DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE MEDICAL SURVEY
OF
BLUE CROSS OF CALIFORNIA

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: APRIL 5, 2006
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Final Report of a Routine Medical Survey
Blue Cross of California
A Full Service Health Plan

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a Routine Medical Survey of Blue Cross of California (the "Plan") from August 22 to 26, 2005. The Department surveyed the Plan's Commercial and Healthy Families products. This is a Preliminary Report of findings and deficiencies from the Routine Medical Survey. The Department conducts a Routine Medical Survey of each licensed health care service plan at least once every three years to evaluate its compliance with the requirements of the Knox-Keene Act (the "Act"). The survey addresses four areas: Quality Management; Grievances and Appeals; Access and Availability of Services; and Utilization Management.

Background

Blue Cross of California, Inc., is an independent licensee of the Blue Cross Association. It originated in 1936 as a not-for-profit hospital service organization responding to the cost of hospital care during the Depression by offering prepaid plans. By 1945, coverage for medical and surgical services was made available. In 1983, the Plan became the first in California to implement a preferred provider organization (PPO) health plan, called the Prudent Buyer Plan, contractually arranging fee discounts with thousands of physicians and hundreds of hospitals throughout the state. In 1986, the Plan introduced its health maintenance organization (HMO) plan, CaliforniaCare.

In 1993, the California Department of Corporations (now the Department of Managed Health Care) granted the Plan a license to operate as a Health Care Service Plan under the Act. The Plan restructured its operations and formed a holding company, WellPoint Health Networks Inc., which merged with, and is now a subsidiary of, WellPoint, Inc. Through intermediate holding companies WellPoint, Inc. owns the Plan, which has operated as a for-profit company since May of 1996.

Survey Results

The Department found no outstanding deficiencies identified during the previous 2003 Routine Medical Survey that are not corrected at the time this Final Report is issued (see Section II.A.).

The Department identified five compliance deficiencies during the current Routine Medical Survey (See Section II.B.). The Plan has implemented corrective actions and has fully corrected all five of these deficiencies at the time of this Final Report.

See Appendix A for an explanation of the Department's approach in surveying California health plans licensed by the Department.

SECTION I. SURVEY HISTORY

The table below is a schedule of survey activities conducted by the Department at the Plan in the past three years.

TABLE 1

SURVEY ACTIVITY	DATE
2002 Routine Survey Onsite Visit	August 26–30, 2002
2002 Preliminary Report	November 14, 2002
Final Report for 2003 Routine Survey	February 18, 2003
Follow-up Report Issued to Plan	August 4, 2004
2005 Routine Survey Onsite Visit	August 22–26, 2005
2005 Preliminary Report Issued to Plan	November 17, 2005
Final Report for 2005 Routine Survey	April 5, 2006

See Appendix B for a list of Enforcement Action(s) taken by the Department within the past 12 months based on completed investigations where sufficient evidence was found to support allegations that the Plan has committed violations of the Act.

SECTION II. DISCUSSION OF DEFICIENCIES, FINDINGS AND CORRECTIVE ACTIONS

A. RE-ASSESSMENT OF OUTSTANDING DEFICIENCIES

At the time the Department initiated the current medical survey, the Plan had no deficiencies outstanding from the previous medical survey conducted August 26–30, 2002.

B. 2005 SURVEY DEFICIENCIES

Table 2 below lists deficiencies identified during the current survey. The Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to: (a) develop and implement a corrective action plan (CAP) for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

TABLE 2

SUMMARY OF 2005 SURVEY DEFICIENCIES		
#	**DEFICIENCY STATEMENT**	**STATUS**
GRIEVANCES AND APPEALS		
1	**The Plan does not adequately address the linguistic and cultural needs of its enrollee population**. [Rule 1300.68(b)(3)] **Product:** Commercial	Corrected
2	**The Plan does not consistently:** • **Provide a clear and concise explanation for its decision in its grievance resolution letters.** • **Provide the exact provision of the contract or the Evidence of Coverage (EOC) that excludes the coverage in its appeal resolution letters for benefit denials.** • **Provide the name and telephone number of the contact person in its grievance acknowledgment letters.** [Section 1368(a)(4) & (5), Rule 1300.68(d)(3)] **Products:** Commercial, Healthy Families	Corrected

