DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

NON-ROUTINE SURVEY

OF

BLUE CROSS OF CALIFORNIA

DBA ANTHEM BLUE CROSS

A DENTAL HEALTH PLAN

MAY 7, 2020

Non-Routine Survey Final Report
Blue Cross of California
DBA Anthem Blue Cross
A Dental Health Plan

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EXECUTIVE SUMMARY

On September 28, 2019, the California Department of Managed Health Care (Department) notified Blue Cross of California dba Anthem Blue Cross (Plan) that it would conduct its scheduled Routine Survey 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 from March 12, 2019 through March 15, 2019.

Throughout the course of the Routine Survey, the Department encountered excessive delays by the Plan to obtain requested documents and information in a timely manner to conduct the survey. Prior to, and during the onsite survey, the Department provided the Plan with written instructions for submitting requested documents and information related to Plan operations. The Plan consistently failed to provide the requested information in a timely manner as instructed by the Department. The Plan's delay interfered with the Department's ability to timely conduct the Routine Survey.

On April 25, 2019, the Department notified the Plan that due to its continuous failure to follow the Department's written instructions, the remaining activities under the Routine Survey would be conducted as a Non-Routine Survey, pursuant to Section 1382(b) and Rule 1300.82.1(a)(1). In addition, the expenses related to completing the remaining survey activities would be charged to the Plan.

The Department assessed the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Utilization Management
Language Assistance

The Department identified **21** deficiencies during the Non-Routine Survey. The 2019 Survey Deficiencies Table below notes the status of each deficiency.

2019 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	
	QUALITY ASSURANCE	
1	**The Plan does not document that quality of care provided is reviewed, that problems are identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.** Rule 1300.70(a)(1).	**Not Corrected**

	GRIEVANCES AND APPEALS	
2	**The Plan does not ensure all oral expressions of dissatisfaction are considered grievances, and therefore does not ensure adequate consideration of enrollee grievances and rectification when appropriate.** Section 1368(a)(1); Rule 1300.68(a)(1).	**Not Corrected**
3	**The Plan's exempt grievance log does not include the nature of the grievance and the nature of the resolution.** Section 1368(a)(4)(B)(i); Rule 1300.68(d)(8).	**Not Corrected**
4	**The Plan does not ensure adequate consideration and rectification of enrollee grievances.** Section 1368(a)(1).	**Not Corrected**
5	**The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on medical necessity do not describe the criteria used and the clinical reasons for its decision.** Section 1368(a)(5); Rule 1300.68(d)(4).	**Not Corrected**
6	**The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on medical necessity do not include independent medical review (IMR) applications and instructions and envelopes addressed to the Department.** Rule 1300.68(d)(4).	**Not Corrected**
7	**The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on a finding that the proposed services are not a covered benefit do not specify the provisions in the contract, evidence of coverage, or member handbook that excludes the service.** Section 1368(a)(5); Rule 1300.68(d)(5).	**Not Corrected**
8	**The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on a finding that the proposed services are not a covered benefit do not include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the enrollee can contact the Department to determine whether the decision is eligible for independent medical review (IMR).** Rule 1300.68(d)(5).	**Not Corrected**

9	**The Plan does not send all acknowledgment letters to enrollees within five calendar days upon the Plan's receipt of the grievance.** Section 1368(a)(4)(A); Rule 1300.68(d)(1).	**Not Corrected**
10	**The Plan does not resolve all exempt grievances by the end of the next business day.** Section 1368(a)(4)(B); Rule 1300.68(d)(1).	**Not Corrected**
11	**The Plan does not consistently provide enrollees with a written statement on the disposition or pending status within three calendar days upon its receipt of the expedited grievance.** Section 1368.01(b); Rule 1300.68.01(a)(2).	**Not Corrected**
12	**When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform enrollees of their right to notify the Department of the grievance.** Section 1368.01(b); Rule 1300.68.01(a)(1).	**Not Corrected**
13	**The Plan does not have a policy to ensure enrollees with visual impairments can fully participate in the Plan's grievance system.** Rule 1300.68(b)(3).	**Not Corrected**
14	**The Plan's acknowledgment letters do not consistently include a notice of the availability of language assistance services.** Section 1367.04(b)(1)(B)(iv); Section 1367.04(b)(1)(C)(i); Section 1367.042(a)(1); Rule 1300.67.04(b)(7).	**Not Corrected**
15	**The Plan's written grievance responses to enrollees do not include the correct statement as required by Section 1368.02(b).** Section 1368.02(b); Rule 1300.68(d)(7).	**Not Corrected**
16	**The Plan's online grievance submission process does not allow enrollees to preview and edit the grievance form prior to submittal, and does not include an accurate version of the Department's quoted statement.** Section 1368.015(c).	**Not Corrected**
	UTILIZATION MANAGEMENT	
17	**For decisions to deny and modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written responses to enrollees a description of the criteria or guidelines used and/or the clinical reasons for its decision.** Section 1367.01(h)(4).	**Not Corrected**

18	**The Plan's written communications to providers of a denial or modification of a request do not consistently include the direct telephone number or extension of the health care professional responsible for the decision.** Section 1367.01(h)(4).	**Not Corrected**
19	**The Plan's denial and modification letters to enrollees do not include the correct statement as required by Section 1368.02(b).** Section 1367.01(h)(4); Section 1368.02(b).	**Not Corrected**
20	**The Plan's explanation of benefits (EOBs) improperly instructs enrollees on how to file an appeal.** Section 1367.01(h)(4); Section 1368(a)(4)(B)(i); Rule 1300.68.01(a)(4).	**Not Corrected**
	LANGUAGE ASSISTANCE	
21	**The Plan does not include the required notice of language assistance (NOLA) with all member grievance forms.** Section 1367.04(b)(1)(B)(v); Rule 1300.67.04(b)(7)(D); Rule 1300.67.04(c)(2)(D).	**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.

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

[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.

The Department issued the Preliminary Report to the Plan on December 12, 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

The Plan is owned by Anthem, Inc., a national for-profit entity. In 2003, WellPoint Health Networks, Inc. acquired Golden West Dental and Vision, which operates as a wholly owned subsidiary of WellPoint, Inc. In 2004, Anthem, Inc. and WellPoint Health Networks, Inc. merged to become WellPoint, Inc. In April 2009, DeCare Dental was acquired by WellPoint. In December 2014, WellPoint, Inc. changed its corporate name to Anthem, Inc.

The Plan serves its commercial enrollees by offering Dental Net and Dental Select HMO through contracted individual dentists. For both products, the enrollee selects a primary care dentist to receive basic dental services. Necessary services beyond the scope of the general dentist, such as those provided by specialists in endodontics, periodontics, pediatric dentists, orthodontists and oral surgeons are coordinated by the primary care dentists. The Plan does not require the general dentist to obtain prior approval for referrals to specialists.

The Plan participates with the Covered California program by offering Individual Stand-Alone Family Dental PPO Coinsurance Plan. Individual Family Dental Plan includes the essential pediatric dental benefits that comply with Section 1367.005. Individual Family Dental PPO Plan follows the Covered California's Standard Dental Benefit Plan Design.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On December 12, 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 document that quality of care provided is reviewed, that problems are identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.**

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

Assessment: The Plan's PQI process aid provides:

> The Quality Assurance Department, headed by the Dental Director, and as directed by the [Quality Improvement Committee (QIC)], is responsible for the implementation of the quality assurance program and the monitoring of quality of care and service. The program includes monitoring of the following quality assurance activities: In-office facility and chart reviews, access, availability, continuity of care, utilization management and review, grievances, language assistance program, and credentialing/re-credentialing. Where provider quality assurance activities are identified as potential quality issues and/or remain uncorrected, the Plan takes appropriate corrective action as noted in this document.[2]

After review of the Plan's exempt grievance and PQI files, the Department found that the Plan does not take appropriate actions to identify, correct, and monitor PQIs.

a. The Plan does not review all quality issues.

The Plan's PQI process aid states:

[2] CA Dental Potential Quality Issues, Process: PQI Identification, Monitoring, and Corrective Action Plans, page 1.

> The Customer Care Advocate [(CCA)] reviews daily all CAT II call entry notes, checks for categorization, then forwards, by email, to the [California Dental Director (CA DD)] or clinical designee for clinical review, verification of resolution, and properly applied categories.
>
> [Call Care Browser (CCB)] CAT II grievances will be recategorized as CAT I non-exempt standard grievance if the complaint is related to quality of care, quality of service, or coverage disputes, or disputed health care services involving medical necessity or experimental or investigational treatment, or the complaint was not resolved within the first 24 hours, or the member is requesting action from the dental plan. The CA DD or clinical designee returns their review comments to the Customer Care Advocate for additional follow-up or re-categorization of the grievance, when required.
>
> CCB CAT II grievance log tracks exempt grievance cases and the log will be given to the Dental Quality Assurance Department to report to Dental Quality Improvement Committee. CCB CAT II exempt grievances are not considered potential quality issues.[3]

The Department reviewed 48 exempt grievance files. Of those, 26 files (54%)[4] contained PQIs that were not forwarded to the dental director or clinical designee for review, as required by the Plan's process aid. For example:

- **File #40:** The enrollee complained about improper dental work on a tooth that resulted in the breaking of a crown on another tooth. The support post sticks out of the broken crown and cuts into the enrollee's cheek. The provider recommended a full porcelain crown as the only option, and gave an appointment date that was three days away.

  The CCA talked to the provider, confirmed the enrollee has covered options for a new crown, and arranged an appointment for the following day. The PQI (improper dental work) was not addressed, it is unknown if the porcelain crown is truly the only option, and the file was not referred for quality review.

The Department also reviewed 31 exempt grievance "Route 57" files. Of those, 15 files (48%)[5] contained PQIs that were not forwarded to the dental director or clinical designee for review, as required by the Plan's process aid. For example:

- **File #13:** The enrollee called because the provider office has been refusing his request for regular cleaning for three years. The office would offer deep tissue cleaning, but would not offer a regular routine cleaning service. The provider's

[3] CA Dental Potential Quality Issues, Process: PQI Identification, Monitoring, and Corrective Action Plans, page 6.
[4] File #5; File #6; File #9; File #14; File #15; File #16; File #17; File #19; File #20; File #23; File #25; File #26; File #27; File #28; File #30; File #31; File #34; File #36; File #39; File #40; File #42; File #43; File #44; File #45; File #46; File #48.
[5] File #9; File #10; File #11; File #13; File #14; File #15; File #16; File #18; File #19; File #20; File #24; File #26; File #27; File #28; File #29.

office would try to delay the service, but never follow-up on performing the regular cleaning.

