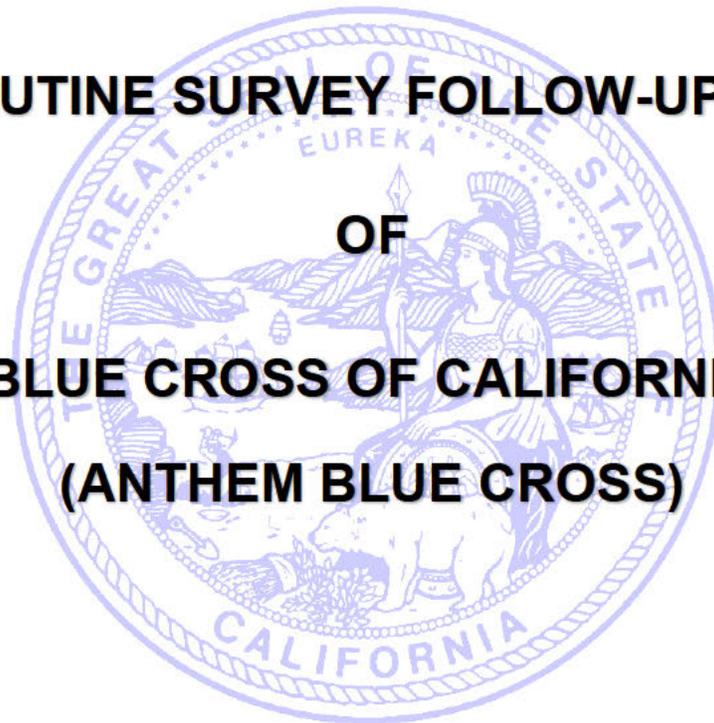




**DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**

NON-ROUTINE SURVEY FOLLOW-UP REPORT

**OF
BLUE CROSS OF CALIFORNIA
(ANTHEM BLUE CROSS)**



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**Non- Routine Survey Follow-Up Report
Blue Cross of California
A Full Service Health Plan
July 22, 2016**

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Introduction

Between January and May 2014, a critical mass of newly enrolled Californians gained access to health care coverage through Covered California, the state's health care exchange. Health plans, in establishing their participation in Covered California, developed and modified existing provider networks to meet the needs of the anticipated increased enrollment in the various product offerings through Covered California. To ensure timely access to health care services, it is critical that enrollees have accurate provider directories to inform their enrollment decisions and from which to locate and select primary care and specialty providers once enrolled in coverage.

Origin of Non-Routine Survey (2014)

Between January and May 2014, the Department of Managed Health Care (DMHC or the Department) received numerous complaints from Blue Cross of California (Plan) individual market enrollees who could not find a primary care physician in their area or alleged that they had been misled by inaccurate health plan provider network directories. Due to the pattern of complaints and the significant risk associated with enrollees' inability to access care, on June 10, 2014, the DMHC initiated a Non-Routine Survey¹. The Non-Routine Survey included a telephone survey of providers listed in the Plan's online provider directory to assess whether the directory information was correct, whether the provider was participating in the Plan's listed Covered California networks and products, and whether the provider was accepting new patients.

The Survey revealed that 12.5% of the sampled providers were not at the location listed in the Plan's provider directory and that 12.8% of surveyed providers reported they were not accepting members enrolled in the Plan's Covered California products even though the providers were listed as such in the Plan's provider directory. Based on the findings from the Non-Routine Survey, the Department cited the Plan for noncompliance with the Knox-Keene Act in four areas. At the conclusion of the Survey, the Department determined the Plan had corrected one of the deficiencies, leaving three uncorrected deficiencies:

1. The Plan operated at variance when its internet website and online provider directory informed enrollees that numerous physicians were participating in the Plan's Covered California products, when they were not.
2. When the Plan failed to correct inaccuracies in its online Provider Directory, the Plan used (or permitted the use of) written or printed statements of items of information that were either untrue or misleading and which were disseminated, at least in part, for the purpose of inducing persons to enroll in the Plan.
3. The Plan failed to meet its statutory obligation to provide enrollees with accurate contracted provider lists, either upon request, or through provider listings set forth on the Plan's internet website.²

Settlement Agreement (2015)

¹ The Non-Routine Survey was conducted pursuant to Cal. Code Regs., tit. 28, § 1300.82(b).