SUMMARY OF 2005 SURVEY DEFICIENCIES		
#	**DEFICIENCY STATEMENT**	**STATUS**
3	**In its benefit denial letters, the Plan does not consistently provide the provision of the benefit contract or EOC that includes the coverage. The EOC language does not consistently support the denial decision.** [Section 1368(a)(5)] **Products:** Commercial, Healthy Families	Corrected
ACCESS AND AVAILABILITY OF SERVICES		
4	**The Plan does not have an adequate system for monitoring and evaluating appointment wait times and the provision of after-hour services including a system for addressing problems that develop. Error! Bookmark not defined.** [Rule 1300.67.2(f)] **Product:** Healthy Families, Commercial	Corrected
UTILIZATION MANAGEMENT		
5	**The Plan does not consistently include a clear reason in letters to enrollees for medical necessity denials.** [Section 1367.01(h)(4)] **Products:** Commercial, Healthy Families	Corrected

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

GRIEVANCES AND APPEALS

Deficiency 1: **The Plan does not adequately address the linguistic and cultural needs of its enrollee population**. [Rule 1300.68(b)(3)]

Product: Commercial

Documents Reviewed:
- Grievance & Appeals (G&A) Plan policy "G&A 9, Grievance Process"

Department Findings: The Plan policy, G&A 9, Grievance Process, states that the Plan has a list of employees proficient in a language other than English. When a Plan associate determines that an enrollee has limited or no English proficiency, the appropriate language interpreter is contacted to assist in communicating with the enrollee. The Plan also uses the AT&T translator line as needed, and has a TDD line for the speech and hearing impaired. The Plan policy references, "G&A associates accommodate members' preferred languages upon request and will send appropriately translated letters."

Plan officials acknowledged that in recent years the Plan responded in written English to some standard grievance cases received in spoken or written Spanish, but that grievance responses written in Spanish would be provided "upon request." The Department has determined that the Plan's practice of providing grievance responses written in the Spanish language only "upon request" is not consistent with Rule 1300.68(b)(3), which requires that a health plan's assistance "… shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, …"

Implications: By not providing grievance resolutions written in the Spanish language when grievances are filed in Spanish, the Plan is not doing enough to ensure that all enrollees can fully participate in the Plan's grievance system.

Corrective Action: The Plan shall submit evidence that its grievance system, including grievance policy and procedures, will ensure that an enrollee's grievance submitted in a language other than English receives a written response in that same language pursuant to Rule 1300.68(b)(3).

Plan's Compliance Effort: The Plan stated in its response that it has undertaken the following process improvements to ensure linguistic compliance in this area:

1. The commercial G&A policies have been revised to meet the linguistic and cultural needs of Blue Cross' commercial member population. The revised language includes the following statement:

   > ". . . . G&A associates will ensure that all members who submit oral or written grievances and appeals in a language other than English, are sent responses in the same language as the member submitted. G&A will use all available internal and external resources for translation services. These resources include an internal list of foreign language interpreters, the services of an external translation vendor, a TDD line for the speech and hearing impaired, and the AT&T translator line."

2. All G&A associates have been provided a copy of the language. Cultural diversity was addressed at G&A staff meetings (HMO and PPO) and the online grievance training module for all Customer Service Representatives will be updated with a section dedicated to the cultural and linguistic requirements. The intranet web site contains a section on "Cultural Diversity and the Workplace" and provides ongoing training and resources for associates.

3. In addition to external vendor contracts, the Plan has an annually updated internal list of associates proficient in a variety of languages who are available for in-house translations.

4. The June edition of the HMO/PPO Member Newsletter will contain an article on the G&A process and will include a section on cultural and linguistic assistance.

5. The Plan will develop Spanish versions of all G&A template letters. In the interim, G&A staff will use available internal/external translation resources to communicate with members in language of origin.