The CCA changed the enrollee to a new office, and notes from the file indicate that the enrollee was not requesting any action. However, upon review of the audio recording of this call, the enrollee stated, "I want to register an official complaint." Nevertheless, notes from the file indicated the enrollee did not request any action, and the file was not referred for quality review.

In addition, it was determined that all PQIs listed on the PQI log were identified from grievances only. The Plan did not include PQIs identified through facility audits, access, credentialing, and other quality assurance activities listed in its PQI process aid, as cited above.

b. The Plan does not identify all quality issues, take effective action to improve care where deficiencies are identified, and/or plan follow-up where indicated.

The Plan was asked to provide the Department with a log of PQIs from November 1, 2016 through October 31, 2018. While onsite, the Department discovered that the log only listed files from August 23, 2017 through October 31, 2018, and the Plan agreed to provide 10 months of missing information. In addition, review of the Plan's Quality Improvement Committee (QIC) meeting minutes for the second quarter of 2018 included a PQI report summary detailing that there had been 76 PQIs to date, which greatly exceeds the 59 PQI cases in the PQI log presented to the Department. During onsite interviews, Plan staff responded that things were now being done differently, without qualifying the details of the implemented activities. Plan staff was unable to explain or reconcile the discrepancy presented by the log and the QIC meeting minutes, and no additional logs or files were received for further assessment.

The Department reviewed 33 PQI files. In 22 files (67%),[6] the Plan did not identify all quality issues, take effective action to improve care, and/or follow-up when necessary. For example:

- **File #1:** The enrollee complained about two defective crowns and periodontal treatment received. The Plan refunded the patient for the unnecessary periodontal treatment, but did not address the enrollee's concerns with the crowns.

  A review of radiographs showed that the provider performed eight crowns on the patient, all which showed signs of being too big, bulky, under contoured, and some with open margins. The provider was using a same day crown making machine, and based on the quality of the work, it did not appear the dentist had been properly trained to operate the machine. This file was discussed during onsite interviews, and the Dental Director was unable to explain why no

[6] File #1; File #3; File #7; File #9; File #10; File #11; File #12; File #13; File #14; File #18; File #19; File #20; File #21; File #22; File #23; File #24; File #26; File #27; File #28; File #29; File #31; and File #33.

additional action was taken on behalf of the enrollee, and to ensure the provider did not provide others with substandard crowns.

- **File #3:** The grievance was about the provider performing four quadrants of scaling and root planing on the same day without using local anesthetic. The Plan sent two letters to the provider requesting a response and asked that the enrollee be refunded. The provider's response to the Plan stated that the enrollee was reimbursed, and requested the enrollee to be reassigned to another office, but did not respond to the Plan's request to address the quality of care issue. While refunding the enrollee was appropriate, the Plan failed to investigate and assess the sub-standard care performed.

Notably, out of the 22 deficient files identified above, 17 files involved enrollee overcharges.[7] The Plan's quality assurance program states:

> Purpose: The purpose of this document is to assure fair and consistent claims processing and review procedures in accordance with all clinical definitions of the enrollee's benefit plan.
>
> Policy: Plan shall periodically calibrate professionals who are making clinical decisions. Plan shall consistently review generally accepted standards of dental practice using standards that are based on credible, scientific evidence published in peer-reviewed literature generally recognized by the dental community.
>
> The Dental Director or his/her designee shall manage the Utilization Management program.[8]

In addition, the Plan's PQI process aid states:

> **Fraud, Waste, and Abuse (F/W/A)**
>
> Based on the results of the Dental Review Unit review and determination of specialty claims, the plan produces WorkClaims (WC) generated monthly of specialty provider claims requiring further scrutiny.
>
> The monthly generated WC Focus Review Report of these claims is reviewed for repeated suspicious claims. When identified, outliers are reported to the Plan's Special Investigations Units (SIU).[9]

During onsite interviews, the Plan's dental director stated that when a provider is cited for a deficiency regarding overcharges, the Plan would conduct an onsite facility audit and chart examination. Although the dental director makes decisions with regard to

[7] File #7; File #9; File #10; File #11; File #12; File #13; File #18; File #19; File #20; File #21; File #23; File #24; File #26; File #27; File #28; File #29; and File #33.
[8] Anthem Blue Cross Dental Quality Assurance Program: Anthem Blue Cross Dental Utilization Review Criteria and Standards, page 16.
[9] CA Dental Potential Quality Issues (PQI): PQI Identification, Monitoring, and Corrective Action Plans, page 5.

fraud and billing concerns (e.g., approves refunds), it was confirmed that the Plan failed to identify outliers, and no providers were brought to the attention of the SIU during the survey period.

Rule 1300.70(a)(1) requires the Plan to document that the quality of care provided is reviewed, that problems are identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. Not only does the Plan fail to review and identify quality issues, but when issues are identified, the Plan is unable to demonstrate appropriate action has been taken. Therefore, the Department finds the Plan in violation of this regulatory requirement.

TABLE 1
Potential Quality Issue File Review

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievance	48	The Plan must document that the quality of care provided is being reviewed	22 (46%)	26 (54%)
Exempt Grievance "Route 57"	31	The Plan must document that the quality of care provided is being reviewed	16 (52%)	15 (48%)
PQI	33	The Plan must identify quality issues, take effective action to improve care, and follow-up where indicated	11 (33%)	22 (67%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated that based on interaction with the Department during the onsite audit, "[it] anticipated this deficiency and has enhanced its Quality Assurance Program (QAP) and [PQI] process." The Plan indicated implementation of the following actions:

1. The PQI log will continue to be presented and reviewed by the QIC at each quarterly meeting. PQIs of any "particular significance" identified by the dental director will be presented to the QIC for review assessment, and further action(s).

2. The PQI log has been enhanced to capture how PQIs were identified and uses the Department's categories (quality of care, quality of service, accessibility/availability and wait time, coverage disputes, and medical necessity). Columns were added to the PQI log to track and trend PQI findings, corrective actions, and resolutions. The Plan also provided a spreadsheet with a

comparison of the old PQI log and new PQI log. The Plan began using the new PQI log in January 2020.

3. Modification of the customer service intake categorization process so all calls from enrollees or their representatives[10] are categorized as exempt grievances by default. Exempt grievances "not resolved within a day" will be manually categorized as standard grievances, and forwarded to the Grievances and Appeals Department.

   Starting April 2019, the Customer Service Lead/Subject Matter Expert (SME) reviews the exempt grievance log daily. Within 24 hours of this review, the log is forwarded to the Dental Director/Designee for review, and the Dental Director/Designee is notified of all PQIs. Review results are emailed back to the Customer Service Lead/SME for documentation, and the exempt grievance log is presented at each quarterly QIC meeting.

4. Revision and implementation of the QAP to include additional guidance on how to handle quality of care issues (coverage disputes, office condition and cleanliness, office wait time). The amended QAP with be filed with the Department by second quarter 2020.

5. Revision of the Fraud, Waste, and Abuse section in the QAP. The Plan will generate corrective action letters and monthly reports of provider claims that may require further scrutiny. Monthly report summaries will be submitted to the QIC on a quarterly basis. Corrective actions will be initiated when potential outliers or patterns are identified.

6. As of June 2018, the Plan stopped using the Route 57 process.

The Plan disagreed with the Department's finding that PQIs were only identified from grievances and stated, "[i]n the PQI log provided to the Department on March 15, 2019, Column D lists the source of the PQI and includes other sources besides grievances such as[:] Audit Extraction, Audit Focus, and Audit NonFocused." The Plan indicated that as of January 2020, the PQI includes sources such as "Audit, Audit Extraction, Breach of Contract, and Grievance," and again referred the Department to the spreadsheet that compares the old PQI log and new PQI log.

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 enhancing its PQI log, modifying the call intake process, documenting the review and identification of PQIs from the exempt grievance log, revising its QAP, and increasing

[10] The Plan's response states, "The Customer Service Department now categorizes all incoming calls *received by a member or on behalf of the member* as CAT II (Exempt Grievances) as the default category (emphasis added). The Department believes the Plan intended to use "received from," not "received by."

reporting and oversight. However, the Department must verify the Plan's corrective actions have effectively corrected this deficiency.

The Plan disagreed with the Department's observation that PQIs were only identified through the grievance process, and indicated that on March 15, 2019 (the last day of the onsite portion of the survey), a new PQI log was provided to the Department that contained additional sources of identification. This new log was provided in response to the Department's request that the Plan provide an explanation with regard to its PQI reporting discrepancies.[11]

Furthermore, the Plan's PQI log contained 59 PQIs, all identified through the grievance process. The March 15, 2019 PQI log included 190 PQIs, identified through four sources – Audit Extraction (12 PQIs), Audit Focus (82 PQIs), Audit NonFocused (32 PQIs), Grievance (64 PQIs). Not only did the number of PQIs increase by 131, but the number of PQIs identified through the grievance process increased by five. The Plan's provision of three PQI logs (an initially incomplete log, a second log the Department used to conduct the survey, and an untimely third log where PQI numbers almost tripled during the same lookback period), taken together with the Plan's inability to explain or reconcile the discrepancies, unequivocally supports the Department's finding that the Plan is unable to accurately identify and track PQIs.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through the review of exempt grievance files, PQI log(s), reports to the QIC, QIC reports and meeting minutes, and PQI files. The Department may also conduct interviews and review any other documents deemed relevant.

GRIEVANCES AND APPEALS

Deficiency #2: **The Plan does not ensure all oral expressions of dissatisfaction are considered grievances, and therefore does not ensure adequate consideration of enrollee grievances and rectification when appropriate.**

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

Assessment: 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.

The Plan's quality assurance program includes a grievance and appeal section that "defines a grievance as any expression of dissatisfaction (written or verbal) and will

[11] Onsite request #14 (March 13, 2019).

include a specific request by a member for the grievance process."[12] The Department finds this sentence problematic for two reasons. First, the Plan's definition of "grievance" is a limited portion of the definition set forth in Rule 1300.68(a)(1). Second, the latter part of the sentence implies that enrollees must request to go through the Plan's grievance process. This is noncompliant with Rule 1300.68(a)(1), as Plan staff should file grievances upon identification, and not require enrollees to ask for a grievance to be filed.

The Department reviewed 71 inquiry files. Of those, eight files (11%)[13] contained expressions of dissatisfaction that the Plan failed to process as grievances. For example:

- **File #25:** The enrollee complained about the provider's quality of service and questioned why the provider was recommending paying additional fees for non-covered services without being offered covered options. The CCA provided information on co-pays and covered benefits, assisted the enrollee in changing the provider dental office, and marked the file as complete without initiating a grievance.

