DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE MEDICAL SURVEY
OF
ANTHEM BLUE CROSS - DENTAL
A DENTAL HEALTH PLAN

DATE ISSUED TO PLAN: JANUARY 3, 2011
DATE ISSUED TO PUBLIC FILE: JANUARY 13, 2011
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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the “Department”) conducted a routine medical survey of Anthem Blue Cross Dental (the “Plan”) from March 29, 2010, to March 31, 2010, pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as amended, codified at Health and Safety Code section 1340 et seq. and Title 28 of the California Code of Regulations section 1000 et seq.¹

This routine medical survey addressed the following areas:

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

See Appendix A for a description of the major areas evaluated during a routine medical survey.

Within these survey areas, the Department gathered information on the following:

**Quality Management:** The Department assessed the adequacy of the staff and administrative support dedicated to carrying out the Plan’s quality management activities. The Department evaluated the processes and criteria the Plan uses to identify, investigate, and resolve potential quality issues. The Department reviewed the Plan’s oversight of its utilization management activities and processes. Finally, the Department reviewed the governing body’s oversight of quality management activities.

**Grievances and Appeals:** The Department reviewed a sample of case files to determine if the Plan consistently acknowledges and resolves grievances within the statutorily-mandated timeframes, and to assess the content and clarity of the Plan’s grievance correspondence. The Department also evaluated whether the Plan accurately tracks and trends grievances in order to identify grievance issues and patterns.

**Access and Availability of Services:** The Department reviewed the Plan’s processes for monitoring and evaluating network-wide accessibility and availability of care.

**Utilization Management:** The Department reviewed the Plan’s processes for developing and updating the criteria for determining utilization management decisions. The Department also reviewed a sample of case files to assess the content and clarity of the Plan’s communications with enrollees and providers, and the Plan’s compliance with mandatory timeframes.

¹ All references to “Section” are to the Health and Safety Code unless otherwise indicated. All references to the “Act” are to the Knox-Keene Health Care Service Plan Act of 1975, as amended, codified at Health and Safety Code section 1340 et seq. All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated.
Language Assistance: The Plan is the specialized dental division of Anthem Blue Cross, and shares the same Knox-Keene license with the full-service plan; therefore, the Department conducted a limited review of the Plan’s implementation of the Language Assistance Program mandated under rule 1300.67.04. The Department reviewed the implementation, staff training, and compliance monitoring of the Language Assistance Program with regards to the dental division and operations. The Plan implemented its Language Assistance Program concurrently with the full-service plan’s Program, combines its staff training with the full-service plan’s curriculum, and monitors its Program through its full-service plan to ensure compliance. The Department will perform a complete evaluation of the Anthem Blue Cross Language Assistance Program during the routine survey of the full-service plan on October 19, 2010.

PLAN BACKGROUND

The Plan, which is located in Camarillo, California, was licensed on January 7, 1993, by the Department of Corporations to operate as a specialty health care plan. In 1997, it merged with Blue Cross of California (“Blue Cross”), and surrendered its WellPoint dental license. Since then, the Plan has become a division of, and currently operates under the licensure of Anthem Blue Cross, which is owned by WellPoint Health Networks, Inc. In 2004, Anthem Blue Cross and WellPoint Health Networks, Inc. merged to become WellPoint, Inc. WellPoint, Inc. is a national for-profit entity, and is currently the parent entity of the Plan.

The Plan serves more than 195,000 commercial enrollees in 24 California counties by offering Dental Net, a traditional Dental Health Maintenance Organization (DHMO) Plan, and Dental Select, a hybrid DHMO Plan, through contracted individual dentists. For both products, the enrollee selects a primary care dentist to provide basic dental services and coordinate any necessary specialty services.

SURVEY BACKGROUND

The Department last conducted a routine medical survey of the Plan in 2006. During that survey, the Department found five deficiencies in the area of Quality Management, one in Access and Availability of Services, and one in Utilization Management. The Plan corrected one Quality Management deficiency by the time of the Final Report; all others remained uncorrected. (See Final Report, dated December 11, 2006.) The Department conducted a Follow Up Review on August 14, 2007, to assess the Plan’s compliance status for outstanding deficiencies and determined that five of the six deficiencies had been corrected.

SURVEY RESULTS

DEFICIENCIES

The Department identified eight survey deficiencies during the current routine medical survey.
1. The Plan does not ensure the provision of preventive health services or effective health education services.

2. The Plan’s Quality Management Program does not ensure that a level of care, which meets professionally recognized standards, is being delivered to all enrollees, and that quality of care problems are identified and corrected for all provider entities.

3. The Plan does not ensure that its grievance system accurately tracks and monitors the number of grievances pending over 30 calendar days, or consistently identifies and takes action to improve care where deficiencies are found.

4. The Plan does not consistently maintain all of the necessary information in its grievance files.

5. The Plan’s notification to its enrollees and providers of the procedure for processing and resolving grievances does not comply with the requirements of the grievance statute or regulations.

6. The Plan does not consistently provide:
   a) A written acknowledgment within five calendar days of receipt of the grievance;
   b) A clear and concise explanation for the Plan’s decision; and
   c) In grievances that involve benefit disputes, specification of the provisions in the contract that exclude that coverage.

7. The Plan does not have an adequate system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting times and appointments.

8. The Plan did not provide evidence:
   a) That it consistently provides written notification to enrollees of decisions to deny, delay, or modify health care services;
   b) That it consistently sent enrollees the written notifications within the statutorily-mandated timeframes; and
   c) That it consistently includes in the written notifications;
      i) A clear and concise explanation of the reasons for the Plan’s decision; and
      ii) The criteria or guidelines used for the decision.

Section II of this Report contains a discussion of these deficiencies, and Appendix C contains the complete text of the relevant statutes and rules.

RECOMMENDATIONS

In accordance with section 1380 (g), Department analysts offer advice and assistance to the Plan in the form of survey recommendations. The Plan is not required to respond to the Department’s recommendations. Survey recommendations are intended to alert the Plan to weaknesses in its
operations that have the potential to become deficiencies in the future. The Plan did not respond to these recommendations.

QUALITY MANAGEMENT

1. Assign a severity level to cases reviewed for potential quality issues.

2. Ensure that the Plan’s mechanism to gauge enrollee satisfaction identifies and resolves potential quality issues effectively.

GRIEVANCES AND APPEALS

3. Streamline the Plan’s procedures for documenting and reporting grievances.

4. Expand the Plan’s “Grievance Report by Reason” to reflect additional grievance categories, including grievances about Plan operations and services.

5. Revise the Plan’s grievances and appeals policies to establish the following;
   a) Allocation of staff to review and resolve grievances at specific levels of the grievance resolution process.
   b) A written policy that details how the Plan informs enrollees of the disposition or pending status of the grievance within 30 calendar days of receipt of the grievance.
   c) A policy that ensures the Plan does not discriminate against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.

6. Update Plan’s Evidence of Coverage (EOC) documents to provide information regarding the procedures for filing urgent grievances. Update the Plan’s policies and procedures regarding urgent grievances to include procedures for handling urgent grievances.

7. Revise the Plan’s policy and procedure for filing urgent grievances to include;
   a) The designated dental plan officer who is authorized to make financial decisions on the Plan’s behalf;
   b) How calls regarding urgent grievances will be received;
   c) Which staff would receive the call;
   d) The telephone numbers to call;
   e) How the Compliance Manager or other designee is notified; and
   f) The process and timeframes for returning the Department’s calls.

8. Ensure that grievances are consistently received, reviewed, and resolved within 30 calendar days of receipt by the Plan.

UTILIZATION MANAGEMENT

9. Ensure that denial notifications to providers consistently contain the statutorily-mandated information.
10. Provide a mechanism for the Plan to provide feedback and analysis to its full-service plan regarding its Language Assistance Program criteria and standards.
SECTION I: SURVEY HISTORY

The Department is required to conduct a routine medical survey of each Knox-Keene licensed health care service plan at least once every three years pursuant to section 1380. During the medical survey, the Department evaluates a Plan’s compliance with the provisions of the Act, which covers eight major areas: Quality Management, Grievances and Appeals, Access and Availability, Utilization Management, Language Assistance, Continuity of Care, Access to Emergency Services & Payment, and Prescription (RX) Drugs. (See Appendix A for a description of the eight major areas evaluated during a routine medical survey.) The Department limited this survey only to those areas of the Act that apply to specialty dental plans (Quality Management, Grievances and Appeals, Access and Availability of Services, Utilization Management, and Language Assistance).

This Final Report addresses the most recent routine medical survey of the Plan, which was conducted from March 29, 2010, to March 31, 2010.

TABLE 1
Survey Activities Conducted by the Department in the Past Three Years

<table>
<thead>
<tr>
<th>PAST SURVEY ACTIVITY</th>
<th>DATE</th>
<th>NUMBER OF UNCORRECTED DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006 Routine Survey Onsite Visit</td>
<td>June 19 - June 21, 2006</td>
<td>7</td>
</tr>
<tr>
<td>2006 Routine Survey Preliminary Report</td>
<td>September 8, 2006</td>
<td>7</td>
</tr>
<tr>
<td>Final Report for 2006 Routine Survey</td>
<td>December 11, 2006</td>
<td>6</td>
</tr>
<tr>
<td>Follow Up Review Report Issued to Plan</td>
<td>December 31, 2007</td>
<td>1</td>
</tr>
</tbody>
</table>

TABLE 2
Enforcement Actions Against the Plan Within the Past 24 Months

<table>
<thead>
<tr>
<th>CITATION</th>
<th>VIOLATION AND ENFORCEMENT ACTION</th>
<th>DATE OF ENFORCEMENT ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No enforcement actions were taken by the Department in the past 24 months.</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 3
Timeline of Current Survey Activities

<table>
<thead>
<tr>
<th>CURRENT SURVEY ACTIVITY</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification Letter and Request for Documents</td>
<td>January 29, 2010</td>
</tr>
<tr>
<td>Pre-survey Questionnaire and Documents Due</td>
<td>March 1, 2010</td>
</tr>
<tr>
<td>Routine Survey Onsite Start Date</td>
<td>March 29, 2010</td>
</tr>
<tr>
<td>Routine Survey Onsite Completed</td>
<td>March 31, 2010</td>
</tr>
<tr>
<td>Preliminary Report Issued</td>
<td>August 19, 2010</td>
</tr>
<tr>
<td>Final Report for Routine Survey</td>
<td>January 3, 2011</td>
</tr>
</tbody>
</table>
## SECTION II: DISCUSSION OF SURVEY DEFICIENCIES AND CURRENT STATUS

Table 4 below lists deficiencies identified during the current survey. The Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to: (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 “Status” column describes the Department’s findings regarding the Plan’s corrective actions.