The Plan submitted the following documents:
- G&A Policy 9 Grievance Process
- G&A Policy 1 Appeal Process
- HMO Staff meeting minutes 2-28-06
- PPO Staff meeting minutes 2-22-06
- Blinded copy of actual grievance response letter in Spanish
- Member Newsletter Article

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan appears to have adequately addressed this deficiency.

The Department finds that the Plan has implemented the process of providing response letters in the language in which the enrollee submitted the grievance, has retrained staff and will revise template letters to further facilitate this process.

Deficiency 2: **The Plan does not consistently:**

- **Provide a clear and concise explanation for its decision in its grievance resolution letters.**
- **Provide the exact provision of the contract or the Evidence of Coverage (EOC) that excludes the coverage in its appeal resolution letters for benefit denials.**
- **Provide the name and telephone number of the contact person in its grievance acknowledgment letters.**

[Section 1368(a)(4) & (5), Rule 1300.68(d)(3)]

Products: Commercial, Healthy Families

Documents Reviewed:
- Fourteen Healthy Families grievance files from the period January–June 2005
- Eight Healthy Families appeal files from the period January–June 2005
- Twenty-five Commercial grievance files from the period January–June 2005
- Eighteen Commercial appeal files from the period January–June 2005

Discussion of Findings:

Healthy Families: The Department reviewed 14 grievance and eight appeal files. Eight resolution letters did not contain a clear and concise explanation for the Plan's decision. Two resolution letters did not address the specific concerns and requests of the enrollees as stated in their grievance letters. Three of the resolution letters did not contain a resolution at all.

Commercial: The Department reviewed 25 grievance files. Eleven of the 25 grievance resolution letters did not provide a clear and concise explanation for the Plan's decision. The resolution letters did not address the specific issues raised by the enrollees. For example, an enrollee was requesting reconsideration of a denied procedure and complained about a provider's unresponsiveness. The resolution letter addressed neither issue.

The Department also reviewed 18 appeal files. Denials were upheld in 13 of the 18 appeals. Five of the 13 upheld denial letters were unclear because the Plan did not provide the exact provision of the benefit contract or the EOC that excludes such coverage.

The Department's review of the same 25 grievance files cited above found that the Plan acknowledged receipt of all grievances in writing; however, it failed to provide the name and telephone number of the contact person in eight of the acknowledgment letters.

Implications: Clear communication of the Plan's decision is an essential component of a fair and effective grievance and appeal system. Not including the name and telephone number of the contact person in the acknowledgement letter prevents the enrollee from being able to easily contact the Plan to discuss the grievance.

Corrective Action: The Plan shall submit:

1) Evidence that it consistently provides a clear and concise explanation for its decision in its grievance resolution letters.
2) Evidence that it provides the exact provision of the contract or the EOC that excludes the coverage in its appeal resolution letters for benefit denials.
3) Evidence that it consistently includes the name and telephone number of the contact person in its grievance acknowledgement letters.

Plan's Compliance Effort:

Healthy Families: The Plan stated in its response that it revised the grievance resolution letter process to include specific information to the member. In May 2005 additional staff training was provided to the G&A clinical staff to ensure that the resolution letters contained case-specific information for the member. The Plan stated that internal monitoring now demonstrates compliance in this area.

Commercial: The Plan stated in its response that the G&A template letters were updated with prompts to both restate the member's issue(s) and insert the correct decision, rationale, and supporting criteria used for benefit denials, medical necessity denials and grievance responses in accordance with regulatory requirements and standards. System-generated acknowledgment

letters were corrected by putting a designated G&A associate's name in the letter. This associate is responsible for answering the G&A 800 phone line. In instances where the Plan must generate a manual letter, it has been reformatted to include a field that requires the customer service representative to put his/her first and last name into the letter.

Furthermore, the Plan stated that the G&A Department is audited on a semi-annual basis by clinical staff from the Regulatory and Accrediting Oversight Department and CAPs are implemented when deficiencies are identified. In addition, the G&A Department has developed an internal audit process to monitor compliance with Department and NCQA[1] standards. In the correspondence section, the audit tool targets benefit denial letters for compliant language. Focused audits and CAPs are used to correct any deficiencies.

