DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

BLUE CROSS OF CALIFORNIA

DBA: ANTHEM BLUE CROSS

A FULL SERVICE HEALTH PLAN

MARCH 13, 2025

Routine Survey Final Report
Blue Cross of California
DBA: Anthem Blue Cross
A Full Service Health Plan

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EXECUTIVE SUMMARY

On April 24, 2020, the California Department of Managed Health Care (Department) notified Blue Cross of California, dba Anthem Blue Cross (Plan) that it would conduct the Plan's 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 desk-level survey from September 21, 2020 through September 25, 2020.

The Department assessed the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Emergency Services and Care
Prescription (Rx) Drug Coverage
Language Assistance

The Department identified **19** deficiencies during the Routine Survey. The 2020 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.

2020 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	QUALITY ASSURANCE	
1	**The Plan did not document that the quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned and indicated.** Rule 1300.70(a)(1), (b)(1)(B).	**Not Corrected**
2	**The Plan did not consistently ensure appropriate licensed professionals participated in quality assurance activity.** Rule 1300.70(b)(2)(E).	**Not Corrected**
3	**The Plan's governing body did not meet on a quarterly basis.** Rule 1300.70(b)(2)(C).	**Not Corrected**

	GRIEVANCES AND APPEALS	
4	**The Plan did not ensure oral expressions of dissatisfaction are considered grievances, and therefore does not ensure adequate consideration of enrollee grievances and rectification when appropriate.** Section 1368(a)(1); Rule 1300.68(a)(1)	**Not Corrected**
5	**The Plan did not consistently send acknowledgment letters to enrollees within five calendar days upon the Plan's receipt of the grievance.** Section 1368(a)(4)(A); Rule 1300.68(d)(1)	**Not Corrected**
6	**The Plan's acknowledgment letters did not consistently include the date of receipt, and the telephone number of the Plan representative who may be contacted about the grievance.** Section 1368(a)(4)(A); Rule 1300.68(d)(1)	**Not Corrected**
7	**Upon receipt of a grievance requiring expedited review, the Plan did not immediately inform enrollees of their right to contact the Department.** Section 1368(a)(1); Rule 1300.68.01(a)(1)	**Not Corrected**
8	**The Plan's written responses to enrollee grievances did not consistently contain a clear and concise explanation of the Plan's response.** Section 1368(a)(5); Rule 1300.68(d)(3)	**Not Corrected**
9	**The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on a finding that the proposed services are not a covered benefit did not include a notice that, if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the enrollee can contact the Department to determine whether the decision is eligible for independent medical review.** Rule 1300.68(d)(5)	**Not Corrected**
10	**The Plan did not consistently ensure adequate consideration and rectification of exempt grievances.** Section 1368(a)(1); Rule 1300.68(a)(4)	**Not Corrected**

11	**The Plan's grievance and appeal decision notices did not consistently include a written notice of (1) the availability of interpretation services in the Plan's threshold language and the top 15 languages spoken by limited-English-proficient individuals as determined by the California Department of Health Care Services and (2) the availability of translated written materials in the top 15 languages.** Section 1367.04(b)(1)(C)(i)	**Not Corrected**
	ACCESS AND AVAILABILITY OF SERVICES	
12	**The Plan's online provider directory did not prominently disclose information for reporting a potential directory inaccuracy.** Section 1367.27(f)	**Corrected**
13	**The Plan did not consistently review or accurately report access to care exempt grievance data.** Rule 1300.67.2.2(d)(2)(D)	**Not Corrected**
	UTILIZATION MANAGEMENT	
14	**The Plan did not consistently provide enrollees with a written notification of a decision to deny or modify a request for health care services on the basis of medical necessity that included a clear and concise explanation of the reason for the Plan's decision and the clinical reasons for the Plan's medical necessity determination.** Section 1367.01(h)(4)	**Not Corrected**
15	**The Plan failed to demonstrate it maintains a process for disclosing utilization review or utilization management criteria and guidelines to the public and to include required notice language.** Section 1363.5(b)(5), (c)	**Corrected**
	PRESCRIPTION DRUG COVERAGE	
16	**For decisions to modify or deny requests for non-formulary prescription drugs based in whole or in part on medical necessity, the Plan did not consistently include in its written responses to enrollees a clear and concise explanation of the reasons for its decision.** Section 1367.01(h)(4)	**Not Corrected**

17	**The Plan did not consistently notify requesting providers of external exception request review decisions within the required timeframes.** Section 1367.24(k); 45 CFR 136.122(c)(3)(ii)	**Not Corrected**
18	**The Plan does not inform enrollees of their right to seek an external exception request review in formulary exception request denial and modification letters.** Section 1367.24(b)	**Not Corrected**
	LANGUAGE ASSISTANCE	
19	**The Plan did not consistently notify enrollees that language assistance services are to be delivered in a timely manner.** Section 1367.042(a)(1)	**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 1975[1] 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.

Continuity of Care – Plans must furnish medical and mental health care services in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Emergency Services and Care – Emergency medical and behavioral health services must be accessible and available, and plan determination of reimbursements made appropriately. Plans must also have poststabilization

[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.

procedures to ensure timely authorization of care or transfer of enrollees who are stabilized following emergency care, and provide coverage or provision of medically necessary services when required.

Prescription Drug Coverage – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescription drugs, benefits, and services, and ensure it communicates benefit coverage information to enrollees.

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

PLAN BACKGROUND

In 1993, the California Department of Corporations, now the Department, granted the Plan a license to operate as a health care service plan under the Knox-Keene Act. The Plan restructured its operations and formed a holding company, WellPoint Health Networks Inc., which merged with, and is now a wholly owned subsidiary of WellPoint, Inc. The Plan headquarters is in Woodland Hills, California. The Plan serves all counties in California. As of December 31, 2019, the Plan's commercial enrollment totaled 1,984,738.

The Plan contracts with participating medical groups to provide health care services, including primary care, specialty care, and some ancillary services. The Plan also contracts with hospitals to provide hospital services, skilled nursing facilities, home health agencies, and freestanding ambulatory surgical centers. Finally, the Plan also contracted with physicians statewide to provide services to its preferred provider organization enrollees.

The Plan contracted with IngenioRx, a subsidiary of the Plan's parent company and pharmacy benefit manager, to perform customer service functions and administer the Plan's prescription drug benefits during the survey review period.[2]

[2] Beginning July 2019, the Plan transitioned from its previous pharmacy benefit manager, Express Scripts. The transition was complete by January 1, 2020.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On June 26, 2024, 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 did not document that the quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned and indicated.**

Regulatory References: Rule 1300.70(a)(1), (b)(1)(B).

Assessment: Section 1300.70(a)(1) requires the Plan to document that the quality of care provided is reviewed, problems are identified, and effective action is taken to improve care where deficiencies are identified. Section 1300.70(b)(1)(B) mandates the Plan ensure all quality of care problems are identified and corrected.

To assess the Plan's compliance with these requirements, the Department reviewed the Plan's potential quality issue (PQI) processes and files. The Department found the Plan utilized two teams to review Medical and Behavioral Health PQIs. To account for differences between these teams, the Department conducted random samplings of the Plan's PQI files as follows:

Medical:
Selection 1 – PQI levels C-4, C-5, C-6 and S-4[3]
Selection 2 – PQI levels S-1, S-2, S-3, C-1, C-2 and C-3
Selection 3 – PQI levels C-0, S-0 and Blanks (no severity level assigned)

Behavioral Health:
Selection 1 – PQI levels C-0, S-0 and Blanks (no severity level assigned)
Selection 2 – PQI levels C-4, C-5 and C-6
Selection 3 – PQI levels S-1, S-2, S-3, C-1, C-2 and C-3

Based on review of these sets of files, the Department found the Plan did not take appropriate actions to identify and investigate all issues presented in PQIs as required by Rule 1300.70(a)(1) and (b)(1)(B) in the following files:

- Medical PQI Selection 2: 16 out of 67 files (24%);[4]
- Medical PQI Selection 3: 13 out of 70 files (19%);[5] and
- Behavioral Health PQI Selection 3: 11 out of 30 files (37%).[6]

Because the Plan failed to identify and investigate all quality issues presented in these PQIs, the Department also determined the Plan did not consistently ensure effective action was taken to correct problems and improve care.

Case Examples

- **DMHC Medical PQI Selection 2 - File 19:** An enrollee filed a grievance regarding care she was receiving from a pain management provider and her medical group. The enrollee felt her care was being compromised by repeated

[3] The Plan's *Member Grievance, PQI and Preventable Adverse Events Process Policy* defines Quality of Care severity levels as follows:
C-0 No quality of care issue found to exist,
C-1 Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern,
C-2 Communication, administrative, or documentation issue that adversely affected the care rendered,
C-3 Failure of a practitioner/provider to respond to a member grievance regarding a clinical issue despite two requests per internal guidelines,
C-4 Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care,
C-5 Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care,
C-6 Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be significantly beneath the standard of care.
The same policy defines Quality of Service severity levels as follows:
S-0 No quality of service or administrative issue found to exist,
S-1 Member grievances regarding practitioner's office: physical accessibility, physical appearance, and adequacy of the waiting-room and examining-room space,
S-2 Communication, administrative, or documentation issue with no adverse medical effect on member,
S-3 Failure of a practitioner/provider to respond to a member grievance despite two requests per internal guidelines,
S-4 Confirmed discrimination, confirmed HIPAA violation, confirmed confidentiality and/or privacy issue.
[4] DMHC Medical PQI Files (Selection 2): 2, 4-8, 12, 19, 31, 32, 34, 37, 41, 42, 48, 58.
[5] DMHC Medical PQI Files (Selection 3): 2, 3, 8, 11, 23, 27, 28, 34, 35, 51, 59, 66, 70.
[6] DMHC Behavioral Health PQI Files (Selection 3): 6, 8-10, 12, 19, 30-32, 35, 36.

treatment delays caused by failure to refer, lack of appointment availability, and failure to fill medications in a timely manner. As a result of these delays, the enrollee indicated she was experiencing increasing impairment to her ability to walk on a daily basis. The Department found evidence showing the Plan investigated the quality of service issues alleged. However, the Plan provided no documentation demonstrating it identified and took effective corrective action to resolve the quality of care concerns presented in the PQI, specifically the enrollee's loss in her ability to walk.

- **DMHC Behavioral Health PQI Selection 3 - File 6:** The mother of a 16-year-old enrollee filed a grievance regarding her son's involvement in his psychiatric intensive outpatient program. The enrollee's mother reported the following concerns:

  1) The enrollee was attracted to the counselor and nothing was done about it.
  2) The enrollee was forced to reveal his sexual orientation out loud for the first time in a group.
  3) Treatment had been focused on the enrollee's gender issues and not his substance abuse.
  4) The enrollee attempted suicide while in the program.

  The Plan contacted the provider about the allegations and requested information about the clinical issues presented. Based on the records submitted by the Plan, the provider failed to respond to these requests for information. The Department found no evidence to demonstrate the Plan made any further efforts to investigate the PQIs presented or take effective corrective action to resolve the problems.

TABLE 1
PQI Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Medical PQI Selection 2	67	The Plan must identify all quality issues and take effective action to improve care	51 (76%)	16 (24%)
Medical PQI Selection 3	70	The Plan must identify all quality issues and take effective action to improve care	57 (81%)	13 (19%)
Behavioral Health PQI Selection 3	30	The Plan must identify all quality issues and take effective action to improve care	19 (63%)	11 (37%)

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

[A]grees with the Department's review and assessment and believes that this deficiency has already been corrected. This issue was also identified in the Department's 2022 Behavioral Health Investigation (BHI) Report to the Plan, dated January 2, 2024. The Plan took corrective actions in 2023 before the BHI Report was issued to the Plan, and before the Department's 2020 Preliminary Report was issued (June 26, 2024). The corrective actions apply to both medical and behavioral health and are outlined below and address how the Plan ensures quality issues are identified and investigated and any necessary follow up is taken:

- The Plan updated the California Peer Review Subcommittee (PRSC) Policy, which was filed and approved in 2023 (See Filing No. 20232520). The new PRSC policy:
  - Eliminates the C-3 level, which closed a case if no response is received by providers/facilities.
  - Establishes severity levels based upon clinical review of all cases, using the best information provided to the Plan.
  - Establishes that all leveled cases are tracked and trended. The previous points system has been eliminated.
  - Established the Peer Review Escalation Committee (PREC), which is chaired by the Plan president. The PREC is designated by the PRSC as the committee responsible for determining further action, if any, to be taken to resolve quality of care (QOC) allegations leveled against practitioners, groups and institutions which are contracted with the Plan, brought forward by the PRSC.

- New Quality of Care and Quality of Service policies were also filed with the Department on February 26, 2024, (Filing No. 20240951 – still pending) that outline the Plan's process.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan documents the quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned and indicated.

The Department also acknowledges the Plan's BHI Report contained similar findings.[7] However, the Plan did not provide sufficient evidence in its response to the Preliminary Report for the Department to determine whether the deficiency is corrected.