### TABLE 4

<table>
<thead>
<tr>
<th>#</th>
<th>DEFICIENCY STATEMENT</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Plan does not ensure the provision of preventive health services or effective health education services. [Rule 1300.67 (f)(8); rules 1300.70 (b)(2)(G)(5) and (6)]</td>
<td>Not Corrected</td>
</tr>
<tr>
<td>2</td>
<td>The Plan’s Quality Management Program does not ensure that a level of care, which meets professionally recognized standards, is being delivered to all enrollees, and that quality of care problems are identified and corrected for all provider entities. [Rule 1300.70 (a)(1); rules 1300.70 (b)(1)(A), (B), and (C)]</td>
<td>Not Corrected</td>
</tr>
<tr>
<td>3</td>
<td>The Plan does not ensure that its grievance system accurately tracks and monitors the number of grievances pending over 30 calendar days, or consistently identifies and takes action to improve care where deficiencies are found. [Rule 1300.68(a); rule 1300.68 (b)(1); rule 1300.68 (e)(1); rule 1300.70 (b)(2)(C)]</td>
<td>Not Corrected</td>
</tr>
<tr>
<td>4</td>
<td>The Plan does not consistently maintain all of the necessary information in its grievance files. [Section 1381 (a); rule 1300.68 (b)(5); rule 1300.68 (d)(6)]</td>
<td>Corrected</td>
</tr>
<tr>
<td>5</td>
<td>The Plan’s notification to its enrollees and providers of the procedure for processing and resolving grievances does not comply with the requirements of the grievance statute or regulations. [Section 1368 (a)(2); rule 1300.68 (a); rule 1300.68 (a)(1); rules 1300.68 (b)(2) and (7)]</td>
<td>Not Corrected</td>
</tr>
</tbody>
</table>
The Plan does not consistently provide:
   a) A written acknowledgment within five calendar days of receipt of the grievance;
   b) A clear and concise explanation for the Plan’s decision; and
   c) In grievances that involve benefit disputes, specification of the provisions in the contract that exclude that coverage.
   [Rules 1300.68 (d)(1) and (5); section 1368 (a)(5)]

ACCESS AND AVAILABILITY OF SERVICES

The Plan does not have an adequate system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting times and appointments.
   [Rule 1300.67.2 (f); rule 1300.70 (a)(1)]

UTILIZATION MANAGEMENT

The Plan did not provide evidence:
   a) That it consistently provides written notification to enrollees of decisions to deny, delay, or modify health care services;
   b) That it consistently sent enrollees the written notifications within the statutorily-mandated timeframes; and
   c) That it consistently includes in the written notifications:
      i) A clear and concise explanation of the reasons for the Plan’s decision, and
      ii) The criteria or guidelines used for the decision.
   [Sections 1367.01 (h)(3) and (4); section 1381 (a); section 1386 (b)(1)]

The following details the Department’s preliminary findings, the Plan’s corrective actions and the Department’s findings concerning the Plan’s compliance efforts.

The following is a discussion of the conditions and implications of each deficiency:

QUALITY MANAGEMENT

Deficiency #1: The Plan does not ensure the provision of preventive health services or effective health education services.

Statutory/Regulatory Reference: Rule 1300.67(f)(8); rules 1300.70 (b)(2)(G)(5) and (6).

Discussion: Rule 1300.67 (f)(8) stipulates that each plan shall provide its enrollees with preventive health services (including services for the detection of asymptomatic diseases) and effective health education services (including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan). Rules 1300.70 (b)(2)(G)(5) and (6) require that if QA activities are delegated to a participating provider, each Plan’s quality assurance/utilization review mechanism must include assessment of appropriate preventive health services based on reasonable standards established by the Plan.
In order to inform enrollees of the recommended types and frequency of preventive care, Plan staff stated that the Plan distributes Anthem Blue Cross oral health guidelines to its providers with the providers’ responsibility to disseminate these guidelines to enrollees. However, the Department did not find any mechanism in place to measure or assess the level at which these guidelines are being distributed and received by enrollees.

Moreover, the Plan has not established performance objectives/standards against which to measure the levels/frequencies that various preventive services are actually received by enrollees. The Dental Director stated that the Plan has begun to collect data via its new utilization software program, which is intended to analyze the level of preventive services being provided. However, the gathered data is currently insufficient for the Plan to establish objectives/standards. As a result, the Plan does not assess and report on its performance against standards, identify any problem areas, or take appropriate action to address problems.

**Implications:** Distribution of guidelines is an important part of each Plan’s health education program because guidelines give enrollees a clear sense of the types and frequency of preventive services that will promote good oral health. Guidelines, in turn, can be used to establish corresponding performance objectives/standards (e.g., 90% of enrollees will receive cleaning procedure annually) against which individual providers can be assessed (allowing for variation in individual enrollee cases). Performance objectives/standards also serve as a measure against which the Plan can assess the overall effectiveness of its educational materials and preventive programs.

**Corrective Action:** Within 30 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department (See rule 1300.80.10), signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

**Plan’s Compliance Effort:** The Plan submitted an audit tool that assesses the provision of preventive services during onsite audits which are evaluated by the Dental Director. The Plan also revised its “Enrollee Dental Health Education Policy” to include the Plan’s wellness program on the Anthem Blue Cross website. To ensure that the Plan’s educational materials and preventive programs are effective, the Plan created a new policy and procedure, “Tracking Preventive Services Policy,” to track and trend preventive services on a quarterly basis, which will be submitted to the Quality Improvement Committee for approval at the next regularly scheduled meeting on September 24, 2010. Through this proposed policy, data will continue to be gathered from the Plan’s Utilization Management Program on a quarterly basis. The Plan will track and review preventive services using an average percentage of dental visits from the Centers for Disease Control (CDC) and Prevention, and adjusting for episodic and non-compliant periods.

**Department’s Finding Concerning Plan’s Compliance Effort:**

**STATUS: NOT CORRECTED**

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.
The Department finds that the health and wellness pages of the Plan’s Web site do not contain readily available dental health-related topics. There appears to be nine health topics on the Web site, but none of which is a dental health-related topic. Links to WebMD and HealthFinder did not appear easy to locate. The Plan also states that providers are not required to distribute its oral health guidelines to enrollees; therefore, the Plan does not submit any documentation that will ensure that preventive guidelines are distributed effectively to enrollees. However, without policies and procedures to ensure that the guidelines are being distributed effectively to enrollees, the Department cannot conclude that the Plan is providing its enrollees with effective health education services pursuant to rule 1300.67 (f)(8).

The Department also finds that while the Plan submitted the new “Tracking Preventive Services Policy,” the policy does not provide details on how the Plan will track preventive services through the Utilization Management Program. The policy does not contain established standards and goals. While the policy mentions that the Plan will use the CDC’s average percentage of dental visits (66%) and will adjust it for episodic and non-compliant patients (10%), the policy does not describe how the Plan will track and address providers that are outliers, nor clearly describe how the Plan will collect and analyze the data. The policy does not mention any designated Plan officer who will be responsible for collecting, presenting, and analyzing the data. Moreover, the policy does not describe what follow up/corrective action is planned when providers fail to deliver preventive services.

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**Deficiency #2:** The Plan’s Quality Management Program does not ensure that a level of care, which meets professionally recognized standards, is being delivered to all enrollees, and that quality of care problems are identified and corrected for all provider entities.

**Statutory/Regulatory Reference:** Rule 1300.70 (a)(1); rules 1300.70 (b)(1)(A), (B) and (C).

**Discussion:** Rule 1300.70(a)(1) requires that each Plan’s Quality Assurance Program ensures that quality of care problems are identified and corrected for all provider entities. Rules 1300.70 (b)(2)(A), (B) and (C) require that a level of care, which meets professionally recognized standards of practice, is being delivered to all enrollees; that quality of care problems are identified and corrected for all provider entities; and that appropriate licensed professionals (i.e., dentists), who provide care to the Plan’s enrollees, are an integral part of the Quality Assurance Program.

The Plan could not demonstrate that the Plan’s Quality Assurance Program consistently ensures that all cases involving potential quality issues undergo review by a clinician to confirm that a problem exists and, if so, to implement appropriate corrective actions. The Plan’s Compliance Manager stated that the grievance process is the primary mechanism used to both identify potential quality issues and to gauge enrollee satisfaction issues. During the interview, the Grievance and Appeals Department Manager and a Grievance Coordinator stated that upon receipt of a grievance from the Customer Service Department in Colorado Springs, a Grievance Coordinator acknowledges the grievance and initiates the investigation process by obtaining the
appropriate dental records from providers. The Grievance Coordinator also decides which grievances to refer for clinical review. However, the Coordinator, who is not a licensed clinician, has been given no professionally developed criteria to guide identification of cases warranting clinical review.

If the Coordinator determines that a grievance warrants clinical review, the Coordinator meets with a dental consultant and the Plan’s Compliance Manager. (A dental consultant is a licensed dentist employed by the Plan to evaluate clinical cases.) The Grievance Coordinator then documents the dental consultant’s determination, which the Coordinator later uses as reference in preparing the resolution letter. The Grievance Coordinator stated that there is no written record of the clinical review other than the Coordinator’s documentation, if any. The Grievance Manager and Grievance Coordinator acknowledged that they need to improve the current process. They stated that the Plan’s Dental Director is in the process of establishing a system to ensure that referrals and dental consultants’ reviews are appropriately documented.