- **File #48:** The enrollee had a quality of service complaint against his current provider and questioned the provider's treatment plan recommending non-covered services. The enrollee felt the provider's proposed treatment plan was much more than what he needed, and asked how to remove himself from his wife's plan. The CCA provided information on co-pays and covered benefits, and advised him to talk to his wife's employer. The CCA closed the file as complete, and did not initiate a grievance.

Section 1368(a)(1) requires the Plan to establish and maintain a grievance system that ensures adequate consideration of enrollee grievances and rectification when appropriate. However, without being able to accurately and consistently distinguish inquiries from grievances, the Plan cannot ensure that all grievances receive adequate consideration, investigation, and resolution. As the Plan fails to treat all expressions of dissatisfaction, complaints, disputes, and requests for reconsideration or appeal as grievances, the Department finds the Plan in violation of these statutory and regulatory requirements.

[12] Anthem Blue Cross Dental Quality Assurance Program: Grievance Resolution Criteria and Standards, page 8.
[13] File #25; File #27; File #31; File #35; File #48; File #54; File #59; File #68.

TABLE 2
Inquiry File Review

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Inquiry	71	Expressions of dissatisfaction and complaints must be processed as grievances	63 (89%)	8 (11%)

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated that its "call tracking system systematically categorizes all incoming member calls as an exempt grievance unless later deemed as an inquiry or a standard grievance." Customer service representatives who support the Department's products were trained on this "enhancement" the week of August 12, 2019, and the process was implemented on August 19, 2019. The Plan provided grievance guidelines "reflecting the Plan's grievance categories."[14]

The Plan indicated that exempt grievance calls and "random incoming Customer Service tracking records" are audited daily by a customer service SME to validate the accuracy of the notes taken by the customer service representative during the call. Identified issues will be documented and addressed, and audit reports will be forwarded to the Dental Director. The Plan provided a document to demonstrate the process.[15]

The Plan stated that the eight deficient inquiry files identified by the Department:

> …occurred prior to the Plan's revised process as of June 2018. The updated process included corresponding training and new processes that require agents to file a grievance upon identification, even if the member does not want a grievance filed. The Customer Service training sessions included the reinforcement that agents can no longer ask "If the member would like to file a Grievance."

The Plan also listed several "enhancements" that have been implemented to ensure the proper identification of grievances. For example, sending emails to customer service representatives when system platform changes are made, additional training for customer service representatives, and random audits on calls categorized as inquiries.

Final Report Deficiency Status: Not Corrected

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

[14] WDS Grievance Guidelines (last revised December 13, 2019).
[15] Handling CAT II Report (last revised January 29, 2020).

The Department finds that the Plan has taken steps to correct this deficiency by modifying the call intake process (e.g., automatically categorize enrollee calls as exempt grievances, no longer asking the enrollee for permission to file a grievance), auditing customer service representative calls, increasing oversight, and providing additional training. However, the Department must verify the Plan's corrective actions have effectively corrected this deficiency.

In addition, since the Plan did not explain the relevance of the grievance guidelines,[16] or specify what should be reviewed, the Department is unclear as to why this document was provided.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through the review of inquiry files (including audio recordings), audit tools and results for exempt grievances and inquiries, and audit reports to the dental director. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #3: The Plan's exempt grievance log does not include the nature of the grievance and the nature of the resolution.

Statutory/Regulatory References: Section 1368(a)(4)(B)(i); Rule 1300.68(d)(8).

Assessment: Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8) require the Plan to maintain a log of exempt grievances that includes the date of the call, the name of the complainant, the complainant's member identification number, the nature of the grievance, the nature of the resolution, and the name of the plan representative who took the call and resolved the grievance. The Department's review of the Plan's exempt grievance log found inadequate documentation of the nature of the grievance and the nature of the resolution.

a. Nature of the Grievance

In the exempt grievance log column marked "Category," the Plan first classifies grievances into four types – Administrative, Benefits, Communications, and "Route 57" (a special category created by the Plan for complainants who called to complain, but do not want to file a grievance). The next column is "Summary," where grievances were sorted into five types – Benefit Clarification, Grievance Process Refused "Route 57," Plan Communications, Provider Administrative Procedures, and Provider Communications. Although the exempt grievance log contains two categorization columns, these broad categories fail to provide a description of the nature of the grievances. Specifically:

- 61 exempt grievances were categorized under the "Administrative" category, and then all were sub-categorized under "Provider Administrative Procedures."

[16] WDS Grievance Guidelines (last revised December 13, 2019).

- Five exempt grievances were categorized under the "Benefits" category, and then all were sub-categorized under "Benefit Clarification."

- 75 exempt grievances were categorized under the "Communications" category. Of those, 67 were sub-categorized as "Provider Communications," and eight were sub-categorized as "Plan Communications."

- 31 exempt grievances were categorized under the "Route 57" category, and then all were sub-categorized under "Grievance Process Refused, Route 57."

Given such broad categories and sub-categories, the Department was unable to determine the nature of the exempt grievances.

b. Nature of the Resolution

The Plan's exempt grievance log also failed to identify the nature of the resolution. For all 172 exempt grievance files listed, the column labeled "Nature of Resolution" contained "Within 24 hours." This statement does not describe the nature or provide any explanation as to how the grievance was resolved.

Since the Plan's exempt grievance log failed to contain the nature of the grievance and the nature of the resolution, the Department finds the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated that "[a]s of June 2018, the Route 57 process was discontinued along with the general call reason categorizations of the Grievances. One column of the current exempt spreadsheet contains the notes of the complete call record."

The Plan indicated that effective January 1, 2020, it will be documenting "a more precise reason for the nature of the exempt grievance" and a "clearer explanation of the results…regarding the closure of the exempt grievances." To demonstrate this, the Plan provided a spreadsheet that compares the old exempt grievance log with the enhanced exempt grievance log.

In addition, the Plan stated that all incoming exempt grievances are audited daily by a customer service SME. Identified issues will be documented and addressed, and audit reports will be forwarded to the Dental Director. The Plan provided a document to demonstrate the process.[17] The Plan also listed several "enhancements" implemented to ensure the proper identification of grievances. For example, sending emails to customer service representatives when system platform changes are made, and additional training for customer service representatives.

Final Report Deficiency Status: Not Corrected

[17] Handling CAT II Report (last revised January 29, 2020).

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 trying to be more precise and clear when documenting the nature of the grievance and the nature of the resolution, auditing exempt grievances, increasing oversight, and providing additional training. However, the Department must verify the Plan's corrective actions have effectively corrected this deficiency.

Previously, the exempt grievance log only contained seven columns (A-G). The new exempt grievance log contains 22 columns (A-V). The columns pertinent to this deficiency are Columns R, U, and V. The changes are as follows:

- In the old exempt grievance log, Column B (Category) contained four options.[18] The corresponding column in the new exempt grievance log is Column U (Reason/Code), and the Plan's explanation of the column is "Reason of the call tracking record (categories continue to be determined by the Plan).

- In the old exempt grievance log, Column C (Summary) contained five options.[19] The corresponding column in the new exempt grievance log is Column R (Note), and the Plan's explanation of the column is "Detailed notes of the call received."

- In the old exempt grievance log, Column F (Nature of Resolution) contained only "Within 24 hours." The corresponding column in the new exempt grievance log is Column V (Resolution/Code), and the Plan's explanation of the column is "Resolution of the call tracking record (categories continue to be determined by the Plan).

As Columns U and V in the new exempt grievance log state "categories continue to be determined by the Plan," the log appears to be a work in progress. In addition, since the Plan did not explain the relevance of the exempt grievance report handling process document,[20] the Department is unclear as to why this document was provided.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through the review of the exempt grievance log, audit tools and results for exempt grievances, and audit reports to the Dental Director. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #4: The Plan does not ensure adequate consideration and rectification of enrollee grievances.

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

[18] Administrative, Benefits, Communications, Route 57.
[19] Benefit Clarification, Grievance Processed Refused Route 57, Plan Communications, Provider Communications, Provider Administrative Procedures.
[20] Handling CAT II Report (last revised January 29, 2020).

Assessment: Section 1368(a)(1) requires the Plan to ensure adequate consideration and rectification of enrollee grievances. The Department reviewed 60 Category I grievance files. Of those, nine files (15%)[21] did not adequately address, investigate, or rectify all issues presented by the enrollees. For example:

- **File #18:** The enrollee called because his five-year-old child was in severe pain from a cavity on a back molar. The dental office did not feel comfortable doing the filling and wanted to refer the child to a pedodontist. The Plan notified the pedodontist that the child is too old. The enrollee was given "an extensive list of offices, which he called around," and finally found another office to see his child. After an examination, the enrollee was again advised that the child needs to see a pedodontist. The enrollee informed the Plan that the child is in severe pain and can hardly eat anything, and requested the case to be expedited.

  Ultimately, the Plan made an exception and allowed the child to see a pedodontist. However, the Plan's internal notes stated that the case could not be expedited unless it is a medical emergency "(i.e. [patient] was admitted to ER)." The Plan did not adequately consider that the child was in severe pain[22] and could "hardly eat anything." The dental director made an administrative exception five days after the enrollee's call, but the resolution letter was dated one month after the date of the call.

The Department reviewed 48 exempt grievance files. Of those, 18 files (38%)[23] did not adequately address, investigate, or rectify all issues presented by the enrollees. For example:

- **File #44:** The enrollee cracked a tooth on Friday. He called the assigned PDO and made an appointment for Saturday. When he arrived at his appointment, he was told they were closed. They were unable to verify his insurance and refused to see him. The enrollee felt they should have seen him since he has an HMO and has been on their roster for over 15 months. He even offered to sign something that stated if his insurance did not cover the procedure, he would pay in full, but they still refused to see him. At the time of this call, he already transferred to a new office, but wanted to file a complaint against the office.

  The Plan categorized the grievance as Provider Administrative Procedures, PDO Transfer, and ID Card, but did not address the potential quality issues.

[21] File #16; File #18; File #21; File #23; File #26; File #30; File #34; File #49; and File #56.
[22] Section 1368.01(b) and Rule 1300.68.01(a) require the Plan's grievance system to "include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function."
[23] File #4; File #9; File #11; File #15; File #25; File #26; File #27; File #28; File #30; File #31; File #34; File #35; File #36; File #39; File #43; File #44; File #45; and File #47.

The Department reviewed 31 exempt grievance "Route 57" files. Of those, 14 files (45%)[24] did not adequately address, investigate, or rectify all issues presented by the enrollees. For example:

- **File #11:** Per CCA notes, the enrollee called because there was no air conditioning; the provider was very rude, talked down and yelled at the enrollee; the assistant is rude and very rough when doing bite wings; and the office is dirty.

