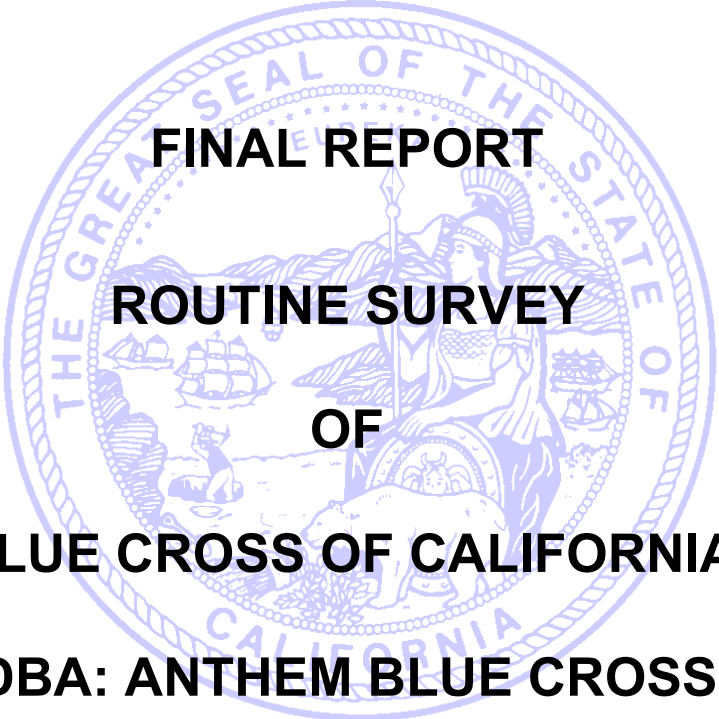




**OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**



**FINAL REPORT
ROUTINE SURVEY
OF
BLUE CROSS OF CALIFORNIA
DBA: ANTHEM BLUE CROSS
A DENTAL HEALTH PLAN**

JULY 21, 2025

**Routine Survey Final Report
Blue Cross of California
DBA: Anthem Blue Cross
A Dental Plan**

TABLE OF CONTENTS

EXECUTIVE SUMMARY _____	3
SURVEY OVERVIEW _____	5
SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS _____	7
QUALITY ASSURANCE _____	7
GRIEVANCES AND APPEALS _____	8
ACCESS AND AVAILABILITY OF SERVICES _____	12
UTILIZATION MANAGEMENT _____	15
SECTION II: SURVEY CONCLUSION _____	23

EXECUTIVE SUMMARY

On August 2, 2023, the California Department of Managed Health Care (Department) notified Blue Cross of California, DBA Anthem Blue Cross (Plan) that it would conduct its scheduled Routine Survey pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The survey team conducted the onsite survey from January 23, 2024, through January 24, 2024.

The Department assessed Plan operations in the following areas:

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

The Department identified **eight** deficiencies during the Routine Survey.

The 2023 Survey Deficiencies Table below provides the status of each deficiency. The report describes each deficiency finding, Plan efforts to correct deficiencies and the Department’s assessment of corrective action as well as the need for continued efforts and follow up.

2023 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
QUALITY ASSURANCE		
1	<p>The Plan's Governing Body did not meet quarterly to oversee its quality assurance program responsibilities. Rule 1300.70(b)(2)(C).</p>	<p>Not Corrected</p>
GRIEVANCES AND APPEALS		
2	<p>The Plan did not properly maintain a grievance system under which enrollees might submit their grievances. Section 1368(a)(1), (4)(A), (5), and (7); Section 1368.01(a); and Rule 1300.68(a)(1), (b)(5), (d)(1), (3), (6), and (e)(1) and (2).</p>	<p>Not Corrected</p>
3	<p>The Plan did not appropriately respond to expedited grievances. Section 1368.01(b) and Rule 1300.68.01(a)(1).</p>	<p>Not Corrected</p>

ACCESS AND AVAILABILITY OF SERVICES		
4	<p>The Plan did not take appropriate steps to ensure the accuracy of the information concerning each provider listed in the Plan's provider directory or directories. Section 1367.27(l)(1) and (2).</p>	Corrected
5	<p>The Plan did not monitor the changes in the names of its provider networks and file updates with the Department. Section 1367.27(r) and Rule 1300.52(f).</p>	Corrected
UTILIZATION MANAGEMENT		
6	<p>The Plan did not timely notify enrollees of its decisions to approve, deny, delay, or modify health care services based in whole or in part on medical necessity. Section 1367.01(h)(1).</p>	Not Corrected
7	<p>The Plan's written responses to enrollees for decisions to deny or modify health care services from providers based in whole or in part on medical necessity did not include a description of the criteria or guidelines used. Section 1367.01(h)(4).</p>	Not Corrected
8	<p>The Plan did not follow its quality assurance processes to assess and evaluate the Plan's compliance with utilization management requirements. Section 1367.01(h)(1) and (4) and (j).</p>	Not Corrected