In its review of 54 grievances regarding quality of care, the Department identified 25 grievance cases that should have been reviewed by a clinician to determine if there exists any potential quality of care issues that warranted an investigation. However, in these 25 cases, the Department did not find evidence of clinical review. Furthermore, in seven of these 25 cases, the Compliance Manager (who is not licensed to make a clinical determination) reviewed the cases and provided a determination only a qualified professional should have made.

The Plan also tallies grievances and, if a provider has been the subject of at least three grievances, the provider is referred to the Quality Oversight Committee for review. In this Committee, the provider is discussed, and appropriate corrective actions and follow-ups are implemented. Multiple grievances may be an appropriate indicator for triggering review; however, the Department is concerned that from staff interviews, the Plan places a strong emphasis in meeting the number threshold of three grievances. The Plan does not have a system to determine the severity of an individual quality of care complaint (regardless of the number of occurrences) to ensure immediate referral. Coupled with the inadequate referral and documentation of clinical review, it is conceivable that a provider who has committed an egregious act, one that warrants an immediate disciplinary action, may continue to see patients and endanger enrollee health.

Based upon the Plan’s failure to ensure clinical review of cases with potential quality issues, the Department finds that the Plan is not compliant with rule 1300.70 (a)(1), and rules 1300.70 (b)(1)(A), (B), and (C).

**Implications:** Failure to identify quality issues and implement appropriate corrective actions can allow the offending providers to continue to provide care that does not meet professionally recognized standards, thus endangering enrollee health. A lack of established written criteria and policies and procedures to guide grievance staff in identifying cases that should be referred for clinical review may lead to arbitrary reviews and poor decision making. While grievances are one key method for assessing satisfaction, relying solely upon grievances submitted by enrollees to assess their satisfaction effectively shifts the responsibility for identifying issues from the Plan to enrollees.
Corrective Action: Within 30 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department (See rule 1300.80.10), signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan’s Compliance Effort: The Plan submitted a copy of the Plan’s “Potential Quality of Care Policy” that states that there are numerous indicators of potential quality issues which are all reviewed by the Plan’s Dental Director and licensed dentists through quarterly Quality Improvement Committee meetings. The Plan also submitted its “Critical Indicators of Care” report that demonstrates which providers/issues, once identified by three grievances within 18 months resolved in favor of the members against one provider, are referred to the Quality Improvement Committee for review. The Plan states that it considers on-site audits, utilization management data, and accessibility monitoring as methods to determine potential quality issues. From 2008 through 2010 thus far, 330 corrective action letters were sent to providers for various reasons. The Plan submitted a representative sampling of these letters to the Department. The Plan will also implement a policy whereby all grievances pertaining to the quality of the dental care provided will be reviewed by a licensed dentist. After review by the dentist, the case will be sent to the Plan’s Compliance department for corrective action and follow-up, including review by the Quality Improvement Committee.

Department’s Finding Concerning Plan’s Compliance Effort:

STATUS: NOT CORRECTED

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

The Department finds that although the Plan states that it will implement a policy whereby all grievances involving quality issues will be reviewed by a licensed dentist, the Plan has not provided a draft copy of such policy nor evidence that the policy has been implemented. Furthermore, the Plan addresses the procedure for handling quality of care issues based on the frequency of the complaints, but does not address the Department’s concerns regarding the lack of a mechanism to determine the severity of an individual quality of care complaint and inadequate documentation of clinical reviews.

GRIEVANCES AND APPEALS

Deficiency # 3: The Plan does not ensure that its grievance system accurately tracks and monitors the number of grievances pending over 30 calendar days, or consistently identifies and takes action to improve care where deficiencies are found.

Statutory/Regulatory Reference: Rule 1300.68 (a); rule 1300.68 (b)(1); rule 1300.68 (e)(1); rule 1300.70 (b)(2)(C).

Discussion: Rule 1300.68 (a) requires a plan to establish in writing and provide for procedures that will receive, review, and resolve grievances within 30 calendar days of receipt by the Plan. Rule 1300.68 (e)(1) requires the Plan’s grievance system to track and monitor grievances.
received by the Plan that are pending over 30 calendar days. Rule 1300.68 (b)(1) requires an officer of the Plan to be designated as having primary responsibility for the Plan’s grievance system who shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. Rule 1300.70 (b)(2)(C) requires reports to the Plan’s governing body shall be sufficiently detailed to include findings and actions taken as a result of the Quality Assurance Program.

The Plan’s “Grievance Resolution Criteria and Standards” indicates that the Dental Director is responsible for reviewing the record of tabulated grievances on a quarterly basis, as well as related reports, to identify any emergent patterns for quality improvement purposes. The Dental Director is to report systemic deficiencies, at least on a quarterly basis, to the Quality Oversight Committee, where corrective actions are to be formulated as appropriate.

The Department reviewed the Plan’s “Grievance and the Specialty Referral Timeframe Report.” This Report is a quarterly report showing the percentage of grievances that are resolved within 30 days. The data is trended over a period of 2.5 years (in this case, from quarter 1 of 2006 to quarter 2 of 2008). In quarter 3 of 2007, the report indicated that timely resolution of grievances decreased to 70% from 88% in the previous quarter.

Minutes of the Quality Oversight Committee meeting for quarter 3 of 2007 reported that the decrease in timely grievance resolution was attributed to a calculation error. According to the minutes, the Grievance Coordinators calculated the time period from initial receipt of the grievance (i.e., when the Customer Service Department or the Grievance and Appeals Department took the call) instead of from the receipt of the grievance by the Grievance and Appeals Department. It appears that the Quality Oversight Committee accepted this report with no further action.

However, during interviews staff confirmed that in practice the actual receipt date for any grievance is the date the enrollee initially contacted the Plan either through the Customer Service Department or through the Grievance and Appeals Department. Staff acknowledged that the Customer Service Department did not always forward grievances to the Grievance and Appeals Department in a timely manner, which resulted in the delay of acknowledging enrollees’ grievances in writing and resolving the grievances within 30 days.

Pursuant to Rule 1300.68 (a), the statutory grievance resolution deadline begins upon receipt of the grievance by the Plan. Therefore, the date of receipt of the grievance is the initial date the enrollee contacts the Plan about the grievance, regardless of the Plan department that receives the initial contact.

The discrepancy between the Plan’s grievance reports and staff interviews has not been reconciled and as a result the Dental Director and the Quality Oversight Committee cannot effectively identify emergent patterns and trends and formulate meaningful corrective action plans pursuant to Rule 1300.68 (b)(1).

Implications: The Plan is obligated by statute to operate a compliant Grievance and Appeals Program that adheres to statutory timeframes for resolution. The Plan must have mechanisms to
track and trend the resolution of grievances and identify system problems that can be resolved in order to better serve Plan enrollees.

**Corrective Action:** Within 30 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department (See rule 1300.80.10), signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

**Plan’s Compliance Effort:** The Plan clarified that the third quarter of 2007 Quality Improvement Committee report documented an incident in which the date of receipt was inaccurately calculated; however, the Plan submitted Quality Improvement Committee minutes that indicate the error was immediately corrected upon discovery, and that the Plan emphasized grievances are calculated from the original date of when the Plan received the grievance instead of when the grievance was received by the Grievances and Appeals Department. The Plan also restated the grievance report presented to the Quality Improvement Committee to correctly report the actual timeframe for grievance resolution. Although the Plan’s policies and procedures state that the timeline for grievance resolution begins when the Plan receives the grievance, the Plan is updating and clarifying its policies and procedures to ensure that grievances are calculated by the date received by the Plan.

The Plan acknowledged that the Customer Service Department did not always immediately forward grievances to the Grievances and Appeals Department. This was because grievances were held by the Customer Service agents when enrollees wanted to submit further information or documentation. Rather than wait for the supplemental information or documentation, the Plan will reinforce policies and procedures so that all grievances will be immediately forwarded to the Grievances and Appeals Department. Also, grievance data collection will occur on a continuous basis and in-services training for the Customer Service Department will be conducted at least twice per year.

**Department’s Finding Concerning Plan’s Compliance Effort:**

**STATUS: NOT CORRECTED**

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

The Department finds that the Plan is in the process of revising its policies and procedures to ensure that its grievance system accurately tracks and monitors the number of grievances pending over 30 calendar days, or consistently identifies and takes action to improve care where deficiencies are found. However, the Plan has not submitted the revised policies and procedures to the Department. With regards to prompt forwarding of grievances, the Plan stated that “policies and procedures will be reinforced” and that “in-services training for the Customer Service Department will be conducted at least twice per year;” however, the Plan has not yet had time to implement these proposed corrective actions and demonstrate that they have been effective.
Deficiency # 4: The Plan does not consistently maintain all of the necessary information in its grievance files.

Statutory/Regulatory Reference: Section 1381 (a); rule 1300.68 (b)(5); rule 1300.68 (d)(6)

Discussion: Section 1381 (a) requires that “[a]ll records, books and appears of a Plan…shall be open to inspection during normal business hours by the director.” Rule 1300.68 (b)(5) requires a written record to be made for each grievance received by the Plan, including the date received, the Plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. Rule 1300.68 (d)(6) requires that “[c]opies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the Plan relied in reaching its decision.”

During review of the Plan’s grievance files, the Department found the following:

- When the survey team randomly selected 163 grievance cases from the Plan’s grievance logs for review, 13 cases were found to be duplicates (even though the grievance log assigned them different identification codes). This suggests that grievances were logged more than once, resulting in inaccurate data for tracking, trending, and review.

- The Plan was unable to locate four of the 163 files selected for review by the survey team. Specifically, three grievance cases were missing from a subset of 54 grievances regarding quality of care and one case was missing from a subset of 67 grievances related to benefit dispute/provider charges that were selected for additional review. When the Department interviewed Plan staff about the missing files, the staff reasoned that it could very well be the Plan’s mail vendor that lost the cases. It is unclear whether or not the missing cases in this review were ever processed by the Grievance and Appeals Department.

