forth in the table above, are identical to deficiencies previously uncorrected by the Plan.[52]

[51] Routine Survey Follow-Up Report of Blue Cross of California, issued December 16, 2016; available on the DMHC Public Website; see Executive Summary, pp. 2 through 6.
[52] Deficiency numbers one, four, three, respectively in the December 2016 Follow-Up Report.

Due to these systemic issues, the Department engaged Navigant Consulting, Inc. (Navigant) to analyze the Plan's administration of G&A during this routine survey, and specifically, to assess the root cause of the issues that may impact the Plan's ability to administer a compliant G&A program. Navigant evaluated documentation and data regarding operations and staffing, and conducted interviews of Plan staff to understand how the Plan's delivery model operates. Navigant focused its review on three areas in the Plan's G&A operations: (1) Training, (2) Call Center, and (3) Systems. See Appendix A for a summary of Navigant's findings for each area.

Recommendations for Best Practices

Health plans that have experienced findings by state or federal regulators provide robust training programs illustrating the findings that were discovered by the regulator and emphasize the importance of how the health plan is going to rectify these issues. Compliance departments are found to be the leaders to champion these efforts and hold business leaders accountable to ensure that compliance will be delivered with frequent reports to the executive team. Therefore, the Department provides the following guidance to the Plan pursuant to Section 1380(g):

1. ***Improve call center training materials.***

The Plan's G&A materials (e.g., trainings, job aids, tools, etc.) for its CSRs contain information that is inconsistent with statutory and regulatory requirements. The Plan should revise these materials to ensure the information is accurate and that CSRs can correctly distinguish grievances from inquiries. CSRs should also be trained to issue spot. To ensure CSRs are performing their jobs properly, as a QA mechanism, the Plan should test and assess its CSRs at least quarterly to ensure they are accurately identifying grievances. In addition, once grievances are identified, CSRs must be trained to process the issues as grievances without asking the enrollee for permission to elevate the issue to a grievance.

2. ***Structure the call center to include a dedicated team of CSRs to handle calls from California enrollees.***

Considering the number of locations available to take calls for California enrollees, it seems logical that a health plan would have several options available to field calls in a timely manner. However, it was discovered by Navigant in the interview process that these call centers also take calls for other Anthem Health Plans across many other states with an expectation that their CSRs would have the ability to have cross functionality and answer questions no matter where enrollees were calling from. It is difficult for CSRs to be fluent in all the details in how to handle calls and special parameters related to each state or group in which a plan is delivered. For a health plan of over two million enrollees, it would be expected that there would be dedicated staff who are experts in the California market they serve.

3. ***The Interactive Voice Response system should have prompts made available for enrollees to file a grievance or an appeal.***

Health plans often have dedicated lines to reach grievance departments. Considering appeals are typically related to a health care service an enrollee or provider is trying to receive services for their patient, by not simplifying this process risks delays in an enrollee receiving care, or a call to be mishandled and not obtain the priority it may need.

4. Implement an integrated systems solution.

Systems with multiple options and the ability for CSRs to select a range of codes or drop-down designations can lead to inconsistencies and impact the ability for a health plan to obtain data reports which accurately represent what has occurred. Most large health plans have focused CSRs on specific products and focused topics to ensure that their skillsets are honed to a particular topic and mitigate variance in the logging and documentation of calls. During the interview process, there was discussion about migration to a new platform (PEGA) which is to overcome many of the complicated current functions. It will also reduce the number of systems used by the Plan.

For more information on Navigant's analysis and findings, please see Appendix A.

ACCESS TO EMERGENCY SERVICES AND PAYMENT

Deficiency #13: The Plan improperly denies emergency services and care based on medical necessity by applying an incorrect standard and allowing non-clinicians to make the determination.

Statutory/Regulatory Reference(s): Section 1371.4(c), Section 1367.01(e).

Assessment: Based on a review of the Plan's policies and procedures and Emergency Room (ER) claim denial files, the Department determined the Plan improperly denies claims for emergency services and treatment by applying an incorrect standard in its review of claims and not conducting a clinical review to make the determination.

The Plan's Emergency Service Coverage policy states:

- Coverage is provided for emergency service visits in or out of the member's service area 24 hours a day, seven days a week if presenting symptoms seem emergent to a prudent layperson.
    - Emergency services are covered to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
        - For purposes of applying this standard, a prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment.
        - A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand,

> that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.[53]

The Plan's Medical Emergencies Policy, intended to "[give] Claims associates the policy, definition, state law requirements and exceptions for California medical emergencies," also provides information on the prudent layperson standard,[54] which is the incorrect standard to apply when determining whether to authorize payment for emergency services in California. Section 1371.4(c) states that reimbursement for emergency services and care may be denied "when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist." The California standard is different because it focuses on whether the enrollee reasonably determined that the situation was emergent, and does not compare the enrollee's determination with how others would have assessed the situation.

The Department reviewed 44 ER facility claim denial files and 10 ER professional claim denial files. All 54 claims were denied because the services rendered were found not to be medically necessary. Review of the files showed that none of these medically necessary determinations were made by licensed physicians or licensed health care professionals, as required by Section 1367.01(e). Instead, the claims were denied via auto adjudication within the Plan's claims system because the system is configured to automatically deny certain emergency diagnosis codes as not medically necessary.[55]

During onsite interviews, the Plan's claims and utilization management staff confirmed the Department's findings. Medical necessity denials were made solely based on ER discharge diagnoses – no medical records were obtained, and no outreach was conducted to obtain information on the enrollees' presenting symptoms.