SURVEY OVERVIEW

The Department conducts a routine survey of each licensed health care service plan at least once every three years to evaluate the plan's health care delivery system. Surveys are conducted pursuant to Section 1380 of the Knox-Keene Health Care Service Plan Act of 1975¹ and include review and assessment of the plan's overall performance in providing health care benefits and meeting the health care needs of its enrollees in the following areas:

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

Grievances and Appeals – Grievance systems must be in writing and include procedures for receiving, reviewing and timely resolving grievances. Plans must adequately consider, promptly review and appropriately document each grievance. A plan officer must have primary responsibility for the grievance system, providing continuous review to identify emergent patterns of grievances. Plans with internet websites must provide information about the grievance system on its website and provide an online grievance submission process.

Access and Availability of Services – Plans must provide or arrange for the provision of health care services in a timely manner, appropriate for the enrollees' condition and consistent with good professional practice. Plan and provider processes necessary for obtaining services must be completed in a manner that ensures timely provision of care.

Utilization Management – Each plan and any entity delegated to perform utilization management functions must ensure that decisions based on medical necessity are consistent with clinical criteria/guidelines; that utilization review and oversight operations are performed by appropriate personnel; and that enrollees and requesting providers receive timely and appropriate information concerning approvals, denials, and modifications of requested services.

Language Assistance – Each plan is required to implement a language assistance program to ensure enrollees have access to no cost interpretation and translation services.

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

PLAN BACKGROUND

Blue Cross of California dba: Anthem Blue Cross received its Knox-Keene License in 1993 and operates as a for-profit corporation in California as a full-service health care plan. This routine survey focuses on the Plan's dental plan operations. The Plan offers stand-alone dental products in individual, small-group, and large-group commercial markets.

Anthem, Inc., a publicly traded corporation owns WellPoint California Services, Inc., which wholly owns the Plan as a subsidiary. The Plan owns Blue Cross of California Partnership Plan, Inc., which also holds a Knox-Keene License.

The Plan does not offer Medicare or Medi-Cal dental plans. The Plan has a network of 33,300 California Dental providers in its PPO plan and 14,700 providers in its HMO plan. As of October 2023, the Plan reported 125,770 enrollees in its commercial stand-alone² dental HMO Plan and 21,696 enrollees in its PPO plans.

² Commercial Dental plan product which the Plan markets and sells independently of the Plan's full-service products.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On February 11, 2025, the Department issued the Plan a preliminary report that described each deficiency, as well as the legal and factual basis for each deficient finding. In that report, the Department instructed the Plan to perform the following within 45 days of issuance of the preliminary report:

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

This Final Report describes the deficiencies identified by the Department, the Plan's 45-day response and proposed corrective actions, and the status of the deficiency following the Department's review of the Plan's compliance efforts. The Department will reassess Plan compliance with all uncorrected deficiencies, including deficiencies that required more than 45 days to correct, during a follow-up survey within 18 months of issuance of this Final Report.

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

DEFICIENCIES

QUALITY ASSURANCE

Deficiency #1: **The Plan's Governing Body did not meet quarterly to oversee its quality assurance program responsibilities.**

Regulatory Reference: Rule 1300.70(b)(2)(C).

Assessment: The Plan's governing body must meet quarterly (or more frequently if problems have been identified) to oversee its respective quality assurance program responsibilities.³

The Plan's governing body is its Board of Directors (BOD). The meeting minutes for the BOD (BOD meeting minutes) showed the BOD met during six out of eight quarters.⁴ The BOD did not meet during two quarters of the survey review period.⁵

³ See Rule 1300.70(b)(2)(C).

⁴ THE BOD met on December 13, 2021, March 24, 2022, October 3, 2022, December 8, 2022, April 3, 2023, and June 22, 2023. The Plan did not have BOD meeting minutes for the second and third quarters of 2022 nor the first quarter of 2023.

⁵ The survey review period began on September 1, 2021, and ended on August 31, 2023.

Plan's Compliance Effort: The Plan submitted *Anthem Blue Cross, 2024 Routine Dental Survey Preliminary Report Corrective Action Plan Response* (CAP Response)⁶ in reply to the Department's Preliminary Report. The CAP Response stated the Plan created the California Management Oversight Committee to govern and oversee compliance, by reviewing and monitoring Plan functions. The Plan's CAP Response also stated the Plan's Exhibit J-1 requires the BOD to meet quarterly to ensure the Plan meets regulations.

Supporting Documentation:

- *Anthem Blue Cross, 2024 Routine Dental Survey Preliminary Report Corrective Action Plan Response* (April 16, 2025)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is not corrected.

The Department finds the Plan's BOD did not meet quarterly during the survey review period. The CAP Response did not sufficiently show how the Plan will correct this deficiency. While the Plan's BOD can delegate quality assurance oversight responsibilities to an internal committee, the Plan's BOD must also meet quarterly to conduct its quality assurance oversight responsibilities.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve the Plan's BOD meeting minutes, and any other review deemed necessary by the Department.