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 review of policies and procedures, PREC meeting minutes, files, interviews, and any other review deemed necessary by the Department.

Deficiency #2: The Plan did not consistently ensure appropriate licensed professionals participated in quality assurance activity.

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

Assessment: Rule 1300.70(b)(2)(E) requires the Plan to ensure participation by appropriate licensed health care professionals in the Plan's quality assurance activities is adequate to monitor the full scope of clinical services rendered, resolve problems, and ensure corrective action is taken when indicated.

To assess the Plan's compliance with this requirement, the Department reviewed the same six sets of PQI files referenced in Deficiency #1. The Department determined 18 out of 67 Medical PQI Selection 2 files (27%)[8] and 12 out of 70 Medical PQI Selection 3 files (17%)[9] did not include documentation demonstrating appropriately licensed staff participated in the Plan's investigation as required by Rule 1300.70(b)(2)(E).

Case Examples

- **Medical PQI Selection 2 - File 12:** The enrollee was diagnosed with pneumonia at urgent care, and then scheduled an appointment with a new primary care provider (PCP). The enrollee complained about the PCP not being at the first appointment, so she was to be seen by the physician assistant (PA). She was upset no one let her know this ahead of time. The enrollee did not want to see the PA and rescheduled a new appointment with the PCP for a later date. At the rescheduled appointment, she stated she waited over an hour to see the doctor. She felt the doctor was rude, did not want to address her health concerns, barely went over her lab results, and the doctor was "blowing her off." The case was handled solely by a G&A Analyst who leveled it as a QOS issue for delay in care without adverse consequences to the enrollee's health. The enrollee's health history and current health issues were unknown, as no medical records were requested, and no clinician evaluation was conducted. This case should have been forwarded to clinical staff to investigate the quality of care provided.

[7] *See* Violation #2, Behavioral Health Investigation Report for Blue Cross of California (March 27, 2024).
[8] DMHC Medical PQI Files (Selection 2): 2, 4-8, 12, 19, 32-34, 37, 41-43, 48, 58, 63. Files 6 and 63 were reviewed by a registered nurse, but presented clinical issues requiring review by a physician. The remaining 16 files were by non-clinical staff.
[9] DMHC Medical PQI Files (Selection 3): 2, 11, 24, 27, 34, 35, 46, 50, 51, 59, 66, 70. Files 11, 23, 27, and 46 were reviewed by a registered nurse, but presented clinical issues requiring review by a physician. The remaining eight files were reviewed by non-clinical staff.

- **Medical PQI Selection 3 - File 27:** The enrollee had multiple complaints about her second hospital stay after suffering an ankle injury. The injury required surgery, which resulted in a septic joint, deep vein thrombosis, and other serious complications. Her cultures were positive for MRSA.[10] The RN reviewer evaluated the care and leveled it as no quality of care issue substantiated. The issue was not escalated for physician review, despite several issues and significant complexity to the enrollee's health history, including the post-operative MRSA infection to the surgical site. Given the complexity of the care, including a surgical complication, the case should have been reviewed by a physician.

TABLE 2
PQI Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Medical PQI Selection 2	67	Appropriate licensed professional participation in QA activity	49 (73%)	18 (27%)
Medical PQI Selection 3	70	Appropriate licensed professional participation in QA activity	58 (83%)	12 (17%)

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

> [A]grees with the Department's review and assessment of this deficiency. . . and implemented the following corrective actions to remediate this deficiency:
>
> Beginning January 2023, licensed clinicians triaged and reviewed member medical complaints for potential quality of care concerns. The G&A clinical associate utilizes clinical knowledge and triage criteria to identify potential quality of care concerns. The clinical associate completes the classification, documents the review in the Nextgen system, and routes the case for further processing.
>
> Beginning March 2023, a quality assurance team has been auditing the triage function and clinical decisions made by the G&A clinical associate. As of June 2023, 5% of 2023 average cases are audited per month. Results are reviewed with clinical G&A management and feedback given to clinical associates as needed.

[10] Methicillin-resistant Staphylococcus aureus (MRSA) is a difficult to treat staph infection commonly spread in hospitals.

> New Quality of Care and Quality of Service policies were filed with the Department on February 26, 2024 (Filing No. 20240951). . . These policies outline the new process by which licensed clinicians' triage and review member medical complaints for potential quality of care concerns. The QOC policy also references the process by which quality of care issues are presented to medical directors.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to determine whether the actions taken are sufficient to ensure appropriate licensed professionals consistently participate in the Plan's quality assurance activities.

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 review of policies and procedures, audit tools and results, files, interviews, and any other review deemed necessary by the Department.

Deficiency #3: The Plan's governing body did not meet on a quarterly basis.

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

Assessment: Rule 1300.70(b)(2)(C) requires the Plan's Board of Directors (BOD) to meet at least quarterly to review the Plan's quality assurance activities.

The Department reviewed the Plan's written quality assurance plan and found it failed to comply with Rule 1300.70(b)(2)(C). The Plan's 2018, 2019, and 2020 Quality Improvement Program Descriptions only require the BOD meet "at least semiannually," which falls short of the quarterly requirement set forth in Rule 1300.70(b)(2)(C).

Additionally, the Plan failed to demonstrate its governing body met on a quarterly basis throughout the survey review period. The Plan only provided minutes for four BOD meetings, including those held on June 13, 2018, October 17, 2018, December 7, 2018, and October 4, 2019. The Plan submitted no supporting documentation to demonstrate its BOD met quarterly for 2019 and 2020.

During interviews, the Department asked the Plan to provide the meeting dates the BOD met during the survey review period. The Plan was unable to provide the dates. The Department requested the Plan to provide all BOD meeting minutes that transpired during the survey period to determine if there were additional meeting minutes that had not been provided. The Plan's written narrative response stated, "The BOD minutes in WatchDox are complete."

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

> [A]grees with this finding and implemented the following corrective actions:
>
> The Plan's Board of Directors ("BOD") directed the Plan President and officers to create the California Management Oversight Committee ("MOC") to provide governance and oversight of the compliance activities relating to Anthem Blue Cross of California ("ABC") health insurance products. The MOC is responsible for reviewing and monitoring plan functions including functions performed by and on behalf of the Plan through affiliates and vendors for purposes of compliance with applicable laws and regulations, contractual and accreditation requirements, policies, and procedures and for continuous quality improvement. As the Plan President is chair of the MOC and chairman of the BOD, anything reported to the MOC, the BOD is aware of. In Filing No. 20204529, the Plan filed for the approval of the MOC which the DMHC approved on May 24, 2021.
>
> The MOC chair and co-chairs approved the establishment of various subcommittees, including the Quality Management Subcommittee ("QMC"), to provide oversight of existing Utilization Management ("UM") and Quality Improvement ("QI") programs whether performed by or on behalf of the Plan through affiliates and vendors for compliance with applicable laws and regulations, contractual and accreditation requirements, policies and procedures, and for continuous quality improvement. On January 19, 2023, the MOC approved separating UM and QI and establishing a separate subcommittee, Utilization Management Subcommittee ("UMC") to oversee UM leaving the QMC to oversee QI. Since inception, the MOC and the QMC met at least quarterly.
>
> The Quality Improvement Program Description ("QIPD") was also updated in 2022 to include the MOC, its subcommittees including the QMC, their role, and meeting frequency of meeting at a minimum quarterly. The QIPD was filed with the Department (Filing No. 20240951-2) and approved. The QIPD was again updated in August 2024 to reflect that the BOD will meet quarterly at a minimum and filed on August 12, 2024 (Filing No. 20243544). Quarterly BOD meetings will be scheduled in advance with an alternate facilitator identified to ensure meetings occur.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan did not provide sufficient evidence to demonstrate its BOD met at

least quarterly. In addition, the Department will need to review meeting minutes during the Follow-Up Survey to determine whether the actions taken are sufficient to ensure the Plan's governing body meets on a quarterly basis.

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 review of BOD meeting minutes, interviews, and any other review deemed necessary by the Department.

GRIEVANCES AND APPEALS

Deficiency #4: **The Plan did not ensure oral expressions of dissatisfaction are considered grievances, and therefore does not ensure adequate consideration of enrollee grievances and rectification when appropriate.**

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

Assessment: Section 1368(a)(1) requires the Plan to ensure adequate consideration and rectification of enrollee grievances. Rule 1300.68(a)(1) defines "grievance" as:

> [A] written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

During the Plan's 2013 Routine Survey, the Department discovered the Plan was not consistently and accurately identifying grievances.[11] On June 5, 2019, the Department and the Plan entered into a settlement agreement resolving the grievance issues identified in the Plan's 2013 Routine Survey.[12]

The Department and the Plan entered into the settlement agreement while the 2016 Routine Survey was underway. The Department again identified this issue in the 2016 Routine Survey.[13] In the settlement agreement, the Plan agreed to implement various corrective actions such as enhancing training for its CSRs, auditing and monitoring CSR compliance, and incorporating process improvements to improve the handling of grievances.[14] The Plan agreed to implement modifications to its grievance identification practices by July 31, 2019, and to provide the Department with periodic status and results of the corrective actions through April 2020.[15]

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[11] Link to 2013 Blue Cross of California DBA Anthem Blue Cross Follow-Up Report. Deficiency #1: The Plan does not maintain a grievance system that consistently ensures any written or oral expression of dissatisfaction is considered a grievance.
[12] Enforcement Matter Number 15-268.
[13] Link to 2016 Blue Cross of California DBA Anthem Blue Cross Follow-Up Report. Deficiency #6: The Plan's grievances and appeals policies and procedures are not in accordance with Department regulations and do not ensure adequate consideration of enrollee grievances.
[14] Enforcement Matter Number 15-268, Exhibit B
[15] *Id*.

To allow the Plan time to fully implement its corrective actions, assessment of the Plan's compliance efforts regarding this deficiency was deferred to this Routine Survey. To assess whether the Plan now consistently identifies grievances, the Department reviewed 71 Call Inquiry files. Of those, 34 files (46%)[16] contained expressions of dissatisfaction the Plan failed to process as grievances.

Case Examples

- **Call Inquiry File 1:** The enrollee contacted the Plan on April 8 expressing dissatisfaction regarding his inability to get an appointment with a rheumatologist before June. The Department found no evidence in the file to demonstrate the Plan processed the enrollee's complaint through its grievance system.

- **Call Inquiry File 16:** The enrollee contacted the Plan to dispute a bill he received. The CSR investigated the issue and determined the claim was incorrectly processed as an out-of-network benefit. The CSR advised the enrollee she would send the claim to be readjusted and informed the enrollee this process could take up to 48 hours. The Department found no evidence in the file to demonstrate the Plan processed the enrollee's coverage dispute and request for reconsideration through its grievance system.

TABLE 3
Call Inquiry Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Call Inquiry	71	Expressions of dissatisfaction, complaints, disputes, requests for reconsideration, and appeals must be processed as grievances	37 (52%)	34 (48%)

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

> [A]ccepts this deficiency and has made the following enhancements since the 2020 Survey:
>
> - Since 2019, all interactions are classified as a grievance. System enhancements and procedures are revised as necessary resulting in the limiting the types of calls that can be reclassified as an inquiry

[16] Call Inquiry Files 1, 2, 8, 13, 16-19, 22, 29, 30, 33, 35, 37, 38, 42-44, 47, 49, 50, 53, 54, 56, 60-67, 69, 70.

to an internal transfer with no additional handling, and/or a simple payment with no expression of dissatisfaction.

- We continue to evaluate our processes to further enhance the service experience while ensuring regulatory requirements are met. System enhancements have continued since the original implementation in 2019 and the 2020 survey:
    - System enhancements made to limit the associate's ability to bypass and reclassify a call as an inquiry.
    - Require the associate to capture the action taken to resolve the grievance prior to the interaction being closed.
    - Automate the process of creating a standard grievance when an exempt grievance is not resolved and closed by the next business day.

- A certification process was developed to ensure associates understand the regulatory requirements and to assess their ability to successfully perform the actions needed to meet all requirements. All new associates are required to successfully complete the certification process as part of our new hire training curriculum.

- The Grievance and Appeals for CA Service Training and the Commercial Grievance and Appeals Business Partner Training are required to be completed annually by all associates.

- There is an additional system enhancement planned to allow interactions related to payments and transfers when there is no expression of dissatisfaction to be classified as an inquiry. This will be completed by the end of August 2024.

- As of October 2021, training for our eCare associates was revised to identify and classify a grievance opportunity for both email and chat interactions. These associates now follow the same guidelines our frontline associates use when assisting members on the phone.

All vendors and affiliates that provide customer service services to the Plan will be required to comply with the Plan's policy. The policy however included the language from Health and Safety Code § 1368 that requires a call to be characterized as a grievance if it is uncertain. Vendors/affiliated [sic] are being required to characterize all calls until they can demonstrate to the Plan that they have both the system functionality and proper training in place to assure that calls will be properly characterized. The Plan's [One Day Grievances (Exempt Grievances) policy] was updated and filed on August 12, 2024 (Filing No. 20243544) to clarify all delegates/vendors are required to follow Plan policy. In cases where the delegate/vendor cannot distinguish between grievance and inquiry due to system limitations, all calls will be treated as a grievance.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan consistently identifies grievances and ensures adequate consideration and rectification of enrollee grievances.