During interviews with Plan staff on September 21, 2017, the Department was informed that after an internal investigation and preparation for the Department's Survey, the Plan discovered ER claims payment issues and will adjust all denied ER claims received between August 1, 2015 and August 24, 2017. The Plan informed the Department that the reprocessing of these claims was completed by September 2017. A "stop edit" was added to the system on August 24, 2017 so the Plan can pay for all capitated ER claims. In addition, Plan staff will perform spot checks and monitor monthly impact reports to ensure the accuracy of the Plan's denials. The Plan also informed the Department that revised policies and procedures were submitted to the Department in September 2017 and that all claims processed after September 2017 were processed according to the revised policies and procedures.

To determine whether to approve payment for emergency services and care, Section 1371.4(c) requires plans to consider whether the enrollee should have known that an

[53] Anthem Blue Cross Life and Health Insurance Company Care Management Operational Guideline, Utilization Management 0.43 – Emergency Service Coverage, page 2.
[54] Medical Emergencies Policy, page 1.
[55] ER facility emergency denial codes: 3, 11, 17. ER professional denial codes: P2, P4.

emergency did not exist. The Plan uses the prudent layperson standard and diagnosis codes instead of considering the enrollee's subjective belief that an emergency existed.

Section 1367.01(e) requires licensed physicians or licensed health care professionals who are competent to evaluate the specific clinical issues involved in the health care services to deny health care service requests based on medical necessity. However, the Plan's claims system automatically denies ER claims for lack of medical necessity based on diagnosis codes. There is no review of medical records and other information pertinent to the enrollees' ER visits. In addition, it is incorrect to determine whether or not to pay the claim based on the diagnosis, as most enrollees do not have medical training to assess whether their symptoms actually constituted a medical emergency. Therefore, the Department finds the Plan in violation of these regulatory requirements

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it agrees that some ER claims were denied incorrectly because its claim system "was configured to deny certain diagnosis codes as not a medical emergency, or due to inaccurate manual processing guidelines." The Plan provided an "impact report" to demonstrate claims from August 24, 2017 through September 19, 2017 were adjusted.

On April 18, 2018, the Plan implemented a Small System Change Request (SSCR) "to ensure all ER Service claims for members with plans regulated by the DMHC would be processed according to the Department's standard." The SSCR was approved on May 15, 2018, and a re-validation check was completed on March 9, 2019, with no issues identified.

The Plan revised and submitted its manual processing guidelines to the Department on September 21, 2017. The Plan implemented a bi-weekly claims audit of all Department regulated ER denied claims. If errors are found, claims will be escalated for adjustment within seven days, and remedial action will be taken with impacted associates.

On September 21, 2017, the Plan stated that it provided the Department with updated policies where "prudent layperson" was replace with "reasonable person." The Plan defines "reasonable person" as, "…a person who is without medical training. They draw on their practical experience when deciding if emergency medical treatment is necessary." The Plan submitted its revised policy via the Department's web portal on September 28, 2017.

Supporting Documentation:

- DMHC HMO ER Claims Impacted Spreadsheet (Version 1)[56]
- DMHC HMO ER Claims Impacted Spreadsheet (Version 2)[57]
- SSCR ER Claims Validation Check Spreadsheet (April 14, 2018)
- Medical Emergencies California (Revision: September 27, 2017)

[56] The spreadsheet contains 4,260 claims from August 24, 2017 through September 19, 2017. The Plan provided Version 1 with its CAP response on April 5, 2019.
[57] Since Version 1 did not include the adjusted amounts for each claim, the Department requested the Plan provide the amounts billed and paid by the Plan. The Plan provided Version 2 on May 30, 2019. In the new spreadsheet, the "Member ID" column was removed and three new columns – "Item Code," "Total Bill," "Paid Amount" were added.

- Process Medical Emergency Claims – CA (Revision: September 27, 2017)

In addition, on June 3, 2019, the Department requested the following information from the Plan related to the HMO ER Claims Impacted Spreadsheet:

> Please add the following three columns to the updated claims report spreadsheet - (1) date of service, (2) date of reimbursement, and (3) enrollee ID number. The spreadsheet should consist of all denied ER claims from August 1, 2015 to date. Please confirm that all re-adjudicated amounts include the appropriate interest and penalties pursuant to Section 1371. The Department noticed that 648 entries where the paid amount column shows 0.00 (593 entries) or is blank (55 entries). Were these files re-adjudicated?
>
> In addition, please provide the Department with:
>
> 1. Templates of communications and samples of correspondence to enrollees and providers with regard to the re-adjudicated ER claims, and the prohibition of balance billing as set forth in Section 1379.
>
> 2. Reports and/or summaries of bi-weekly claims audits conducted between September 20, 2017 to date. For any claims in which errors were found, include evidence that the claim was adjusted within seven days, per the Plan's new process.

The Plan was given until June 10, 2019 to respond to the Department's request, but the Plan requested an extension, and provided the documents on June 24, 2019.

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that that the Plan has taken steps to correct this deficiency by reprocessing incorrectly denied claims, making system changes, and amending its policies. Although the Plan has amended its ER policies to replace "prudent layperson" with "reasonable person" and included a definition of "reasonable person," the Department must verify the Plan's corrective actions have effectively corrected this deficiency. The Plan sent the Department an ER Claims Validation Check Spreadsheet that contains 18 entries, with a column called "DCN" and a column called "Checkout Status." The Plan's narrative indicates that this spreadsheet is evidence that the SSCR validation process was completed; however, the information on this spreadsheet is unclear.