- A Plan Grievance Coordinator stated during an interview that a tracking summary sheet is created for every grievance processed by the Grievance and Appeals Department. However, the Department found that the Plan does not consistently use a tracking summary sheet for all grievances. Among the 67 grievance files regarding benefit dispute/provider charges that were selected for review, 15 files did not contain summary sheets; and among the 54 grievance files regarding quality of care that were selected for review, two files did not contain summary sheets.

- The information contained in the tracking summary sheet does not consistently reflect the information found in the file. For example:
  - Case A: The enrollee complained that the service quotes from a dentist were much more than she anticipated. The tracking sheet labeled and recorded this grievance issue as “quality of service” instead of correctly “provider charges.”
  - Case B: The enrollee complained that she was not informed that her membership was assigned to another entity. The tracking sheet labeled and recorded this
Case C: The tracking sheet indicated that the case was resolved in favor of the provider; however, the case was actually resolved in favor of the enrollee.

Case D: The tracking sheet indicated an initial contact date of 3/27/08, but the acknowledgment letter indicated an earlier receipt date of 3/13/08. The tracking sheet also indicated that the case was resolved in favor of the provider; however, the resolution was actually resolved in favor of the enrollee.

The Plan did not consistently provide all of the requested grievance files during the onsite portion of the routine survey, as mandated by section 1381 (a). In addition, the Plan did not consistently include a summary sheet or other document describing the grievance, as mandated by rule 1300.68 (b)(5) and rule 1300.68 (d)(6), in every grievance file, or ensured that summary sheets were consistently accurate. Therefore, the Department has determined the Plan’s deficiency based upon the accumulation of the findings specified above.

**Implications:** Maintaining complete and accurate information in the Plan’s grievance files is essential to the overall performance of the Plan’s grievance system. Incomplete and inaccurate information may lead to erroneous tracking and trending of grievance, which may prevent identification and correction of systemic issues. In addition, failure to provide the Department all of the requested information may hinder the survey process and subject the Plan to possible penalties.

**Corrective Action:** Within 30 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department (See rule 1300.80.10), signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

**Plan’s Compliance Effort:** The Plan reviewed the duplicate files and offered explanations of why the grievance files may have appeared to be duplicates, including where the provider independently initiated a dispute of the original findings, or when one member initiates two grievances. In response to the Department’s finding of four missing files, the Plan provided documentation for the four files that included the date of Plan’s receipt of the grievance and a copy of the dated response letter, which summarized the grievance and provided the Plan’s decision and rationale. The Plan acknowledges that two of the four files were missing the dental reviewer’s notes, dental chart summaries and x-rays and three of the four files were missing the original grievance. In October 2009, to prevent the occurrence of lost files, the Plan engaged a new vendor for scanning documents, including x-rays. Also in October 2009, the Grievances and Appeals Department adopted a practice of scanning the completed file in its entirety into an electronic storage system. The Plan notes that not all summary sheets were included in the grievance files, because the sheets were mainly for the convenience of the dental review consultants. The Plan points to its Dental Inquiry Tracking System which has summaries for all of the grievance cases. In addition, the Plan will begin including a summary sheet in all of the case files going forward.

**Department’s Finding Concerning Plan’s Compliance Effort:**

**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 is recognizing deficiencies in maintaining records of grievance files by revising its procedure to require scanning the completed file in its entirety into an electronic storage system, and by contracting with a new vendor for scanning documents. The effectiveness of the new policies and procedures, and the new vendor would be evident in the upcoming grievance file review for the next routine medical survey of the Plan.

Deficiency # 5: The Plan’s notification to its enrollees and providers of the procedure for processing and resolving grievances does not comply with the requirements of the grievance statute or regulations.

Statutory/Regulatory Reference: Section 1368 (a)(2); rule 1300.68 (a); rule 1300.68 (a)(1); rules 1300.68 (b)(2) and (7).

Discussion: Rule 1300.68 (a) requires the Plan to establish in writing and provide for procedures that will receive, review, and resolve grievances within 30 calendar days of receipt by the Plan, or any provider or entity with delegated authority to administer and resolve the Plan’s grievance system. Rule 1300.68 (a)(1) defines a grievance as “a written or oral expression (emphasis added) of dissatisfaction regarding the Plan and/or provider…”

Section 1368 (a)(2) requires a Plan to “[i]nform its subscribers and enrollees upon enrollment in the Plan and annually thereafter of the procedure for processing and resolving grievances.”

Rule 1300.68 (b)(2) requires the Plan’s notification of its grievance system to include the telephone number and address for presenting a grievance.

Rule 1300.68 (b)(7) requires the Plan’s grievance forms and a description of the grievance procedure to be readily available at each facility of the Plan, on the Plan’s Web site, and from each contracting provider’s office or facility.

The Plan’s policy #GA-001-07 indicates that the process for filing grievances is provided in the Evidence of Coverage (EOC). The Department examined two Plan EOCs and found the following:

- Dental Net Evidence of Coverage states that the enrollee may call the customer service number indicated in the enrollee’s ID card with a grievance, and if the Customer Service Department is unable to resolve the grievance, the enrollee may file a formal grievance in writing to the Plan.
- Select HMO Evidence of Coverage instructs the enrollee to contact customer service with a grievance, and also instructs the enrollee to submit a formal grievance in writing requesting review of the grievance by the Grievance Committee.
Pursuant to the definition of “grievance” from rule 1300.68 (a)(1), when an enrollee calls customer service with a complaint, that complaint is considered a grievance. However, the instructions in the Plan’s Dental Net Evidence of Coverage suggest that the grievance filed with customer service is not a formal grievance and if the enrollee files a “formal” grievance, this grievance must be in writing. The Select HMO Evidence of Coverage directs the enrollee to submit a grievance in writing. The Plan’s interpretation of the statutory grievance process, which is reflected in the Evidence of Coverage, is not correct or compliant with the Act. An enrollee is entitled to file a grievance with the Plan, either orally or in writing, which must be resolved within 30 days.

The Department examined a copy of the Plan’s provider manual and the grievance form template contained within the provider manual. Neither the provider manual nor the grievance form template provide information to the enrollee regarding the ability to call a toll-free number to file a grievance by telephone. Neither documents reference the availability of the Plan’s Web site for filing online grievances even though the Plan has a Web site for filing online grievances. Similar to the Plan’s Evidence of Coverage, the provider manual instructs the enrollee to submit a formal written grievance if Customer Service Department is unable to resolve the complaint.

Implications: EOCs are informational materials designed to inform enrollees of the benefits covered under the Plan and their rights and responsibilities. The information conveyed must be clear and accurate and comply with the legal requirements under the Act. Provider manuals and the grievance template forms within those manuals must also contain accurate information on the Plan’s grievance process in the event an enrollee needs information on how to contact the Plan and register a complaint at the point of care.

Corrective Action: Within 30 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department (See rule 1300.80.10), signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan’s Compliance Effort: The Plan notes that the Evidence of Coverage for the Dental Net and Select HMO were filed as an endorsement with the Department on April 1, 2003. The Plan accepts the Department’s recommendation to update the Plan’s provider manual (and grievance form templates) to include the grievance process, including clear instructions to enrollees that grievances may be submitted in writing or orally. The update will also include the toll free customer service telephone number, the mailing address and website for submitting grievances.

Department’s Finding Concerning Plan’s Compliance Effort:

STATUS: NOT CORRECTED

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

The Department finds that the Plan’s filed Evidence of Coverage revisions in 2003 remains misleading, because it instructs the member to file a formal complaint in writing. Therefore, Plan should correct the misleading text in its informational materials distributed to enrollees and file an amendment with the Department. The Plan should also submit the draft copy of the
Deficiency # 6: The Plan does not consistently provide:
   a) A written acknowledgment within five calendar days of receipt of the grievance;
   b) A clear and concise explanation for the Plan’s decision; and
   c) In grievances that involve benefit disputes, specification of the provisions in the contract that exclude that coverage.

Statutory/Regulatory Reference: Rules 1300.68 (d)(1) and (5); section 1368 (a)(5).

Discussion: Rule 1300.68 (d)(1) requires each plan to acknowledge grievances in writing within five calendar days of receipt, except one-day exempt grievances.

Section 1368 (a)(5) specifies that written responses to grievances contain a clear and concise explanation of the reasons for the Plan’s response. For grievances involving the delay, denial, or modification of health care services, the Plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a Plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the response shall clearly specify the provisions in the contract that exclude that coverage.

Rule 1300.68 (d)(5) specifies that the excluded benefit response shall either identify the 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.

To assess the Plan’s compliance with these requirements, the Department reviewed the following 163 randomly selected grievance files out of a universe of 650 grievances:
   • 67 grievances regarding benefit disputes and provider charges (Plan was unable to locate one case\(^2\) file);
   • 54 grievances regarding quality of care (Plan was unable to locate three case files); and
   • 42 grievances regarding access to services.\(^3\)

\(^2\) Rule 1300.68(d)(6) requires that each plan maintain files of grievances and responses for five years, including a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision; therefore, if a plan is unable to produce a file for the Department’s review during a survey, the file is considered to be deficient for all requirements under review.

\(^3\) The Department selected 42 grievances regarding access issues from the Plan’s log in its sample for review. Ten of the sample entries were later determined to be duplicates (due to duplicates in the Plan’s log). Therefore, the sample was composed of 32 unique cases. As per Department policy, cases selected twice (e.g., due to sampling
Written acknowledgment within five calendar days of receipt of grievance: Thirty of the 67 (44%) grievances regarding benefit disputes and provider charges (including the missing case and a case that did not show a clear date of receipt) were not acknowledged within five calendar days. Additionally, 25 of the 54 (46%) grievances regarding quality of care (including missing cases), and 20 of the 42 (47%) grievances regarding access were not acknowledged within the required timeframe. Collectively, the Plan did not acknowledge grievances, in writing and within five calendar days, in 75 out of 163 (46%) sampled grievance files.

