DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

FOLLOW UP REVIEW REPORT

OF

BLUE CROSS OF CALIFORNIA

DBA ANTHEM BLUE CROSS

A BEHAVIORAL HEALTH PLAN

DATE ISSUED TO PLAN: DECEMBER 27, 2012
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Follow Up Review Report of a Routine Medical Survey
Blue Cross of California
dba Anthem Blue Cross
A Behavioral Health Plan
December 27, 2012

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EXECUTIVE SUMMARY

On June 5, 2012, the California Department of Managed Health Care (the “Department”) notified Anthem Blue Cross Behavioral Health (the “Plan”) that the follow up portion of the Routine Medical Survey had commenced, and requested the Plan to submit information regarding its uncorrected deficiencies as cited in the Final Report dated July 28, 2011. The survey team conducted the onsite portion of the survey from October 19, 2010 through October 22, 2010.

The Department assessed the following areas:

- Quality Management
- Grievances and Appeals
- Access and Availability of Services
- Utilization Management
- Continuity of Care
- Access to Emergency Services and Payment
- Language Assistance

In the Preliminary Report for the Routine Medical Survey, the Department identified three deficiencies and instructed the Plan to implement corrective actions. By the date the Final Report was issued, the Plan had fully corrected two deficiencies. One deficiency remained uncorrected. The Plan was advised that the Department would conduct a desk level Follow Up Review to assess the status of this outstanding deficiency and issue a report within 18 months of the date of the Final Report.

The Department conducted its Follow Up Review and found one outstanding deficiency cited in the Final Report.

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<th>ACCESS AND AVAILABILITY OF SERVICES</th>
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<td>3</td>
<td>The Plan does not take effective action to address problems that have been identified in appointment wait times and the provision of after-hours services. [Rule 1300.67.2 (b), (c), (e), and (f); rule 1300. 70 (a)(3)]</td>
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SECTION I: SUMMARY OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT AND FOLLOW UP REVIEW STATUS

The following details the Department’s findings regarding the outstanding deficiencies. The Plan’s failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health and Safety Code section 1380(i).

ACCESS AND AVAILABILITY OF SERVICES

Deficiency #3: The Plan does not take effective action to address problems that have been identified in appointment wait times and the provision of after-hours services.

Statutory/Regulatory Reference:  (Rules 1300.67.2 (b), (c), (e), and (f); rule 1300.70 (a)(3).)

Plan’s Initial Compliance Effort: The Plan stated it has compliant policies and procedures in place to ensure availability and accessibility for enrollees. The procedures include, but are not limited to, accessibility surveys conducted annually by the Plan, one during normal business hours and one during non-business hours.

After-Hours Availability:
After comparing 2008, 2009 and 2010 accessibility survey results, the Plan noted an upward improvement trend. While scores continue to fall below the threshold, the lack of member grievances (including one day grievances) related to after-hours access helps to support the Plan’s conclusion that there is no network access problem. The Plan explained that it used a standard that requires a provider’s after-hours answering machine or answering service attendant to inform the member that the provider will return his/her call “within four hours.” The Plan stated that it removed this “very prescriptive” requirement for 2011 and will instead allow the provider to alert the caller to the timeframe in which they can actually expect to receive a return call. The Plan explained that to be compliant with the after-hours coverage standard, contracted mental health providers are also required to have an answering service, cell phone or pager, or voicemail which refers the patient to an emergency room, 911 or a crisis hotline for emergencies.

The Plan also intends to collaborate with other [health] plans on an approach that will both comply with the statute and support the Timely Access Regulations Policies and Procedures. This collaboration will help to support consistent messaging to providers from the Plans.

In addition to the above efforts, the Plan stated that it undertook numerous activities, including but not limited to the following:

- Any provider who was deemed “non-compliant” with the standards during the survey was “re-surveyed” following a corrective action. The corrective action plan was included in the 2010 Network Accessibility Survey report and included but was not limited to the following:

- Direct intervention with non-compliant providers, including obtaining written attestations from each provider
Re-surveys of non-compliant providers following direct intervention (Interim Survey)

Sharing survey results with network providers and re-educating providers about standards through various educational avenues

Implemented process with all newly contracted providers to ensure the provider understands the standards and is in compliance prior to acceptance into the network

Monitored appointment availability via member-generated grievances. In the Plan’s review of 2008-2011 grievance data including one-day grievances, one grievance related to after-hours coverage was identified.