GRIEVANCES AND APPEALS

Deficiency #2: **The Plan did not properly maintain a grievance system under which enrollees might submit their grievances.**

Statutory and Regulatory References: Section 1368(a)(1), (4)(A), (5), and (7); Section 1368.01(a); and Rule 1300.68(a)(1), (b)(5), (d)(1), (3), (6), and (e)(1) and (2).

Assessment: The Plan must establish and maintain a grievance system under which enrollees may submit their grievances⁷ to the Plan.⁸ The Plan's grievance system must do the following:

⁶ The Plan timely submitted its initial CAP Response on March 14, 2025. The Plan amended its CAP Response on April 16, 2025. For its assessment of the Plan's corrective actions, the Department reviewed the April 16, 2025, amended CAP Response.

⁷ A grievance is "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." (See Rule 1300.68(a)(1)).

⁸ See Section 1368(a)(1)).

- Make a written record of each grievance it receives, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition,⁹ and keep copies of all grievances and the responses for a period of five years.¹⁰
- Provide for a written acknowledgment within five days of receiving a grievance¹¹ and a written response with a clear and concise explanation of the reason for its response.¹²
- Resolve all grievances within 30 days¹³ and send a grievance resolution letter.¹⁴
- Track and monitor the grievances it receives,¹⁵ which includes monitoring the number of grievances the Plan receives and resolves¹⁶ and tracking the total number of grievances received, pending, and resolved in favor of the enrollee at all levels.¹⁷

The Department reviewed 70¹⁸ of the Plan's Customer Service Enrollee Contacts/Inquiries (call inquiries).¹⁹ Twenty-two²⁰ (31%) of the 70 call inquiries involved a complaint meeting the definition of a grievance under Rule 1300.68(a)(1). The Plan did not receive these 22 call inquiries as grievances.

Case Examples

- **DMHC Customer Service Enrollee Contacts/Inquiries no. 33:** The enrollee contacted the Plan to determine the cost of a service. The enrollee expressed dissatisfaction with the Plan's automated telephone system saying he had "been jumping through hoops" to get his question answered. The Plan did not receive this as a grievance.
- **DMHC Customer Service Enrollee Contacts/Inquiries no. 66:** The enrollee contacted the Plan and expressed dissatisfaction with a dental provider. The Plan did not receive this as a grievance.

Plan's Compliance Effort: The CAP Response stated the Plan agreed with the Department's findings. According to the CAP Response, the Plan implemented revised criteria for its associates to use when classifying grievances and inquiries and trained its

⁹ See Rule 1300.68(b)(5).

¹⁰ See Section 1368(a)(7) and Rule 1300.68(d)(6).

¹¹ See Section 1368(a)(4)(A).

¹² See Section 1368(a)(5) and Rule 1300.68(d)(1).

¹³ See Section 1368.01(a).

¹⁴ See Rule 1300.68(d)(3).

¹⁵ See Rule 1300.68(e).

¹⁶ See Rule 1300.68(e)(1).

¹⁷ See Rule 1300.68(e)(2).

¹⁸ DMHC Customer Service Enrollee Contacts/Inquiries Files: 1-55, 57-61, and 63-72.

¹⁹ A call inquiry is a telephone call initiated by an enrollee to the Plan that the Plan reported to the Department that it did not receive as a grievance.

²⁰ DMHC Customer Service Enrollee Contacts/Inquiries Files: 1, 2, 5, 7, 14, 21-22, 31-34, 36, 39, 45, 52, 54, 58, 61, 65-67, and 72.

Dental Customer Service associates on classifying grievances and inquiries. The CAP Response stated the Plan reviewed each deficient call inquiry against the revised criteria and determined it would have classified each deficient call inquiry as a grievance under its revised criteria.²¹

Supporting Documentation:

- *Anthem Blue Cross, 2024 Routine Dental Survey Preliminary Report Corrective Action Plan Response (April 16, 2025)*

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is not corrected.

The Department finds the Plan did not maintain a grievance system under which enrollees might submit their grievances. For its corrective actions, the Plan revised its criteria for classifying inquiries and grievances and trained its Dental Customer Services associates on the revised criteria. The Plan reviewed the 22 deficient call inquiries against its revised criteria and determined it should have received the 22 deficient call inquiries as grievances. While the Plan's corrective actions would remedy this deficiency, the Plan needs additional time to fully implement its compliance efforts and demonstrate their effectiveness.

At the Follow-Up Survey, the Department will assess the Plan's implementation of the corrective actions and whether the deficiency has been corrected. Assessment may involve a review of the Plan's revised criteria for classifying inquiries and grievances, call inquiries, interviews with the Plan's staff, and any other review deemed necessary by the Department.