² [Final Report](#), November 7, 2014.

The Department took enforcement action, with a penalty in the amount of \$250,000 for the violations listed. A Settlement Agreement dated October 29, 2015 confirmed the penalty and outlined a corrective action plan.³ The Settlement Agreement required the Plan to continue its corrective action measures commenced in response to the Survey and to take additional corrective action to improve the accuracy of its provider directories, including reimbursement to enrollees who may have been financially impacted by inaccuracies in provider directories. The Plan agreed to pay damages based on claims reimbursement to those consumers or enrollees negatively impacted by the inaccuracy of its provider directory through the resolution of the pending lawsuits consolidated under the *Felser et al. v. Blue Cross of California* class action lawsuit filed in the Superior Court of Los Angeles, Case number L.A. BC 550739 (“Felser matter”).

The Plan also committed to overhaul its policies and procedures and data systems to ensure the accuracy of its provider directory as set forth in Section 1367.26.⁴ The Plan committed to improve outreach, education, and training to providers on their Covered California affiliation status and their obligation to provide correct and timely updates to the Plan regarding demographic and other changes of information contained in the directory. The Plan also agreed to dedicate a separate phone line for consumer assistance with provider directory concerns and to assist enrollees in finding in-network providers. Lastly, the Plan committed to process and data management enhancements to improve the accuracy of its provider directory, including semi-annual audits of provider information and training for all Plan employees and vendors who administer and maintain the provider directory.

Based on the DMHC’s continued communications with the Plan, and regular reports by the Plan to the Department, the Department has confirmed that the Plan has initiated the corrective actions summarized in the Settlement Agreement and is currently in compliance, or on track for compliance, with the terms of the Settlement Agreement.

Follow-Up Survey Activity (2015)

In October 2015, the Department initiated its statutorily required Follow-Up Survey⁵. The Department reviewed the Plan’s policies and practices relative to provider directory maintenance, conducted an automated verification of provider directory data elements, and performed a telephone survey of a randomly selected and statistically valid number of providers listed in the Plan’s online directory.

Despite the Plan’s efforts outlined in its corrective action plan and Settlement Agreement, the survey yielded disappointing results. The Department acknowledges the complexities involved in keeping up with constant changes and recognizes that unilateral actions of health plans to maintain provider directories is not enough. Lack of

³ [Settlement Agreement](#), October 29, 2015.

⁴ The Knox-Keene Act is codified at California Health and Safety Code section 1340 et seq. All references to “Section” are to the California Health and Safety Code unless otherwise indicated.

⁵ Section 1380(i)(2). The Department engaged Milliman, Inc. to conduct various aspects of the Follow-Up Survey. Milliman arranged for LexisNexis to support the automated verification of provider data elements and the provider telephone survey.

provider responses to Plan inquiries contributes to the challenge of maintaining accurate information.

Policy and Procedures Review

Onsite interviews with Plan staff and the review of the Plan's policies and practices for provider directory management revealed that the Plan has conducted a review of its processes and provided documentation governing its management of provider directory data. Most of the policies included measurable performance standards and reporting tied to standards within specific departments. The Plan appeared to meet performance against its standards based on the sample of reports provided. The Plan performs regular process audits and has an understanding of the importance of provider data quality. Additionally, the Plan has emphasized the importance of provider data quality and accuracy, and has employed knowledgeable staff members who understand both the business issue and consumer need. This is evidenced by the Plan's implementation of efforts to improve the quality of its provider directory data, as required by the Settlement Agreement, including hiring additional personnel and developing specific initiatives and provider outreach programs focused solely on improving directory quality.

Automated Verification

The Follow-Up Survey included an automated verification of provider directory data elements using the LexisNexis ProviderPoint® system. ProviderPoint® measures provider directory data quality by comparing selected data elements⁶ in a plan's provider directory to data contained in the ProviderPoint® referential database of provider data. The data quality of the Plan's provider directory was quantified using a score called the "Enclarity Quality Index" or EQI. This score provides a benchmark for comparing directory quality among provider files and for measuring changes in provider directory quality over time. National health plan EQI scores range from zero to 950, with an average score of 590. The Plan's EQI was 681. Notably, ProviderPoint® does not measure certain factors impacting accuracy of provider directories, such as open panel status and a provider's network participation.