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 review of delegate and vendor oversight reports, policies and procedures, meeting minutes, training documents, files, interviews, and any other review deemed necessary by the Department.

This is a repeat deficiency from the Plan's 2013 and 2016 routine surveys.[17,18]

Deficiency #5: The Plan did not consistently send acknowledgment letters to enrollees within five calendar days upon the Plan's receipt of the grievance.

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

Assessment: Section 1368(a)(4)(A) and Rule 1300.68(d)(1) require the Plan to provide written acknowledgments to enrollees within five calendar days of the receipt of standard grievances and appeals.

To assess the Plan's compliance with these requirements, the Department reviewed the Plan's Standard Grievance and Standard Appeal files. The Department found the Plan utilized two teams to review Medical and Behavioral Health Grievances and Appeals. To account for differences between these teams, the Department conducted random samplings of the Plan's grievance and appeal files as follows:

Medical:
Medical Standard Grievances
Medical Standard Appeals

Behavioral Health:
Behavioral Health Standard Grievances

[17] The 2013 Blue Cross of California DBA Anthem Blue Cross Follow-Up Report is located on the Department's website.
[18] The 2016 Blue Cross of California DBA Anthem Blue Cross Follow-Up Report is located on the Department's website.

Behavioral Health Standard Appeals

The Department reviewed 68 Medical Standard Grievance files. Among these grievances, the Plan failed to send an acknowledgment letter within five calendar days upon receipt of the grievance in 19 files (28%).[19]

The Department reviewed 71 Medical Standard Appeal files. Among these appeals, the Plan failed to send an acknowledgment letter within five calendar days upon receipt of the appeal in 18 files (25%).[20]

The Department reviewed 13 Behavioral Health Standard Grievance files. Among these grievances, the Plan failed to send an acknowledgment letter within five calendar days upon receipt of the grievance in four files (31%).[21]

Finally, the Department reviewed 64 Behavioral Health Standard Appeal files. Among these appeals, the Plan failed to send an acknowledgment letter within five calendar days upon receipt of the appeal in 18 files (28%).[22]

TABLE 4
Standard Grievance and Appeal Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Medical Standard Grievance	68	Acknowledgment letter sent to enrollee within five calendar days of receipt of the grievance	49 (72%)	19 (28%)
Medical Standard Appeal	71	Acknowledgment letter sent to enrollee within five calendar days of receipt of the grievance	53 (74%)	18 (26%)
Behavioral Health Standard Grievance	13	Acknowledgment letter sent to enrollee within five calendar days of receipt of the grievance	9 (69%)	4 (31%)

[19] Medical Standard Grievance Files 2, 4, 5, 8, 11, 17, 18, 20, 21, 23, 25, 28, 31, 35, 44, 50, 54, 62, 65.
[20] Medical Standard Appeal Files 2-4, 8, 13, 16, 26, 27, 35, 36, 38, 48-50, 53, 55, 62, 71.
[21] Behavioral Health Standard Grievance Files 8, 11, 12, 16.
[22] Behavioral Health Standard Appeal Files 5, 7, 9, 12-14, 16, 20, 21, 25, 26, 30, 38, 43, 50, 56, 59, 62.

Behavioral Health Standard Appeal	64	Acknowledgment letter sent to enrollee within five calendar days of receipt of the grievance	46 (72%)	18 (28%)

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

> [A]grees with this finding. . . and started remediation to automate the letters into a single Grievance and Appeals (G&A) tracking system.
>
> Remediation efforts started in June of 2020 with an implementation of automated acknowledgement letters in March 2021. The Plan had a complete rollout with enhanced reporting in May 2021 to ensure standard grievances and appeals filed were acknowledged within 5 calendar days of receipt….
>
> With the launch of the enhanced reporting, the Plan has also put in place an ongoing tracking and monitoring of acknowledgement letter compliance.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan consistently sends acknowledgment letters to enrollees within five calendar days upon the Plan's receipt of the grievance.

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 review of tracking and monitoring tools and reports, files, interviews, and any other review deemed necessary by the Department.

Deficiency #6: The Plan's acknowledgment letters did not consistently include the date of receipt and the telephone number of the Plan representative who may be contacted about the grievance.

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

Assessment: Section 1368(a)(4)(A), Rule 1300.68(d)(1), and the Plan's grievance and appeal policy[23] require the Plan's written acknowledgment to advise complainants of the date of receipt and the name and telephone number of the Plan representative who may be contacted about the grievance.

The Department reviewed 64 Behavioral Health Standard Appeal files. The Department found the Plan's acknowledgment letters in 39 files (61%)[24] failed to include the date of receipt and the telephone number of the Plan representative who may be contacted about the grievance.

TABLE 5
Behavioral Health Standard Appeal Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Behavioral Health Standard Appeal	64	Acknowledgment letter includes the date of receipt and the name and telephone number of the Plan representative who may be contacted about the grievance	25 (39%)	39 (61%)

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

> [A]grees with this deficiency and…started remediation in 2020 to automate the Acknowledgement letters into a single Grievance and Appeals (G&A) tracking system.
>
> The automation would ensure acknowledgment letters would include the date of receipt and telephone number of the Plan representative who may be contacted about the grievance.
>
> The Plan also put in place ongoing compliance tracking and is averaging 96% overall compliance for year-to-date 2024.

The Plan also provided the Department with an acknowledgment letter template that was released on March 27, 2021.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)
- Acknowledgment Letter Template [undated]

[23] Grievances and Appeals for Health Plan Members Policy, page 2.
[24] Behavioral Health Standard Appeal Files 1, 3, 5-7, 9, 12-15, 18-21, 23, 25-30, 33, 36-38, 41, 43, 47, 48, 50-52, 55, 56, 58, 59, 61, 62, 64.

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan's acknowledgment letters consistently include the date of receipt and the telephone number of the Plan representative who may be contacted about the grievance. The Department also recognizes the Plan's assertion it "is averaging 96% overall compliance for year-to-date 2024." However, the Department is unable to confirm the Plan's representation without reviewing the Plan's audit results.

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 review of tracking and audit tools and reports, letter templates, files, interviews, and any other review deemed necessary by the Department.

Deficiency #7: Upon receipt of a grievance requiring expedited review, the Plan did not immediately inform enrollees of their right to contact the Department.

Statutory and Regulatory References: Section 1368(a)(1); Rule 1300.68.01(a)(1).

Assessment: When the Plan has notice of a grievance requiring expedited review, Section 1368.01(b), Rule 1300.68.01(a)(1), and the Plan's policies[25] require the Plan to immediately inform enrollees of their right to contact the Department regarding the expedited grievance.

The Department reviewed 63 Expedited Behavioral Health Grievance and Appeal files. The Department found 28 files (44%)[26] did not contain documentation demonstrating the Plan immediately notified the complainant of their right to contact the Department regarding the expedited grievance.

The Department also reviewed 30 AB 2470 Expedited Grievance and Appeal files.[27] The Department found none of the files (100%)[28] contained documentation demonstrating the Plan immediately notified the complainant of their right to contact the Department regarding the expedited grievance.

[25] *Grievances and Appeals for Health Plan Members Policy*, page 4. *Grievance Call Checklist*, page 2. *CA AB2470 Grievances*, page 3.
[26] BH Expedited Grievance and Appeal Files 2, 3, 5, 7, 8, 13, 17-24, 29, 30, 33, 37, 42-45, 47-49, 51, 56, 60.
[27] The Department selected files categorized by the Plan as "AB 2470," which pertain to requests for reinstatement of rescinded coverage pursuant to Section 1365.
[28] AB 2470 Expedited Grievance and Appeal Files 1-17, 19-23, 26-28, 30-34.

TABLE 6
Expedited Grievance and Appeal Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Behavioral Health Expedited Grievance and Appeal	63	Immediate notification to the complainant of the right to contact the Department regarding the grievance	35 (56%)	28 (44%)
AB 2470 Expedited Grievance and Appeal	30	Immediate notification to the complainant of the right to contact the Department regarding the grievance	0 (0%)	30 (100%)

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

> [A]cknowledges this was a deficiency in 2020 and agrees with the Department's review and assessment. This issue was also identified in the Department's 2022 Behavioral Health Investigation (BHI) Report to the Plan, dated January 2, 2024. The Plan took corrective actions before the BHI Report was issued to the Plan, and before the Department's 2020 Preliminary Report was issued (June 26, 2024).
>
> During the DMHC 2020 Routine Survey the Plan had a different process for Behavioral Health expedited grievances with partnerships between Utilization Management (UM) and Grievances and Appeals (G&A) to inform enrollees of their right to contact the Department upon receipt of a grievance requiring expedited review. This caused a delay in the notification to the enrollee. . . In October 2023, the Plan changed the process to ensure that the notification to the complainant, who may be an enrollee, subscriber, provider, or other person submitting the complaint, is provided after the Plan receives a grievance or appeal of an expedited review request.
>
> Additional actions taken include: 1) communication to all Behavioral Health Grievance and Appeal associates of the requirements of notification of DMHC rights for expedited cases, 2) use of best practices to make the appropriate call, and 3) confirmation of the notification prior to assignment of expedited review. These metrics are measured and monitored weekly so immediate intervention or remediation can be made by the Plan if needed.
>
> Specific to AB 2470, the Plan identified in April 2020 that verbal acknowledgement of the right to contact the DMHC was not occurring. Initially, the AB 2470 verbal acknowledgement requirement was

implemented into Solution Central in June 2020 where the Member Service Representative (MSR) selected a box which was timestamped, indicating that they read the script to the member. Subsequently in October 2020, systematic enhancements were implemented in which the script presents on the screen, the MSR would read the script, and then the MSR would click a box to acknowledge it has been read to the caller.

In January 2021, System enhancements were made to ensure that members requesting a reinstatement request through Secure Messaging are also receiving the verbal acknowledgment via a pop-up message that the member needs to acknowledge before proceeding with their reinstatement request.

The Plan continues to monitor all processes to ensure compliance with the verbal acknowledgement requirement. In addition to Enrollment & Billing (E&B) validating verbal acknowledgement has been given for each case received, compliance is also reported monthly via the Plan's Management Oversight Committee (MOC).

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan is providing enrollees with immediate notification of their right to contact the Department as required by Section 1368.01(b), Rule 1300.68.01(a)(1), and the Plan's policies.

The Department also acknowledges the Plan's BHI Report contained similar findings.[29] However, the Plan did not provide sufficient evidence in its response to the Preliminary Report for the Department to determine whether the deficiency is corrected.

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 review of monitoring tools and reports, reports to the MOC, files, interviews, and any other review deemed necessary by the Department.

Deficiency #8: The Plan's written responses to grievances did not consistently contain a clear and concise explanation of the Plan's response.

[29] *See* Violation # 3, Behavioral Health Investigation Report of Blue Cross of California (March 27, 2024).

Statutory and Regulatory References: Section 1368(a)(5); Rule 1300.68(d)(3).

Assessment: Section 1368(a)(5) and Rule 1300.68(d)(3) require the Plan to provide enrollees with written responses to grievances with a clear and concise explanation of the reasons for the Plan's response.

The Department reviewed 63 Behavioral Health Expedited Grievance and Appeal files. The Department found the Plan's resolution letter failed to provide a clear and concise explanation of the Plan's decision in 47 files (75%).[30]

The Department also reviewed 13 Behavioral Health Standard Grievance files. The Department found the Plan's resolution letter failed to provide a clear and concise explanation of the Plan's decision in three files (23%).[31]

Case Examples

- **BH Expedited GA File 2:** The resolution letter in this file states:

  > We reviewed all the information that was given to us with the first request for coverage. We also reviewed all that was given to us for the appeal. Your doctor wanted you to have more intensive outpatient program (IOP) care. You were getting this because you had serious problems being able to function. This was due to depression. This had been too serious to be treated with regular outpatient care. We understand that you would like us to change our first decision. Now we have new information from another telephone call with your treatment team staff. We still do not think this is medically necessary for you. We believe our first decision is correct for the following reason: you had improved to the point that could usually be treated with regular outpatient services. Staying longer would not likely help you any better than outpatient care. We based this decision on this health plan guideline. MCG Guideline Residential Behavioral Health Level of Care, Adult) ORG: B-901-RES).
  >
  > Please refer to page 157 of the Definition section of your Evidence of Coverage for more information on services that considered medically necessary.

The Department found the letter unclear because the Plan did not indicate what new information was provided over the telephone. Also, the Plan did not explain what information demonstrated the enrollee's condition had improved. Furthermore, the Department found the Plan use of words such as "usually" and "would not likely" without further explanation confusing.

[30] Behavioral Health Expedited Grievance and Appeal Files 2, 7, 8,10-14, 16-18, 20-26, 28-42, 44-58, 61.
[31] Behavioral Health Standard Grievance Files 12, 14, 16.