Deficiency #3: The Plan did not appropriately respond to expedited grievances.

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

Assessment: The Plan's grievance system must expedite the review of grievances involving cases with an imminent and serious threat to the health of the patient, including severe pain, potential loss of life, limb, or major bodily function (expedited grievances). The Plan must immediately inform the enrollees in writing of their right to notify the Department of the grievance when the Plan has notice of a grievance requiring expedited review.²² The notice need not be in writing but may be accomplished by a documented telephone call.²³

²¹ The Plan challenged the Department's assessment of Call Inquiry File 52, contending it erroneously listed the file in its log because the enrollee was under the medical line of business. However, the Plan did not submit the Call Inquiry File 52 to the Department after multiple requests. Therefore, the Department determined Call Inquiry File 52 noncompliant.

²² See Section 1368.01(b).

²³ See Rule 1300.68.01(a)(1)].

The Department reviewed 70 Expedited Grievances and Appeals Files (expedited grievance files). The Plan did not document the immediate notification to the enrollee of the right to contact the Department with the expedited grievance in 44²⁴ (63%) of the 70 expedited grievance files.

TABLE 1
Expedited Grievance and Appeal Files and Immediate Notification

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Grievance and Appeal	70	To immediately notify the enrollee of the right to contact the Department with the expedited grievance	26 (37%)	44 (63%)

Plan’s Compliance Effort: The CAP Response stated:

The Plan disagrees with the DHMC’s findings on Deficiency 3, which claims a failure to respond to [expedited] grievances. After reviewing the cases, the Plan believes it handled them appropriately. They ensured verbal notification to [enrollees] about expedited grievance, as detailed in the case submission to the DMHC on page three.

The Plan submitted a spreadsheet²⁵ which identified the deficient files. The spreadsheet contains the following comment for each deficient file: “The acknowledgment of verbal notification can be found in the expedited case submission . . . found in the Service Request details section and also in the note section of the [enrollee’s] request.” Each expedited grievance file contained sections titled “expedited case submission” and “Service Request details.” The “expedited case submission” and “Service Request details” sections reference an “AB 2470 notice,” but do not record the immediate verbal notice to an enrollee of the right to contact the Department with the expedited grievance.

Supporting Documentation:

- Plan Preliminary Report Corrective Action Plan (April 16, 2025)
- Plan response to Department Preliminary Report²⁶ (May 7, 2025)

Final Report Deficiency Status: Not Corrected

The Department has determined that this deficiency is not corrected.

²⁴ DMHC Expedited Grievances and Appeals Files: 1, 2, 6-15, 17-21, 23-26, 28-30, 32, 35-40, 46-50, 53, 55-56, 59-62, and 65.

²⁵ D3_GA_Plan Review

²⁶ D3_GA_Plan Review

The Department finds the Plan did not immediately notify the enrollee of the right to contact the Department with the expedited grievance. The Plan challenged the deficiency, asserting it appropriately handled the deficient expedited grievance files, contending that the expedited grievance files recorded the immediate verbal notice. However, the deficient expedited grievance files only reference an "AB 2470 notice." The Department finds no grounds for revising this deficiency. The deficient expedited grievance files did not document the immediate verbal notice to the enrollee. The Plan did not provide the "AB 2470 notice," or script, so the Department could not determine whether the "AB 2470 notice" or script contained the required notice. Additionally, Assembly Bill (AB) 2470²⁷ did not change requirements to immediately and verbally notify the enrollee of the right to contact the Department.²⁸ Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve a review of the Plan's expedited grievance files, and any other review deemed necessary by the Department.

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

ACCESS AND AVAILABILITY OF SERVICES

Deficiency #4: **The Plan did not take appropriate steps to ensure the accuracy of the information concerning each provider listed in the Plan's provider directory or directories.**

Statutory References: Section 1367.27(l)(1) and (2).

Assessment: The Plan must take appropriate steps to ensure the accuracy of the information concerning each provider listed in the Plan's provider directory or directories. The Plan must notify all contracted providers each calendar year.²⁹

The Plan's notice must include the following:

- The information the Plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider groups; and
- A statement that failure to respond to the notice may result in a delay of payment or reimbursement of a claim pursuant to Section 1367.27.³⁰

²⁷ AB 2470 (2009-2010) added Section 1368(a)(6) which required health care plans to continue coverage to the enrollee when the enrollee makes a grievance involving the cancellation, rescission, or nonrenewal of a health care service plan contract "until the Department has made its final determination pursuant to Section 1365."

²⁸ See Section 1368.01(b) and Rule 1300.68.01(a)(1).

²⁹ See Section 1367.27(l)(1).

³⁰ See Section 1367.27(l)(2).