  In the audio recording of the call, the enrollee stated she was in pain, needed two extractions (urgently needed one), and had found a local dentist she was paying out-of-pocket to handle one of the extractions. There was no documentation in the file that the grievance was referred for review of a potential quality issue. Furthermore, the exempt grievance log states, "Grievance Process Refused," while in the audio recording, the enrollee clearly demands a grievance to be filed against the dental office.

  Here, the CCA's documentation of the call was incomplete. The grievance was incorrectly identified as involving a provider location. The Plan did not identify and address the PQIs, and did not assess whether the extraction should have been expedited.

The Department's issues with "Route 57" files was addressed in Deficiency #2 of the Final Report of the last Routine Survey.[25] In response to the deficiency, the Plan revised the definition of "grievance" in its Grievance Resolution Criteria and Standards policy to reflect the definition of "grievance" set forth in Rule 1300.68(a)(1). The Plan also eliminated its exempt grievance "Route 57" category. In the Department's Routine Survey Follow-Up Report,[26] the Plan reported the category was eliminated as of November 1, 2016. However, during onsite interviews, the Clinical Quality/Compliance Administrator and the Grievances and Appeals Manager admitted that the "Route 57" category was not eliminated until October 2018. The Plan expressed concern that the "formal grievance process" may disrupt the provider-patient relationship, and claimed that enrollees preferred having a process to exempt complaints from requiring a review and resolution process.

In reviewing the inquiry files, exempt grievance files, and exempt grievance "Route 57" files, the Department also listened to audio recordings of the interactions between CCAs and enrollees, when available. It appears that while CCAs encourage the filing of grievances, they are instructed to advise enrollees expressing dissatisfaction with the Plan or providers that they can file a formal grievance if they are seeking action (e.g., refund, appeal a denial). If no action is requested, the CCA will offer to take down a "verbal complaint" which will be kept on file, but not submitted to providers. The CCAs tell complainants that the Plan will initiate action if enough complaints are filed against a

[24] File #1; File #2; File #7; File #8; File #11; File #12; File #13; File #15; File #16; File #17; File #19; File #26; File #27; and File #30.
[25] Anthem Blue Cross Dental Final Report (December 15, 2016).
[26] Anthem Blue Cross Dental Follow-Up Report (May 4, 2018).

provider. The Department finds this practice problematic because grievances should be immediately filed upon identification.

Since the Plan's approach to the identification and resolution of enrollee grievances do not consistently ensure adequate consideration and rectification of enrollee grievances, the Department finds the Plan in violation of this statutory requirement.

TABLE 3
Adequate Consideration and Rectification of Grievances

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance & Appeal	60	Plan must ensure adequate consideration of enrollee grievances and rectification when appropriate	51 (85%)	9 (15%)
Exempt Grievance	48	Plan must ensure adequate consideration of enrollee grievances and rectification when appropriate	30 (62%)	18 (38%)
Exempt Grievance "Route 57"	31	Plan must ensure adequate consideration of enrollee grievances and rectification when appropriate	17 (55%)	14 (45%)

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated that "Exempt Grievance Route 57 was ended as of June 25, 2018." Starting August 19, 2019, the Plan's call tracking system "defaults all incoming member calls as an exempt grievance." The Plan also indicated:

> The Dental Call Tracking Systems modified the exempt and standard grievance tracking records template. The templates walk the Dental Customer Service Agents (CSAs) through the appropriate documentation of the verbal complaint. If further information is required from the provider affiliated with the member's exempt grievance, the CSA will contact the provider. If the CSA cannot obtain appropriate information within the 24 hour turn-around time, CSA will forward the grievance to Dental Grievances and Appeals Department to handle as an expedited/urgent or standard grievance…The CSAs were trained the week of August [12], 2019 on these enhancements by team huddle and/or email.

The Plan indicated that exempt grievance calls and "random incoming Customer Service tracking records" are audited daily by a customer service SME to validate the

accuracy of the notes taken by the customer service representative during the call. Identified issues will be documented and addressed, and audit reports will be forwarded to the dental director. Furthermore:

> The updated process and corresponding training included new processes requiring CSAs to file a grievance even if the member does not want a grievance filed. The training sessions reinforced that CSAs can no longer ask "If the member would like file a Grievance."

The Plan also listed several "enhancements" that have been implemented to ensure the proper identification of grievances. For example, sending emails to customer service representatives when system platform changes are made, additional training for customer service representatives, and random audits on calls categorized as inquiries.

In addition, the Plan provided two documents for the Department's review.[27] To address the portion regarding the inadequacy to address, investigate, or rectify enrollee issues, the Plan referred the Department to the Plan's response in Deficiency #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 correct this deficiency by modifying the call intake process (e.g., automatically categorize enrollee calls as exempt grievances, no longer asking the enrollee for permission to file a grievance), modifying its grievance tracking records template, auditing customer service representative calls, increasing oversight, and providing additional training.

However, the Plan appears to focus on the accurate identification of issues in inquiries and exempt grievances (e.g. random audits of inquiries, daily audits of all incoming exempt grievances); not how it would ensure adequate consideration and rectification of exempt grievances and standard grievances and appeals. Two documents were produced as part of the corrective action, but the Plan did not provide any reasoning as to the relevance of the documents as it pertains to this deficiency. In addition, the Plan referred the Department to its response in Deficiency #1, but did not explain which part of that response is applicable to this finding.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through the review of standard grievance and appeal files and exempt grievance files (including audio recordings), audit tools and results, and audit reports to the Dental Director. The Department may also conduct interviews and review any other documents deemed relevant.

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[27] WDS Grievance Guidelines (last revised December 13, 2019) and Handling CAT II Report (last revised January 29, 2020).

Deficiency #5: **The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on medical necessity do not describe the criteria used and the clinical reasons for its decision.**

Statutory/Regulatory References: Section 1368(a)(5); Rule 1300.68(d)(4).

Assessment: When the Plan's written responses to grievances involve the denial or modification of health care services based in whole or in part on medical necessity, Section 1368(a)(5) and Rule 1300.68(d)(4) require the Plan's response to describe the criteria used and the clinical reasons for its decision.

The Department reviewed 60 standard grievance and appeal files. Of those, three files involved medical necessity determinations,[28] and none of the files included criteria and/or clinical reasoning used to make the decision. For example:

- **File #21:** The enrollee requested the Plan reconsider payment on the removal of her teeth. The Plan's written response to the enrollee stated:

  …however, based on the additional documentation provided, our decisions did not change, as the documentation submitted did not support the need for the removal of these teeth. In order for us to consider payment, we would need the symptoms and pathology on each individual tooth…

  The Plan's response does not clearly state the criteria, clinical guidelines, or medical policies used. In addition, although the provider submitted additional information, the Plan provided a broad denial reason ("the documentation submitted did not support the need for the removal of these teeth"), and made no reference to the enrollee's clinical condition.

- **File #45:** The enrollee requested the Plan to approve a pre-authorization for the surgical removal of four teeth. The Plan's written response to the enrollee stated:

  …After review of all of the submitted documentation…it was determined that the previous denial stands, as the office did not provide the signs, symptoms and pathology for each individual tooth. The previous denial stated, "Non pathologic third molar extractions are excluded from the plan."

  Removal of impacted teeth is limited to impactions which show radiographic evidence of a pathologic condition on or for which the *member* experiences unresolved symptoms of infection, swelling or chronic pain…

  The Plan's response cites the previous denial, but does not clearly state the criteria, clinical guidelines, or medical policies used. In addition, although the provider submitted additional information, the Plan provided a broad denial

[28] File #21; File #40; File #45.

> reason ("the office did not provide the signs, symptoms and pathology for each individual tooth"), and made no reference to the enrollee's clinical condition.

Based on the Department's review of standard grievance and appeal files, when the grievance involves the denial or modification of health care services based in whole or in part on medical necessity, the Plan's written responses to enrollees do not include a description of the criteria used or the clinical reasoning for its determination. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

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

> …has enhanced its member and provider clinical criteria and reasoning/rationale for the determinations, which will be included in the grievance resolution letters by the end of the first quarter 2020.

The Plan also provided an Excel spreadsheet titled, "Clear and Concise Clinical Criteria and Reasoning Rationale."

Final Report Deficiency Status: Not Corrected

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

While the Plan did not offer an explanation as to how the spreadsheet is applicable to its corrective action, the Department finds that the Plan has taken steps to correct this deficiency by enhancing and including clinical criteria and reasoning/rationale in its grievance resolution letters. 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 #6: The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on medical necessity do not include independent medical review (IMR) applications and instructions and envelopes addressed to the Department.

Statutory/Regulatory Reference: Rule 1300.68(d)(4).

Assessment: When the Plan's written responses to grievances involve the denial or modification of health care services based in whole or in part on medical necessity, Rule 1300.68(d)(4) requires the Plan's response to include IMR applications and instructions, and envelopes addressed to the Department.

The Department reviewed 60 standard grievance and appeal files. Of those, three files involved medical necessity determinations.[29] Since none of the letters include IMR applications, instructions, and envelopes, the Department finds the Plan in violation of this regulatory requirement.

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

> …revise the grievance process involving the denial or modification of health care services due to health care services due to medical necessity to include IMR application, instructions, and envelope addressed to the Department.

Once the amended IMR policy receives internal approval, the Plan indicated that it will file the policy with the Department. In addition, the Plan created a grievance resolution template letter that includes the IMR application, instructions, and a reminder to the grievance and appeal analyst to insert an envelope addressed to the Department.

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 amending its IMR policy and creating a grievance resolution template letter. 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 #7: **The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on a finding that the proposed services are not a covered benefit do not specify the provisions in the contract, evidence of coverage, or member handbook that excludes the service.**

Statutory/Regulatory References: Section 1368(a)(5); Rule 1300.68(d)(5).

Assessment: When the Plan's written responses to grievances involve the denial or modification of health care services based in whole or in part that the proposed services are not a covered benefit, Section 1368(a)(5) and Rule 1300.68(d)(5) require the Plan's

[29] File #21; File #40; File #45.

response to specify the provisions in the contract, evidence of coverage, or member handbook used for its decision.

The Department reviewed 60 standard grievance and appeal files. Of those, 17 files involved findings that proposed services are not covered.[30] Of the 17 files, 13 files (76%)[31] did not include contract, evidence of coverage, or member handbook provisions on which the Plan based its decision. For example:

- **File #1:** In response to the enrollee's dispute of the charge of a root canal obstruction, the Plan responded, "…however, root canal obstruction (D3331) is not a covered benefit under your dental plan." The Plan also mentions that since the enrollee signed a consent form, she accepts "full financial responsibility for all charges not covered by insurance," and that she must resolve charges for non-covered services with her dental office. The resolution letter to the enrollee did not contain provisions in the contract, evidence of coverage, and/or member handbook that indicate the service is not covered.