TABLE 7
Standard and Expedited Grievance and Appeal Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Behavioral Health Expedited Grievance and Appeal	63	Written response contains a clear explanation of the Plan's decision	12 (19%)	51 (81%)
Behavioral Health Standard Grievance	13	Written response contains a clear explanation of the Plan's decision	10 (77%)	3 (23%)

Plan's Compliance Effort: In response to the Preliminary Report, the Plan "disagree[d] with the Department's review and assessment" and complained "the Department did not provide an explanation for each purported deficient file." In addition:

> The Department cited one example file as part of the assessment for Behavioral Health (BH Expedited GA File 2). The Department's review found the letter to be unclear and confusing to an enrollee therefore concluding the Plan response was not clear and concise. BH Expedited GA File 2 included the requested service, the reviewers board certification, the rationale on the grounds of the decision along with the clinical guidelines used for the Plan's decision.
>
> The Plan submits the Department did not comply with Health and Safety Code § 1380(e) which provides:
>
> > (e) The procedures and standards utilized by the survey team shall be made available to the plans prior to the conducting of medical surveys.
>
> In this survey, the Plan did not receive any standards by which the Department would review files for meeting the clear and concise standard. A recitation to the statute and regulation does not satisfy this requirement because of the underlying subjective nature of this determination. As noted above, the Plan believes the sample was clear and concise for the reasons stated. The same rationales were submitted and reviewed as part of the 2022 Behavioral Health Investigation and no findings were made. Now a different survey team is coming to a different conclusion. The Plan believes this demonstrates the subjective nature of the review. Further, such a disparate review from one team to another suggests that there is no consistency making any determination arbitrary.
>
> In order for a deficiency to be stated, the Plan suggests that the Department provide specifics on each file reviewed that the Department

> considered confusing, and not clear and concise. The Plan's review found no consistent trends or specific causes of the lack of clear and concise responses to enrollees in the same files reviewed by the examiners. . .
>
> Third, as stated earlier, the Plan expended a significant amount of time and money on establishing and running the Committee. Fundamental to its efforts is the existence of objective measures that can be used to measure and identify satisfactory performance. This finding exemplifies the lack of any analysis or details by which the Plan can glean the standards being applied meaning the Plan has not basis to measure future performance to determine compliance. The Plan submits if the goal is compliance that standard must be developed and made open and known in order for meaningful compliance to occur. Otherwise, the Plan will be guessing on what is required.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

Based on the Plan's response, the Department has determined this deficiency is not corrected.

The Department acknowledges the Plan challenged its file review findings. However, the Plan did not identify the specific files it disagreed with or provide evidence to demonstrate the letters were compliant.

The Plan stated BH Expedited GA File 2 is clear and concise because it "included the requested service, the reviewers board certification, the rationale on the grounds of the decision along with the clinical guidelines used for the Plan's decision." The Department disagrees with the Plan's position, as Section 1368(a)(5) requires the Plan to:

> 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.

Section 1368(a)(5) sets forth three separate requirements that must be in the Plan's response (clear and concise explanation, criteria, clinical reasons). However, the Plan's response for BH Expedited GA File 2 did not include a clear and concise explanation and the clinical reasons related to its medical necessity determination.

The Plan also contends the Department did not comply with Section 1380(e) because it "did not receive any standards by which the Department would review files for meeting the clear and concise standard." The Department's assessment for compliance with Section 1368(a)(5) and Rule 1300.68(d)(3) is based on the specific facts present in

each file. Further, the Department does not use any standards other than the statutory and regulatory factors described in Section 1368(a)(5) and Rule 1300.68(d)(3) when determining whether a file is deficient.

The Department also acknowledges this deficiency was not identified in the Plan's BHI Report. However, the Department's review during its BHI of the Plan did not include assessment for compliance with Section 1368(a)(5) and Rule 1300.68(d)(3). Therefore, the absence of similar findings in the Plan's BHI Report does not offer any insights to the Department regarding the Plan's current compliance status.

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 review of files, interviews, and any other review deemed necessary by the Department.

Deficiency #9: **The Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on a finding that the proposed services are not a covered benefit did not include a notice that, if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the enrollee can contact the Department to determine whether the decision is eligible for independent medical review.**

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

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

The Department reviewed:

- 68 Medical Standard Grievance files, seven of which involved a decision the requested service was not a covered benefit;[32]
- 71 Medical Standard Appeal files, 13 of which involved a decision the requested service is not a covered benefit;[33]
- 13 Behavioral Health Standard Grievance files, two of which involved a decision the requested service is not a covered benefit;[34]
- 64 Behavioral Health Standard Appeal files, 15 of which involved a decision the requested service is not a covered benefit;[35]

[32] Medical Standard Grievance Files 11, 14, 19, 22, 25, 27, 31.
[33] Medical Standard Appeal Files 14, 15, 21, 27, 30, 31, 36, 47, 50, 54, 59, 61, 71.
[34] Behavioral Health Standard Grievance Files 8, 11.
[35] Behavioral Health Standard Appeal Files 1, 7, 12, 16, 18, 22, 23, 27, 33, 37, 45, 50, 51, 60, 61.

- 53 Medical Expedited Grievance and Appeal files, 16 of which involved a decision the requested service is not a covered benefit;[36] and
- 63 Behavioral Health Expedited Grievance and Appeal files, one of which involved a decision the requested service is not a covered benefit.[37]

In all the coverage denial files identified above, the Department found the Plan's resolution letter failed to notify the enrollee that if they believe the decision was denied based on medical necessity, they could contact the Department to determine whether their case is eligible for an IMR.

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

> [A]grees with the Department's review and assessment of the Plan's written responses to grievances involving the denial or modification of health care services that are not a covered benefit did not include a specific notice that, if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the enrollee can contact the Department to determine whether the decision is eligible for independent medical review.
>
> All Plan responses of denial or modifications of health care services include what an enrollee can do if they don't agree with the decision, the Department's contact information and how to file an independent medical review (IMR) along with an Independent Medical Review (IMR) Application/Complaint Form.
>
> Although the Plan has not changed process to written responses to grievances for any denial or modifications of health care services in response letters and no deficiencies were identified in the DMHC 2016 Routine Survey and most recently the Department's 2022 Behavioral Health Investigation, the Plan has updated all letter templates and has added specific language to comply with Rule 1300.68(d)(5).
>
> Effective 8/1/2024, Plan letters now include the following notice for any denial or modification of health care services that are not a covered benefit.
>
> > "If you believe this decision was denied on the grounds that it was not medically necessary, the Department of Managed Health Care (DMHC) should be contacted to determine whether the decision is eligible for an independent medical review."

The Plan also submitted an administrative denial letter template and a clinical denial letter template with the above notice.

[36] Medical Expedited Grievance and Appeal Files 2, 3, 5, 6, 10, 11, 13, 15, 22, 24, 26-31, 36, 38, 42-44, 47, 50.
[37] Behavioral Health Expedited Grievance and Appeal File 27.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)
- Administrative Denial Letter Template [undated]
- Clinical Denial Letter Template [undated]

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan's written responses to grievances involving the denial or modification of health care services based in whole or in part on a finding that the proposed services are not a covered benefit did not include a notice that, if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the enrollee can contact the Department to determine whether the decision is eligible for IMR.

The Department also acknowledges this deficiency was not identified in the Plan's BHI Report. However, the Department's review during its BHI of the Plan did not include assessment for compliance with Rule 1300.68(d)(5). Therefore, the absence of similar findings in the Plan's BHI Report does not offer any insights to the Department regarding the Plan's current compliance status.

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 review of letter templates, files, interviews, and any other review deemed necessary by the Department.

Deficiency #10: The Plan did not consistently ensure adequate consideration and rectification of exempt grievances.

Statutory and Regulatory References: Section 1368(a)(1); Rule 1300.68(a)(4).

Assessment: Section 1368(a)(1) requires the Plan's grievance system to ensure adequate consideration, investigation, and rectification of enrollee grievances. Rule 1300.68(a)(4) defines "resolved" as "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 . . ."

During the Plan's 2013 Routine Survey, the Department discovered the Plan did not ensure adequate consideration and rectification of grievances.[38] In addition, the Plan

[38] Link to 2013 Blue Cross of California DBA Anthem Blue Cross Follow-Up Report. Deficiency #4: The Plan does not maintain a grievance system that ensures adequate consideration of enrollee grievances and rectification where appropriate.

did not resolve exempt grievances by the close of the next business day.[39] On June 5, 2019, the Department and the Plan entered into a settlement agreement resolving the grievance issues identified in the Plan's 2013 Routine Survey.[40]

The Department and the Plan entered into the settlement agreement while the 2016 Routine Survey was underway. The Department again identified these issues in the 2016 Routine Survey.[41] In the settlement agreement, the Plan agreed to implement various corrective actions such as enhancing training for its CSRs, auditing and monitoring CSR compliance, and incorporating process improvements to improve the handling of grievances.[42] The Plan agreed to implement modifications to its grievance identification practices by July 31, 2019, and to provide the Department with periodic status and results of the corrective actions through April 2020.[43]

To allow the Plan time to fully implement its corrective actions, assessment of the Plan's compliance efforts regarding this deficiency was deferred to this Routine Survey. To assess whether the Plan now adequately considers, rectifies, and resolves grievances by the close of the next business day, the Department reviewed 54 Exempt Grievance files. Of those, 35 files (65%)[44] were not adequately considered, rectified, and resolved by the close of the next business day.

Case Examples

- **Exempt Grievance File 9:** The enrollee requested a referral for physical therapy. The CSR documented the enrollee's dissatisfaction as related to "Access to Care," and the enrollee is dissatisfied with Anthem. The Plan's records indicated the CSR resolved the enrollee's complaint during the telephone call. However, the Department found no evidence in the file documenting what actions the CSR took to investigate the grievance. Further, the Plan failed to provide any documentation reflecting how the grievance was resolved, including whether the enrollee received a referral to physical therapy as requested.

- **Exempt Grievance File 11:** The enrollee contacted the Plan regarding a prescription she was unable to fill. The Plan's records indicated the CSR resolved the enrollee's complaint. However, the Department found no evidence in the file documenting what actions the CSR took to investigate the grievance. Further, the Plan failed to provide any documentation reflecting how the grievance was resolved, including whether the enrollee was able to fill her prescription.

[39] Link to 2013 Blue Cross of California DBA Anthem Blue Cross Follow-Up Report. Deficiency #3: The Plan impermissibly processes standard grievances that are not resolved by the close of the next business day through its exempt grievance process.
[40] Enforcement Matter Number 15-268.
[41] Link to 2016 Blue Cross of California DBA Anthem Blue Cross Follow-Up Report. Deficiency #9: The Plan does not ensure adequate consideration and rectification of exempt grievances; Deficiency #10: The Plan does not resolve all exempt grievances by the close of the next business day following receipt of the grievance.
[42] Enforcement Matter Number 15-268, Exhibit B
[43] *Id*.
[44] Exempt Grievance Files 1-4, 9-18, 20-22, 24, 26, 27, 29-33, 35-39, 41, 44, 47-54.

TABLE 8
Exempt Grievance Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievance	54	Plan adequately investigates and resolves all issues within the grievance by the end of the next business day	19 (35%)	35 (65%)

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

> [A]grees with this deficiency and the same corrective actions outlined in response to Deficiency #4 apply to this Deficiency:
>
> - Since 2019, all interactions are initially classified as a grievance. However, if the interaction leads to an internal transfer with no additional handling, and/or a simple payment with no expression of dissatisfaction, then these interactions are reclassified as inquiries.
>
> - We continue to evaluate our processes to further enhance the service experience while ensuring regulatory requirements are met. System enhancements are continuous and recent enhancements have included:
>   - System enhancements made to limit the associate's ability to bypass and reclassify a call as an inquiry.
>   - Require the associate to capture the action taken to resolve the grievance prior to the interaction being closed.
>   - Automate the process of creating a standard grievance when an exempt grievance is not resolved and closed by the next business day.
>
> - A certification process was developed to ensure associates understand the regulatory requirements and to assess their ability to successfully perform the actions needed to meet all requirements. All new associates are required to successfully complete the certification process as part of our new hire training curriculum.
>
> - The Grievance and Appeals for CA Service Training and the Commercial Grievance and Appeals Business Partner Training are required to be completed annually by all associates.
>
> - There is an additional system enhancement planned to allow interactions related to payments and transfers when there is no

expression of dissatisfaction to be classified as an inquiry. This will be completed by the end of August 2024.

- As of October 2021, training for our eCare associates was revised to identify and classify a grievance opportunity for both email and chat interactions. These associates now follow the same guidelines our frontline associates use when assisting members on the phone.