In response to the Department's request for the Plan's provider notice templates, the Plan submitted three provider notification template letters³¹: Each provider notification template letter contained the subject line "*Legal Requirement -- Verification of your provider profile for our member directories.*" The provider notification template letters did not include a list of networks and Plan products that include the contracted provider or provider groups. Additionally, the provider notification template letters did not include a statement that failure to respond to the notice may result in a delay of payment or reimbursement of a claim pursuant to Section 1367.27.

Plan's Compliance Effort: The CAP Response stated the Plan agreed with the Department and it would include the required information on each template. The CAP Response also stated the Plan amended the language in its provider notification template letters to include the statement "California Providers Only: Failure to respond to this notice may result in a delay of payment or reimbursement of a claim pursuant to Cal. Health & Saf. Code section 1367.27." According to the CAP Response, the Plan needed to integrate the amended templates into its dental system, however, integrating the amended templates would exceed 45 days due to the work involved. The CAP Response stated the Plan expected to implement the revised provider notification template letters before July 25, 2025, and expected to fully implement corrective action by the end of the third quarter of 2026.

The Plan submitted two revised provider notification template letters.³² The revised provider notification template letters contain information regarding the provider, including provider directory information and a list of the networks and the products that include the provider. The revised provider notification template letters also state "failure to respond may result in a delay of payment or reimbursement of a claim pursuant to Section 1367.27."

Supporting Documentation:

- *Anthem Blue Cross, 2024 Routine Dental Survey Preliminary Report Corrective Action Plan Response* (April 16, 2025)
- Plan response to Department Preliminary Report³³ (March 14, 2025)
- Plan response to Department Preliminary Report (March 14, 2025)
- Plan response to Department Preliminary Report (March 14, 2025)

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is corrected.

The Department finds the Plan took appropriate steps to ensure the accuracy of the information concerning each provider listed in its provider directory or directories. For its corrective action, the Plan revised its provider notification template letters. While the Plan will not fully implement its corrective action until the end of the third quarter of

³¹ See AA007_3 Tmpl DA1 HMO; AA007_3 Tmpl DA3 NonHMO; and AA007_3 Mailing Survey.

³² D4_AA_Template DA1-HMO, and D4_AA_Tempalte DA3-NonHMO.

³³ D4_AA_Template DA1-HMO, and D4_AA_Tempalte DA3-NonHMO

2026, the revised provider notification template letters now include the required information.

Deficiency #5: The Plan did not monitor the changes in the names of its provider networks and file updates with the Department.

Statutory and Regulatory References: Section 1367.27(r) and Rule 1300.52(f).

Assessment: The Plan must file an amendment to its licensure application with the Department consistent with Rule 1300.52(f) whenever it determines its network for a product in a region has changed by 10 percent.³⁴ The Plan must file the amendment when 10 percent or more of the names are contained in the list for the geographic regions designated as the Plan's Service Area have changed.³⁵

As pre-on-site document requests, the Department asked the Plan to submit "amendment filings reflecting a 10% change in networks" and "provider network tracking reports." The Plan responded to the request for amendment filings reflecting a 10% change in networks with the following statement:

On an annual basis Anthem evaluates the network change to determine if 10% of the network has been impacted. We have not had to do any network filings as a result of a 10% network change during the [survey] period.³⁶

The Plan responded to the Department's request for "provider network tracking reports" by submitting its California Dental Reports, which are the quarterly reports the California Dental Director makes to the Plan's Quality Improvement Committee (QIC). The California Dental Reports show the QIC received reports on the number of general and specialist dentists participating in its Dental Net and SelectHMO product lines. The California Dental Reports show the following:

- The Plan's Dental Net, dental network, grew by 20% from 8,562 providers to 10,646 providers (a change of 2,084 providers) between the third quarter of 2019 and the third quarter of 2022.
- The Plan's SelectHMO dental network grew by 10% by growing from 8,142 providers to 9,056 providers (a change of 914 providers) between the third quarter of 2019 and the third quarter of 2022.

Plan's Compliance Effort: The CAP Response stated the Plan agreed with the Department's findings. According to the CAP Response, the Plan reviewed its network change calculations and determined it used the incorrect criteria when determining a 10% change. In its CAP Response, the Plan stated it would submit a 10% network change since its network has changed by more than 10% since the last eFiling.

³⁴ See Section 1367.27(r).

³⁵ See Rule 1300.52(f).

³⁶ Document Request # AA007_7.

The Plan filed two Amendment eFilings³⁷ (eFiling #20251956 and eFiling #20251957)³⁸ on April 30, 2025. The Department is currently reviewing these eFilings.

Supporting Documentation:

- *Anthem Blue Cross, 2024 Routine Dental Survey Preliminary Report Corrective Action Plan Response* (April 16, 2025)
- eFiling #20251956 (April 30, 2025)
- eFiling #20251957 (April 30, 2025)

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is corrected.

The Department finds the Plan monitors the changes in the names of its provider networks and files updates with the Department when required. The Plan reviewed the calculations it used to determine whether its networks have changed by 10% or more. The Plan identified and corrected errors in its calculations. The Plan filed its updated networks using the Department's eFiling system.