The Plan submitted the following documents:

- Sample revised benefit denial template
- Blinded copy of actual coverage denial letter
- Blinded copy of actual acknowledgment letter
- Examples of State Sponsored Business Grievance Resolution letters

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan appears to have adequately addressed this deficiency.

The Department finds that the Plan has revised its template documents and has demonstrated implementation of these documents through submission of sample letters. The Plan will ensure continued compliance through internal monitoring.

Deficiency 3: **In its benefit denial letters, the Plan does not consistently provide the provision of the benefit contract or EOC that includes the coverage. The EOC language does not consistently support the denial decision.** [Section 1368(a)(4)]

Products: Commercial, Healthy Families

[1] The NCQA (National Committee for Quality Assurance) is an independent, non-profit organization that certifies physician organizations and accredits managed care organizations and preferred provider organizations. Its stated mission is "to improve the quality of health care" through a variety of programs. More information can be found at the Committee's website at www.ncqa.com.

Documents Reviewed:

- Eight Healthy Families benefit denial files from the period January–June 2005
- Five Commercial benefit denial files from the period November 2004–June 2005
- Twenty-two Healthy Families and Commercial pharmacy denial files from the period November 2004–June 2005

Department Findings: The Department reviewed eight Healthy Families benefit denial files and five Commercial benefit denial files. All benefit denials for Healthy Families were compliant. In three of the commercial denial letters the Plan notified the enrollee that the requested service was not a covered benefit because the requested provider was not a Plan-designated Center of Excellence for the requested service. The Plan did not refer in its letter to the provision in the contract or EOC that excludes such coverage.

The Department also reviewed a combined total of 22 Healthy Families and Commercial pharmacy denial files; six were benefit denials. Of the six, three did not properly refer enrollees to the provision of the contract or the EOC that excludes such coverage. Two of the letters referred the enrollee to the EOC; however, when the EOC was reviewed, it did not contain the language referred to in the denial letter. The third made no reference to the EOC or contract.

Implications: Unclear denial communications can cause frustration and confusion on the part of the enrollee and result in denial of a service that is, in fact, medically necessary and a covered benefit.

Corrective Action: The Plan shall submit evidence that letters denying a requested service on the basis that it is not a covered benefit clearly refer to the appropriate EOC or contract language by:

1) Referring to the provision in the EOC or contract which contains the appropriate language;
2) Quoting the pertinent EOC or contract language in the denial letter; or
3) Including a copy of the pertinent EOC or contract language in the denial letter as an enclosure.

Plan's Compliance Effort: The Plan stated in its response that only Commercial pharmacy denial files were actually selected for review so the response relates to Commercial denials.

The Plan also stated that G&A policy #1 (Standard Appeal Process) lists the elements that must be contained in a benefit denial letter. In addition, the benefit denial letter template contains prompts for the required language. The required elements for a benefit denial letter were discussed at HMO and PPO G&A staff meetings and G&A associates were given refresher training. The G&A Department has developed an audit process and tool for conducting random audits on G&A cases to ensure compliance.

The Plan also revised its denial letter templates for pharmacy prior authorization of benefits letters. Language discussing medical necessity will not appear on denial letters which are based on lack of coverage under the member's benefits. In those cases where the denial of coverage is based on a finding that the medication or its use is not covered under the member's coverage, the following language has been inserted into the denial letter:

> "This medication will not be covered in this case as it is excluded from coverage under the patient's member benefits. Please refer to the section of the member's Evidence of Coverage entitled: PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED for more details on limitations and exclusions that apply to the member's particular coverage."

In order to ensure compliance, the Plan will conduct internal audits on a quarterly basis.

The Plan submitted the following documents:

- G&A Policy 1 Appeal Process
- HMO Staff meeting minutes 2-28-06
- PPO Staff meeting minutes 2-22-06
- G&A Audit Tool
- G&A PowerPoint Presentation of Audit Results
- Blinded copy of actual appeal benefit denial letter
- Pharmacy benefit denial letter template

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan appears to have adequately addressed this deficiency. The Department finds that the Plan has revised its template documents and will ensure continued compliance through internal monitoring.