All vendors and affiliates that provide customer service services to the Plan will be required to comply with the Plan's policy. The policy however included the language from Health and Safety Code § 1368 that requires a call to be characterized as a grievance if it is uncertain. Vendors/affiliated [sic] are being required to characterize all calls until they can demonstrate to the Plan that they have both the system functionality and proper training in place to assure that calls will be properly characterized. The Plan's [One Day Grievances (Exempt Grievances) policy] was updated and filed on August 12, 2024_(Filing No. 20243544) to clarify all delegates/vendors are required to follow Plan policy. Except in cases where delegate/vendor cannot distinguish between grievance and inquiry due to system limitations, all calls will be treated as a grievance.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan consistently performs adequate investigation and resolution of exempt grievances.

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 review of delegate and vendor oversight reports, policies and procedures, meeting minutes, training documents, files, interviews, and any other review deemed necessary by the Department.

This is a repeat deficiency from the Plan's 2013 and 2016 routine surveys.[45,46]

Deficiency #11: The Plan's grievance and appeal decision notices did not consistently include a written notice of (1) the availability of

[45] The 2013 Blue Cross of California DBA Anthem Blue Cross Follow-Up Report is located on the Department's website.
[46] The 2016 Blue Cross of California DBA Anthem Blue Cross Follow-Up Report is located on the Department's website.

interpretation services in the Plan's threshold language and the top 15 languages spoken by limited-English-proficient individuals as determined by the California Department of Health Care Services and (2) the availability of translated written materials in the top 15 languages.

Statutory References: Section 1367.04(b)(1)(C)(i); Section 1367.042(a)(1).

Assessment: Section 1367.04(b)(1)(C)(i) requires the Plan to include a written notice of the availability of interpretation services in the Plan's threshold languages and "the top 15 languages spoken by limited-English-proficient (LEP) individuals in California as determined by the State Department of Health Care Services [(DHCS)]" with documents sent to enrollees pertaining to the right to file a grievance or appeal. In addition, Section 1367.042(a)(1) requires the written notice in the top 15 languages as determined by the DHCS to also notify enrollees of the availability of translated written materials.

The Department reviewed 50 Behavioral Health Standard Appeal files. Of the 50 files, the Plan failed to include a notice of the availability of language assistance services[47] in the Plan's threshold languages and 15 DHCS-determined languages in eight acknowledgment letters (16%)[48] and nine resolution letters (18%).[49]

The Department reviewed 13 Behavioral Health Standard Grievance files. Of the 13 files, the Plan failed to include a notice of the availability of interpretation services in the Plan's threshold languages in two acknowledgment letters (15%).[50] In addition, the Plan failed to include a notice of the availability of interpretation and translation services in the 15 DHCS-determined languages in three acknowledgment letters (23%).[51]

The Department reviewed 50 Behavioral Health Expedited Grievance and Appeal files. Of the 50 files, the Plan failed to include a notice of the availability of language assistance services in the Plan's threshold languages and 15 DHCS-determined languages in eight disposition letters (16%).[52]

The Department reviewed 53 Medical Expedited Grievance and Appeal files. Of the 53 files, the Plan failed to include a notice of the availability of language assistance services in the Plan's threshold languages and 15 DHCS-determined languages in 10 disposition letters (19%).[53]

Finally, the Department reviewed 68 Medical Standard Grievance files. Of the 68 files, the Plan failed to include a notice of the availability of interpretation services in the Plan's threshold languages in eight resolution letters (12%).[54] In addition, the Plan failed

[47] Language assistance services include both interpretation and translation services.
[48] Behavioral Health Standard Appeal Files 5, 7, 9, 19, 21, 26, 38, 43.
[49] Behavioral Health Standard Appeal Files 3, 4, 6, 20, 21, 36, 38, 44, 47.
[50] Behavioral Health Standard Grievance Files 11, 16.
[51] Behavioral Health Standard Grievance Files 11, 14, 16.
[52] Behavioral Health Expedited Grievance and Appeal Files 1, 4, 6, 14, 26, 37, 40, 48.
[53] Medical Expedited Grievance and Appeal Files 4, 15, 18, 20, 23, 31, 32, 36-38.
[54] Medical Standard Grievance Files 9, 10, 28, 31, 42, 51, 57, 60.

to include a notice of the availability of interpretation and translation services in the 15 DHCS-determined languages in 10 resolution letters (15%).[55]

TABLE 9
Behavioral Health Standard and Expedited Grievance and Appeal Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Behavioral Health Standard Appeal	50	Acknowledgment letter includes a notice of the availability of language assistance services	42 (84%)	8 (16%)
Behavioral Health Standard Appeal	50	Resolution letter includes a notice of the availability of language assistance services	41 (82%)	9 (18%)
Behavioral Health Standard Grievance	13	Acknowledgment letter includes a notice of the availability of interpretation services in the Plan's threshold languages	11 (85%)	2 (15%)
Behavioral Health Standard Grievance	13	Acknowledgment letter includes a notice of the availability of interpretation and translation services in the 15 DHCS-determined languages	10 (77%)	3 (23%)
Behavioral Health Expedited Grievance and Appeal	50	Disposition letter includes a notice of the availability of language assistance services	42 (84%)	8 (16%)

[55] Medical Standard Grievance Files 3, 9, 10, 28, 31, 42, 51, 57, 59, 60.

TABLE 10
Medical Standard and Expedited Grievance and Appeal Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Medical Expedited Grievance and Appeal	53	Disposition letter includes a notice of the availability of language assistance services	43 (81%)	10 (19%)
Medical Standard Grievance	68	Resolution letter includes a notice of the availability of interpretation services in the Plan's threshold languages	60 (88%)	8 (12%)
Medical Standard Grievance	68	Resolution letter includes a notice of the availability of interpretation and translation services in the 15 DHCS-determined languages	58 (85%)	10 (15%)

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

> [A]grees with the Department's assessment and recognizes this was an issue with the print vendor at the time of the Department's review, and the process to include the required notice was manual. To address this deficiency, the Plan implemented the following corrective actions that were completed by September, 2021:
>
> The Notice of Language Assistance enclosure and templates for California being used in the current application are now automated.
>
> The Plan also incorporated review of decision letters to ensure the DMHC approved Notice of Language Assistance into its Quality Audit Program, YTD Quality Audit results for NOLA attached to decision is 99.97%.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan's grievance and appeal decision notices include the required interpretation and translation notices. In addition, the Department also acknowledges the Plan's assertion its "YTD Quality Audit results for NOLA attached to decision is 99.97%." However, the Department is unable to verify the Plan's representation without reviewing the audit results.

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 review of the Plan's oversight of its print vendor, letter templates, audit tools and reports, files, interviews, and any other review deemed necessary by the Department.

ACCESS AND AVAILABILTY OF SERVICES

Deficiency #12: The Plan's online provider directory did not prominently disclose information for reporting a potential directory inaccuracy.

Statutory Reference: Section 1367.27(f).

Assessment: Section 1367.27(f) requires the Plan's provider directory to "include both an email address and a telephone number for members of the public and providers to notify the plan if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the plan's Internet Web site."

During the Plan's online provider directory demonstration, the Department found the Plan did not prominently disclose its contact information for reporting a directory inaccuracy. At the bottom of each page of the online provider directory, the Plan includes a paragraph under the bolded header "IMPORTANT." The displayed paragraph states:

> The information is updated every week. Find out how we make sure our information is correct (PDF).[56]
>
> While we make efforts to ensure that our lists of doctors and hospitals are up to date and accurate, providers do leave our networks from time to time, and these listings do change. There are hospitals, doctors or other providers who are not included in every plan network. Please make sure you are searching the right network. Logging in as a member is the most accurate method to search for providers in your plan network. You may also enter your Prefix (the first three values of your member number on your ID card). There may be higher costs to you if you visit a provider who

[56] Link to PDF on Plan's website.

> is not in your plan network. We recommend you contact the provider to confirm that they are in your plan network and that the desired service is covered. If you are an HMO member, you may need a referral from your Primary Care Physician (PCP) before you receive care for non-emergency services.

Below this paragraph was a hyperlink titled "Show More." When clicked, four additional paragraphs become visible. The third of these four paragraphs included the Plan's telephone number and email address for enrollees to report "inaccurate, incomplete or misleading information" on the online provider directory. However, this information was only available if the user clicks the "Show More" hyperlink.

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

> [A]ccepts this deficiency. Although the Plan's online provider directory does provide information for enrollees to report a potential directory inaccuracy, the Plan acknowledges it took multiple user clicks to report the information. The Plan is updating the design whereby the process to report inaccurate provider data information is always displayed on the search results page without invoking [show more]. The work has begun and will be completed by September 2024.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Corrected

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

At the bottom of each page of the online provider directory, there are now two paragraphs between the bolded header "IMPORTANT" and a hyperlink title "Show More." The first paragraph is the one previously listed above. The second paragraph states:

> Found inaccurate, incomplete or misleading information in this directory? If so, call us. California members can call 844-839-4049. Non-California members should call 833-941-3649. Send an email to ProviderDirectoryDiscrepancy@Anthem.com.[57] Or use our online reporting tool.[58] Members who have relied on inaccurate, incomplete or misleading information can also file a complaint online or call the Member Services number on their ID card.[59]

When one clicks on the "Show More" hyperlink, two additional paragraphs become visible. However, the only paragraph about how to report inaccurate provider directory

[57] Link to Plan's provider directory discrepancy reporting email address.
[58] Link to Plan's online reporting tool.
[59] Link to Plan's online complaint form.

information is no longer hidden. In addition, the paragraph now includes a link to an "online reporting tool" which takes individuals to a "Provider Directory Discrepancy Form" that allows users to report inaccuracies found in the provider directory.

Deficiency #13: The Plan did not consistently review or accurately report access to care exempt grievance data.

Regulatory Reference: Rule 1300.67.2.2(d)(2)(D).

Assessment: Rule 1300.67.2.2(d)(2)(D) requires the Plan's quality assurance program to include compliance monitoring policies and procedures "designed to accurately measure the accessibility and availability of network providers," including, the review and evaluation "on not less than a quarterly basis, all the information available…regarding the plan's ability to meet timely access compliance and network adequacy requirements set forth under the Knox-Keene Act…"

The *CA Enterprise Accessibility Policy Adoption* policy described monitoring and reporting mechanisms the Plan utilizes to monitor network compliance to regulatory access standards. The policy requires the Plan review grievances quarterly for timely access monitoring, stating:

> Grievances and appeals not limited to and including the following categories will be reviewed quarterly for Timely Access monitoring by provider type as possible. Prompt investigation and corrective action implementation will include research and direct correspondence with providers as applicable to investigate and resolve issues as well as trending of provider issues with submission of recurrent issues to the plan's Provider Relations Committee for action. These will include an analysis of any one (1) day grievances for access.[60]

Upon request for evidence of quarterly timely access monitoring as referenced in this policy,[61] the Plan directed the Department to its Western Region Quality Committee (WRQC)[62] meeting minutes. The meeting minutes reflect the WRQC received reports evaluating grievance data, including "Access to Care" exempt grievances. The following exempt grievance data was reported to the WRQC during the survey review period:

- July 17, 2018: 92 access to care exempt grievances reported for Q2 2018. The Plan documented 25 were incorrectly labeled as access to care.
- October 23, 2018: 168 access to care exempt grievances reported for Q3 2018. The Plan documented 16 were incorrectly labeled as access to care.
- February 19, 2019: 15 access to care exempt grievances reported for Q4 2018.
- April 16, 2019: 20 access to care exempt grievances reported for Q1 2019.
- December 17, 2019: 1,326 access to care exempt grievances reported for Q3 2019. The Plan documented 1,054 were incorrectly labeled as access to care.

[60] CA Enterprise Accessibility Policy Adoption, page 11.
[61] Department request #130
[62] The WRQC reports to the Provider Relations Committee.

- April 21, 2020: 647 access to care exempt grievances reported for Q1 2020, through March 17, 2020. The Plan documented 547 were incorrectly labeled as access to care.

The Department found no evidence demonstrating the WRQC received reports on access-related exempt grievances during the second and fourth quarters of 2019. A total of 2,268 access to care exempt grievances were reported to the WRQC from Q2 2018 through Q1 2020.[63] However, the Plan's exempt grievance log contained a total of 22,343 access to care issues.[64, 65] Based on review of the Plan's exempt grievance log, the Department determined Access to Care exempt grievance data was substantially underreported to the WRQC.

Since there was no evidence to explain this discrepancy, the Department determined the failure to report accurate exempt grievance data prevented the WRQC from fulfilling its obligation to identify trending access issues and recurrent provider issues for the PRC as required by Rule 1300.67.2.2(d)(2)(D) and the Plan's *CA Enterprise Accessibility Policy Adoption* policy.