UTILIZATION MANAGEMENT

Deficiency #6: The Plan did not timely notify enrollees of its decisions to approve, deny, delay, or modify health care services based in whole or in part on medical necessity.

Statutory Reference: Section 1367.01(h)(1).

Assessment: Because the Plan performs utilization review, (i.e. determining whether to approve, modify, or deny requests by providers before, during, or after the provision of service to enrollees, based in whole or in part on medical necessity) the Plan must do the following:

- For prior authorizations, the Plan must make the decision timely as appropriate for the nature of the enrollee's condition, but 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.
- For retrospective review, the Plan must communicate its decision within 30 calendar days from receipt of the information that is reasonably necessary to make the determination.³⁹

³⁷ The eFiling system is the Department's system for receiving and processing Applications, Amendments, and Material Modifications for a health care Plan's Application for Licensure.

³⁸ eFiling #20251956 changed to the Plan's Dental HMO network, while eFiling #20251957 changed to the Plan's Dental PPO Network.

³⁹ See Section 1367.27(h)(1).

The Plan did not communicate denial or modification decisions to the enrollee in writing within the required turn-around-times (TAT) in eight⁴⁰ (15%) of 53 Utilization Management Denial and Modification (UM) files. The Plan did not meet the five-business-day TAT in one⁴¹ (50%) of two⁴² UM files involving prior authorizations. The Plan did not meet the 30-day TAT in seven⁴³ (14%) of 51 UM files involving retrospective review.

TABLE 2
Utilization Management Files and Turn-Around-Times

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Utilization Management Denial and Modification Files (all types)	53	To meet the turn-around-time requirements of Section 1367.27(h)(1).	45 (85%)	8 (15%)
Utilization Management Denial and Modification Files (prior authorization)	2	To make the decision timely, as appropriate for the enrollee's condition, but not to exceed five business days from receipt of all information reasonably necessary to make the determination.	1 (50%)	1 (50%)
Utilization Management Denial and Modification Files (retrospective review)	51	To communicate the decision to the enrollee within 30 calendar days from the receipt of the information reasonably necessary to make the determination.	44 (86%)	7 (14%)

Plan's Compliance Effort: In its CAP Response, the Plan stated it both agreed and disagreed with the Department's assessment. According to the CAP Response, the Plan evaluated the deficient UM files and determined it did not timely notify the enrollee in three of the UM files.⁴⁴ The Plan stated it determined the causes of the deficient files were either an isolated system error or human error. The Plan reported implementing a

⁴⁰ DMHC Utilization Management Denial and Modification Files: 1, 2, 4, 9, 18, 36, 40, and 53.

⁴¹ DMHC Utilization Management Denial and Modification File: 40.

⁴² DMHC Utilization Management Denial and Modification Files: 10 and 40.

⁴³ DMHC Utilization Management Denial and Modification Files: 1, 2, 4, 9, 18, 36, and 53.

⁴⁴ DMHC Utilization Management Denial and Modification Files: 9, 40, and 53.

new manual control to confirm the Plan automatically generates the enrollee notification letters and consulting with the associate involved in the error and instructing the associate to avoid the error in the future.

The Plan disagreed with the Department's findings in five of the deficient UM files.⁴⁵ According to the CAP Response, those deficient UM files involved an "adjustment" where the Provider submitted additional information to the Plan, which may have led to a misunderstanding in calculating the regulatory TAT. The CAP Response explained in detail why the Plan believed it complied with the statutory TAT for the UM files.

Supporting Documentation:

- *Anthem Blue Cross, 2024 Routine Dental Survey Preliminary Report Corrective Action Plan Response (April 16, 2025)*

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is not corrected.

The Department finds the Plan did not timely notify enrollees of its UM decisions. The Department acknowledges the Plan's challenge of the Department's findings regarding five deficient retrospectively reviewed UM files. The Plan contended that five UM files involved an "adjustment" where the provider submitted additional information, which "may have led to a misunderstanding on the regulatory turn-around-times."

The Plan analyzed the deficient UM files and identified the causes which resulted in improperly generating the enrollee's written notice. The Plan implemented a "new manual control" to improve UM enrollee response communications tracking and provided training.

However, the Department finds no grounds for revising this deficiency. The Department concedes the Plan may have met the TAT requirements in the five deficient UM files. However, the deficient UM files did not clearly document when the Plan received the information reasonably necessary to make the decision. The Department will re-assess the issue in the follow-up survey. Additionally, the Plan's response misstated the Section 1367.01(h)(1) TAT standards, which require the Plan to send the notice within 30 *calendar* days. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve Plan's utilization management delay, modification, and denial files to determine whether the Plan timely notifies its enrollees of its decision, and any other review deemed necessary by the Department.