The Plan's June 24, 2019 ER claims spreadsheet should have been comprehensive and contain re-adjudicated ER claims from August 2015 to June 2019. However, in comparing all five ER claims spreadsheets the Plan provided in relation to this deficient finding, the Department found discrepancies between each of the spreadsheets. The Plan also provided two copies of explanations of benefits to enrollees and two copies of

explanations of payment to hospitals to show refunded amounts. The results of the Plan's internal ER claims audits from March 2019 to June 2019 show that the Plan is proactively remediating claims errors, and the Department will continue to work with the Plan to reconcile its data and to ensure completion of its re-adjudication efforts.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of the Plan's bi-weekly claims audit tools and findings, as well as denied and modified ER claims based on medical necessity. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #14: The Plan's written communications to enrollees pertaining to denied emergency room (ER) claims do not include a clear and concise explanation for the Plan's decision, a description of the criteria or guidelines used, or the clinical reasons for the decisions.

Statutory/Regulatory Reference(s): Section 1367.01(h)(4).

Assessment: Section 1367.01(h)(4) requires communications regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing…and shall include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

The Department reviewed 44 ER facility claim denial files and 10 ER professional claim denial files. In all 54 denial letters, the Explanation of Benefits (EOB) supplied to the enrollees as notification of the medical necessity reason for the denial of the ER visit only stated: "These services are not payable because it appears from the information we have that this was not a medical emergency under the terms of the members benefit agreement." As these explanations are unclear, do not include a description of the criteria or guidelines used, or the clinical reasons for the decisions, the Department finds the Plan in violation of this regulatory requirement.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan requested that the Department remove this deficiency. The Plan stated:

> While there was an error in denying the ER claims, it is not an accurate statement that medical necessity denials were made solely based on the ER discharge diagnosis because there was no medical necessity review performed. Therefore the Explanation of Benefits (EOB) message would not include a description of the criteria or guidelines used, or the clinical reason for the decision because of the Claims System coding error and processing guidelines explained previously in the Response to Deficiency 13. Because this is duplicative of Deficiency 13, the Plan requests this Deficiency be removed from the Final Report.

Final Report Deficiency Status: Not Corrected

The Department denies the Plan's request to remove this deficiency from the Final Report. Although the Plan asserts no medical necessity review was performed, the language in the EOB indicates that the service was denied because it was "not a medical emergency." By stating that the services are not medical emergencies, the Plan is in effect informing enrollees that the emergency services rendered were not medically necessary. If the Plan informs enrollees that the denial is based on lack of medical necessity, then the Plan is required to provide enrollees with a clear and concise explanation, description of the criteria or guidelines, and clinical reasoning, as required by Section 1367.01(h)(4).

Since the Plan has not proposed or undertaken any corrective actions, the Department has determined that this deficiency has not been corrected.

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a CAP that addresses all elements of this deficiency, and provide a status report on the Plan's compliance efforts.

To demonstrate compliance with Section 1367.01(h)(4), the Plan shall also provide the Department with:

- Copies of all denied ER claims based in whole or in part on medical necessity between March 9, 2019 and June 30, 2019. Please include all written communications to enrollees pertaining to these denials.
- Templates of EOBs and other written communications to enrollees regarding denied ER claims based in whole or in part on medical necessity.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of denied and modified ER claims based on medical necessity. The Department may also conduct interviews and review any other documents deemed relevant.

SECTION II: SURVEY CONCLUSION

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web Portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

Once logged in, follow the steps below to submit the Plan's response to the Final Report:

- Click the eFiling link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the **DPS Routine Survey Document Request** titled, **2016 Routine Full Service Survey – Document Request**.

The Department has completed its Routine Survey. Where indicated, the Plan shall submit a supplemental 60-day response through the Department's Web Portal. In addition, the Department may request subsequent supplemental responses to assess progress with the Plan's corrections actions.

If the Plan's corrective actions result in revisions to documents and/or information previously submitted to the Department's Office of Plan Licensing, or new documents required to be filed as an Amendment or Notice of Material Modification, please submit those documents to the Department's eFiling Web Portal using the File Documents link. Please indicate in the Exhibit E-1 that the filing is in response to the survey. All applicable documents must be submitted as an Amendment or Notice of Material Modification, as applicable (see Section 1352 and Rule 1300.52.4).

The Department will conduct a Follow-Up Review of the Plan and issue a Report within 18 months of the date of this Final Report.

APPENDIX A: NAVIGANT ANALYSIS AND FINDINGS

Routine medical surveys of the Plan performed by the Department in 2010, 2013, and 2014 demonstrated the Plan's non-compliance with numerous grievance system requirements of the Knox-Keene Act and Rules. The 2013 through 2014 outstanding deficiencies regarding the Plan's administration of its grievance system are as follows:

- The Plan does not maintain a grievance system that consistently ensures any written or oral expression of dissatisfaction is considered a grievance. Section 1368 (a)(1) and Rule 1300.68(a)(1).
- The Plan impermissibly processes standard grievances that are not resolved by the close of the next business day through its exempt grievance process. Section 1368(a)(4)(B); Rule 1300.68(a)(4); and Rule 1300.68(d)(8).
- The Plan does not maintain a grievance system that consistently ensures adequate consideration of enrollee grievances and rectification where appropriate. Section 1368(a)(1), (4)(A) and (5); Rule 1300.68 (a)(1); and Rule 1300.68(d)(1)-(3) and (5).

The Department engaged Navigant Consulting, Inc. (Navigant) to assist with analysis the Plan's administration of G&A during this Routine Survey. The analysis focused on three areas: (1) Training, (2) Call Center, and (3) Systems. Navigant evaluated documentation and data regarding operations and staffing, and conducted interviews of Plan staff to understand how the Plan's delivery model operates, and the Department assessed the Plan's training materials and grievance policies.