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

> [A]grees with the Department's assessment. To address this deficiency and ensure consistent and accurate review of Access to Care exempt grievance data, the Plan implemented the following corrective actions that were completed by May, 2021.
>
> The Plan's Member Service team conducted a complete and thorough review of the grievance reporting and discovered that the 22,343 exempt grievances were overstated. It was determined that many of these particular grievances did not fall under "Access to Care." In 2018 and 2019, the Member Services team transitioned from the Call Care Browser System to the Solutions Central System. Additionally, during the Department's Survey review lookback period, reporting was extracted from two different data systems and the plan had to combine the reporting. When the two systems were merged, the PCP change category was included within the "Access to Care" grievances category. Also, there were instances where associates mislabeled exempt grievances in the categorization process. Mislabeling instances included cases where members asked to change their Primary Care Physician (PCP) or when members used out-of-network providers due to their own personal preferences and not as a recommendation from their provider.
>
> Currently, there are daily reviews of exempt grievances that include categorizing complaints correctly and immediate feedback is provided to

[63] Q2-Q4 2018: 275 access to care exempt grievances. Q1-Q4 2019: 1,346 access to care exempt grievances. Q1 2020: 647 access to care exempt grievances.
[64] Column E: Nature of Grievance.
[65] May 1, 2018 through December 31, 2018: 1,117 access to care exempt grievances. January 1, 2019 through December 31, 2019: 16,040 access to care exempt grievances. January 1, 2020 through April 30, 2020: 5,186 access to care exempt grievances.

the associate. The Access to Care complaint process is part of the Plan's internal criteria and will be evaluated for the appropriate classification, resolution and documentation requirements. These results are rolled into the overall results of all audits completed for DMHC compliance. Enhanced reporting of audit results specific to Access to Care were implemented August 9, 2024.

In 2021, system enhancements were implemented to accurately reflect the accurate scope of "Access to Care" issues. Additional training was completed in 2020 and 2021 to help member services associates identify proper "Access to Care" issues. Continuous associate training occurs through annual training sessions as well as one-on-one personal training stemming from audit reviews of the associates' work. Newly hired staff participate in this training as well as group associate "refresher" guidance sessions.

Furthermore, improvements in the reporting processes have occurred allowing for a more precise depiction of "Access to Care" issues to be identified and presented to the "Access and Availability Sub-Committee" (AASC) on a quarterly basis. This information is also used when reviewing PAAS results and during our quarterly Network Adequacy Review when determining access gaps and to review open panel results.

In January 2021, the AASC was established to build a cross-functional end-to-end process that demonstrates oversight and continuous improvement for Access and Availability. The AASC includes representation from various Anthem Departments such as Health Care Networks, Provider Relations, Grievances and Appeals, Member Services, Utilization Management, Behavioral Health, Regulatory Affairs, Compliance, and other departments within Anthem Blue Cross.

The AASC reviews and evaluates Access & Availability from a holistic perspective. This includes, but is not limited to, analyzing quarterly and/or annual reporting of: Standard Grievances and Appeals, Exempt Grievances, Network Adequacy, Language, Race, Gender, and Ethnicity assessments, Member and Provider Survey Results, and 24-Hour Nurse Line results…

Upon identifying any access gaps, appropriate actions are guided by the processes outlined in our Availability and Accessibility policies (Filing No. 20233458). Often ad-hoc meetings are convened among Member Services, Grievance and Appeals, and other departments to review and discuss the Grievance reports to ensure the effective and appropriate monitoring of access grievances and appeals.

The Plan also provided quarterly "Access to Care One Day Grievances" reports and Access and Availability Oversight Subcommittee meeting minutes.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)
- Access to Care Review (Q1 2021, Q2 2021, Q3 2021, Q4 2021, Q1 2022, Q2 2022, Q3 2022, Q4 2022, Q1 2023, Q2 and Q3 2023, Q4 2023, Q1 2024)

Final Report Deficiency Status: Not Corrected

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

The Plan provided quarterly "Access to Care One Day Grievances" reports prepared by the Access & Availability Sub-Committee from Q1 2021 through Q1 2024. Report data is generated by Member Services, who "monitors Access to Care grievances on a quarterly and annual basis and looks for top 5 trends to see where improvements may be required….We do review our top 5 trends and determine if we have overall access issues in particular specialties or areas that we can address on a holistic basis."[66]

The "Access to Care Exempt Grievances - Medical" data is categorized by DMHC complaint categories[67] and then further broken down by provider type.[68] The quarterly reports submitted from Q1 2021 through Q1 2023 included the top five access to care grievance trends; however, starting with the Q2 2023 reports, only three PCP trends were identified. For example:

The Q3 2023 report only listed the top three trends:

1. Timely Access - PCP: 292 exempt grievances
2. Providers not Accepting New Patients - PCP: 25 exempt grievances
3. Geographic Access - PCP: 11 exempt grievances[69]

However, according to the raw data, the top five trends were:

1. Timely Access - PCP: 292 exempt grievances
2. *Timely Access - Specialist: 32 exempt grievances*
3. Providers not Accepting New Patients - PCP: 25 exempt grievances
4. *Timely Access - Ancillary Provider: 12 exempt grievances*
5. Geographic Access - PCP: 11 exempt grievances[70]

The Q4 2023 report only listed the top three trends:

1. Timely Access - PCP: 348 exempt grievances
2. Geographic Access - PCP: 102 exempt grievances

[66] Access to Care Review Q2 and Q3 2023, page 5
[67] The DMHC complaint categories are Continuity of Care, Geographic Access, Language Assistance Provider, Office Wait Time, Other, Provider Directory Error, Provider Not Taking New Patients, Telephone Access Provider, Timely Access, and Timely Authorization. Access to Care Review Q2 and Q3 2023, page 3.
[68] The provider types are Ancillary Provider, Clinic, Hospital, PCP, and Specialist. Access to Care Review Q2 and Q3 2023, page 3
[69] Access to Care Review Q2 and Q3 2023, page 2
[70] Access to Care Review Q2 and Q3 2023, page 3

3. Providers not Accepting New Patients - PCP: 19 exempt grievances[71]

However, according to the raw data, the top five trends were:
1. Timely Access - PCP: 348 exempt grievances
2. Geographic Access - PCP: 102 exempt grievances
3. *Timely Access - Specialist: 71 exempt grievances*
4. *Geographic Access - Specialist: 53 exempt grievances*
5. *Timely Access - Clinic: 22 exempt grievances*

Based on review of the quarterly reports, the Department determined that starting in Q2 2023, the Access & Availability Sub-Committee did not accurately identify the top five access to care grievance trends. In addition, as the numbers and findings reported in the committee meeting minutes mirror the information in the reports, the Plan does not adequately review and evaluate all information available regarding the Plan's ability to meet timely access compliance and network adequacy requirements.

Furthermore, the Plan did not provide the Department with an exempt grievance log. Without this evidence, the Department is unable to confirm whether the numbers reported by the Access & Availability Sub-Committee are consistent with the data in the Plan's exempt grievance log.

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 review of reports, meeting minutes, exempt grievance log, interviews, and any other review deemed necessary by the Department.

UTILIZATION MANAGEMENT

Deficiency #14: **The Plan did not consistently provide enrollees with a written notification of a decision to deny or modify a request for health care services on the basis of medical necessity that included a clear and concise explanation of the reason for the Plan's decision and the clinical reasons for the Plan's medical necessity determination.**

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

Assessment: Section 1367.01(h)(4) requires written notices regarding the Plan's decision to deny or modify requested health care services based, in whole or in part, on medical necessity include "a clear and concise explanation of the reasons for the plan's decision" and "the clinical reasons for the decisions regarding medical necessity."

The Plan's *Utilization Review Process* policy states:

> NOTIFICATION OF ADVERSE DETERMINATIONS
> We will provide electronic or written notification for all adverse determinations to the covered person and attending practitioner or treating

[71] Access to Care Review Q4 2023, page 2

> practitioner, as applicable. Electronic or written notification of an adverse determination will be in a manner calculated to be understood by the covered person. Electronic or written notification will include the notification requirements listed above, and the following:
>
> 1. The specific reason or reasons for the adverse determination in terms specific to the covered person's condition or request and in language that is easy to understand, so the covered person and practitioner know why we issued an adverse determination and have enough information to file an appeal. The notification includes a complete explanation of the grounds for the adverse determination, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. We are not required to spell out abbreviations/acronyms if they are clearly explained in lay language . . .[72]

To assess the Plan's compliance with these requirements, the Department reviewed the Plan's Utilization Management (UM) Denial, Delay, and Modification files. The Department found the Plan utilized two teams to review Medical and Behavioral Health UM decisions. To account for differences between these teams, the Department conducted random sampling of the Plan's UM Denial, Delay, and Modification files as follows:

Medical:
Selection 1 – Review Urgency "Emergency"
Selection 2 – Review Urgency "Urgent"
Selection 3 – All other UM Denial, Delay, and Modification files

Behavioral Health:
Selection 1 – Review Urgency "Urgent"
Selection 2 – All other UM Denial, Delay, and Modification files

The Department reviewed 68 Medical UM files. Among these files, the Department found 21 deficient enrollee written notifications (31%).[73] Specifically:

- 10 denial and modification notices failed to include a clear and concise explanation of the reasons for the Plan's decision;[74] and

- 21 denial and modification notices failed to specify the clinical reason for the decision regarding medical necessity.[75]

[72] *Utilization Review Process*, page 10.
[73] DMHC Medical UM Files (Selection 3): 2, 7, 12, 14, 15, 21, 24, 30, 37, 41-44, 48, 56, 58, 64, 70, 76.
[74] DMHC Medical UM Files (Selection 3): 2, 14, 15, 24, 30, 37, 41, 43, 44.
[75] DMHC Medical UM Files (Selection 3): 2, 7, 12, 14, 15, 21, 24, 30, 37, 41-44, 48, 56, 58, 64, 70, 76.

The Department also reviewed 66 Behavioral Health UM files. Among these files, the Department found 65 deficient written notifications (98%).[76] Specifically:

- 62 denial and modification notices failed to include a clear and concise explanation of the reasons for the Plan's decision;[77] and

- 60 denial and modification notices failed to specify the clinical reason for the decision regarding medical necessity.[78]

Case Examples

- **DMHC Medical UM File 24:** The Plan's denial letter to the enrollee states:

  > Sclerotherapy or echosclerotherapy, including ultrasound guided foam sclerotherapy (UGFS), of varicose tributary or extension (for example, anterolateral thigh vein, anterior accessory saphenous vein, or intersaphenous vein[s]) or perforator veins is considered medically necessary when the following criteria are met (A and B or A and C):
  > A. Vein being treated is greater than 3.0 mm in diameter with reflux confirmed by Doppler or duplex ultrasound evaluation and report; and
  > B. When performed at the same time as an endoluminal radiofrequency ablation procedure or endoluminal laser ablation procedure which meets the criteria above; or
  > C. When performed for the treatment of residual or recurrent symptoms which meet the following criteria: 1. Surgical ligation and stripping, endoluminal radiofrequency ablation, or endoluminal laser ablation of the great or small saphenous veins was previously performed; and
  > 2. One or more of the following criteria (a, b, or c) are met: a. Symptoms of venous insufficiency or recurrent thrombophlebitis (including but not limited to: aching, burning, itching, cramping, or swelling during activity or after prolonged sitting) which:
  > i. are causing discomfort to the degree that employment or activities of daily living are compromised; and
  > ii. persist despite appropriate non-surgical management for 6 weeks, excluding similar management prior to the required treatment of the great or small saphenous vein; and
  > iii. persist despite a trial of properly fitted gradient compression stockings for at least 6 weeks, excluding similar management prior to the required treatment of the great or small saphenous vein; or
  > b. There is ulceration secondary to stasis dermatitis; or
  > c. There is hemorrhage from a superficial varicosity.

[76] DMHC Behavioral Health UM Files (Selection 2): 2-4, 6-11, 13, 15, 16, 18-20, 22, 23, 25, 26, 28-31, 33, 35-38, 40-45, 47-50, 52, 53, 55-57, 60, 62-64, 66, 68, 70, 72, 73, 79, 83-85, 87-90, 93, 95-98.
[77] DMHC Behavioral Health UM Files (Selection 2): 2-4, 6-11, 13, 15, 16, 18, 20, 22, 23, 25, 26, 28-31, 33, 35-38, 40-45, 47-50, 52, 53, 55-57, 60, 62-64, 68, 70, 72, 73, 79, 83, 84, 87-90, 93, 95-98.
[78] DMHC Behavioral Health UM Files (Selection 2): 2-4, 6-11, 13, 15, 16, 18-20, 22, 23, 25, 26, 28, 30, 31, 33, 36-38, 42-45, 47, 48, 50, 52, 53, 55-57, 60, 62-64, 66, 68, 70, 72, 73, 79, 83-85, 87-90, 93, 95-98.

> We based our decision on the health plan medical policy, Treatment of Varicose Veins (Lower Extremities) (SURG.00037)

The letter was not clear and concise. It included the entire set of criteria used to determine the medical necessity of varicose vein treatment using clinical terminology without definition that would be difficult for a layperson to understand. The letter also failed to specify the clinical reasons for its determination that the requested services were not medically necessary for the enrollee.