Provider Telephone Survey

To replicate the consumer experience and in keeping with the original Non-Routine Survey approach, the DMHC conducted a provider telephone survey. The calls took place in December 2015 and January 2016. The purpose of the survey was to validate the accuracy of certain provider data elements contained in the Plan's provider directory and each providers' participation in relevant Plan products. Agents made outbound telephone calls to a statistically significant sample of providers listed in the Plan's provider directory.⁷ Agents attempted to contact a total sample of 4,951 providers and ultimately reached 3,063 (62%). Thirty-eight percent (1,888) could not be reached after two attempts. This significant percent of unanswered provider contacts underscores the

⁶ The Plan's provider directory, dated November 25, 2015, was processed through the ProviderPoint® system to evaluate the accuracy of the provider's listed address, using the following five data elements: (1) Provider Name; (2) Provider Status (Actively Practicing or Not Practicing) (3) Practice Address; (4) Practice Phone Number; and (5) Taxonomy (Provider Type or Specialty).

⁷ The sample of providers was sized such that it achieved a 95% confidence level and 5% confidence interval, which is equivalent to a precision level of +/- 2.5%.

challenges health plans face in maintaining accurate provider directories. The findings presented below relate to the responses received from provider offices reached during the telephone survey. The phone script is provided in Appendix A.

- 1,716 (56%) confirmed the provider participates in the plan's Covered California products as listed in the plan's provider directory.
- 274 (8.9%) stated that the provider did not participate in the product(s) listed in the directory.
- 141 (4.6%) were unsure whether the provider participated in the products listed.
- 756 (24.7%) stated the provider no longer practiced at the listed location.
- 176 (5.7%) indicated that phone number listed in the provider directory was wrong.

Enactment of Senate Bill 137

Importantly, and subsequent to the Department's 2014 Non-Routine Survey, California Senate Bill (SB) 137 was enacted, providing a new and comprehensive framework for the regulation of provider directories. To ensure provider directories remain current and accurate, the Legislature repealed Section 1367.26 and added Section 1367.27, imposing new provider directory requirements for health care service plans and their contracted providers. The effective date of the legislation was July 1, 2016. Legislative committee hearing minutes and analyses cite the DMHC Non-Routine Survey Final Report as one of the many indications of growing problems with provider directory accuracy.

SB 137 includes several key provisions pertaining to both health care service plans and their contracted providers, which were not previously required under the repealed Section 1367.26. These provisions add significant accountability for health plans and providers, including strict timeframes for verification of provider information, investigation of inaccuracies, frequent updating, and consistency of the information displayed for all health plans.

The changes to the law are described below:

1. Plans must update online provider directories weekly.

The repealed statute required quarterly updates.

2. Plans must maintain printed and online provider directories, which allow for the easy identification of the networks and products in which providers participate.

Under the repealed statute, plans were required to list certain contracted providers, but were not required to identify the medical groups with which the providers are associated. Such information is critical for an enrollee to identify all the providers available within an assigned medical group.

3. Provider directories must be publicly accessible online without any restrictions or limitations.

Under the repealed statute, the provider directory was required to be available only upon request.

4. Plans must conduct biannual or annual provider verification through outreach and notification to ensure provider directory accuracy. Providers who fail to respond to a plan's outreach are subject to provider directory removal and financial penalties.

The repealed statute had no explicit requirements on plans regarding provider verification and no requirements that providers respond to plan requests to verify and update their data.

5. Provider directories must display specific information for individual providers and facilities, including contact information, area of specialty, National Provider Identifier number, California license number, and whether the provider is accepting new patients.

This information is valuable for several reasons, including allowing the plan to verify accuracy and eliminate duplicate listings, allowing the DMHC to better verify the information and cross-reference it with network adequacy data, and allowing enrollees to more easily seek information about the provider, for example on the California Medical Board's database. The repealed statute required less information, and required that information to be available only upon request.