1. Training Assessment

Grievance Overview: Grievance and Appeals Training is a PowerPoint presentation, of which only three slides addressed grievances and inquiries.[58] Slide #7 defines "grievance" as "an expression of dissatisfaction or a complaint." This definition is problematic because it is only a portion of the definition set forth in Rule 1300.68(a)(1).[59] The Plan's incomplete definition leaves out disputes, requests for reconsideration, and appeals, which must be classified and treated as grievances. The definition also omits who can file grievances (the enrollee or the enrollee's representative), as well as the fact that grievances must only pertain to plans or providers. In addition, the bottom of the slide provides, "It is not always a phrase, it can also be a tone of voice." As there are situations where dissatisfied individuals can be polite, the Plan should use caution when instructing CSRs to identify grievances based on the enrollee's tone of voice.

[58] Slides 7 through 9.
[59] Rule 1300.68(a)(1) defines "grievance" as "a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance."

Slide #8 defines "inquiry" as a "request for information and can be in the form of a question." The slide contains four claims related questions as examples of inquiries,[60] and instructs CSRs to ask probing questions as there could be a gray area where "some grievances may appear to be inquiries." The Plan's failure to teach CSRs that grievances must include disputes, requests for reconsideration, and appeals will undoubtedly cause CSRs to be predisposed to identify claims issues as inquiries instead of grievances. Moreover, although the Plan is correct with respect to "gray areas," the Plan fails to instruct its CSRs that when in doubt whether the enrollee is calling with an inquiry or grievance, the law requires the matter shall be processed as a grievance.[61]

CA Grievances and Appeals Overview is a training module that defines grievances and inquiries, and provides operational steps for CSRs to input information into the Call Care Browser (CCB) system. In this document, "grievance" is defined as "any written or oral expression of dissatisfaction regarding the plan and/or provider made by the member or member's representative. Grievances include complaints about the QOC and QOS concerns."[62] Although this definition contains more elements than the definition in the PowerPoint presentation discussed above, it is still incomplete as it again fails to instruct CSRs to classify disputes, request for reconsideration, and appeals as grievances. It is concerning that the Plan uses incomplete and inconsistent definitions in its training materials.

Furthermore, the Plan incorrectly trains its staff to distinguish between inquiries and grievances by assessing enrollee satisfaction. If the enrollee is satisfied, then it is an inquiry. If the enrollee is dissatisfied, then it is a grievance.[63] This is extremely problematic, as whether the enrollee's issue is an inquiry or grievance is completely unrelated to the enrollee's satisfaction. Instead, the Plan should train CSRs to assess whether enrollees are expressing dissatisfaction, complaining, disputing, requesting reconsideration, or appealing.

This *CA Grievances and Appeals Overview* states that one-day grievances, the Plan's term for exempt grievances, must be "resolved by the close of the next business day."[64] This definition for exempt grievances is incomplete because Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8) specifically exclude coverage disputes, disputed health care services involving medical necessity, and experimental or investigational treatment to be classified and handled as exempt grievances. The Plan left out the three types of excluded issues from its exempt grievance definition. On page 16, "coverage dispute" is tucked away in a list of 16 examples of what cannot be routed as one-day grievances, but the list does not contain disputes regarding medical necessity and experimental or investigational treatment. Although the three types of excluded issues are later listed on

[60] The four questions are: (1) How did you pay my claim? (2) Why was my claim paid that way? (3) Has my claim been received by your office? (4) Why did you not pay the entire bill?
[61] *See* Footnote 4, Rule 1300.68(a)(1), last sentence.
[62] CA Grievances and Appeals Overview, page 3.
[63] *Id*. at 8.
[64] *Id*. at 7.

page 18, it would be less confusing for Plan staff if complete definitions are provided throughout the training document, instead of in piecemeal fashion.

The module also provides, “One-day grievances are an expression of dissatisfaction and are taken over the phone.”[65] This is inaccurate, because in addition to telephone, Section 1368(a)(4)(B)(i) allows enrollees to submit grievances “by facsimile, by email, or online through the plan’s Internet Web site[.]”

Another problematic definition and instruction is found in the Standard/Priority Grievances module. The training states, “An appeal is a request for reconsideration of a previous adverse decision or denial. This is handled as a standard grievance.”[66] First, Rule 1300.68(a)(1) distinguishes between requests for reconsideration and appeals, so the Plan should not use one term to define the other. Second, depending on the enrollee’s condition, appeals can be expedited, so it is incorrect to instruct staff to handle appeals as standard grievances.

The Plan requires expedited grievances to be resolved in 72 hours, and service associates to “notify the member of their right to contact DMHC.”[67] This instruction is incomplete, as Section 1368.01(b) and Rule 1300.68.01(a)(1) require plans to notify enrollees of their right to notify the Department once plans have notice of a case requiring expedited review. Although the immediate notification requirement is later found on page 26 of the Urgent/Expedited Grievances module, the Plan should provide accurate and complete definitions throughout its training materials to avoid confusion and inconsistent application of the requirements.

One Day Grievance Guidelines is the Plan’s exempt grievance standard operating procedure. The purpose of this document is to “describe the guidelines for documenting a One Day Grievance and the most common One Day Grievance inquiries.”[68] The usage of “one day grievance inquiries” may be confusing to Plan staff. Similar to the training above, this guideline states that one-day grievances are “taken over the phone,”[69] and omit the other methods these grievances can be received until the second page, where it is acknowledged that grievances may be submitted in writing, via the Plan’s website, mail, or fax.

Interestingly, the guideline instructs that if the grievance cannot be resolved by the end of the next business day, then “the CSR must notify the member that we are treating this as a Standard Grievance.”[70] There is no script or instructions as to what CSRs are supposed to tell enrollees, and it is unclear why this notification is necessary.