Deficiency #7: The Plan's written responses to enrollees for decisions to deny or modify health care services from providers based in

⁴⁵ DMHC Utilization Management Denial and Modification Files: 1, 2, 4, 18, and 36.

whole or in part on medical necessity did not include a description of the criteria or guidelines used.

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

Assessment: The Plan must send the enrollee and provider a response when it denies, delays, or modifies health care service requests by providers, based in whole or in part on medical necessity. The response must include a description of the criteria or guidelines used.⁴⁶

The Plan did not include a description of the criteria or guidelines in any of the enrollee response communications contained in 30⁴⁷ (100%) UM files.

TABLE 3
Utilization Management Files and Enrollee Letters Containing Criteria or Guidelines

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Utilization Management	30	To include a description of the criteria or guidelines used to make the determination in the enrollee’s response	0 (0%)	30 (100%)

Plan’s Compliance Effort: The CAP Response stated the Plan reviewed the 30 UM files and agreed with the Department’s findings. For its corrective action, the Plan reported changing the wording in the enrollee response communications to refer to the applicable “Dental Clinical Policies,” which contain the “criteria/guidelines” used. According to the CAP Response, the Plan implemented the revision on February 17, 2025 and the Plan included an updated UM enrollee response communication.⁴⁸ The CAP Response stated the updated UM enrollee response communication references the applicable clinical policies to include the following language:

The determination(s) above are based on utilization criteria and guidelines used by the plan to reach clinical and benefit decisions and are available to the public, enrollee, or designated person upon written or electronic request.

Supporting Documentation:

- *Anthem Blue Cross, 2024 Routine Dental Survey Preliminary Report Corrective Action Plan Response (April 16, 2025)*

⁴⁶ See Section 1367.01(h)(4).

⁴⁷ DMHC Utilization Management Denial and Modification Files: 1 through 30.

⁴⁸ See D7_UM_Denial Letter.

- Plan response to Department Preliminary Report⁴⁹ (February 26, 2025)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is not corrected.

The Department finds the Plan's UM enrollee response communications do not include the criteria or guidelines used. For its corrective actions, the Plan updated its UM enrollee denial communication to state the Plan reached its decision "based on utilization criteria and guidelines." However, Section 1367.01(h)(4) requires the Plan's UM enrollee communications contain "a *description* of the criteria or guidelines used" (emphasis added). The Plan's proposed statement does not *describe* the criteria or guidelines used to make the decision. Section 1367.01(h)(4) requires the Plan's written communication to specify the criteria used to make the decision or identify the guideline where the provider or enrollee can find the criteria.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve a review of the Plan's UM files, and any other review deemed necessary by the Department.

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

Deficiency #8: The Plan did not follow its quality assurance processes to assess and evaluate the Plan's compliance with utilization management requirements.

Statutory References: Section 1367.01(h)(1) and (4) and (j).

Assessment: The Plan must establish, as a part of the quality assurance program required by Section 1370, a process by which the Plan assesses and evaluates its compliance with Section 1367.01.⁵⁰ The process must include the provisions for evaluating complaints, assessing trends, implementing actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluating any corrective action plan to measure performance.⁵¹

The Plan submitted Dental Quality Assurance Program in response to the Department's pre-on-site document request for the Plan's policies and procedures to assess and evaluate the Plan's compliance with UM standards. According to the Dental Quality

⁴⁹ D7_UM_Denial Letter

⁵⁰ In the context of Section 1367.01, utilization management is the process by which the Plan or its delegates "prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrently with the provision of health care services to enrollees."

⁵¹ See Section 1367.01(j).

Assurance Program, the Plan documents the audit process to track the timeliness of decision making, notifications and TAT in the California Quarterly Claims Report (California Dental Reports), DMHO Specialty TAT Report, and Specialty Referral Time Frames (QIC/BOD) Reports.⁵² The Dental Quality Assurance Program states the following about the "Audit Process of Communication of Health Care Services/UR Decision":

The Plan monitors and audits denial EOBs and denial letters to ensure required information is included and communicated to the appropriate user. The Plan uses EOB monthly Audit process, CA HMO EOB Auditing Document, Plan Dental EOB Final, and Clear and Concise Letters as the documents to audit denial, delay, and modification letters.⁵³

In response to the Department's pre-onsite document request for the Plan's UM Annual Work Plan, trending reports, activity summaries, and audit reports, the Plan submitted the California Dental Reports.

Each of the California Dental Reports contains a slide titled "Specialty Referral Time Frames Anthem," with a graph showing two lines: one line is titled "30 Days" and the other "DRU 5 Days."⁵⁴ On the vertical access of the graph are numbers in descending order in range from 100% to 94%. On the horizontal access of the graph are numbers which indicate the quarter of the data. The graph shows the Plan maintained above 98% with the "DRU 5 days" requirement and near 99% compliance with the "30 days" requirement (except for a brief drop in the second quarter of 2021, where the Plan fell to 95% compliance). However, the Plan did not submit any underlying information to provide the context for the data behind the slides, the methodology used to generate the findings within the slides, nor any other contextual evidence.