- **DMHC Behavioral Health UM File 7:** The Plan's denial letter to the enrollee states:

> We previously approved TMS (transcranial magnetic stimulation) to treat depression for a course of 36 treatments. We received a new request for you to continue with TMS. The plan medical policy considers this treatment medically necessary for adults with Major Depressive Disorder when the treatment is given in a standard course. This consists of 30 treatments in 6 weeks followed by 6 less frequent treatments. A course of treatment that differs from this is not considered medically necessary. The information we have shows your doctor is requesting five more treatments. For this reason, the request for TMS is denied as not medically necessary.

The letter was not clear and concise because it focused on the previously approved request instead of the current request for five additional treatments. The letter also failed to specify the clinical reasons for its determination that the requested treatments were not medically necessary for the enrollee.

TABLE 11
UM Denial, Delay, and Modification Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Medical UM Selection 3	68	Response includes a clear and concise explanation of the reason for the Plan's decision, description of the criteria or guidelines used, and the clinical reason	47 (69%)	21 (31%)
Behavioral Health UM Selection 2	66	Response includes a clear and concise explanation of the reason for the Plan's decision, description of the criteria or guidelines used, and the clinical reason	1 (2%)	65 (98%)

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

> [C]onducted in-depth reviews of the Medical/Physical Health and Behavioral Health files identified in the Report as deficient and disagrees with the Department's finding based on the following information:
>
> …disagrees with the Department's assessment on 2 cases (one partially and one in total) identified as failing to include a clear and concise explanation…[D]isagrees with the Department's assessment on 9 cases identified as failing to specify the clinical reason…
>
> The Plan has a well-developed Denial Rationale SharePoint site that is reviewed and updated as needed. The Plan uses these denial rationales as the framework for all denials other than coding denials. They include the references to Medical Policy and Clinical Guidelines specific to the decision. A Quick Reference Guide was also created to provide Medical Directors with a process for using the Denial Templates. In addition, the Anthem Writing Style Guide and other references are additional tools used to ensure denial rationales are clear and concise. Medical Directors are trained on the process of using the denial rational templates and the medical necessity criteria and internal audits of denial rationales are conducted monthly to further ensure the Plan is meeting all the required components. Those audits, with opportunities for improvement, are distributed back to the reviewers.

The Plan provided the Department with a spreadsheet assessing the 21 deficient Medical UM Selection 3 files identified by the Department.

Regarding the 65 deficient Behavioral Health UM Selection 2 files, the Plan stated it:

> [C]onducted an in-depth review of the 15 ABA Behavioral Health UM files[79] that the Department found deficient. The Plan disagrees with the Department's review and assessment and believe that the ABA denial rationales provide clear and concise information regarding the medical necessity determination.
>
> The Plan conducted an in-depth review of File #85 (OP Professional Out of Network Behavioral Health). This was the only file cited as deficient for OP Out of Network services. The Plan disagrees with the Department's review and assessment and believe the denial statement was clear and concise. The Report cited that the denial rationale did not provide a reason for the medical necessity determination, when in fact, this was not a medical necessity determination but a benefit determination.
>
> The Plan conducted an in-depth review of the nine (9) Transcranial Magnetic Stimulation (TMS) files[80] and 38 MH/SUD RTC/PHP/IOP Behavioral Health UM Files[81] that the Department found deficient. The Plan disagrees with the Department's review and assessment and believe that the selected files have denial rationales that are clear, concise, and specify the clinical reason for the medical necessity determination.
>
> Since the Department's review in 2020, the Plan has improved the denial rationale. These changes include new medical necessity criteria in use, and the addition of substantive detail, to provide members with beneficial information to assist with understanding of medical necessity decisions. Additionally, we also review to ensure that letters are customized to suit the specific member's behavioral condition. Denial rationales are dynamic and are updated annually, at a minimum, in accordance with adopting and updating clinical criteria. We have modified denial rationale statements to adhere with new 10th circuit court guidance identifying specificity in denial rationale.
>
> New medical necessity criteria were adopted, resulting in updated written notices for the following:
>
> - 1/1/2021 ASAM criteria were adopted for all substance use requests per SB 855
> - 1/1/2021 LOCUS/CASII were adopted for all mental health requests per SB 855
> - 7/1/2021 MCG guideline, Transcranial Magnetic Stimulation (ORG: B-801-T (BHG)), adopted for all TMS requests.

[79] [DMHC Behavioral Health UM Files (Selection 2): 2, 10, 11, 25, 29, 30, 37, 40, 41, 49, 53, 62, 63, 79, 95]
[80] [DMHC Behavioral Health UM Files (Selection 2): 7, 19, 33, 42, 47, 66, 72, 73, 96]
[81] [DMHC Behavioral Health UM Files (Selection 2): 3, 4, 6, 8, 9, 13, 15, 16, 18, 20, 22, 223, 28, 31, 35, 36, 38, 43-45, 48, 50, 52, 55-57, 60, 64, 68, 70, 78, 83, 84, 88-90, 93, 98]

- 7/25/2023 update to denial rationale statements related to ASAM 2022

Behavioral Health UM files were also subsequently reviewed by the Department during the 2022 Behavioral Health Investigation and the Plan did not receive any deficiencies specific to Section 1367.01(h)(4).

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)
- UM Medical Physical Internal File Review [undated]

Final Report Deficiency Status: Not Corrected

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

Although the Plan disagreed with the Department's assessment of two cases identified as failing to include a clear and concise explanation, only one file was identified in the Plan's spreadsheet.[82] In addition, the Plan stated it disagreed with the Department's assessment of nine cases identified as failing to specify the clinical reason. However, 11 files were identified in the Plan's spreadsheet.[83] Since the number of files in the Plan's response and its spreadsheet do not match, it is unclear to the Department which deficient files the Plan is contesting.

Furthermore, the Department disagrees with nine of the 11 findings disputed by the Plan. For example, the denial reasoning in six files states:

> The request tells us your doctor ordered a special device that can prevent blood clots from forming in the legs (pneumatic compression device). This device is not approvable under the plan clinical criteria because there is no proof or not enough proof it works as well as other treatments. For this reason, this request is denied as not medically necessary. It may help your doctor to know we reviewed this request using the plan clinical guideline called Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Lower Limbs (CG-DME-46).[84]

The Plan contested the Department's determination that the denial reasoning in these six files did not include clinical reasoning and stated, "The request is for prevention of a clinical issue that is not currently present for the member, the clinical indication of the condition to be prevented is stated."[85] The Department maintains these files are deficient as the denial reason is unrelated to the enrollee's condition. The request for

[82] Only File 6 was identified in the Plan's spreadsheet. Upon review, the Department agreed with the Plan's assessment the enrollee letter was clear and concise.
[83] DMHC Medical UM Files (Selection 3): 6, 7, 10, 15, 21, 42, 48, 56, 58, 64, 76. Upon review, the Department agreed with the Plan's assessment the enrollee letters in File 6 and 10 included clinical reasoning.
[84] DMHC Medical UM Files (Selection 3): 7, 21, 42, 56, 58, 76.
[85] UM Medical Physical Internal File Review

the device is denied "because there is no proof or not enough proof it works as well as other treatments" pertains to the device. The letter does not mention the enrollees' clinical conditions and why the device would not work on the enrollees.

In BH UM Selection 2 files, the Department found 65 out of 66 files deficient. Of the 65 deficient files, 62 files contained enrollee letters that were not clear and concise. However, the Plan indicated it disagreed with the Department's findings in 63 files.[86] The Plan also "disagree[d] with the Department's review and assessment [of File #85] and believe the denial statement was clear and concise." The Plan stated this case "was not a medical necessity determination but a benefit determination." However, the Department did not identify a clear and concise issue with this file. Also, the Department requested the Plan provide UM files based in whole or in part on medical necessity. Even though the Plan subsequently determined the file to be a benefit determination, the Department assessed this file for compliance with UM requirements based on the Plan's representation the denial was based in whole or in part on medical necessity. Finally, of the 65 deficient BH UM Selection 2 files, 60 files contained enrollee letters that did not contain clinical reasons for the Plan's determination. The Plan indicated it disagreed with the Department's findings in 47 files.[87]

Unlike the Medical UM Selection 3 files, the Plan did not provide the Department with a spreadsheet assessing the deficient BH UM Selection 2 files identified by the Department. The Plan also did not submit evidence to demonstrate the letters were compliant.

The Department also acknowledges this deficiency was not identified in the Plan's BHI Report. However, the Department's review during its BHI of the Plan did not include assessment for compliance with Section 1367.01(h)(4). Therefore, the absence of similar findings in the Plan's BHI Report does not offer any insights to the Department regarding the Plan's current compliance status.

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 review of audit tools and results, files, interviews, and any other review deemed necessary by the Department.

Deficiency #15: **The Plan failed to demonstrate it maintains a process for disclosing utilization review or utilization management criteria and guidelines to the public and to include required notice language.**

Statutory References: Section 1363.5(b)(5), (c).

Assessment: Section 1363.5(b)(5) requires the Plan make available to the public, upon request, the criteria or guidelines the Plan uses to determine whether to authorize,

[86] DMHC Behavioral Health UM Files (Selection 2): 2-4, 6, 8-11, 13, 15, 16, 18-20, 22, 23, 25, 28-31, 33, 35-38, 40, 42-45, 47-50, 52, 53, 55, 56, 57, 60, 62-64, 66, 68, 70, 72, 73, 78, 79, 83, 84, 88-90, 93, 95, 96, 98
[87] DMHC Behavioral Health UM Files (Selection 2): 3, 4, 6-11, 13, 15, 16, 18-20, 22, 23, 28, 31, 33, 35, 36, 38, 42-45, 48, 50, 52, 55, 56, 57, 60, 64, 66, 68, 70, 72, 73, 78, 83, 84, 88, 89, 90, 93, 96, 98

modify, or deny health care services. When the Plan responds to a public request for its UM criteria and guidelines, Section 1363.5(c) requires the Plan's response to include the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

The Plan's *Utilization Review/Management Processes: State Specific Addendum-California* which specifies the required disclosure as:

> **NOTIFICATION OF ADVERSE DETERMINATIONS**
> . . . An adverse determination must include a description of the criteria or guidelines used.
>
> Upon request, the criteria or guidelines used as the basis of a decision to modify, delay, or deny services in a specified case under review shall be disclosed to the provider and covered person in that specified case for the specific procedures or conditions requested.
>
> The disclosure must include the following statement:
>
> *"The materials provided to you are guidelines used by this (*insurer/plan) to authorize, modify, or deny health care benefits for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your (*insurance contract/contract)."*[88]

The Department found the Plan's policy only described providing its criteria and guidelines to providers and covered persons. The Plan submitted no evidence demonstrating how the public may request the Plan's utilization review or UM criteria and guidelines, or how the Plan communicates the disclosure notice required by Section 1363.5(c) to the public.

In addition, the Plan's UM criteria and guidelines are available to the public on the Plan's website.[89] During interviews, the Department asked the Plan to locate the Section 1363.5(c) disclosure notice on the Plan's website. The Plan was unable to locate the disclosure notice.

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

> [A]grees with the Department's review and to address this deficiency, the Plan implemented the following corrective actions:
>
> The Plan updated the *Utilization Review/Management Processes: State Specific Addendum – California* document on 8/13/2020 to include the word "public" when describing the entities to which the Plan will provide

[88] *Utilization Review/Management Processes - State Specific Addendum – California*, page 10.
[89] Link to Plan's UM criteria and guidelines.

> UM criteria and guidelines (Filing No. 20212085). Evidence of the updated policy is provided in the supporting attachment.
>
> The Anthem.com/ca website has open access to the public by selecting any of the entry options such as "member" or "provider" without requiring any member or provider identification and without log on ID/passwords being required. However, noting the Department's concern, the Plan will update the Anthem.com/ca website to more easily identify the site as publicly accessible by inserting a "public" selection option in order to view UM criteria and guidelines with the required disclosure notice statement displayed. This work will be complete by October 1, 2024.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)
- Utilization Review/Management Processes: State Specific Addendum – California (August 13, 2020)

Final Report Deficiency Status: Corrected

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

The Department found the Plan updated its policy and added a paragraph pertaining to the public between the two paragraphs cited above. The new paragraph states:

> The process, criteria or guidelines that are used to authorize, modify, or deny services shall be available to the public upon request. **We** are only required to disclose the criteria or guidelines for the specific procedures or conditions requested. **We** may also make the criteria or guidelines available through electronic communication means.[90]

In addition, the Plan added the Section 1363.5(c) disclosure notice under the "About These Policies" section of the clinical guidelines page on its website.[91]

PRESCRIPTION DRUG COVERAGE

Deficiency #16: **For decisions to modify or deny requests for non-formulary prescription drugs based in whole or in part on medical necessity, the Plan did not consistently include in its written responses to enrollees a clear and concise explanation of the reasons for its decision.**

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

Assessment: Section 1367.01(a) requires the Plan and "any entity with which it contracts for services that include utilization review or UM functions. . . or that delegates

[90] *Utilization Review/Management Processes: State Specific Addendum – California*, page 10.
[91] Link to Plan's UM criteria and guidelines.

these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section." Section 1367.01(h)(4) mandates written communications regarding decisions to deny, delay, or modify requested health care services based in whole or in part on medical necessity 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 reasons for the Plan's decision.