The document provides examples of issues that cannot be processed as one-day grievances and examples of most common one-day grievances. For example, “[e]nrollment & billing issues (COB, COBRA)” cannot be processed as a one-day

[65] *Id*. at 15.
[66] Standard/Priority Grievances module, page 20.
[67] *Id*. at 7.
[68] One Day Grievance Guidelines, page 1.
[69] *Ibid*.
[70] *Id*. at 3.

grievance.[71] However, on page six, the most common examples of one-day grievances include several billing issues and "COB Issues." While examples may be helpful, they may also be a source of confusion, as some appear contradictory, and the guidelines do not offer definitions or explanations. In addition, "cancellation of policy reasons" is incorrectly listed as a common example.[72] This is inconsistent with Section 1368(b)(1)(A), which requires "cancellations, rescissions, or the nonrenewal of a health care service plan contract" to be handled through the expedited grievance process.

The Plan's *Close of Call Script – Grievance Identification* policy provides definitions for Inquiry, Grievance/Complaint, Appeal, and Complaint (Plan Administration Issues). Some of these definitions do not comport with the regulatory definitions set forth in Rule 1300.68. For example, Rule 1300.68(a)(1) defines "grievance" as:

> [A] written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and inquiry, it shall be considered a grievance."[73]

In the script, "Grievance/Complaint" is defined as:

> [A] written or oral expression of dissatisfaction regarding our company or a provider, including quality of care concerns. **Grievances** must include any complaint, dispute, reconsideration request or appeal made by the member or the member's representative. Only those issues that can be resolved in one day may be handled by the CSR. Any quality of care concern, medical necessity, coverage dispute or experimental/investigational issues are to be automatically routed as a Standard or Priority Grievance depending on the urgency. **When in question you MUST default to the full grievance process.**

The first two sentences of the Plan's definition are very similar to the first sentence of Rule 1300.68(a)(1). The next two sentences of the Plan's definition restricts the types of issues CSRs can handle. It appears that the last sentence of the Plan's definition attempts to mirror the last sentence of Rule 1300.68, which requires plans to default to a grievance if it cannot be determined whether the issues is an inquiry or a grievance. However, the Plan's definition is very broad, and it is unclear when CSRs must default to the full grievance process.

In addition, "Complaint (Plan Administration Issues)" is defined in the call script as:

> An inquiry with an expression of dissatisfaction by a member or applicant. These types of complaints will be resolved as a one day grievance by the CSR if the issue does not involve medical necessity, coverage dispute or

[71] *Id*. at 5.
[72] *Id*. at 6.
[73] Rule 1300.68(a)(2) states: "Complaint is the same as "grievance."

> experimental/investigational issues. Complaints of any type need to be routed as Standard Grievances if they cannot be resolved in one day.

This definition is problematic from the beginning, as expressions of dissatisfaction cannot be classified as inquiries. Also, as the regulatory definition specifically requires grievances to be "made by an enrollee or the enrollee's representative," the Plan is improperly allowing applicants to file a complaint. This definition is not only inaccurate, but is also very similar to the definition of "Grievance/Complaint," and could confuse CSRs.

CSRs are required to use the Close of Call Script to "maintain full regulatory compliance and increase overall customer satisfaction." The script lays out three steps. The first step instructs CSRs to ask the caller if all questions have been answered. The second step instructs CSRs to ask if there is anything else the CSR can do for the caller. The third step instructs CSRs to ask if the caller is satisfied with the services provided by the CSR. This final step is discretionary, as CSRs do not have to ask the question if the caller is clearly dissatisfied. However, if the CSR asks and the caller expresses dissatisfaction, then the CSR is instructed to ask the caller whether he or she would like to file a grievance. While customer satisfaction is important, this final question is problematic. Section 1368 and Rule 1300.68 require CSRs to file a grievance as soon as he or she detects an expression of dissatisfaction or identifies a complaint, dispute, request for reconsideration or appeal. CSRs are not required to ask enrollees for permission to file grievances, and the Plan should not be instructing its staff to do so.

The Plan provided the Department with a presentation titled *Anthem Member Experience and Grievances and Appeals Overview* with many of the same issues identified in the training materials discussed above. For example, on page 12, "one day grievance" is defined as "any expression of dissatisfaction taken over the phone," omitting other methods in which grievances may be received. On page 13, "appeal" is included in the Standard/Priority Grievance section, but not in the Urgent Grievance section.

"Quality of Care" is defined as "a *formal* expression of dissatisfaction of medical care not based on an adverse benefit determination (emphasis added)."[74] "Quality of Service" is defined as "an expression of dissatisfaction that is not an adverse benefit determination."[75] The presentation does not include an explanation as to how a formal expression of dissatisfaction differs from an expression of dissatisfaction. In addition, two of the QOS examples – "My doctor made me wait for over [two] hours to be seen" and "My doctor has not returned my calls and I need my lab results" could also be QOC issues, depending on the enrollee's condition.

Training for grievance and appeals for California is limited to new hire training and an annual on-line training. Based on the documentation provided, the training is not robust because it is heavily focused on coding and first call resolution. What is especially concerning is that none of the training materials assessed above mentioned the

[74] *Anthem Member Experience and Grievances and Appeals Overview,* page 24.
[75] *Id*. at 25.

definition of "resolved" set forth in Rule 1300.68(a)(4).[76] In addition, there is a significant amount information for CSRs to consume, and the training can be very complicated for a new hire responsible for taking calls for multiple products.