Clear and concise explanation for the Plan’s decision: One of the 67 grievances related to benefit disputes and provider charges was closed by the Plan before a resolution could be reached. Of the remaining 66 grievances, 27 (39%) resolution letters did not contain a clear and concise explanation of the Plan’s decision. Of the 54 grievances regarding quality of care, eight (14%) resolution letters did not contain a clear and concise explanation of the Plan’s decision. Of the 42 grievances regarding access, one did not contain a clear and concise explanation of the Plan’s decision. Collectively, the Plan failed to provide resolution letters containing a clear and concise explanation for the Plan’s decision in 36 out of 162 (22%) sampled grievance files.

In grievances that involve benefit disputes, specification of the provisions in the contract that exclude the coverage: One of the 67 grievances related to benefit disputes and provider charges was closed by the Plan before a resolution could be reached. In 43 of the remaining 66 grievances, rule 1300.68 (d)(5) did not apply. Of the remaining 23 grievances in which rule 1300.68 (d)(5) did apply, 10 (43%) of the resolution letters did not contain the provision in the contract that excludes the coverage, nor did the letters identify the document and page where the provision is found or direct the grievant to the applicable section of the contract containing the provision that excludes the coverage. The letters simply declared that the service was not a covered benefit.

The Plan did not consistently provide 1) written acknowledgments within five calendar days of receipt of the grievances, 2) clear and concise explanations for the Plan’s decisions in its resolution letters, and 3) in grievances that involve benefit disputes, specification of the provisions in the contract that exclude the coverage in its resolution letters, therefore, the Department finds that the Plan is not compliant with rules 1300.68(d)(1) and (5), and section 1368 (a)(5).

Implications: Timely acknowledgment is required and ensures a fair and reasonable grievance system allowing enrollees the ability to follow up with the Plan, if needed, to provide information that might impact the outcome of their grievance. Timely resolution letters containing clear and concise explanations gives enrollees an understanding of the Plan’s deliberation process and the options and rights available to enrollees. Complete and clear disclosure of benefit exclusions and limitations promotes fuller enrollee understanding of the scope of the enrollee’s covered health care benefits.

with replacement or inaccurate logging) are counted twice in the sample; therefore, if any of the 10 duplicate cases failed in any measure, such failure was counted twice. For example, six of the grievances were not resolved within 30 days and three of the six were duplicate entries. Therefore, nine of the 42 grievance sample cases were not resolved in 30 days.
### TABLE 5

**Grievance Handling**

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>FILE TYPE</th>
<th>NUMBER OF FILES</th>
<th>COMPLIANT</th>
<th>DEFICIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timely Acknowledgement</strong></td>
<td>Benefit/Charge Grievances</td>
<td>67</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Quality Of Care Grievances</td>
<td>54</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Access To Service Grievances</td>
<td>42</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>163</strong></td>
<td><strong>88</strong></td>
<td><strong>75 (46%)</strong></td>
</tr>
<tr>
<td><strong>Clear and Concise Explanation</strong></td>
<td>Benefit/Charge Grievances</td>
<td>66</td>
<td>39</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Quality Of Care Grievances</td>
<td>54</td>
<td>46</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Access To Service Grievances</td>
<td>42</td>
<td>41</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>162</strong></td>
<td><strong>126</strong></td>
<td><strong>36 (22%)</strong></td>
</tr>
<tr>
<td><strong>Inclusion of Contract Provisions</strong></td>
<td>Benefit/Charge Grievances</td>
<td>23</td>
<td>13</td>
<td>10 (43%)</td>
</tr>
</tbody>
</table>

**Corrective Action:** Within 30 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department (See rule 1300.80.10), signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

**Plan’s Compliance Effort:** The Plan analyzed the root cause of delay and developed processes to streamline grievance referrals to the Grievances and Appeals Department from Customer Service. The Plan is building awareness of the importance of recognizing and referring grievances timely through interdepartmental in-services training, continuous reinforcement, and audits. The Plan also implemented a one-day grievance report process with the Customer Service Department to promote timely referrals of grievances that could not be resolved to the enrollee’s satisfaction within 24 hours. To ensure that all resolution letters include clear and concise explanations and specific references to the contract, when necessary, the Dental Grievances and Appeals Department is participating in an enterprise-wide writing clinic, which will be completed by all associates by the end of 2010. The Plan mandates the writing clinic for all new associates as a part of the training process. Furthermore, the Plan has implemented an auditing process to identify associates with critical errors in their resolution letters and to place them on performance improvement plans.

**Department’s Finding Concerning Plan’s Compliance Effort:**

**STATUS: NOT CORRECTED**

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.
The Department finds that the Plan’s corrective action is ongoing and consistent with the corrective action plan of its full service line of business. The Plan states it has implemented an auditing process to identify associates who need to be placed on performance improvement plans. However, the Plan has not submitted a corresponding policy and procedure for such auditing process, nor results of the audits to substantiate their effectiveness. In addition, the Plan has not presented any evidence that its staff members are attending the writing workshop (e.g., sign in sheet, training manual). The Plan should submit: 1) evidence that staff members have attended the writing workshop, 2) the corresponding policy and procedure for its auditing process, 3) a copy of the audit tool, and 4) the results of the last two audits to determine if the corrective activities are producing desired results.

ACCESS AND AVAILABILITY OF SERVICES

Deficiency #7: The Plan does not have an adequate system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting times and appointments.

Statutory/Regulatory Reference: Rule 1300.67.2 (f); rule 1300.70 (a)(1).

Discussion: Rule 1300.67.2 (f) requires each health care service plan to have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but are not limited to, waiting times and appointments. Rule 1300.70 (a)(1) requires that the Plan’s Quality Assurance Program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

The “Anthem Blue Cross Quality Assurance Program Description” requires that the Plan produce customer service tracking and trending reports, enrollee complaints/grievance action reports, and Geo Access reports as part of its network monitoring process. In practice, the Plan produces quarterly Geo-Access reports, and records grievances. Although the overall results of the data are presented to the Quality Improvement Committee, the Department did not find any evidence that the Plan analyzes the data in order to: 1) Identify gaps or trends in the dental delivery network; 2) Determine excessive waiting times or problems with appointment access; 3) Take action if services are not available to its enrollees; or 4) Monitor improvements to ensure that they are sustained.

For example, the Plan’s Geo-Access report, dated February 18, 2010, identified 1,281 enrollees without desired access (i.e., not within the Plan’s access standard of 35 miles/35 minutes of primary dental services). The overall average of miles and minutes access were noted in the minutes of the Quality Oversight Committee meetings, but the Department found no evidence that discussions were made of the areas without the desired access, and no documentation that actions were taken to improve access in those areas. Similarly, a listing of access grievances was
presented to the Committee, but no discussion of identified trends or issues was noted, and no documentation that actions were taken to address those issues.

In addition, although the Plan has established standards for primary and specialty care providers, preventive care or hygiene appointments, routine care appointments, and emergency care during or after regular office hours, the Department found that the Plan has not established standards for in-office waiting times. The Plan has an informal waiting time expectation of 45 minutes, but does not monitor in-office waiting times.

Based on the Plan’s failure to adequately monitor access to care, or identify and follow-up on access problems, the Department finds that the Plan is not compliant with rule 1300.67 (f) and rule 1300.70 (a)(1).

**Implications**: Failure to monitor and analyze compliance with access and availability standards is likely to impede the Plan’s ability to identify, and correct any accessibility issues. A system that does not ensure adequate enrollee access may lower enrollee satisfaction and impact the quality of care.

**Corrective Action**: Within 30 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department (See rule 1300.80.10), signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

**Plan’s Compliance Effort**: The Plan states that on a quarterly basis the Compliance Manager reviews a Geo-Access report to determine network adequacy. Enrollees without desired access in this report are brought to the attention of the Dental Director, who determines adequacy of the network. When additional providers are required, the Dental Director and/or Compliance Manager at his/her direction would request a recruitment effort in that area. The Plan also submitted Quality Improvement Committee meeting minutes indicating that accessibility of care is monitored and evaluated on a regular basis.

To address in-office wait times, the Plan revised its “Accessibility Monitoring Process and Procedures Policy” to randomly make "secret shopper telephone calls" to the provider offices to verify the appointment availability time and the average wait time in the office.

**Department’s Finding Concerning Plan’s Compliance Effort:**

**STATUS: NOT CORRECTED**

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

The Department finds that although access issues are reported to the Quality Improvement Committee, the Department has not received sufficient evidence that the data presented to the Quality Improvement Committee is effectively analyzed and acted upon. The February 18, 2010, Geo-Access report identified 1,281 enrollees without desired access, and was noted in the Quality Improvement Committee meeting minutes, but no mention was made of the areas without the desired access, and no actions were taken to improve access to those areas. If the Plan states that it would request a recruitment effort in that area, then the Plan should submit
documentation of such corrective actions. Similarly, a listing of grievances was presented to the committee, but no discussion of identified trends or issues was noted, and no actions were taken. The Plan should submit documentation of discussions and corrective actions taken on identified trends or issues noted in the grievances brought to the Quality Improvement Committee.

Although the Plan has revised its policies and procedures to include the secret shopper telephone calls to randomly selected providers to assess in-office wait time, its revised policies and procedures for monitoring access does not include established standards for in-office wait times to evaluate the findings of these secret shopper telephone calls. In addition, the Plan states in its policy that it “recognizes the fact that waiting time in the waiting room and in the chair can be subjective, and considers these factors an access concern only when they reflect on quality of care.” However, rule 1300.67.2 (f) requires that the Plan have a system for monitoring waiting times, and does not give the Plan the option to assess wait times “only when they reflect on quality of care.” Without establishing standards for in-office wait times, the Department cannot find how the Plan determines when an excessive wait time becomes a quality of care issue.

**UTILIZATION MANAGEMENT**

**Deficiency # 8:** The Plan did not provide evidence:

a) That it consistently provides written notification to enrollees of decisions to deny, delay, or modify health care services;

b) That it consistently sent enrollees the written notifications within the statutorily-mandated timeframes; and

c) That it consistently includes in the written notifications; i) A clear and concise explanation of the reasons for the Plan’s decision; and ii) The criteria or guidelines used for the decision.