6. Providers must notify plans within five business days if the provider is not accepting new patients.

This provision obligates providers to proactively update the health plan of this important change so that enrollees are not misled or delayed access to services. The repealed statute did not place obligations on providers.

7. Plans must have an online interface for providers to promptly verify and submit changes to their provider directory information. Providers must use the process required by plans.

The repealed statute did not place obligations on providers or specify requirements for verification of provider data.

8. Plans must have a telephone number, email address, and hyperlink form to receive reports of provider directory inaccuracies. Plans must investigate and document all reports relating to provider directories, including contacting the affected provider within five business days and taking any necessary corrective action within thirty business days.

The repealed statute did not provide a process for handling of reports of inaccuracies.

9. Plans must maintain and file with the Department, annually, policies and procedures regarding the regular updating of provider directories.

The repealed statute did not require the plan to maintain or file policies and procedures regarding provider directories.

10. The Plan must “honor” its provider directory. In circumstances where an enrollee reasonably relied upon materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories, the Department may require the health plan to reimburse the enrollee for any amount beyond what the enrollee would have paid, had the services been delivered by an in-network provider under the enrollee's plan contract.

The repealed statute required the provider directory to include information advising enrollees that it was subject to change without notice and provide a telephone numbers for enrollees to obtain information regarding a particular provider.

Keeping provider directories accurate and current requires participation by both health plans and providers. SB 137 requires health plans to develop online interfaces for providers to quickly and easily verify or update information, and for the public and health plan enrollees to report inaccurate information. Upon receipt of such information, SB 137 provides clear timeframes for investigation and update of the provider directory. This increased transparency and accessibility of provider directories will allow for faster identification of inaccuracies and corresponding updates and, accordingly, more reliable provider directories.

DMHC Implementation of SB 137

The Department is actively monitoring health plans' implementation of SB 137. Through compliance filings, health plans have been required to establish policies and procedures that demonstrate compliance with Section 1367.27, including making all necessary revisions to existing contracts with providers, provider groups, and specialized health plans. The Department issued guidance to health plans to facilitate these compliance filings.

Additionally, health plans must comply with the Department's development of uniform provider directory standards described in Section 1367.27(k) to permit consistency of the information displayed in provider directories for all health plans. In compliance with the new law, the Department is presently engaging with stakeholders and interested parties to develop the uniform provider directory standards by December 31, 2016. Health plans are required to comply with these standards within 12 months of development. The DMHC will continue to monitor compliance with all aspects of SB 137 through review of annual filings, routine medical surveys and other monitoring efforts.

Conclusion

The Follow-Up Survey activity predates the implementation requirements of SB 137, posing timing challenges for the Department in that most provisions of the law became effective July 1, 2016. As a result, the Department is aggressively implementing the strong consumer protections of the new provider directory statute, which places obligations on both plans and providers and requires plans to honor the information in the directory when a consumer has relied upon it.

The Plan's actions required under the Settlement Agreement, while well underway and on track for compliance thus far, have not been fully implemented; this poses an additional timing challenge for the Department in determining whether deficiencies found in the Non-Routine Survey were corrected. While the Settlement Agreement closely mirrors the new law, the new law goes even further than the corrective actions the plan took pursuant to its Settlement Agreement, requiring three new processes for verifying provider information and investigating inaccuracies, each supported by an online interface.

While the Department was disappointed to find that the corrective actions implemented by the plan did not result in more accurate directories, it expects measurable improvement with the full implementation of SB 137 in the months to come.

Although the Department has determined the three deficiencies remain uncorrected, primarily based on the results of the provider telephone survey, the robust requirements under SB 137 add significant accountability for health plans and providers, including strict timeframes for verification of provider information, investigation of inaccuracies and frequent updating.

The Department considers the Non-Routine Survey closed and will continue to monitor the Plan's progress under the new and comprehensive framework for the regulation of provider directories.

In the event the Plan would like to append a brief statement to the Follow-Up Report as set forth in Section 1380(i)(3), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, [DMHC Web Portal](#).