The training documentation provided has limitations that may not fully prepare CSRs to the extent in which they would need to thoroughly perform their duties. Call center documentation and interviews (discussed below) confirm there are a number of call centers involved with the intake of calls for California enrollees and a tremendous volume of resources for CSRs to use specifically for California. Although resources are available, the ability to sift through these documents, many of which contain varying definitions and examples of grievances, and many that have a focus on the coding of the call, can be difficult while on a call with enrollees. Review of the training documentation revealed that training was below standards and contained examples that may not be appropriate for exempt grievance processing.

2. Call Center(s) Assessment

CA Commercial Call Centers is a document that lists 12 call centers that take calls for California, two of which are international. Three call centers in California, one in Colorado, one in Connecticut, one in Georgia, and two in Virginia are available to answer calls for enrollees in California managed care products. Documentation also included the IVR system used, and some of the resources available for CSRs to use while taking calls such as procedures and job aids. The Plan also provided a flow diagram of the IVR system and the choices enrollees can make when calling into Anthem's Call Center. During staff interviews, information about the various call centers was also discussed.

There were several documents provided that are available to CSRs that provide information necessary for the CSR to intake the call and log the call into the system. However, these documents can be long and detailed and difficult for CSRs to attempt to review and comprehend while on a call with an enrollee and provide customer service at a high level. Formal training is provided at on-boarding and annually thereafter, with staff meetings and other forums used for CSR feedback.

Enrollees in California products may have their calls answered by CSRs who handle phone calls for multiple states and jurisdictions. On the IVR, there is not choice for enrollees to choose the option to speak to a CSR about a grievance or an appeal. The call centers and the G&A Department report to different leadership.

3. Systems Assessment

Review of documentation showed that there were many systems used by CSRs and the G&A department, CCB, MAGI, WMDS, and Solutions Central, among others. These systems also require a number of combinations of codes for CSRs to input in order to accomplish certain tasks such as routing or identifying a call accurately. Although the

[76] "Resolved'' means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

reference documentation provides general descriptions about what each code means, it appears that this can cause confusion and great inconsistency across CSRs and G&A staff.

Wrapping Up a Call – California is a document that describes the process of wrapping up a call. Important fields which CSRs use are the Inq Type (Inquiry Type), Analysis (provides result or outcome of call), Action (describes the action the CSR took on the call), and Class (defining the classification of the call). The Inq Type and Action fields are pre-populated based on "navigation in CCB" and other rules that Navigant has not explored. The document states:

> You will not need to change this code when speaking with members and providers unless the situation requires it. For example, if a member or provider shows any dissatisfaction then the code should be changed. If the caller is a member then an appropriate grievance code should be selected. If the caller is a provider change the code to CM.

Although unclear, it does appear that the Class field is initially prepopulated, but CSRs have the option to change it. However, if this is not modified the grievance would be mishandled by the CSR.

The *Access Database of Codes used: DataExtracts2_3_Question_2* shows there are numerous codes that can be selected in the CCB system. There are some situations where codes are very similar and can lead to confusion and inconsistency in logging of calls accurately. ACTION field has 252 codes; ANALYSIS field has 303 codes; CLASSIFICATION field has 33 codes.

Classification Code Tier Descriptions is an illustrative document providing screen prints and brief descriptions of the fields in the system and provided insight into the number of drop down fields a G&A team member must navigate. There are 10 different fields each providing a unique set of designations. Within the 10 fields, there are seven fields (Code Tiers- which provide detail around the case). In the data file of grievances received from the Plan, Navigant was able to identify the number of codes used by CSRs in each Code Tier: Code Tier 1- 5; Code Tier 2- 107; Code Tier 3- 66; Code Tier 4- 125; Code Tier 5- 156; Code Tier 6- 43; Code Tier 7- 7.

Alike discussions above regarding the CCB there are also a number of options for G&A agents to choose from, creating opportunities for greater disparity between cases and variability from CSR to CSR.

Call and Grievance Data Analysis

The Department obtained three files from the Plan:

1. Data Extract 1.1.17_7.31.17 DMHC-Routine Medical Survey_FINAL- Cases from the Grievance and Appeal systems: MAGI, CCB, WMDS
2. DataExtract2_3_Question_2- (Multiple tables) Extract of Calls from the Call Center
3. DataExtract2_3_Question_2- (Multiple tables) Extract of Exempt Grievances

The data was from a date range of January 1, 2017 through July 31, 2017. Navigant analyzed this data to identify trends and potential areas of risk in the Call Center and in the G&A department.

Count of Calls by Month

Year	Month	Count of Inquiry Tracking IDs (Calls)	Count of Unique Enrollee (HCID) IDs
2017	1	182,171	122,012
2017	2	159,922	106,594
2017	3	164,454	111,333
2017	4	130,001	89,553
2017	5	126,931	83,915
2017	6	130,596	85,912
2017	7	137,816	89,128

When a CSR enters a call into the Plan's system, it is done so on what the Plan calls an Inquiry Tracking (IQT). Review of *DataExtract2_3_Question_2- (Multiple tables) Extract of Calls from the Call Center*, revealed that more calls are received in the first quarter of the year weaning off into the summer months (as expected due to open enrollment and other annual triggers). Of note, the Count of Unique Enrollee (HCID) IDs column identifies that there are enrollees who call the Plan multiple times each month. For example, in January 2017 (Month 1), the Plan received 182,171 calls from 122,012 enrollees or the enrollees' representatives. An indicator of call location was requested from the Plan, but was not provided; therefore, no distribution analysis was conducted.

Count of Exempt Grievances

DataExtract2_3_Question_2- (Multiple tables) Extract of Exempt Grievances reveals that there were 10,973 exempt grievances during this time period. Trend shows more in first quarter and then tapering off, with a spike in July. Data shows that there were enrollees who filed more than one exempt grievance in a given month.