ACCESS AND AVAILABILITY

Deficiency 4: **The Plan does not have an adequate system for monitoring and evaluating appointment wait times and the provision of after-hour services, including a system for addressing problems that develop.** [Rule 1300.67.2(f)]

Product: Healthy Families, Commercial

Documents Reviewed:
- Quality Improvement Program Annual Report
- Access and Availability Comprehensive Analysis
- Access Standards Policy
- Member satisfaction with access results

Discussion of Findings:

Healthy Families: The Plan has established standards for appointment availability including requirements for emergencies (immediate), urgent examinations (within 24 hours), non-urgent routine examinations (within 14 days) and consults/specialty referrals (within 21 days). The Plan has not regularly compiled and analyzed data that compares provider performance to its appointment availability standards. Historically, the Plan has participated in the Consumer Assessment of Health Plans Providers and Systems[2] survey, which includes items on member satisfaction with appointment wait times, but does not supply provider-specific compliance information. To address this deficiency, the Plan is currently conducting its first survey of a sample of offices of primary care physicians covering an expected 65–75% of enrollees and is also working on analysis of appointment availability with LA Care. The Plan will also sample and survey specialists; however, this survey is not scheduled to begin until next year.

Commercial: The Plan has established standards for appointment availability including emergency care (immediate), urgent care (24 hours), routine primary care non-urgent care for symptomatic conditions (7 days) and consult/specialty referral (14 days). The Plan monitors provider compliance through the California Cooperative Healthcare Reporting Initiative (CCHRI)[3] telephone survey of provider offices, member grievances and member surveys. The Plan's most recent survey (2004) demonstrated compliance with its standards for urgent and non-urgent primary care physician appointments and for urgent specialty appointments; however, the Plan failed to meet its 14-day specialist appointment standard. Only 77% of HMO providers and 72% of PPO providers met the standard. This represented a decrease from the previous year's rates (82% and 85%).

The Plan monitors after-hours availability of its providers using the CCHRI after-hours survey, and notifies non-compliant providers/provider groups by letter. However, the letter does not require that providers submit a CAP or evidence of correction, and the Plan does not reassess compliance until the next annual survey; the Plan has not implemented adequate corrective actions and follow-up components to ensure that those providers make required changes.

Implications: Failure to ensure timely access to appointments can result in delays in care, deterioration of the enrollee's condition, and enrollee dissatisfaction.

To provide enrollees with access to professional consultation and care in emergency and urgent situations, the Plan must ensure that its providers have made adequate provisions for after-hours access. A delay in addressing and reevaluating providers identified as having inadequate after-hours provisions may result in continued non-compliant behavior.

[2] The Consumer Assessment of Healthcare Provider and Systems Program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

[3] The California Cooperative Healthcare Reporting Initiative (CCHRI) is a collaborative of health care purchasers, plans and providers. The Pacific Business Group on Health initially convened CCHRI and now manages it. In order to supplement important access information obtained from the Consumer Assessment Survey (CAS), such as appointment availability and access to care information, CCHRI also conducts an annual after-hours telephone survey of physicians' offices. This Provider Telephone Access Survey focused on the same primary care physicians associated with the medical groups and IPAs participating in the CAS.

Corrective Action:

Healthy Families: The Plan shall provide:

1) Evidence that it has completed its initial monitoring of primary care physicians' offices and that it has implemented a monitoring system for appointment wait times for specialists.
2) Evidence that it has analyzed the results of the monitoring and that based on these results, it has implemented corrective actions with non-compliant providers and followed up to assess the effectiveness of those actions.

Commercial: The Plan shall provide:

1) Evidence that it has fully implemented its corrective actions and that it has overseen implementation of its providers' CAPs. The Plan shall submit the results of its re-measurements to demonstrate the effectiveness of these corrective actions.
2) Evidence that it has implemented a system for requiring corrective actions of providers who are non-compliant with its after-hours requirements and for conducting timely follow-up to verify that those corrective actions have been effectively implemented.