- **File #39:** The enrollee's child was referred by his assigned dental office to a pediatric dentist. The enrollee contacted the Plan when he was informed that his child was ineligible to be referred to a pedodontist because he was over the age of five. In the resolution letter, the Plan reiterated that the enrollee's child is ineligible for a pedodontist referral, and the enrollee would be financially responsible for the visit. The Plan stated that they "must adhere to the exclusions and limitations under your dental plan," but the resolution letter did not contain provisions in the contract, evidence of coverage, and/or member handbook where this could be found.

Based on the Department's review of standard grievance and appeal files, when the grievance involves the denial or modification of health care services based in whole or in part that the proposed services are not a covered benefit, the Plan's written responses to enrollees do not cite the provisions in the contract, evidence of coverage, or member handbook used for its decision. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

[30] File #1; File #17; File #21; File #23; File #26; File #28; File #31; File #34; File #37; File #39; File #40; File #42; File #44; File #45; File #48; File #55; File #56.
[31] File #1; File #21; File #23; File #26; File #28; File #31; File #34; File #39; File #40; File #44; File #45; File #48; File #56.

TABLE 4
Requested Service Is Not a Covered Benefit

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance & Appeal	17	Plan's written response must specify the provision in the contract, EOC, or member handbook that excludes the service	4 (24%)	13 (76%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated that its member grievance resolution letters will:

> …identify the contract/evidence of coverage document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee.[32]

Final Report Deficiency Status: Not Corrected

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

Although the Plan indicated that enrollee grievance response letters will include specific provisions from the contract and/or evidence of coverage that exclude the services, the Plan did not explain how that would be accomplished. Therefore, 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 #8: **The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on a finding that the proposed services are not a covered benefit do not include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the enrollee can contact the Department to determine whether the decision is eligible for independent medical review (IMR).**

[32] The Plan indicated that its dental enrollees do not have member handbooks.

Statutory/Regulatory Reference: Rule 1300.68(d)(5).

Assessment: When the Plan's written responses to grievances involve the denial or modification of health care services based in whole or in part that the proposed services are not a covered benefit, Rule 1300.68(d)(5) requires the Plan's response to include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the enrollee can contact the Department to determine whether the decision is eligible for IMR.

The Department reviewed 60 standard grievance and appeal files. Of those, 17 files involved findings that proposed services are not covered.[33] Since none of the letters notified enrollees that they can contact the Department to determine whether their case is eligible for IMR, 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 written grievance responses to enrollees have been updated to "state he/she may contact the Department to determine whether the decision is eligible for [IMR]." The notice will include the IMR application, instructions, and an envelope addressed to the Department.

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 updating written grievance responses to enrollees. 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 #9: The Plan does not send all acknowledgment letters to enrollees within five calendar days upon the Plan's receipt of the grievance.

Statutory/Regulatory References: Section 1368(a)(4)(A); Rule 1300.68(d)(1).

Assessment: Section 1368(a)(4)(A), Rule 1300.68(d)(1), and the Plan's Grievance Resolution Criteria and Standards[34] require the Plan to provide enrollees with acknowledgment letters within five calendar days of the receipt of a grievance.

[33] File #1; File #17; File #21; File #23; File #26; File #28; File #31; File #34; File #37; File #39; File #40; File #42; File #44; File #45; File #48; File #55; and File #56.
[34] Anthem Blue Cross Dental Quality Assurance Program, page 9.

The Department reviewed 60 standard grievance and appeal files. Of those, seven files (12%)[35] contained acknowledgment letters that were sent between six and 33 calendar days after the Plan's receipt of the grievance. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

TABLE 5
Timeliness of Acknowledgment Letters

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance & Appeal	60	Plan must provide enrollees with acknowledgment letters within five calendar days of the receipt of the grievance	53 (88%)	7 (12%)

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated the following enhancements were implemented in April 2019. The customer service SME monitors exempt grievances to ensure appropriate closure and turnaround times. The SME also monitors standard grievances to ensure the cases are appropriately categorized and routed to Grievances and Appeals, and the "internal routing turn-around time by the next day is met."

The Plan stated that customer service representatives are trained on the handling of grievances and "requirement of routing to Grievances and Appeals Department within 24 hours from the date the call was received," and provided its grievance guidelines to demonstrate its process.[36] The Plan indicated that Grievances and Appeals Lead Analysts monitor standard grievances each day to confirm the cases were appropriately documented and routed to the Grievances and Appeals Department in a timely manner. The lead analysts assign standard grievances to grievance and appeal analysts on the same day, and the analysts "mails the acknowledgment letter within one day of receipt."

In addition, the Plan asserted that there has been a 400 percent increase in grievances and appeals analyst staffing for Department-regulated products. The Plan also stated that the Dental Director or Clinical Designee reviews exempt grievances and standard grievances, and provided an exempt grievance process document.[37]

Final Report Deficiency Status: Not Corrected

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

[35] File #22; File #23; File #43; File #47; File #52; File #55; and File #61.
[36] WDS Grievance Guidelines (last revised December 13, 2019).
[37] Handling CAT II Report (last revised January 29, 2020).

The Department finds that the Plan has taken steps to correct this deficiency by monitoring standard grievance categorization and turnaround times, increasing staffing, and requiring grievance and appeal analysts to mail acknowledgment letters within one day upon their receipt of the standard grievance. However, the Department must verify the Plan's corrective actions have effectively corrected this deficiency.

Furthermore, this deficiency is about the timeliness of acknowledgment letters that accompany standard grievance and appeal cases. As the Plan's exempt grievance process document does not contain any information about the timeliness of acknowledgment letters, the Department is unclear as to why this document was provided.

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 #10: The Plan does not resolve all exempt grievances by the end of the next business day.

Statutory/Regulatory References: Section 1368(a)(4)(B); Rule 1300.68(d)(1).

Assessment: Section 1368(a)(4)(B) and Rule 1300.68(d)(1) require the Plan to resolve exempt grievances by the end of the next business day. The Department reviewed 48 exempt grievance files. Of those, nine files (19%)[38] were not resolved timely, with resolutions ranging from two to 70 days past the deadline.

The Department also reviewed 31 exempt grievance "Route 57" files. Of those, 11 files (35%)[39] were not resolved timely, with resolutions ranging from two to 45 days past the deadline. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

TABLE 6
Timeliness of Exempt Grievance Resolution

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievance	48	Plan must resolve exempt grievances by the end of the next business day	39 (81%)	9 (19%)

[38] File #5; File #7; File #9; File #10; File #11; File #12; File #27; File #30; and File #42.
[39] File #7; File #11; File #12; File #14; File #15; File #17; File #22; File #23; File #25; File #28; and File #31.

Exempt Grievance "Route 57"	31	Plan must resolve exempt grievances by the end of the next business day	20 (65%)	11 (35%)

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

> Effective August [19], 2019, process improvements were made to the Dental Customer Service process and call tracking record reporting." To ensure correct categorization and processing of grievances, a daily audit of all incoming exempt grievances from the business day prior are performed by a Dental Customer Service Subject Matter Expert (SME)…The SME will confirm closure of the exempt grievance or forward the grievance to Dental Grievances and Appeals to handle as an expedited/urgent or standard grievance. Any development opportunities are documented and sent to the Dental Customer Service Representative, manager, and operations expert to review and discuss. After the audit process is completed, the report is updated and forwarded to the Dental Director or Designee for review and approval.

The Plan stated that the Route 57 process was eliminated as of June 2018. The Plan also listed several "enhancements" that were implemented "to be consistent with the requirement of Rule 1300.35(a)(1)." For example, sending emails to customer service representatives when system platform changes are made, additional training for customer service representatives, and random audits on calls categorized as inquiries. In addition, the Plan provided two documents for the Department's review.[40]

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 making process improvements, auditing exempt grievances, increasing oversight, and providing additional training. However, the Department must verify the Plan's corrective actions have effectively corrected this deficiency.

As stated in the Plan's Compliance Effort section, the Plan cited Rule 1300.35(a)(1), which does not exist. In addition, the Plan provided two documents in its response to this deficiency, but did not offer an explanation as to their significance to this deficiency.

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

[40] WDS Grievance Guidelines (last revised December 13, 2019) and Handling CAT II Report (last revised January 29, 2020).

Deficiency #11: The Plan does not consistently provide enrollees with a written statement on the disposition or pending status within three calendar days upon its receipt of the expedited grievance.

Statutory/Regulatory References: Section 1368.01(b); Rule 1300.68.01(a)(2).

Assessment: Section 1368.01(b) and Rule 1300.68.01(a)(2) require the Plan to send a written statement on the disposition or pending status to enrollees within three calendar days upon the Plan's receipt of the expedited grievance. The Department reviewed 58 expedited grievance and appeal files. Of those, the written statement in 14 files (24%)[41] were sent to enrollees between four and 51 days after the Plan's receipt of the expedited grievance.

Since the written statements to the enrollees did not meet the three calendar day requirement, the Department finds the Plan in violation of these statutory and regulatory requirements.

TABLE 7
Written Statements on the Disposition of Pending Status

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Grievance & Appeal	58	Written statement on the disposition or pending status sent to enrollee within 3 calendar days upon the Plan's receipt of the expedited grievance	44 (76%)	14 (24%)

Plan's Compliance Effort: The Plan disagreed with this deficiency because it "did not receive any expedited/urgent grievances during the Department's look back period." The Plan also indicated:

> …An explanation was given to the Department during the onsite survey.
>
> The Plan made an error by categorizing enrollment and billing incoming verbal enrollee calls as expedited grievances when they should have been categorized as standard grievances…Because the Plan did not receive any expedited grievances, the Plan was not required to send a written statement on the disposition or pending status to enrollees within three calendar days of receipt.

[41] File #8; File #12; File #23; File #24; File #27; File #29; File #32; File #33; File #40; File #41; File #50; File #52; File #54; File #56.

Final Report Deficiency Status: Not Corrected

On December 6, 2018, the Plan provided the Department with an expedited grievance and appeal log. On January 23, 2019, the Plan submitted the Department-selected expedited grievance and appeal files. The Plan's onsite survey took place from March 12, 2019 through March 15, 2019. On May 10, 2019, the Plan provided an updated expedited grievance and appeal log to the Department.

The Plan's assertion that there were no expedited grievance and appeal files during the lookback period is contrary to the information the Department received. First, the Plan provided an updated expedited grievance and appeal log two months after the onsite portion of the survey. The submission of this amended log invalidates the Plan's explanation during onsite interviews that no expedited grievance and appeal files were received. Second, although the Plan claims these calls were erroneously categorized as expedited, three dates in the log (receipt date, date enrollee letter sent, resolution date) show that the majority of the files were processed and resolved within the three calendar day requirement set forth in Section 1368.01(b) and Rule 1300.68.01(a)(2).