The Department reviewed 70 Formulary Exception Request (FER) Denial, Delay, and Modification files processed by the Plan's PBM. The Department found the letters in 67 of these files (96%)[92] did not include a clear and concise explanation of the reasons for the Plan's decision.

Case Examples

- **DMHC File 6:** The denial notice states:

> We denied your request because we did not see certain details about your illness and treatment. We see that this request for a drug called fluticasone propionate for your illness (Cough). We may consider approval of this drug in certain situations (after a trial and inadequate response or intolerance to two preferred nasal corticosteroids; preferred agents include mometasone [generic Nasonex, may require prior authorization] and all commercially available over-the-counter [OTC] formulations of the following drugs: OTC fluticasone propionate, OTC triamcinolone acetonide, and OTC budesonide; or for those who are requesting this drug for non-allergic rhinitis). We did not see records that show one of these applies to you. We based this decision on your health plan's prior authorization criteria for Non-Preferred Nasal Corticosteroids.

The letter's explanation that the PBM "did not see certain details about" the enrollee's treatment was overly vague and failed to clearly communicate the decision was based on a medical necessity determination. Further, the Plan used several medical terms that, without definition, would be difficult for a layperson to understand. The Department also found the PBM's use of a long run-on sentence to summarize the situations in which the drug might be approved to be confusing and difficult to follow.

- **DMHC File 34:** The denial notice states:

> We denied your request because we did not see certain details about your use and treatment. We see that this request is for a drug called Vivelle-Dot 0.1 mg patch for your use (ICD code Z79.090). We may consider approval of this drug for certain conditions (treatment of moderate to severe vasomotor symptoms due to menopause; treatment of moderate to severe symptoms of vulvar and vaginal atrophy due to menopause; treatment of hypoestrogenism due to hypogonadism, castration, or primary ovarian failure; prevention of

[92] DMHC Files 1-11, 13-17, 19-21, 23-25, 27-37, 39-70, 72, 75.

> postmenopausal osteoporosis). We did not see records that show you have this condition (or another condition that is supported by literature in accordance with your health plan's off-label use guideline).
>
> We based this decision on your health plan's prior authorization criteria for Non-formulary drugs. . . Please note that, this drug is not on your list of covered drugs (formulary). For medically accepted uses, your health plan requires that certain drugs on your list of covered drugs (formulary) are tried first.

The letter's explanation that the PBM "did not see certain details about" the enrollee's treatment was overly vague and failed to clearly communicate the decision was based on a medical necessity determination. Further, the letter contained medical terms and billing codes that, without definition, would be difficult for a layperson to understand. Finally, the Department found inclusion of a long list of medical conditions difficult to follow and failed to meet the requirement to provide a concise explanation.

TABLE 12
FER Denial, Delay, and Modification Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
FER Denial, Delay, and Modification	70	Written notice includes a clear and concise explanation of the reason(s) for the decision	3 (4%)	67 (96%)

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

> [A]grees with Department's assessment. To address this deficiency, all non-formulary denial rationales will be reviewed and updated as needed to ensure written responses to enrollees, include a clear and concise explanation of the reason for the decision to modify or deny requests for non-formulary prescription drugs. This work is expected to be complete by October 2024. Once all updates are complete, the Plan will monitor compliance by reviewing a sample of files on a monthly basis.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan includes a clear and concise explanation of the reason for its decisions to modify or deny requests for non-formulary prescription drugs based in whole or in part on medical necessity in its written responses to enrollees.

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 review of monitoring tools and results, files, interviews, and any other review deemed necessary by the Department.

Deficiency #17: The Plan did not consistently notify requesting providers of external exception request review decisions within the required timeframes.

Statutory and Regulatory References: Section 1367.24(k); 45 CFR 156.122(c)(3)(ii).

Assessment: Section 1367.24(k) requires the Plan to comply with requests for external exception request review (EERR) processes described in subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. Subsection (c)(3)(ii) of this federal regulation mandates the Plan to notify the requesting provider of the independent review organization's (IRO) decision no later than 24 hours after receipt of an expedited EERR and no later than 72 hours after receipt of a standard EERR.

The Plan's *Pharmacy Exception Process for Non-Formulary Drugs* policy described its ERRR process, stating:

> **VI. G&A Responsibility**
>
> F. The request will be categorized as an Inquiry with the exception of a CA DMHC regulated plans which will be categorized as a Grievance.
>
> 2. The assigned analyst will be accountable for notifying the member, the member's authorized representative and the prescribing physician of the outcome of the review by phone AND in writing (scripting and letters will be available).
> 3. The timeframes for completion of the review are the same as those for the Exception Process:
> - 72 hours if standard
> - 24 hours if urgent[93]

The Department reviewed 64 EERR files. Among these files, the Department found the Plan failed to provide notice of the IRO's decision within the applicable timeframe in 46

[93] *Pharmacy Exception Process for Non-Formulary Drugs,* page 2.

files (72%).[94] These deficient files included 20 expedited files[95] in which the Plan did not notify the requesting provider within 24 hours of receipt of the EERR request. They also included 26 standard request files[96] in which the Plan did not notify the requesting provider within 72 hours of receipt of the request.

TABLE 13
EERR Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
EERR	64	Plan provided notice to prescribing provider within 24 hours of receipt for expedited requests and within 72 hours of receipt for standard requests	18 (28%)	46 (72%)

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

> [A]cknowledges this was a deficiency in 2020 and implemented the following corrective actions to improve the process and timeliness of external exception reviews for non-formulary drugs:
>
> - In **Q2 2023,** the Plan added a new internal shared mailbox as a centralized location for all non-formulary requests.
> - In **Q3 2023**, the Plan also added additional staff and coverage to handle these requests 7 days a week to monitor, triage, task to Independent Review Organizations and fulfill notifications to providers and members within the regulatory timeframe of 24- or 72- hours.
>
> The Plan also made systematic enhancements to ensure all 24- or 72-hour turnaround requirements are met for all external exception non-formulary requests. These enhancements were put in place to capture all external exception non-formulary requests to Grievances and Appeals with a systematic approach and automation where these reviews prioritized into their own workbaskets for improved monitoring and urgent handling for timely resolution. These metrics are measured and monitored weekly so immediate intervention or remediation can be made by the Plan if needed. In addition to monitoring metrics weekly, the Plan provides monthly reports on (NBPP) to the Operations Oversight Committee, a

[94] DMHC Files 1-3, 6, 7, 9-13, 15, 16, 18-21, 23-25, 27-34, 37-40, 42-47, 49, 50, 52, 54, 59, 61, 62, 64, 65.
[95] DMHC Files 1-3, 6, 15, 21, 27, 28, 31, 33, 34, 37, 38, 40, 43, 46, 47, 49, 50, 59.
[96] DMHC Files 7, 9-13, 16, 18-20, 23-25, 29, 30, 32, 39, 42, 44, 45, 52, 54, 61, 62, 64, 65.

subcommittee of the Management Oversight Committee.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure requesting providers are notified of EERR decisions within the required timeframes.

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 review of monitoring tools and results, files, interviews, and any other review deemed necessary by the Department.

Deficiency #18: The Plan did not inform enrollees of their right to seek an external exception request review in formulary exception request denial and modification letters.

Statutory References: Section 1367.24(b); Section 1367.01(h)(4).

Assessment: Section 1367.24(b) requires the Plan to indicate in its written FER denial, delay, and modification notices the enrollee may seek an EERR with an IRO.[97] Section 1367.01(h)(4) mandates these notices "include information as to how the enrollee may file a grievance with the plan."

The Department reviewed 70 FER denial, delay, and modification files processed by the Plan's PBM. The Department found none of the letters (100%)[98] in these files advised enrollees of their right to seek an EERR or provided information on how to request such review by an IRO as required by Section 1367.24(b) and Section 1367.01(h)(4).

[97] This requirement does not apply to the Plan's Medi-Cal line of business pursuant to Section 1367.24(l).
[98] DMHC Files: 1-17, 19-25, 27-70, 72, 75

TABLE 14
FER Denial, Delay, and Modification Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
FER Denial, Delay, and Modification	70	External exception request review information included in enrollee denial, delay, and modification letters	0 (0%)	70 (100%)

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

> [A]grees this was a deficiency in 2020. All letters will be updated to include required language that informs enrollees of their right to seek an external exception request review in formulary exception request denial and modification letters. All letters will be updated and implemented effective August 19, 2024.

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Department will need to conduct file review during the Follow-Up Survey to confirm whether the actions taken are sufficient to ensure the Plan is informing enrollees of their right to seek an EERR in FER denial and modification letters.

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 review of files, interviews, and any other review deemed necessary by the Department.

LANGUAGE ASSISTANCE

Deficiency #19: The Plan did not consistently notify enrollees that language assistance services are to be delivered in a timely manner.

Statutory References: Section 1367.042(a)(1), (b)(2)-(3).

Assessment: Section 1367.042(a)(1) requires the Plan to notify enrollees and members of the public of "the availability of language assistance services, including oral

interpretation and translated written materials, free of charge and in a timely manner pursuant to Section 1367.04, and how to access these services." Section 1367.042(b)(2) and (3) mandates the Plan provide this information to enrollees on an annual basis and on its Internet Web site.

To assess the Plan's compliance with these requirements, the Department reviewed the Plan's *Standard Notice of Language Assistance*, *Annual Notice of Language Assistance*, and Internet Web site. The Department found none of the Plan's notices advised language assistance services are available to enrollees in a timely manner as required by Section 1367.042(a)(1).

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

> [D]isagrees with the Department's review and assessment of this deficiency. The Report references the Standard Notice of Language Assistance, the Annual Notice of Language Assistance, and the Plan's online nondiscrimination notice, which was visited by the Department on March 7, 2024.
>
> The Standard Notice of Language Assistance (NOLA) was reviewed and approved by the DMHC (Filing No. 20173144). That same language that was approved by the DMHC for the Standard Notice of Language Assistance was used on the main landing page (https://www.anthem.com/ca) (tab Language Assistance) for our online notice, and reflects an enrollee's ability to receive free help, right away, by calling the Member Service number listed. This informs enrollees about their ability to receive no-cost help immediately by calling the Member Service number provided.
>
> Additionally, this deficiency was not identified in the 2022 Behavioral Health Investigation and contrasts the Plan's online notifications with those of other California health plans, asserting that it is in line with industry standards for notifying enrollees about access to free language services in a timely manner.
>
> Also of note, in accordance with APL-22-007, which required Plans to incorporate SB 221 standards into their monitoring processes, as applicable, the Plan updated its LAP Program (Policy) to reflect that coordination of interpreter services with appointments shall not delay the scheduling of the appointments. However, APL-22-007 focused on the Timely Access Regulations through policy and procedure changes and did not require a change to the Notice of Language Assistance. The Plan's LAP was reviewed and approved by the DMHC in September of 2023 (Filing No. 20233788).

Supporting Documentation:

- 2020 Routine Medical Survey Preliminary Report Corrective Action Plan Response (August 12, 2024)

Final Report Deficiency Status: Not Corrected

Based on the Plan's response, the Department has determined this deficiency is not corrected.

The Plan's Standard NOLA and notice on its website provide:

> Curious to know what all this says? We would be too. Here's the English version:
>
> IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at {1-888-254-2721. (TTY/TDD: 711)}

The notice is noncompliant because it does not say an enrollee can "receive free help, right away, by calling the Member Service number listed" as the Plan purports. Rather. The notice instructs the enrollee to "call right away" for free help. In addition, the notice only pertains to translation services and does not mention oral interpretation services. Although the Department reviewed and did not object to the Plan's implementation of the filing, the Department's closing letter to the Plan states:

> This letter does not constitute a waiver of any compliance issues that may be identified on subsequent review and analysis of the Amendment, whether or not highlighted to reflect a change, or of any other Plan documents or operations, whether or not disclosed in the Amendment.
>
> The Department reserves the right to require additional revisions to the Plan's operations and documents, including but not limited to subscriber and provider documents, and written policies and procedures, as further review may indicate is necessary for compliance with the Act.[99]

Thus, although eFiling 20173144 was closed, the Department is not precluded from identifying deficiencies with the NOLA or asking the Plan to correct the identified issues. Furthermore, the Plan did not provide an explanation as to why the Annual NOLA is compliant.

The Department also acknowledges this deficiency was not identified in the Plan's BHI Report. However, the Department's review during its BHI of the Plan did not include assessment for compliance with Section 1367.042. Therefore, the absence of similar findings in the Plan's BHI Report does not offer any insights to the Department regarding the Plan's current compliance status.

[99] eFiling 20173144 Closing Letter.

At the Follow-Up Survey, the Department will assess whether the deficiency has been corrected. Assessment may involve review of policies and procedures, templates, interviews, and any other review deemed necessary by the Department.

SECTION II: SURVEY CONCLUSION

The Department's 2020 routine survey of the Plan is complete.

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

The Department will conduct a Follow-Up 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, **2020 Routine Full Service Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.