Year	Month	Count of Inquiry Tracking IDs (Calls)	Count of Unique Enrollee (HCID) IDs
2017	1	2,206	2,135
2017	2	1,608	1,560
2017	3	1,732	1,684
2017	4	1,316	1,270
2017	5	1,266	1,225
2017	6	1,235	1,195
2017	7	1,610	1,550

Count of Members with High Call Volume (listed Top 10 HCIDs)

HCID	Count of Tracking ID[77]	First Date of Call	Last Date of Call	Time Period of Calls by Member[78]	HCID in MAGI[79]	# of Exempt Grievances Filed
NULL	1921	1/2/2017	7/31/2017			
225A73592	253	1/3/2017	7/31/2017	209	N	0
389T60278	106	2/16/2017	2/16/2017	0	N	0
479A67924	96	1/10/2017	7/27/2017	198	Y	12
117A73679	94	1/2/2017	7/28/2017	207	N	6
553A79929	73	1/4/2017	7/20/2017	197	Y	1
903A63003	64	1/5/2017	7/26/2017	202	Y	2
827A21965	63	1/25/2017	7/26/2017	182	Y	1
744A75507	57	1/10/2017	6/28/2017	169	Y	0
229A72727	52	3/9/2017	7/20/2017	133	Y	1
805A79761	47	1/9/2017	7/10/2017	182	N	0

This data shows the top 10 enrollees with the highest call volumes during the seven-month period. The first row of data shows that between January 2, 2017 and July 31, 2017, there were 1,921 rows of data with no HCID. The Plan was unable to provide an explanation as to why 1,921 calls were not associated with enrollees. The second row of data shows that between January 3, 2017 and July 31, 2017 (209 days), the enrollee with HCID 225A73592 called the Plan 253 times. This HCID was not found in MAGI, which means there was no expedited grievance or standard grievance filed for the enrollee. Furthermore, the last column shows that no exempt grievances were filed for the enrollee. The third row shows the enrollee with (HCID 389T60278) called the Plan 106 times on February 16, 2017. The Plan was unable to provide a reason for this.

Of interest is the column “HCID in MAGI.” Navigant queried the individuals with high call volume to see if their HCID was in the Plan’s G&A files. Four enrollees have a high volume of calls, but no grievances were identified in the Plan’s grievance systems. Of the top 50 enrollees who had high call volume, 21 enrollees (42%) were not found in any of the three grievance systems. Attention is drawn to this as individuals who have a frequency of calling often have some concern with their benefit that may be a grievance that was not identified by CSRs.

Navigant also compared these top callers to the exempt grievance file to determine if the issues raised by enrollees were addressed by the plan as an exempt grievance. The number of exempt grievances are captured in the column titled “# of Exempt Grievances Filed.” Of the top 50 callers, 23 enrollees (46%) did not have an exempt grievance on

[77] The number of times the enrollee or the enrollee’s representative called the Plan between the First Date of Call and the Last Date of Call.
[78] The number of days between the First Date of Call and the Last Date of Call.
[79] Whether the enrollee’s HCID was found in MAGI, the Plan’s G&A system. If Y, then there was at least one expedited grievance or standard grievance filed on the enrollee’s behalf.

file. Eleven out of 23 enrollees (48%) also did not have a grievance filed with the G&A department.

Variance in Exempt Grievance logging in CCB: Top 10 Combinations of Codes

Classification	ACTN	ACTN_Desc	INQ_Type	INQ_Type Desc	Analysis	Analysis Desc	Occurrence
1_Day GRV	AL	APPEAL/ REQUEST DENIED	BE	Benefits/Eligibility	OG	OTHER ISSUES	3,714
1_Day GRV	AL	APPEAL/ REQUEST DENIED	BE	Benefits/Eligibility	TX	OTHER - EXPLAINED IN TEXT	904
1_Day GRV	AL	APPEAL/ REQUEST DENIED	CS	CLAIMS STATUS / QUESTIONS	OG	OTHER ISSUES	492
1_Day GRV	AA	APPEAL/ REQUEST APPROVED	BE	Benefits/Eligibility	OG	OTHER ISSUES	356
1_Day GRV	AL	APPEAL/ REQUEST DENIED	MB	Membership/ Including Billing	OG	OTHER ISSUES	284
1_Day GRV	AL	APPEAL/ REQUEST DENIED	BE	Benefits/Eligibility	OD	ONE DAY GRIEVANCE	284
1_Day GRV	AA	APPEAL/ REQUEST APPROVED	BE	Benefits/Eligibility	TX	OTHER - EXPLAINED IN TEXT	228
1_Day GRV	AL	APPEAL/ REQUEST DENIED	CS	CLAIMS STATUS / QUESTIONS	TX	OTHER - EXPLAINED IN TEXT	221
1_Day GRV	CT	CALL REFERRED	BE	Benefits/Eligibility	TX	OTHER - EXPLAINED IN TEXT	208
1_Day GRV	AA	APPEAL/ REQUEST APPROVED	CS	CLAIMS STATUS / QUESTIONS	OG	OTHER ISSUES	200

As noted, the systems used by the CSRs have many coding options. It is also identified that the frequency in which a CSR utilizes the exempt grievance process is very low. Without repetition consistency is typically a concern especially considering the number of options a CSR can choose from using the current system(s).

Of the OG (One-Day Grievance) classification in the CCB system it was found that there was a combination of 882 different coding methods used. 62% of the combinations were used in the top 10; however, 507 of 882 of these combinations were only used once. There very well could be unique scenarios that these exempt grievances presented but the opportunity for such a large range highlights there may be difficulty in administration and assurance of a consistent process.