**Statutory/Regulatory Reference:** Sections 1367.01 (h)(3) and (4); section 1381 (a); section 1386 (b)(1).

**Discussion:** Section 1367.01 (h)(3) states that, “[e]xcept for concurrent review decisions pertaining to care that is underway…decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision.

Section 1367.01 (h)(4) states that, “[r]esponses 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 enrollees shall be communicated to the enrollee in writing…and shall include a clear and concise explanation of the reasons for the Plan’s decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Section 1381 (a) requires that all records, books, and papers of a Plan shall be open to inspection during normal business hours by the director. Section 1386 (b)(1) provides grounds for discipline by the director if “[t]he plan is operating at variance with the basic organizational documents as filed pursuant to section 1351 or 1352, or with its published plan, or in any manner
contrary to that described in, and reasonably inferred from, the Plan as contained in its application for licensure and annual report, unless amendments allowing the variation have been submitted to, and approved by, the director.”

Although the Plan’s written utilization management policies and procedures appear to describe utilization management timeframes, review activities, and document content requirements, the Plan did not provide evidence that its actual operations consistently complied with its policies and procedure, or with sections 1367.01 (h)(3) and (4), section 1381 (a), and section 1386 (b)(1):

- The Department found that most of the 20 medical necessity denial files had one or more missing documents or key pieces of information. All 20 of the files were missing one or more notes detailing the decision rationale from the Plan’s reviewing dentists. In addition, missing elements essential to the utilization management determinations included Explanation of Benefits (EOB) documents, diagnostic radiographs (many radiographs were not diagnostic), decision dates, and dates notifying the providers of the decision. (See Table 7 below.)

- According to the Plan, “…[we] do not use a template letter for denials. All of our denials are done through the claims system, and the notifications of these denials are noted on an Explanation of Benefits.” Therefore, the Explanation of Benefits contained in the denial files may serve as evidence of notification and is essential to the Department’s review. However, 13 of the 20 denial files did not contain the Explanation of Benefits. In those cases, the Department could not determine if the Explanation of Benefits was missing because the Plan did not provide the enrollee with notification of the denial, or if the Explanation of Benefits was missing because the filing/documentation process did not consistently maintain all essential documents in the files. As per Department policy, files with missing documents that are essential for review are regarded as deficient for that review section.

- The Plan uses the Explanation of Benefits as the denial letter to explain the reasons for the Plan’s decisions to its enrollees, and because 13 of the 20 denial files did not contain the Explanation of Benefits (as discussed in the above paragraph), the Department also found those 13 denials to be deficient in providing enrollees a clear and concise explanation of the reasons for the Plan’s decision. In addition, out of the remaining seven files that contained the Explanation of Benefits documentation of an enrollee notification, two files did not contain notifications with a clear and concise explanation of the reasons for the Plan’s decisions. The Explanation of Benefits in the first file did not list the correct response code that was used in the decision. The Explanation of Benefits in the second file did not include a definition of the clinical terms associated with the response code.

- The Department reviewed sample Explanation of Benefits and found that the Plan does not include an introductory letter, clinical definition(s), or explanation template to the Explanation of Benefits that would clearly and concisely inform the enrollee of the reasons for the Plan’s decision. The Department also reviewed the Plan’s list of response codes used on the Explanation of Benefits, and found that the codes contain technical/clinical language. For example, code 576 states, “When there are several
missing teeth and/or advanced periodontitis is evident, fixed bridges are not covered.
Allowance has been made for partial denture. Abutment teeth are not covered unless
there is evidence of decay or extensive coronal destruction.” A lay person or enrollee
may not understand words such as: pathological, periodontitis, abutment, or coronal
destruction. Simply providing the response codes in the Plan’s denials does not ensure
that the Plan is providing enrollees with a clear and concise explanation of the reasons for
the Plan’s decision.

From the Department review of the denial files, the Plan did not present evidence that it
consistently sent written denial notifications in a timely manner with the statutorily-required
information. In addition, the Plan did not provide denial files that contained all of the
information required by its own utilization management policies and procedures, or information
that was essential to the Department’s review. Therefore, the Department finds the Plan to be
out of compliance with sections 1367.01 (h)(3) and (4), section 1381 (a), and section 1386 (b)(1).

Implications: Without timely written notification to enrollees regarding decisions to deny,
delay, or modify requested health care services, enrollees may be subject to undue delays in
accessing care and/or may be exposed to an unexpected financial burden if they receive care
while waiting for a decision and that care is later denied. Furthermore, the Plan’s failure to
consistently provide clear and concise explanations of its decisions may result in the inability of
enrollees to understand the reason for the delay, denial, or modification of requested dental care
services. This may prevent enrollees from effectively addressing their health care needs.

TABLE 7
Utilization Management File Review

<table>
<thead>
<tr>
<th>FILE TYPE</th>
<th>NUMBER OF FILES</th>
<th>ELEMENT</th>
<th>COMPLIANT</th>
<th>DEFICIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Necessity Denials</td>
<td>20</td>
<td>Denial notification was sent to enrollee in writing</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denial notification was sent to enrollee within prescribed timeframes</td>
<td>5</td>
<td>15 *</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enrollee denial notification contained a clear and concise explanation of the reason for the denial</td>
<td>5</td>
<td>15 *</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enrollee denial notification contained a description of the criteria or guidelines used</td>
<td>4</td>
<td>16 *</td>
</tr>
</tbody>
</table>

*Includes 13 cases for which no enrollee Explanation of Benefits (and, therefore, no evidence of
notification) was provided in the files.

Corrective Action: Within 30 days following notice to a Plan of a deficiency, the Plan is
required to file a written statement with the Department (See rule 1300.80.10), signed by an
officer of the Plan, describing any actions that have been taken to correct the deficiency.
Plan’s Compliance Effort: The Plan offered to produce the 20 Explanation of Benefits for the denial files that the Department reviewed onsite for another reevaluation. The Plan also states that the Plan is not subject to URAC or NCQA and therefore uses the EOB as the "introductory letter" and "explanation template." Every denial has a reason code that informs the member and treating dentist the reason for the Plan's decision.

As stated in the earlier deficiency, the Plan’s staff is undergoing training through an extensive writing clinic to ensure that all resolution letters, including denials, contain clear and concise language. The Quality Improvement Committee will also be reviewing and assessing response codes in the Explanation of Benefits to ensure that the Plan is providing enrollees with a clear and concise explanation of the reasons for the Plan’s decision.

Department’s Finding Concerning Plan’s Compliance Effort:

STATUS: NOT CORRECTED

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

The Department finds that the Plan has not submitted evidence that the Quality Improvement Committee has reviewed, assessed, or revised the response codes to ensure clarity, evidence that the training to improve written responses from the Plan had occurred, or audit results to provide evidence of improvement. Furthermore, the Plan should develop and implement a policy that ensures timely notification of enrollees of the Plan’s denial decisions.

Although the Plan may use the Explanation of Benefits as a form of denial notice in cases where the denial is retrospective (a claim is submitted after service is rendered and the Plan processes the claim and issues an Explanation of Benefits). Nonetheless, the Plan is still required to ensure that explanations of denials are clear and concise pursuant to section 1367.01 (h)(4).
SECTION III: DISCUSSION OF RECOMMENDATIONS

In accordance with section 1380(g), Department analysts offer advice and assistance to the Plan in the form of survey recommendations. The Plan is not required to respond to the Department’s recommendations. These recommendations are not a statement of current Plan deficiencies. Survey recommendations are intended to alert the Plan to weaknesses in its operations that have the potential to become deficiencies in the future. Plan executive staff has been apprised of these issues and the possible negative impact to the Plan’s operations. **The Plan did not respond to these recommendations.**

QUALITY MANAGEMENT

1. **Assign a severity level to cases reviewed for potential quality issues.**

   Rule 1300.70 (b)(1)(B) requires plans to design a Quality Assurance Program that ensures that quality of care problems are identified and corrected for all provider entities.

   The Plan identifies cases that have potential quality issues and reviews these cases to assess whether or not problems exist, but the Plan does not rate these cases by severity of the problem. Assignment of a severity rating would enhance the Plan’s ability to categorize and prioritize problems and identify trends and/or patterns. Severity ratings would also provide a standardized framework for Plan action (e.g., referral to Committee, special audit) on cases and/or providers receiving specific severity ratings.

2. **Ensure that the Plan’s mechanism to gauge enrollee satisfaction identifies and resolves potential quality issues effectively.**

   Rule 1300.70 (b)(1)(B) requires plans to design a Quality Assurance Program that ensures that quality of care problems are identified and corrected for all provider entities.

   During interviews, the Plan’s staff stated that the grievance process is the primary mechanism the Plan uses to gauge enrollee satisfaction issues. The Plan does not conduct provider or enrollee satisfaction surveys or use other approaches to effectively assess enrollee satisfaction with care. Plan staff stated that the Plan had discontinued satisfaction surveys due to cost considerations. Although complaints from enrollees and providers may serve as one potential method for assessing patient and/or provider satisfaction, the use of additional methods for identifying individual problem cases and systemic issues may help ensure that the Plan identifies and resolves all potential quality issues, as pursuant to rule 1300.70 (a)(1).

GRIEVANCES AND APPEALS

3. **Streamline the Plan’s procedures for documenting and reporting grievances.**

   Rule 1300.68 (a) requires plans to establish a grievance system in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt...
by the Plan or any provider or entity with delegated authority to administer and resolve the Plan’s grievance system.

During an interview, staff described the logging and reporting process for grievances as follows:

a) Upon initial receipt of a grievance, a customer service representative enters the grievance data into its Call Care browser.

b) The Call Care browser electronically forwards the data to the Grievance and Appeals Department. A Grievance Coordinator enters the data into a second log, which is a customized computer Excel spreadsheet established by the Grievance and Appeals Department.

c) A Grievance Coordinator periodically provides a copy of the Excel log, along with the tracking summary sheets, to the Compliance Manager.

d) The Compliance Manager enters the grievance data from the Excel log and the tracking summary sheets into a third log which she separately maintains for reporting purposes.

e) The Compliance Manager prepares reports for the Dental Director and presents them to the Quality Oversight Committee on a quarterly basis for review.