Third, both logs show that all of the files were requests for reinstatement. When enrollees ask the Plan to review a cancellation, rescission, or nonrenewal of coverage, Rule 1300.65(d)(2) requires the Plan to provide the enrollees "with a disposition or pending status on the Request for Review within 3 calendar days of receipt by the plan pursuant to Health and Safety Code section 1368 and section 1300.68.01…" Since requests for reinstatement must meet the three calendar day requirement, it is reasonable that these entries were found in the Plan's expedited grievance and appeal log. Therefore, since the Plan processed these calls as expedited, the Department appropriately reviewed these files for compliance with Section 1368.01(b) and Rule 1300.68.01(a)(2).

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

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

Deficiency #12: When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform enrollees of their right to notify the Department of the grievance.

Statutory/Regulatory References: Section 1368.01(b); Rule 1300.68.01(a)(1).

Assessment: When the Plan has notice of a case requiring expedited review, Section 1368.01(b) and Rule 1300.68.01(a)(1) require the Plan to immediately inform enrollees of their right to notify the Department of the grievance. The Department reviewed 58 expedited grievance and appeal files and found that none of the files contained

documentation that the Plan immediately notified enrollees of their right to notify the Department of the expedited grievance. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: The Plan disagreed with this deficiency because it "did not receive any expedited/urgent grievances during the Department's look back period." The Plan also indicated:

> …An explanation was given to the Department during the onsite survey.
>
> The Plan made an error by categorizing enrollment and billing incoming verbal enrollee calls as expedited grievances when they should have been categorized as verbal call tracking inquiries…

Final Report Deficiency Status: Not Corrected

See Deficiency #11 for the Department's reasoning as to why these files were appropriately reviewed for compliance with Section 1368.01(b) and Rule 1300.68.01(a)(1). The Department disagrees with the Plan's contention that the calls should have been categorized as inquiries. If these calls to request reinstatement include an expression of dissatisfaction, complaint, dispute, and/or a request for reconsideration or appeal, then these calls must be categorized as grievances.[42]

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

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

Deficiency #13: The Plan does not have a policy to ensure enrollees with visual impairments can fully participate in the Plan's grievance system.

Statutory/Regulatory Reference: Rule 1300.68(b)(3).

Assessment: Rule 1300.68(b)(3) requires the Plan to develop and file with the Department a policy that addresses the needs of enrollees with visual impairments. The Plan's quality assurance program contains a language assistance program section[43] that contains information about telephonic interpreter services and translated vital

[42] 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."
[43] Dental Quality Assurance Program, pages 19 to 21.

documents,[44] but does not address assistance provided for enrollees with visual impairments.

The Plan's language assistance program addresses enrollee linguistic and cultural needs, including TTY access and sign language services for enrollees with hearing impairments, but also does not address assistance to visually impaired enrollees. During the onsite survey, the Plan's Compliance Administrator was asked to provide additional policies and procedures addressing services for enrollees with visual impairments. However, since no documents were provided, the Department finds the Plan in violation of the regulatory requirement.

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

> …Although the policy was inadvertently not previously provided, the Plan has a policy, which has been in place for several years, which addresses the needs of enrollees with visual impairments…

The Plan also provided a copy of its policy titled, "Provide Materials in Alternate Formats for Visually Impaired Members," last revised on January 24, 2020.

Final Report Deficiency Status: Not Corrected

Based upon the Plan's response and submission of the aforementioned policy, the Department has determined that this deficiency has not been corrected.

Although the Plan provided a copy of the policy, Rule 1300.68(b)(3) requires the Plan to file the policy with the Department. Since the Plan's response did not include a filing number, within 60 days of issuance of this Final Report, the Plan shall either provide the Department with the applicable filing number, or file this policy as an Exhibit W-1 (Grievance Procedure/Policy).

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency by confirming the policy was filed. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #14: The Plan's acknowledgment letters do not consistently include a notice of the availability of language assistance services.

Statutory/Regulatory References: Section 1367.04(b)(1)(B)(iv); Section 1367.04(b)(1)(C)(i); Section 1367.042(a)(1); Rule 1300.67.04(b)(7).

Assessment: Sections 1367.04(b)(1)(B)(iv), 1367.04(b)(1)(C)(i), 1367.042(a)(1), and Rule 1300.67.04(b)(7) require the Plan's enrollee acknowledgment letters to include a notice of the availability of language assistance services. The Department reviewed 60

[44] Dental Quality Assurance Program, pages 19 to 20.

standard grievance and appeal files. In 39 of 60 files (65%),[45] the Plan failed to include this notice along with the acknowledgment letters. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

TABLE 8
Notification of Language Assistance in Acknowledgment Letters

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance & Appeal	60	Acknowledgment letter includes a notice of the availability of language assistance services	21 (35%)	39 (65%)

Plan's Compliance Effort: The Plan disagreed with this deficiency because its Grievances and Appeal Department "always includes the notice of availability of language assistance services (LEP) in enrollee member communications, including the acknowledgment letters." The Plan indicated that "the scanned images reviewed by the Department appeared to not include the appropriate LEP notice," and "affirm[ed] that the LEP notice was in fact included in the actual member communications." In addition, the Plan stated that it revised its enrollee/member grievance letter templates to include the LEP insert, and provided an acknowledgment letter template.

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 revising its enrollee/member grievance letter templates. However, the Plan conceded that the 39 deficient files did not include appropriate LEP notices. Furthermore, the Plan's assertion that acknowledgment letters "always include" these notices is insufficient evidence, and 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.

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[45] File #2; File #3; File #4; File #6; File #7; File #8; File #10; File #11; File #12; File #13; File #14; File #17; File #19; File #21; File #24; File #25; File #27; File #29; File #33; File #34; File #35; File #36; File #39; File #40; File #43; File #44; File #46; File #47; File #48; File #49; File #50; File #53; File #54; File #55; File #57; File #58; File #60; File #61; File #62.

Deficiency #15: The Plan's written grievance responses to enrollees do not include the correct statement as required by Section 1368.02(b).

Statutory/Regulatory References: Section 1368.02(b); Rule 1300.68(d)(7).

Assessment: Rule 1300.68(d)(7) and Section 1368.02(b) require all acknowledgments and responses to grievances to include the quoted statement set forth in Section 1368.02(b) with the Department's telephone number, TDD line, website address, and the Plan's telephone number in 12-point boldface type.

The Department reviewed 58 expedited grievance and appeal files, and found that none of the written responses included a Section 1368.02(b) paragraph that meets the regulatory and statutory requirements. In all of the Plan's letters to enrollees, there was additional bolding ("toll-free telephone number," "a TDD line," "Website"); "experimental or investigational" was italicized; and in 34 letters,[46] the Plan added an additional sentence to the end of the statutorily mandated paragraph.

The Department also reviewed 60 standard grievance and appeal files, and found that that formatting of the Section 1368.02(b) paragraph in acknowledgment and resolution letters fail to comply with the requirements. Specifically, words such as "toll-free telephone number," "TDD line," and "Web site" should not be bolded.

Since the Plan's acknowledgment and written responses to grievances failed to comport with the requirements set forth in Rule 1300.68(d)(7) and Section 1368.02(b), the Department finds the Plan in violation of these statutory and regulatory requirements.

In taking corrective actions regarding this deficiency, the Plan should note the passage of Assembly Bill 1802,[47] which contains amendments to the statement prescribed by Section 1368.02(b).

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated that it "has updated all grievance member communications…to be consistent [with] Section 1368.02(b). The Plan also provided its acknowledgment letter template and resolution letter templates.

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 updating its grievance member communications. However, since the Section 1368.02(b)

[46] File #1; File #4; File #5; File #7; File #11; File #12; File #13; File #17; File #19; File #20; File #21; File #24; File #26; File #27; File #28; File #29; File #30; File #31; File #32; File #34; File #36; File #38; File #39; File #42; File #43; File #44; File #45; File #48; File #49; File #50; File #51; File #53; File #54; File #55.
[47] See Assembly Bill 1802.

paragraph is in quotes, the paragraph in the acknowledgment and resolution letter templates cannot contain additional information (i.e., the TDD/TTY number).

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

Deficiency #16: The Plan's online grievance submission process does not allow enrollees to preview and edit the grievance form prior to submittal, and does not include an accurate version of the Department's quoted statement.

Statutory/Regulatory Reference: Section 1368.015(c).

Assessment: The Plan's website requires enrollees to log in with a username and password to access the grievance form. Scrolling down the enrollee homepage takes one to a hyperlink identified as "Submit a GRIEVANCE FORM."[48] Clicking on the hyperlink takes enrollees to a Message Center with "Grievances / Appeals" as the pre-selected subject of the message.

Right before the portion where enrollees enter their grievance information, there is a link titled, "California members: Downloadable forms and more info about filing a grievance or appeal." Clicking on the link opens a text box titled "How to File a Grievance or Appeal." The box contains three ways to file a grievance (online, call customer support, or download a grievance form),[49] as well as the Department paragraph and a current hyperlink to the Department that is embedded in the Department's paragraph. However, the paragraph does not comply with Section 1368.015(c)(3) because it is missing the Plan's telephone number and the Department's website address. Instead of inserting the Plan's telephone number, the paragraph states, "the toll free telephone number listed on your ID card." In addition, instead of inserting the Department's website (http://www.hmohelp.ca.gov) as required, the Plan turned "Internet website" into a hyperlink, and opted not to display the Department's website address.

Once information is entered into the grievance form, enrollees can click either the "Send" button to submit the grievance, or the "Cancel" button to stay on the current page. The website does not allow enrollees to preview and edit the form prior to submittal, as required by Section 1368.015(c)(2).

Since the Plan's online grievance submission process does not allow enrollees to preview and edit the grievance form prior to submittal and does not contain the correct

[48] Only "GRIEVANCE FORM" is a hyperlink.
[49] Downloading a printable grievance form involves linking to the Plan's forms library and scrolling through multiple documents to find the PDF. During the website demonstration, Plan staff was unable to download the form and stated the process would be fixed.

quoted statement as set forth in Section 1368.015(c)(3), the Department finds the Plan in violation of this statutory requirement.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan indicated that it has "enhanced its online grievance form." The Plan stated that it added a "Preview and Send" button and a "Cancel" button to the online grievance form in April 2019; "[m]ade the DMHC paragraph in legible font and distinguishable from other content on the page" in August 2019; and "[c]hanged the DMHC paragraph to be compliant with Section 1368.02(b)" in October 2019. The Plan also provided screenshots of its online grievance process and of the Department's paragraph.