The California Dental Reports were the only evidence the Plan submitted showing it monitored its UM files for TAT compliance. The Plan did not submit any evidence showing it assessed or evaluated its enrollee response communication for compliance with the requirements of Section 1367.01(h)(4). Since the Department's findings regarding TAT compliance differed significantly from the Plan's findings⁵⁵ and the Plan did not include all the required information in its enrollee response communication,⁵⁶ the Department concludes the Plan did not assess its UM program for compliance with Section 1367.01(h)(1).

Plan's Compliance Effort: The CAP Response stated the Plan disagreed with the Department's findings, contending it followed its Dental Quality Assurance Program to assess and evaluate the Plan's compliance with utilization management requirements. The CAP Response detailed how the Plan believes it complies and included a spreadsheet⁵⁷ to show the Department where it can find the specific information in the

⁵² See Dental Quality Assurance Program Page 28.

⁵³ Dental Quality Assurance Program.

⁵⁴ The Department assumes the line titled "DRU 5 days" applies to prior and concurrent authorizations and the line titled "30 Days" applies to retrospective review under Section 1367.01(h)(1).

⁵⁵ See Deficiency #6.

⁵⁶ See Deficiency #7.

⁵⁷ D8_UM_Crosswalk

pre-onsite and post-onsite documents. According to the CAP Response, the spreadsheet identifies the required information and the corresponding document where the Department can find the information.

Supporting Documentation:

- *Anthem Blue Cross, 2024 Routine Dental Survey Preliminary Report Corrective Action Plan Response* (April 16, 2025)
- Plan response to Department Preliminary Report ⁵⁸ (March 28, 2025)
- California Dental Report Third Quarter 2021, Quality Improvement Committee Meeting (December 10, 2021)

Final Report Deficiency Status: Not Corrected

The Department has determined that this deficiency is not corrected.

The Department finds the Plan did not follow its quality assurance processes to assess and evaluate the Plan's compliance with the UM requirements. The Plan challenged the Department's assessment, contending it submitted the evidence with the pre-onsite and post-onsite documents as described in the spreadsheet. According to the Plan, the spreadsheet shows the Plan submitted "Specialty Referral Time Frame" "QIC/BOD Reports," "EOB monthly Audit process" and "Clear and Concise Letters" reports to the QIC quarterly through the California Dental Reports. The spreadsheet refers to the information contained in the California Dental Reports. However, the California Dental Reports did not include context, information on identified deficiencies, or corrective actions to improve UM performance. Nor did the California Dental Reports show the Plan meaningfully assessed or evaluated its UM program to identify problems or take corrective actions. The Department reviewed the various documents provided by the Plan and concedes they show the plan conducts UM audits. However, the Department's re-review of the California Dental Report continues to show the California Dental Reports did not demonstrate how the Plan effectively analyzes its UM audits to identify problems for compliance with Section 1367.01. For instance, Section 1367.01(h)(4) requires the UM enrollee response communications to include a *description* of the criteria or guidelines used. The California Dental Reports did not show whether the Plan's UM enrollee response communications complied with the Section 1367.01(h)(4) standard to describe the criteria or guidelines used.^{59, 60}

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve a review of the Plan's utilization management policies and procedures, any

⁵⁸ D8_UM_Crosswalk

⁵⁹ Under Section 1367.01(h)(4), the communication to the enrollee must include a clear and concise explanation of the reason for the Plan's decision, a description of the criteria or guidelines used, and the clinical reason for the decision regarding medical necessity.

⁶⁰ As referenced in Deficiency #7, the Plan's enrollee response letters did not contain a description of the criteria or guidelines used to make the decision. The Plan's corrective action for Deficiency #7 did not address the deficiency and the Department directed the Plan to submit a supplemental response. The California Dental Reports did not evaluate whether the Plan's enrollee response communications included a description of the criteria or guidelines used to make the determination.

Blue Cross of California
DBA: Anthem Blue Cross
Routine Full-Service Final Report

reports regarding compliance with Section 1367.01, and any other material it deems necessary.

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

SECTION II: SURVEY CONCLUSION

The Department's 2024 routine survey of the Plan is complete. Where indicated, the Plan shall submit a supplemental 60-day response through the Department's Survey Web Portal. In addition, the Department may request subsequent supplemental responses to assess progress with the Plan's corrections actions.

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

The Department will conduct a Follow-Up Survey of the Plan to assess outstanding deficiencies and will issue a Report within 18 months of the date of this Final Report. The Plan may elect to append a brief statement to the Final Report as set forth in Section 1380(h)(5). To append a statement, please submit the response via the Department's Survey Web Portal, eFiling application. Please click on the following link to login: [DMHC Web Portal](#).

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

- Click the eFiling link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the **DPS Routine Survey Document Request** titled, **2024 Routine Full-Service Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.