The assembling of grievance data in multiple logs, manually, by several people without a reliable audit system to ensure that all grievances are captured creates the potential for introducing human error. Reliance on manual processes limits the Plan’s ability to maintain compliance in the event the membership increases beyond its current 200,000 enrollees.

4. Expand the Plan’s “Grievance Report by Reason” to reflect additional grievance categories, including grievances about Plan operations and services.

Rule 1300.68 (b)(1) requires a Plan’s designated officer to continuously review the operation of the grievance system to identify any emergent patterns of grievances, and that the grievance system shall include reporting procedures in order to improve Plan policies and procedures.

The Plan generates a “Grievance Report by Reason” that reflects different categories of grievances. The reports from quarter 1 of 2006 to quarter 2 of 2008 show two major categories: quality of care/service and benefit disputes. In late 2008, an access category was added.

While the Plan gathers data regarding other grievance reasons, as evidenced on the grievance tracking summary, the final report generated for management review does not reflect these categories. For example, the Plan includes “communication” (communication issues between enrollee and provider, or enrollee and Plan) in its checklist of issue types, but the “Grievance Report by Reason” does not include this category. As a result, issues regarding the Plan’s operations or services, including communications, may not be properly tracked and trended to allow for meaningful analysis, review by the Plan’s designated officer, and formulation of corrective actions, as necessary.
5. Revise the Plan’s grievances and appeals policies to establish the following:
   a) Allocation of staff to review and resolve grievances at specific levels of the grievance resolution process.
   b) A written policy that details how the Plan informs enrollees of the disposition or pending status of the grievance within 30 calendar days of receipt of the grievance.
   c) A policy that ensures the Plan does not discriminate against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.

Section 1368 (a)(1) requires each plan to establish a grievance system that shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate. The Plan’s grievance policies do not address whether the Dental Director, or appropriately licensed dental care provider, who reviewed a contested claim would participate in an appeals review and determination of that same claim. Staff who reviewed the original denial may affirm the bias of their original decision if they review the same issue upon appeal, thus hindering an objective consideration of an enrollee’s appeal.

Section 1368 (a)(2) requires each plan to “[i]nform its subscribers and enrollees upon enrollment in the Plan and annually thereafter of the procedure for processing and resolving grievances.” The Plan’s grievance policies do not detail how the Plan informs enrollees of the disposition or pending status of the grievance within 30 calendar days of receipt of the grievance. Although the Plan may comply operationally with section 1368(a)(2), establishing a written policy would help to ensure that Plan staff are adequately informed of the grievance resolution process.

Rule 1300.68 (b)(8) requires each plan to “assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance. The Plan’s grievance policies do not detail how the Plan shall assure that there is no discrimination against complainants who file a grievance. Establishing a written policy would help to ensure that Plan staff are adequately informed not to discriminate against complainants.

6. Update Plan’s Evidence of Coverage (EOC) documents to provide information regarding the procedures for filing urgent grievances. Update the Plan’s policies and procedures regarding urgent grievances to include procedures for handling urgent grievances.

Rule 1300.68.01 (a) requires every plan to include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, as specified.

Neither the Dental Net Explanation of Benefits nor the Select HMO Explanation of Benefits mentions the process of filing urgent grievances. The Plan’s policy and procedures regarding urgent grievances do not clearly describe the process for handling urgent grievances. The policy simply declares that all urgent grievances will be referred to the Dental Director.
Although the Plan has not received any urgent grievances within the last two years, establishing procedures for handling urgent grievances will help guide Plan staff upon receiving an urgent grievance. In addition, enrollees must be informed of the availability of an urgent grievance process through appropriate member materials such as the Plan’s Explanation of Benefits.

7. **Revise the Plan’s policy and procedure for filing urgent grievances to include:**
   - a) The designated dental plan officer who is authorized to make financial decisions on the Plan’s behalf;
   - b) How calls regarding urgent grievances will be received;
   - c) Which staff would receive the call;
   - d) The telephone numbers to call;
   - e) How the Compliance Manager or other designee is notified; and
   - f) The process and timeframes for returning the Department’s calls.

Rule 1300.68.01(a) requires every plan to include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, as specified.

The Plan’s grievance policy and procedures state: “Anthem Blue Cross Corporate Quality Review is the point for receiving urgent grievances or other urgent issues. This entity is responsible for immediately notifying the Compliance Manager of these urgent issues so that they can be handled in the mandated timeframes.”

In an interview, the Compliance Manager stated that all department communications go through “corporate” (meaning Anthem Blue Cross of California) and that the Plan has provided the list of contact persons to the Department. Corporate is responsible for notifying the Compliance Manager at the dental plan division for any urgent issues. The Compliance Manager stated that she is now the Plan’s representative who is authorized to make financial decisions; however, she conceded that there are no existing policies and procedures that indicate this authority or the Plan’s overall urgent grievance process, including its integration with the full-service plan. She acknowledged that a policy should be formalized.

8. **Ensure that grievances are consistently received, reviewed, and resolved within 30 calendar days of receipt by the Plan.**

Rule 1300.68 (a) requires plans to establish a grievance system in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the Plan or any provider or entity with delegated authority to administer and resolve the Plan’s grievance system.

The Department randomly sampled 163 grievance files selected from the universe of 650 grievances from the period 1/31/2008 through 1/31/2010. One of the grievances was closed by the Plan before a resolution could be reached due to the enrollee obtaining a lawyer to handle her case. In 19 (12%) of the remaining 162 grievance files, the Department found that the Plan failed to resolve the grievance within 30 calendar days and did not notify the enrollee of the pending status of the grievance. Resolving grievances in a timely manner
ensures that necessary services are provided and concerns are addressed, thus promoting enrollee health and satisfaction.

**UTILIZATION MANAGEMENT**

9. **Ensure that denial notifications to providers consistently contain the statutorily-mandated information.**

Section 1367.01 (h)(4) requires Plan responses regarding decisions to deny, delay, or modify health care services be communicated to providers and shall include a clear and concise explanation of the reason for the decision, a description of the criteria or guidelines used, and the name and telephone number of the health care professional responsible for the denial, delay, or modification.

The Department found in its review of 20 medical necessity denial files that four files did not contain notifications with a clear and concise explanation, seven files did not contain notifications with a description of the criteria or guidelines used, and five files did not contain notifications with the name and phone number of the reviewing dentist. By consistently including the statutorily-mandated information in the Plan’s denial notifications, the Plan may ensure its providers understand the reasoning behind the denials and enrollees are thoroughly informed by their providers of the Plan’s decisions.

**LANGUAGE ASSISTANCE**

10. **Provide a mechanism for the Plan to provide feedback and analysis to its full-service plan regarding its Language Assistance Program criteria and standards.**

Rule 1300.67.04 (c)(4)(A) requires every plan to monitor its Language Assistance Program, including delegated Programs, and make modifications as necessary to ensure compliance with section 1367.04 of the Act and rule 1300.67.04.

The Plan’s language assistance policy states that the Plan “will rely upon the analysis done by the medical plan to determine the number and percentage of LEP individuals in their respective geographies within the Service Area. The rationale for this methodology is that most of the dental plans are sold in conjunction with a medical plan.” Interviews confirmed that although the Plan integrates functions of its Language Assistance Program with the full-service plan, there is no mechanism for the Plan to provide feedback and analysis to its full-service plan. Open communication between the dental division and the full-service plan may help ensure that the Language Assistance Program maintains compliance and receives consistent improvements.
SECTION IV: SURVEY CONCLUSION

The Department has completed its routine medical survey. 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.
A.  THE MEDICAL SURVEY PROCESS

The Department conducts a routine medical survey of each licensed health care service plan at least once every three years in order to evaluate the Plan’s compliance with the Knox-Keene Health Care Service Plan Act. Generally, the Department evaluates a Plan’s performance in eight major areas:

(1) **Quality Management** – Each plan is required to assess and improve the quality of care it provides to its enrollees.

(2) **Grievances and Appeals** – Each plan is required to resolve all grievances and appeals in a professional, fair and expeditious manner.

(3) **Access and Availability of Services** – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

(4) **Utilization Management** – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

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

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

(7) **Access to Emergency Services and Payment** – Each plan is required to ensure that emergency services are accessible and available and timely authorization mechanisms are provided for medically necessary care.

(8) **Prescription Drugs** – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescriptions and ensure benefit coverage is communicated to enrollees.
### Summary of Survey Activities and Timeframes

#### Onsite Visit and Preliminary Report

<table>
<thead>
<tr>
<th>SURVEY ACTIVITY: PRELIMINARY REPORT</th>
<th>TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification Letter and Request for Documents</td>
<td>Prior to onsite visit</td>
</tr>
<tr>
<td>Routine Survey Onsite Visit</td>
<td>At least once every three years</td>
</tr>
<tr>
<td>Preliminary Report issued by the Department to the Plan</td>
<td>Within 60-80 days close of the survey</td>
</tr>
<tr>
<td>Report of Correction of Deficiencies due from Plan to the Department (Rule 1300.80.10)</td>
<td>30 calendar days from date of receipt of Preliminary Report</td>
</tr>
</tbody>
</table>

#### Final Report

<table>
<thead>
<tr>
<th>SURVEY ACTIVITY: FINAL REPORT</th>
<th>TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final Report due from the Department to the Plan</td>
<td>Within 170 days from the close of the survey</td>
</tr>
<tr>
<td>Response from Plan to Department on any matters in the Final Report</td>
<td>Within ten calendar days from receipt of Final Report. Included in Public File with Final Report</td>
</tr>
<tr>
<td>Final Report due from Department to the Public File (Section 1380(h)(1))</td>
<td>Within 180 days from the close of the survey</td>
</tr>
</tbody>
</table>

#### Follow Up Survey

<table>
<thead>
<tr>
<th>SURVEY ACTIVITY: FOLLOW UP SURVEY</th>
<th>TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Up Review Conducted</td>
<td>Any time within 16 months of the date a Final Report is issued to the Public File</td>
</tr>
<tr>
<td>Follow Up Report issued by the Department to the Plan</td>
<td>No later than 18 months from the date the Final Report is issued to the Public File</td>
</tr>
<tr>
<td>Response from the Plan to the Department on any matters in Follow Up Report</td>
<td>Within ten calendar days from receipt of a Follow Up Report. Included in Public File with Follow Up Report</td>
</tr>
<tr>
<td>Follow Up Report due to the Public File (Section 1380(i)(2))</td>
<td>No later than 18 months from the date the Final Report is issued to the Public File</td>
</tr>
</tbody>
</table>
Survey Preparation
The Routine Survey begins when the Department provides notice of a pending survey and supplies the Plan with a questionnaire and a list of documents to be submitted to the Department for review prior to an onsite visit. In advance of the onsite visit, the Department provides the Plan a list of materials to be available to the survey team upon arrival.