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 changes to its online grievance form. However, based on the screenshots, two of the three online grievance form enhancements do not meet the requirements set forth in Section 1368.015(c).

First, page two of the online grievance process screenshot only has a "Send" and "Cancel" button. There is no preview option. The "Preview and Send" button shows up on page three of the screenshot. Once someone clicks on the "Preview and Send" button, page four of the screenshot shows a majority of the same information as page three, with most of the same text boxes containing the same information enrollees entered, and the same selected radio buttons. At the bottom of page four, there are options to "Edit" and "Send." However, the "Send" button is grayed out, and does not look functional. Thus, the Department cannot rely on these screenshots to find this deficiency corrected.

Second, the screenshot of the Department's paragraph shows the paragraph in a gray shaded box with a black border around it, effectively making the paragraph distinguishable from the other content on the page. However, the Plan should not refer to Section 1368.02(b), as that provision applies to written documentation and communications to enrollees. Instead, the Plan should refer to Section 1368.015(c)(3), which sets forth requirements for the Department's paragraph on plan websites. Furthermore, the DMHC paragraph on the Plan's website remains noncompliant. Since the Section 1368.015(c)(3) paragraph is in quotes, the paragraph cannot contain additional information (i.e., the TDD number).

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

UTILIZATION MANAGEMENT

Deficiency #17: For decisions to deny and modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written responses to enrollees a description of the criteria or guidelines used and/or the clinical reasons for its decision.

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

Assessment: The Plan's utilization review policy requires:

> 4) Communications regarding decision to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to members shall specify the specific health care service approved. Responses regarding decisions to deny, delay or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to members shall be communicated to the members and providers in writing and shall include a clear and concise explanation of the reason for Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding dental necessity.[50]

From review of files and onsite discussions with the Plan, the Department found that the Plan sends enrollees Explanation of Benefits (EOBs) and denial/modification letters (the Plan calls these letters "clear and concise member letters"). The Plan sends the automatically generated EOBs to enrollees and providers four to five days prior to sending the denial/modification letters. EOBs are sent separately because each EOB sent to a provider may contain information on more than one enrollee.

The Department reviewed 65 utilization management denial and modification files and found that none of the EOBs and letters included a description of the criteria or guidelines used. In 30 out of 65 files (46%),[51] the Plan did not include the clinical reasoning in either the EOB or the letter.[52] For example:

- **File #1:** Denial of a bicuspid root canal and pulp vitality test. The EOB cites dental procedure code 708 for the pulp vitality denial reason, which states:

  The requested procedure(s) does not meet the established criteria for specialty referral under the member's plan. The participating dental office is responsible for providing this service. The member is not responsible for payments in excess of applicable co-payments.

[50] UM-003-01 UR Time Frames, page 2.
[51] File #1; File #3; File #4; File #6; File #10; File #13; File #14; File #15; File #16 ; File #20; File #21; File #22; File #24; File #25; File #26; File #32; File #34; File #35; File #37; File #38; File #39; File #40; File #41; File #42; File #45; File #46; File #53; File #55; File #67; and File #68.
[52] The clinical reasoning was only found in denial/modification letters, not EOBs. In addition, three files contained only EOBs and no denial/modification letters (File #3; File #4; File #6).

In addition, the denial letter states:

Upon review and consideration of the information provided (x-rays, narrative, and/or records) it has been determined that we are unable to provide benefits for the procedures submitted for following reason(s): … Based on your X-rays and dentist notes, you don't need a specialist for this root canal treatment, which can be done by a general dentist.

Assessing the auto-generated EOB and denial letter together, the communications to the enrollee did not include a description of the criteria or guidelines used or the clinical reasons for the decision. The EOB indicates that the established criteria for specialty referral is not met, but fails to provide a description of the criteria, and the origin of the criteria is unknown. In addition, the denial letter alludes to the review of x-rays and dentist notes, but it is unknown what clinical information the Plan relied upon to determine that the treatment could be performed by a general dentist instead of a specialist.

- **File #13:** Denial of a consult and root canal from an endodontist/specialist. The EOB cites dental procedure code 706 for the denial reason, which states:

  Radiographic evidence and/or narrative documentation does not meet established endodontic specialty referral criteria of calcified roots, severe curvature of roots, or extraordinary difficult access.

  In addition, the denial letter states:

  Upon review and consideration of the information provided (x-rays, narrative, and/or records) it has been determined that we are unable to provide benefits for the procedures submitted for following reason(s): … Based on x-rays and dental notes the procedure should have been done by the general dentist.

  Assessing the auto-generated EOB and denial letter together, the communications to the enrollee did not include a description of the criteria or guidelines used or the clinical reasons for the decision. The EOB indicates that the established criteria is not met, but fails to provide a description of the criteria, and the origin of the criteria is unknown. In addition, the denial letter alludes to the review of x-rays and dental notes, but it is unknown what clinical information the Plan relied upon to determine that the treatment could be performed by a general dentist instead of a specialist.

Section 1367.01(h)(4) requires responses regarding decisions to deny, delay, or modify health care services based in whole or in part on medical necessity to 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. Since all of the written communications to enrollees (EOB and letter) fail to include the description of the criteria or guidelines used and/or the clinical reasons, the Department finds the Plan in violation of this statutory requirement.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated it "revised its Clear and Concise letter content and clinical rationale verbiage inserted into the letters," and anticipates these "letter enhancements" to be implemented in second quarter 2020.

In addition, "to resolve the conflicts in language between EOB and the Clear and Concise letter, the Plan stated that it has enhanced the [member letters'] explanations of clinical determination to provide clarity." The Plan indicated that the Clear and Concise letters will state the reasons for the determination, and provided a spreadsheet with "revised explanations."[53]

The Plan stated that "Clear and Concise letters will be revised to include the clinical criteria used by Plan dental consultants to deny, modify, or request additional information." In response to this deficiency, the Plan also provided a provider letter template (Re: Explanation of Clinical Determination for Dental Claim).

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 revising its Clear and Concise letters. However, with regard to the spreadsheet, the Plan did not explain what changes were made, why the changes are relevant to this deficiency, how the Plan will use the spreadsheet, and what is relevant for the Department to assess whether this deficiency is corrected. The Department reviewed Column D (Member Reason for Determination) in the "DRU Clinical Ration 20191231" tab of the spreadsheet. Of the 48 cells in Column D,[54] 29 were highlighted in yellow. The Plan provided no explanation as to why the cells are highlighted. Furthermore, the Department questions the sufficiency of the clinical reasoning, as the reasons appear generally applicable, and may not adequately address enrollees' conditions.

In addition, since this deficiency is about utilization management denial and modification letters to enrollees, the provider letter template is not relevant. The Department did not assess that document.

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

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[53] The file name of the spreadsheet is "Clear and Concise Clinical Rationale and Clinical Determination Verbiage." The document itself is untitled.
[54] The spreadsheet contains 50 rows, but the first two rows does not contain any substantive information.

Deficiency #18: The Plan's written communications to providers of a denial or modification of a request do not consistently include the direct telephone number or extension of the health care professional responsible for the decision.

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

Assessment: Section 1367.01(h)(4) and the Plan's utilization review policy[55] require any written communication to a provider of a denial, delay, or modification of a request to include a telephone number of the health care professional responsible for the decision. In addition, the telephone number should be either a direct telephone number or an extension to allow for easy contact.

The Department reviewed 65 UM denial and modification files. In 57 out of 65 files (88%),[56] the Plan's written communications to providers did not include the direct telephone number or extension of the health care professional responsible for the decision. In the EOBs sent to providers, there is a phone number on the upper right corner, under "EXPLANATION OF BENEFITS." However, this is the same general customer service number found in the same location of all enrollee EOBs.

The eight compliant letters sent to providers include a signature block under the dental director's signature with the following information:

> Mark Kahn, DDS
> Dental Director
> Dental Review Unit Phone Number: (805) 713-3615
> Anthem Blue Cross of CA Dental Plans

During onsite interviews, Plan staff indicated that the Dental Review Unit (DRU) is comprised of three dental service analysts who are registered dental assistants and three licensed dentists. Messages left in the DRU's voice mailbox are retrieved daily, and anyone on the team can respond.

In the non-compliant letters, the third line with the DRU phone number is missing. Since the EOBs and denial letters do not contain a direct telephone number or extension for providers to easily contact the professional responsible for the decision, the Department finds the Plan in violation of this statutory requirement.

[55] UM-003-01 UR Time Frames, page 2.
[56] File #1; File #3; File #4; File #5; File #6; File #7; File #8; File #9; File #10; File #11; File #12; File #13; File #14; File #15; File #16; File #17; File #18; File #19; File #20; File #21; File #22; File #23; File #24; File #25; File # 27; File #29; File #31; File #32; File #33; File #34; File #35; File #37; File #38; File #39; File #40; File #42; File #43; File #44; File #45; File #46; File #47; File #48; File #49; File #50; File #53; File #54; File #55; File #56; File #57; File #60; File #61; File #62; File #63; File #64; File #65; File #67; File #68.

TABLE 9
UM Letters to Providers

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
UM Denial & Modification	65	Written communications to providers include a telephone number of the health care professional responsible for the decision	8 (12%)	57 (88%)

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated that the deficient cases identified by the Department "are related to the generation of the Plan's bulk [EOBs] mailed to the provider." According to the Plan, "bulk EOBs are created when multiple claims affiliated with the same provider are closed within the same timeframe," and "each EOB is combined into one document and sent to the provider."

After reviewing its bulk EOB process, the Plan indicated that system enhancements will be developed by the end of first quarter 2020. The provider letters "will be enhanced to reference the direct telephone number and name of the dental consultant." The Plan anticipates the implementation of the system enhancement during second quarter 2020.

The Plan also provided two versions of its provider letter template (redlined and clean). On the bottom of page two in the redlined version, an added sentence states, "You may reach the dental consultant that reviewed the claim, <Dental Consultant Name with title>…at <toll free phone number>."

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions taken, 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 assessing its bulk EOB process, identifying the root cause of this issue, enhancing its system to include dental consultant information in letters to requesting providers, and updating its provider letter template. 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 utilization management denial and modification files. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #19: The Plan's denial and modification letters to enrollees do not include the correct statement as required by Section 1368.02(b).

Statutory/Regulatory References: Section 1367.01(h)(4); Section 1368.02(b).

Assessment: The Plan's denial and modification letters must comply with the requirements of Section 1367.01(h)(4). One of the requirements is that these letters must include information as to how enrollees may file grievances with the Plan. In addition, written communications offering enrollees the opportunity to participate in the Plan's grievance process must include the paragraph set forth in Section 1368.02(b).