CSR Staffing

As stated above, CSRs who support California enrollees are located in several call centers in different states. Calls are taken by these CSRs on a "next agent available" basis. Calls received can be for a multitude of Anthem Health Plans in various locations across the country. The Plan's data showed 4,317 CSRs answered 1,031,891 calls from California enrollees between January 1, 2017 and July 31, 2017. There was one CSR who answered 3,400 calls during the seven-month period. In contrast, 1,666 CSRs took 10 calls or less, with 593 (out of 1,666) only taking one call. Noting that there are CSRs who have only taken one call for a California enrollee during a seven-month period raises the concern that the majority of CSRs do not have enough exposure to the state's unique requirements.

The CSRs' infrequent exposure to exempt grievances is also a concern. 664 CSRs processed exempt grievances in the seven-month period. One CSR processed 442 exempt grievances. 472 processed 10 or less, with 201 (out of 472) only handling one exempt grievance. Reiterating the "next agent available" model also raises concern for the administration of exempt grievances. The ability to identify and document an exempt grievance will be difficult for an individual to execute if they perform these tasks intermittently.

Grievance and Appeal Statistics

Count of Agents administering Grievance and Appeals

Alike what was observed in the call center data, there are employees in the G&A department who appear to have processed very few cases. 42 agents processed 10 or less cases in the seven-month time span.[80] 18 agents accounted for 50% of all of the grievance and appeal cases.

Onsite Interviews with Plan staff

[80] Navigant requested the tenure of these agents from the Plan, but the information was not provided. It is possible that some of these individuals with low numbers may be new hires.

On September 18 and 19, 2017, Navigant participated in interviews with the Department of varying levels of leadership responsible for the administration of G&A and the Call Center. These positions ranged from Vice President (VP) to Managers. Grievance and Appeal staff report up to the VP of Commercial Operations Insights and Analytics and Customer Service staff report up to the VP of Member Experience. The Department and Navigant staff asked questions to gain a better understanding of the role and responsibility each of these employees play in this delivery model.

It was learned that a number of systems are used by various staff, and the teams interact with approximately eight to 10 more independent systems depending upon the job function. The Plan provided an overview of its distributions of calls for its Large Group products in Georgia, California and Colorado and for the Individual and Small Group products (ISG) in Georgia, California, Colorado and two locations in Virgina. The information provided by the Call Center managers discussed the fact that none of these locations have dedicated staff to California and that these individuals take calls for a variety of other Anthem health plans. There was no indication that all 12 call centers were active for California and it was unclear if these locations were used when these five locations were over capacity.

The Plan has changed its organizational structure with new individuals who assumed key leadership roles and the G&A department moved in the organizational structure beginning in early 2017 to report up through the Commercial Operations Insights and Analytics Department.

The Commercial business is moving to a new platform called PEGA. This effort is to consolidate the number of systems used and streamline processes reducing the number of codes that are currently used in CCB and allow all systems to communicate instead of working in separate capacities.

During interviews, the separation of the Call Center and the G&A departments was confirmed. Individuals who work in G&A are the subject matter experts when it relates to California requirements, however their relationship with the Call Center was distant and they lack input into the processes and direct education of the CSRs. This silo mentality was evident in the responses from VP and Director levels. They were unaware of processes within the Call Center and only knew the process once the cases hit their systems. However, the G&A Managers seem to work closer with the Call Center teams when issues arise through email correspondence with CSRs and their superiors.

Navigant was unable to identify an individual who owned the grievance process from end-to-end. Because of the division of Call Center and G&A departments, the beginning of the processes occurring in the Call Centers is not owned by individuals in the G&A department. Considering that exempt grievances are administered by individuals in the Call Center and they are the first line of contact for an enrollee who calls in a grievance or appeal request it seems warranted that the subject matter experts would have oversight or a more collaborative role with management over the Call Center.

Managers in the G&A department oversee large teams, averaging 35 members. There are leads in the departments but they do not have supervisory roles. Within these teams

most of the staff work from home and occasionally meet face to face for team meetings. Managers and Directors did not know statistical data or trends within their department. When asked how many cases are processed per day/per month they were unable to provide a clear response.

However, during interviews with VPs, they explained that their teams receive reports and that these metrics are shared with them perpetually and through the internal audit mechanisms. Managers and Directors also did not run data analytics to query data for outlier scenarios such as enrollees with multiple calls and the rationale for their calls.

Operational challenges such as staffing models, large teams working independently from home, and lack of operational insight such as data trends and statistics were observed throughout the interviews.

Conclusion: Notably, three of the Grievance and Appeals System deficiencies that led to the Department's engagement of Navigant are repeat deficiencies in the current survey.[81] The Call Center documentation and data analysis illustrated, and interviews confirmed, that there are a number of Call Centers involved with the intake of calls for California enrollees and a tremendous volume of resources for CSRs to use specifically for California. Although resources are available, the ability to sift through these documents can be difficult while on a call with an enrollee. Systems Documentation showed that the CCB system used by CSRs have many codes that are required to be input for each call and cause wide variability from CSR to CSR.

Trends and areas for attention were identified by querying the data. Notably, 4,317 CSRs handled calls for California and the range in volume of calls and exempt grievances handled across the group. The infrequency of performing efforts for California could be contributing to the inconsistencies or miss handling of a grievance or appeal. Other observations related to the codes that are in the systems used by the CSRs and the G&A teams. Attributed to the large number of codes that are available to be used there is a wide variability in how the codes are applied.

Recommendations for Best Practices: Navigant has provided grievance system recommendations for best practices. Navigant's recommendations can be found on pages 31 through 32.

[81] Deficiency numbers 6, 9, and 10.