Pre-Onsite Activities
The Department reviews written materials submitted by the Plan in response to its questionnaire and document request. The Department also considers internal data sources, including past survey reports, Help Center complaint data, enforcement actions and licensing requests. An in-depth study of the written materials and Department’s data provides the opportunity to define the scope of the survey.

Onsite Visit
During the onsite visit, the survey team reviews materials and conducts interviews with Plan staff, reviews the Plan’s oversight of its provider network and may conduct interviews with providers.

Preliminary Report
Within 60-80 days of the close of the survey, the Department provides the Plan with a Preliminary Report, which details deficiencies and survey recommendations. Preliminary and Final Reports are deficiency- and recommendation-based reports; therefore, only specific areas found by the Department to be deficient or of concern are included in these reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Act.

Plan’s Response to the Preliminary Report
All deficiencies cited in the Preliminary Report require corrective action by the Plan. Within 30 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department pursuant to the requirements of rule 1300.80.10. For those deficiencies that are expected to require longer than 30 days to remedy, a Plan may submit evidence that the Plan has initiated remedial action to achieve compliance. Designated portions of the response may be maintained as confidential, pursuant to section 1380 (h)(6).

The Plan’s response should include the following information for each deficiency identified in the Preliminary Report:

(1) The Plan’s response to the Department’s identified deficiencies, including a corrective action plan;

(2) If the corrective action plan is fully designed and implemented, the Plan should provide evidence that the deficiencies have been corrected;

(3) If the corrective action plan is not fully implemented by the time the Plan submits its response, the Plan should submit evidence that the corrective action plan has been developed and remedial action has been initiated. The date of expected compliance
should be included, as well as a full description of the evidence demonstrating compliance that the Plan will submit for the Department's Follow Up Review.

In addition to requiring corrective action, the Department may take other actions with regard to violations, including enforcement actions.

Any new or amended policies and procedures required for implementation of the corrective action plan are filed as Plan amendments and/or material modifications pursuant to section 1352 and rule 1300.52.4. The Plan should file both a clean and redline version of revised policies and procedures through the Department’s Web portal. The Plan is to clearly note in its response to the Preliminary Report, submitted via e-mail, hard copy and CD to the Department, that the revised policies and procedures have been filed via the Web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department’s Web portal. Criteria for the submission of amendments and modifications are found in section 1352 and rule 1300.52.4 of the Act.

**Final Report and Summary Report**

Upon review of the Plan’s response to the Preliminary Report, the Department will issue a Final Report to the Plan, followed by a copy to the public file. The report is available to the public by mail or on the Department Web portal at the following Web site:4


The Final Report will contain the deficiencies and recommendations as they were reported in the Preliminary Report, a summary of the Plan’s response and compliance efforts and the Department’s determination concerning the adequacy of the Plan’s response. (Section 1380 (h)(1) through (6)) The Plan’s failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by section 1380 (i)(1).

At the same time the Department makes the Final Report available to the public, a summary of the report will be issued to the public file. One copy of the summary is available free of charge to the public by mail. Additional copies of the summary and copies of the entire Final Report and the Plan’s response can be obtained from the Department at cost.

**Follow Up Review**

The Department may contact the Plan by letter and/or conduct a Follow Up Review to confirm correction of deficiencies identified in the Final Report. (See Health and Safety Code section 1380 (i)(2)). (Deficiencies left uncorrected will be subject to review and disciplinary action as appropriate pursuant to Health & Safety Code section 1380 (i)(1)).

4 Current as of 12/31/2010
B. OVERVIEW OF PLAN OPERATIONS

The table below summarizes the information submitted to the Department by the Plan in response to the pre-survey questionnaire:

**PLAN PROFILE**

<table>
<thead>
<tr>
<th>Type of Plan</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Area(s) (Counties, in full or in part)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Commercial</strong></td>
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<tr>
<td>Alameda</td>
<td>Orange</td>
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<td>Contra Costa</td>
<td>Placer</td>
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<td>Riverside</td>
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<tr>
<td>Kern</td>
<td>Sacramento</td>
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<td>Kings</td>
<td>San Bernardino</td>
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<td>Los Angeles</td>
<td>San Diego</td>
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<td>Marin</td>
<td>San Francisco</td>
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<td>Monterey</td>
<td>San Joaquin</td>
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<tr>
<td><strong>Number of Providers</strong></td>
<td><strong>Primary Care</strong></td>
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<td></td>
<td>2,992</td>
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<td><strong>Number of Enrollees as of February 1, 2010</strong></td>
<td><strong>Product Lines</strong></td>
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<tr>
<td></td>
<td>Commercial HMO</td>
</tr>
<tr>
<td>Total</td>
<td>195,759</td>
</tr>
</tbody>
</table>
Rule 1300.67 (f)(8)
The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve:
(f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision,
(8) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

Rule 1300.67.2 (f)
Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

Rule 1300.68 (a)
Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.
(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:
(1) "Grievance" means 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.
(2) "Complaint" is the same as "grievance."
(3) "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.
(4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.
(A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.
(B) Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to Subsection (f) until the review and any required action by the plan resulting from the review is completed.
Rule 1300.68 (b)(1)  
(b) The plan's grievance system shall include the following:  
(1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

Rule 1300.68 (b)(4)  
(b) The plan's grievance system shall include the following:  
(4) The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances.

Rule 1300.68 (b)(5)  
(b) The plan's grievance system shall include the following:  
(5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other documents describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or his designee. This review shall be thoroughly documented.

Rule 1300.68 (b)(7)  
(b) The plan's grievance system shall include the following:  
(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan’s website, and from each contracting provider’s office or facility. Grievance forms shall be provided promptly upon request.

Rule 1300.68 (b)(8)  
(b) The plan's grievance system shall include the following:  
(8) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.

Rule 1300.68 (d)(1)  
(d) The plan shall respond to grievances as follows:  
(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.

Rule 1300.68 (d)(3)  
(d) The plan shall respond to grievances as follows:  
(1) The plan’s resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan’s decision. Nothing in
this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

**Rules 1300.68.01 (a) and (b)**

(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function (“urgent grievances”). At a minimum, plan procedures for urgent grievances shall include:

1. Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.
2. A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the plan.
3. Consideration by the plan of the enrollee’s medical condition when determining the response time.
4. No requirement that the enrollee participate in the plan’s grievance process prior to applying to the Department for review of the urgent grievance.

(b) Each plan’s grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

1. The system established by the plan shall provide for the availability of a plan representative with authority on the plan’s behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee’s plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

2. Plans shall provide the Department with the following information concerning urgent grievances:
   a. A description of the system established by the plan to resolve urgent grievances. The description shall include the system’s provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievances. Provisions for scheduling shall include the names and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.
   b. A description of how the Department may access the grievance system established by the plan. If the plan revises the system established pursuant to subsection (b), the plan shall notify the Department at least thirty (30) days in advance of implementing the revisions.
Rules 1300.70 (a)(1) and (3)
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.
(3) A plan's QA program must address service elements, including accessibility availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meet professionally recognized standards of practice.

Rule 1300.70(b)(1)(B)
(b) Quality Assurance Program Structure and Requirements.
(1) Program Structure.
To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:
(B) quality of care problems are identified and corrected for all provider entities.

Rule 1300.70 (b)(2)(E)
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

Rules 1300.70 (b)(2)(G)(5) and (6)
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.
If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.
(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.
Section 1363.5 (b)(4)
(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:
(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, (the criteria shall) be disclosed to the provider and the enrollee in that specified case.

Section 1367.01 (e)
(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.

Sections 1367.01 (h)(1) through (5)
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with, the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee’s condition, not to exceed five business days from the plan’s receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual’s designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law.
(2) When the enrollee’s condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee’s life or health or could jeopardize the enrollee’s ability to regain maximum function, decision to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion, not to exceed 72 hours after the plan’s receipt of the information reasonably necessary and requested by the plan to make the determination.
(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decision pertaining to care that is underway, which shall be communicated to the enrollee’s treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision.
(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees 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 service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan’s decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding clinical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary…the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever comes first, ... notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

Section 1368 (a)(1)
(a) Every plan shall do all of the following:
(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Section 1368 (a)(2)
(a) Every plan shall do all of the following:
(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

Section 1368 (a)(5)
(a) Every plan shall do the following:
(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan’s response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.
Rule 1300.67.04 (c)(4)(A)
(c) Language Assistance Program Requirements. Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(4) Compliance Monitoring.
(A) Every plan shall monitor its language assistance program, including delegated programs, and make modifications as necessary to ensure compliance with Section 1367.04 of the Act and this section.

Section 1381
All records, books, and papers of a plan, management company, solicitor, solicitor firm, and any provider or subcontractor providing health care or other services to a plan, management company, solicitor, or solicitor firm shall be open to inspection during normal business hours by the director.