The Plan notifies enrollees of UM denials and modifications by first mailing an EOB, followed by a written response four to five days later. Plan staff indicated that a complete denial notification consists of the EOB and separately sent letter. The Department reviewed 65 utilization management denial and modification files and found that none of the files were compliant with Section 1368.02(b) requirements.[57]

Section 1368.02(b) requires the Department's telephone number, TDD line, website address, and the Plan's telephone number in the quoted paragraph to be in 12-point boldface type. However, the statutorily mandated paragraph in the EOB is completely bolded. In addition, the Plan failed to include the Plan's telephone number, added additional text to the second and third sentences, and included the Department's address and email address as additional ways to contact the Department.

Section 1367.01(h)(4) requires the Plan's denial and modification letters to include information on how enrollees may file grievances with the Plan. In addition, any written communications to enrollees that offer the opportunity to participate in the Plan's grievance process must include the Section 1368.02(b) paragraph. Since none of the Plan's EOBs contain the correct Section 1368.02(b) paragraph, or the Plan's telephone number, the Department finds the Plan in violation of these statutory requirements.

In taking corrective actions regarding this deficiency, the Plan should note the passage of Assembly Bill 1802,[58] which contains amendments to the statement prescribed by Section 1368.02(b).

Plan's Compliance Effort: In response to the Preliminary Report, the Plan reviewed its EOBs and enrollee letters, and "confirmed IT system enhancements are required." Specifically, the Plan indicated that EOBs will include the Plan's toll-free phone number and will be updated to comply with AB 1802.[59] For enrollee letters, the Plan indicated that it will "add enrollee grievance rights that includes appropriate statements according

[57] The Section 1368.02(b) paragraph is only in the EOB.
[58] See Assembly Bill 1802.
[59] The Plan's response also stated that grievance submission timeframes will be updated "to reflect for at least 180 calendar days following any incident or action," which is not relevant to this deficiency.

to Section 1367.01(h)(4) and 1368.02(b)."[60] The Plan anticipates the implementation of the system enhancements during second quarter 2020.

The Plan also provided an enrollee letter template (Re: Explanation of Clinical Determination for Dental Claim); a document titled "Important Information about Your Grievance Rights as a Member"; and a spreadsheet.[61]

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 assessing its EOB and enrollee letters, identifying system enhancements, and updating EOB and enrollee letter templates. However, the Section 1368.02(b) paragraphs in the two templates are still incorrect. Since the Section 1368.02(b) paragraph is in quotes, the paragraph in the templates cannot contain additional information (i.e., the TDD/TTY number). In addition, the Section 1368.02(b) paragraph is not mentioned in the spreadsheet, so the Department is unclear as to why this document was provided.

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

Deficiency #20: The Plan's explanation of benefits (EOBs) improperly instructs enrollees on how to file an appeal.

Statutory/Regulatory References: Section 1367.01(h)(4); Section 1368(a)(4)(B)(i); Rule 1300.68.01(a)(4).

Assessment: The Plan's clinical determination explanation template letter to enrollees concludes with:

> If you disagree with this decision, you have the right to file an appeal. Please submit additional dental records and other supporting documentation for reconsideration of this determination. You will find a copy of the Dental Appeals Process Description for your review on the back side of the Explanation of Benefits.[62]

[60] The Plan's response also stated that the system enhancement will include adding a language assistance insert to enrollee letters, and using "clearer and easier to read UM clinical rational [sic] decisions along with the EOB remark code description. These proposed changes are also not relevant to this deficiency.
[61] The file name of the spreadsheet is "Clear and Concise Clinical Rationale and Clinical Determination Verbiage." The document itself is untitled.
[62] UM Clear Concise Member Letter Template (Re: Explanation of Clinical Determination for Dental Claim), page 2.

The Department reviewed the Plan's retrospective utilization management denial and modification files and found that the Plan's EOBs provide enrollees with inaccurate information on how to request an appeal.

The Plan's EOB provides a Grievances and Appeals post office box address in San Antonio, Texas, and states:

> You should request appeals in writing. However, unless your evidence of coverage states otherwise, you may request an appeal verbally by calling **the Member Services phone number on your ID card**. You can request an appeal online at **anthem.com/ca/mydental**.

Section 1368(a)(4)(B)(i) allows grievances to be received by telephone, facsimile, email, or online through the Plan's internet website.[63] The Plan's EOB is confusing because it leads enrollees to think that it is best to submit appeals in writing, and does not present enrollees with all the methods in which appeals may be submitted.

In addition, in urgent situations, the EOB provides enrollees with instructions on how to request an expedited appeal:

> …If it's urgent, your review will generally be done in 72 hours, unless your evidence of coverage states otherwise. Follow the directions above for filing an internal appeal. To request an expedited appeal you, your provider or your representative can contact the Member Services phone number on your ID Card.

The expedited appeal instructions are inaccurate because Rule 1300.68.01(a)(4) allows enrollees to contact the Department about the expedited appeals without first participating in the Plan's grievance and appeal process. In addition, since enrollees are instructed to "follow the directions above for filing an internal appeal," enrollees may again be led to erroneously believe that they should file a written appeal with the Plan.

Section 1367.01(h)(4) requires the Plan's responses regarding decisions to deny, delay, or modify health care services to enrollees to include information as to how the enrollee may file a grievance with the Plan pursuant to Section 1368. The Plan's template denial letter directs enrollees to the EOB for instructions on how to file an appeal. However, since the EOB includes misleading and inaccurate information about its appeal process, the Department finds the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan reviewed its EOBs and enrollee letters, and "confirmed IT system enhancements are required." The three EOB system enhancements are identical to the Plan's response in Deficiency #19: (1) Include the Plan's toll-free phone number; (2) update grievance submission timeframes to at least 180 calendar days following any incident or action; and (3) update the Section 1368.02(b) paragraph to comply with AB 1802. In addition, the Plan listed

[63] The definition of "grievance," as set forth in Rule 1300.68(a)(1), includes appeals, and provides no difference in the treatment of grievances and appeals.

several system enhancements it planned to make to enrollee letters.[64] The Plan anticipates the implementation of the system enhancements during second quarter 2020.

The Plan also provided a redlined enrollee letter template (Re: Explanation of Clinical Determination for Dental Claim); a redlined provider letter template (Re: Explanation of Clinical Determination for Dental Claim); and a document titled "Important Information about Your Grievance Rights as a Member."[65]

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 the Plan's corrective action inadequate. This deficiency is based on template language in the Plan's EOB that conveys inaccurate information to enrollees wishing to file appeals (standard and expedited). The Plan's response to this deficiency and EOB system enhancements did not refer to the problematic template language cited in the Assessment section above. Furthermore, the system enhancements for the enrollee letters and the three documents submitted by the Plan are not relevant to this deficiency.

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

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

LANGUAGE ASSISTANCE

Deficiency #21: The Plan does not include the required notice of language assistance (NOLA) with all member grievance forms.

Statutory/Regulatory References: Section 1367.04(b)(1)(B)(v); Rule 1300.67.04(b)(7)(D); Rule 1300.67.04(c)(2)(D).

Assessment: The Plan's language assistance program (LAP) states:

B. LANGUAGE ASSISTANCE SERVICES:

[64] Revise grievance statement and refer enrollees to the grievance rights insert; include Section 1367.01(h)(4) and 1368.02(b) statements; add a language assistance insert, and use "clearer and easier to read UM clinical rational [sic] decisions along with the EOB remark code description.
[65] The file name of the spreadsheet is "Clear and Concise Clinical Rationale and Clinical Determination Verbiage." The document itself is untitled.

> 1. Identification and Notification of Language Assistance Services to Members
>
> Anthem complies with the requirements to provide free language assistance services to LEP members in accordance with 28 CCR § 1300.67.04 and 10 CCR § 2538.1 et seq., Members are informed of the availability of Language Assistance services at no cost via member newsletters, the Plan website, and the Plan's Notice of Language Assistance (NOLA). Anthem utilizes a regulatory agency (DMHC/CDI) specific NOLA that is provided with Vital Documents and certain member materials and also provides an annual NOLA with more detail each calendar year.[66]

The Plan defines "vital documents" as:

> Vital Documents – Standard:
>
> The following standardized documents, when produced by Anthem or its contractors/vendors/providers: Applications; Consent forms; Letters containing important information regarding eligibility and participation criteria; Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance/complaint or appeal; Notices advising members of the availability of free language assistance and other outreach materials that are disseminated…[67]

Section 1367.04(b)(1)(B)(iv), Rule 1300.67.04(b)(7)(D), and the Plan's LAP identify notices pertaining to the right to file a grievance or appeal as a type of vital document. In addition, Rule 1300.67(c)(2)(D) and the Plan's LAP require vital documents to be accompanied with a NOLA. The Plan's online grievance form and Member Grievance Form are not accompanied with a NOLA. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: The Plan disagreed with this deficiency because it filed a NOLA with the Department[68] and its public website and member portal contain "a drop down function titled 'Select a language' that reflect multiple language options." The Plan stated:

> Each language referenced in the drop down function reflects a pop-up message translated in the language selected and informs the user how to contact the Plan and that our language assistance services are free. The multiple languages referenced in the drop down option include the Plan's required 15 languages (and includes English)…

The Plan also provided screenshots of its member portal and public website.

[66] California Language Assistance Program, page 4.
[67] California Language Assistance Program, page 12.
[68] eFiling #20180255.

Final Report Deficiency Status: Not Corrected

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

Scrolling all the way down the Plan's public website (https://www.anthem.com/ca/), the webpage changes from a white background to a blue background. This is where the "Select a language" drop down is located. The placement and design of the drop down is not intuitive, and it is doubtful that enrollees who do not understand English would scroll almost to the bottom of the website, and know to click on the drop down. Scrolling to the very bottom of the public website, there are three NOLAs in English, Spanish, and Chinese combined into one paragraph. However, since the Plan's threshold languages are Spanish, Chinese, Korean, Vietnamese, and Tagalog,[69] the Spanish and Chinese language assistance notifications are insufficient to inform enrollees of the availability of free language services.

In the member portal, the same drop down can be found at the bottom of every page. The Department has the same concerns about the intuitiveness and the usefulness of this drop down as mentioned above. Unlike the public website, the member portal contains no NOLAs.

In addition, this deficiency is also based on the Plan's Member Grievance Form not accompanied by a NOLA. The Plan's response did not address this portion of the deficiency.

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

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through the review of the Plan's website, member portal, and Member Grievance Form. The Department may also conduct interviews and review any other documents deemed relevant.

[69] In response to the Department's onsite request #46 (March 14, 2019), the Plan indicated these five languages are the Plan's threshold languages.

SECTION II: SURVEY CONCLUSION

The Department has completed its Non-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.

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, **2019 Routine Dental Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.