Appendix A

Direct Verification Phone Call Script

This call script will guide the calling agent's interaction with provider offices. If the survey is refused, the provider record will be marked "refused to participate." If a provider representative cannot be reached for an initial call or a single follow-up call, the provider record will be marked as "unable to be reached." Upon successfully reaching a provider's office (including reaching a provider or provider's representative) the calling agent will execute the following script:

1. Confirm Provider Name and Number

"Good morning/afternoon, my name is [YOUR NAME], and I am calling on behalf of the California Department of Managed Health Care. I would like to confirm that the number I am calling is for [PROVIDER'S NAME]."

Yes: *"Okay, thank you."* Record result. <MOVE TO ITEM #2>

No: *"Okay, thank you for your time."* Record result. <END CALL>

2. Confirm Appropriate Contact Is On The Line

"I am calling today to verify information about providers who are contracted to participate in Anthem Blue Cross of California's Covered California plans. Are you able to answer questions about [PROVIDER NAME]'s practice and network participation?"

Yes: *"Okay, thank you. I have four questions for you which should take less than two minutes to complete."* <MOVE TO ITEM #3>

No: *"May I speak to someone in your office who would be able to answer questions of this nature? I have four questions which should take less than two minutes to complete."*

Yes: Ask to speak with the alternate. <REPEAT SCRIPT STARTING WITH ITEM #1>

No: Request a more convenient time during the same or following day for a follow-up call if possible, or within the following seven days otherwise. Schedule and conduct follow-up. <END CALL>

3. Confirm Provider's Address

"Is [ADDRESS] where patients go for appointments with [PROVIDER NAME]?"

Yes: "Okay, thank you." Record result. <MOVE TO ITEM #4>

No: "Okay, thank you." Record result. <MOVE TO ITEM #4>

4. Confirm Specialty

"The Anthem Blue Cross of California provider directory lists [PROVIDER NAME] as a [SPECIALTY], is that correct?"

Yes: "Okay, thank you." Record result. <MOVE TO ITEM #5>

No: "Okay, thank you." Record result. <MOVE TO ITEM #5>

5. Confirm Participation In Listed Network(s)

"Does [PROVIDER NAME] participate in Anthem Blue Cross's Covered California [NETWORK LISTED (EPO/PPO/HMO)] plan? You may also recognize this network by the name [PATHWAY X TIERED EPO/PATHWAY X PPO/PATHWAY X HMO]."

Yes: "Okay, thank you." Record result. <REPEAT ITEM #5 FOR ALL LISTED NETWORKS, THEN MOVE TO ITEM #6>

No: "Okay, thank you." Record result. <REPEAT ITEM #5 FOR ALL LISTED NETWORKS, THEN MOVE TO ITEM #6>

6. Confirm Panel Status

"Is [PROVIDER NAME] accepting new patients for the Anthem Blue Cross Covered California [FIRST NETWORK CONFIRMED IN ITEM #5] at this time?"

Yes: "Okay, thank you." Record result. <REPEAT ITEM #6 FOR ALL CONFIRMED NETWORKS, THEN MOVE TO ITEM #7>

No: "Okay, thank you." Record result. <REPEAT ITEM #6 FOR ALL CONFIRMED NETWORKS, THEN MOVE TO ITEM #7>

7. End Call

"We appreciate your participation; thank you for your time."

<END CALL>

If the representative or the physician asks for additional information regarding the reason for the call:

The Department of Managed Health Care is investigating the accuracy of Anthem Blue Cross's published Covered California networks after identifying a pattern of consumer complaints regarding access issues.

If the representative or the physician asks who or what the Department is:

The Department of Managed Health Care is a regulatory body governing managed health care plans, sometimes referred to as Health Maintenance Organizations (HMOs) in California.

Providers working in the same office location with same phone number:

The final provider sample may contain multiple providers at the same address and phone number (presumably because the providers work in the same office). In this case, the caller may inquire during the initial survey call if the caller can ask about other doctors working in the same office. For example, assume Doctor A, Doctor B, and Doctor C are selected for the survey and all three doctors work at the same physical address and have the same office phone number. When the caller calls to survey Doctor A, the caller can ask the office scheduler (or other appropriate office representative) whether they are also able to answer questions regarding which insurance plans Doctor B and Doctor C accept. If so, then the plan can conduct the survey for Doctor B and Doctor C during the same phone call.