**Non-Life Threatening Emergency and Urgent Care Appointment Timeliness Standards:**

The 2006-2008 compliance results of annual accessibility surveys conducted during business hours for Non-Life Threatening Emergency and Urgent Care Appointment Timeliness exceeded thresholds, but declined in 2009. As a result, the Plan reported that it took immediate corrective action with all providers who were identified as “non-compliant,” including direct correspondence to each non-compliant provider, provider education through newsletters and inserting updated information in the Provider Operations Manual. In addition, direct calls were made to providers to obtain their input regarding their responses. These provider outreach calls provided very helpful feedback regarding the providers’ understanding and/or perception of the questions that were asked during the surveys. These calls also provided the Plan with a good understanding of how these provider offices were providing appointments to enrollees appropriately and not delaying care to an enrollee.

Following this outreach, the Plan stated that it reviewed and analyzed the survey tool itself and specifically noted the wording of the questions had changed between 2008 and 2009, which created confusion. Noting that the language was confusing to providers, the Plan reverted back to the original survey language for the 2010 survey.

The Plan’s 2010 annual accessibility survey results indicates that the scores for Non-Life Threatening Emergency and Urgent Care Appointment Timeliness improved and are better than or equal to the 2006-2008 scores. The Plan’s provider outreach, question analysis and changes to ensure the 2010 was less confusing, appears to have addressed the drop in scores between 2008 and 2009 scores.

**Department’s Finding Concerning Plan’s Initial Compliance Effort: NOT CORRECTED**

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

The Plans efforts to address non-compliance with the Plan’s after-hours standards was to eliminate the 4 hour response time standard in favor of a standard established at the discretion of the Physician. Eliminating the Plan’s 4-hour response time standard and substituting variable

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5 The original question: “How would provider handle a member who is experiencing a non-life threatening emergency? The 2009 question: “On what day and time could provider see a member who is experiencing a non-life threatening emergency?”
standards set by individual providers precludes the Plan’s ability to demonstrate timely access to after-hours care.

The Plan’s corrective action included the 2010 Accessibility Report which demonstrated that the corrective action applied by the Plan was successful and yielded positive 2010 results. The Plan’s response stated that going forward, the Plan will conduct the 2011 Business Hours and After-Hours Surveys and review all results against the standards.

However, the Department notes that the Plan’s response did not address its scoring methodology to determine what provider responses will meet the Plan’s standards; access to care within 6-hours of the request.

The Department requests that the Plan; 1) establish a consistent standard for call backs, and 2) revise the scoring methodology to specify acceptable provider responses. The Department anticipates working with the Plan to correct this deficiency within 4-6 weeks of the issuance of the Final Report.

**Plan’s Subsequent Compliance Efforts:**

On June 29, 2012, the Plan informed the Department its Access and Availability policy was revised to establish a consistent standard for call backs for access to urgent, non-emergent after hours care. Providers are now instructed to inform patients at the time of their call as to when they should expect to receive a call back from the behavioral health provider. More importantly, the Plan instructs its providers to deliver face-to-face care to their members within 6 hours of a non-life threatening emergency, not just simply a call back. The Plan submitted a copy of its revised policy on December 5, 2012 to the Department.

The Plan also conducted numerous educational webinars for providers in 2012 and educated providers through its Behavioral Health Network Update newsletters (November 2011, March 2012, and July 2012) with information on the access to care standards and the Plan’s new call back standard. In addition, the Plan implemented NurseLine that is available to members 24 hours a day, seven days a week. This NurseLine provides triage and screening for behavioral health issues as well as addresses emergent and urgent needs after hours for all members. The Plan revised its enrollee contracts and member identification cards to inform members of this service.

Lastly, the Plan submitted the updated version of the Behavioral Health Provider Access Fall Survey Script for 2011 which includes the revised scoring methodology for provider responses that comply with the Plan’s standards for access to care. The revised methodology now specifies that acceptable/compliant responses to the question, “How would Dr./Ms./Mr. (Name) handle an [[Brand]] member who is experiencing a **Non-Life Threatening Emergency**?” include “Can be seen in office by Clinician or an on-call Clinician within 6 hours” and “Will refer patient to nearest emergency room (ER) /Crisis center/Hospital/Call 911.”
Department’s Findings Concerning Plan’s Subsequent Compliance Efforts:

STATUS: CORRECTED

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

The Department finds that the Plan provided documentation that substantiates the efforts taken by the Plan to establish a consistent standard for call backs for access to urgent, non-emergent after hours care and educate providers of the access to care standards. Also, the plan established a NurseLine that provides triage and screening for behavioral health issues and addresses developing behavioral health concerns for all members after hours. In addition, the Plan revised the methodology used for scoring provider responses regarding timely access to care. The Plan will be able to monitor compliance to after-hour access to behavioral health providers through various provider and member accessibility surveys, including quarterly reporting to the Quality Committee on whether the NurseLine meets performance standards outlined in the plan’s access policy.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Medical Survey of the Plan.