Plan's Compliance Effort:

Healthy Families: The Plan conducted a survey of a random sample of primary care providers from its Medi-Cal and Healthy Families HMO in July 2005 to assess compliance with appointment access standards. The Plan surveyed 2,174 Primary Care Providers (PCPs) utilizing a script that provided clinical scenarios to schedule an appointment for a new patient. Approximately 54% of providers were found to be compliant with established appointment access standards, 36% non-compliant and 10% unclassified.

The Plan analyzed the results, identified barriers and made recommendations for improvement. The Plan submitted a work plan for 2006 that ensures that all aspects of the continuous quality improvement process (measurement, analysis, corrective action interventions and re-measurement) will be completed during 2006. The non-compliant physicians from 2005 will be resurveyed in 2nd quarter, 2006. In addition, the 2006 process will include the monitoring of high volume specialists. The survey and follow-up process will be repeated annually.

Commercial: At the time of the Department's on-site audit, the 2005 access results were not completed. In its response, the Plan provided updated results, which demonstrated that urgent PCP and specialist access, non-urgent PCP visit within 7 days, routine PCP & Specialist OB/GYN, and after-hours coverage continue to meet access standards. Non-urgent specialist visits within 14 days improved for the HMO and PPO as did ER instruction and after-hours physician availability.

The Plan stated that it provides detail of the survey results to individual physicians who are not in compliance with access standards, apprises the physicians of the standards and requests corrective actions. Survey detail is also sent to medical groups and a CAP is requested when the overall rate for a medical group does not comply with the Plan's access standards. A follow-up

telephone call/e-mail is sent to the medical directors and Quality Management (QM) managers to discuss requirements. Medical groups must provide written or verbal documentation of their CAP to the Plan. As a result of discussions with the Department's audit team during the on-site visit in 2005, the Plan added a mid-cycle re-audit of physicians not in compliance with after-hours ER requirements to its processes.

In the future, the Plan stated it will require that individual physicians who are non-compliant with the physician availability standard implement a CAP. Physicians will also be asked to complete and fax back an attestation of implementation of their CAP for both after-hours ER instruction and for physician availability as applicable.

The Plan submitted the following documents:

- Letter informing non-compliant individual physicians of Plan Access Standards and a request for CAP for after-hours ER instruction
- Provider Medical Group medical director letter to inform of Blue Cross Access Standards and a request for CAP for after-hours ER instruction
- Non-compliant individual physician letter to inform of Plan Access Standards and a request for CAP for after-hours physician availability
- Physician attestation to inform Plan of CAP implementation
- 2005 State Sponsored Business Appointment Access Survey Report

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan appears to have adequately addressed this deficiency. The Department finds that the Plan has demonstrated improved rates in its most recent survey and has strengthened its follow-up processes for non-compliant providers.

UTILIZATION MANAGEMENT

Deficiency 5: The Plan does not consistently include a clear reason in letters to enrollees for medical necessity denials. [Section 1367.01(h)(4)]

Products: Commercial, Healthy Families

Documents Reviewed:
- Fifteen Healthy Families denial files from the period January–June 2005
- Twenty-seven Commercial medical necessity denial files from the period November 2004–June 2005

Department Findings: The Department reviewed 15 Healthy Families medical necessity denial files, including two pharmacy denials. In three of the files, the Plan never received the requested information. The remaining 12 files all contained a standardized template letter that included

line items with the Current Procedural Terminology (CPT)[4] code and narrative descriptions of the denied service that did not correspond to the body of the letter. For example, one denial letter stated the denied service as physical therapy in the CPT code narrative and as exercise programs for weight loss in the body of the letter; another denial letter stated the denied service as Oxford shoes in the CPT code narrative and orthopedic shoes in the body of the letter.

The Department also reviewed 27 Commercial medical necessity denial files. Of these 27, three did not include a clear explanation of the reasons for the Plan's decision. Where the Industry Collaborative Effort (ICE)[5] letter template[6] was used, the medical group did not customize the letter to individual circumstances. For example, the Plan listed medical necessity criteria that would not justify the requested service; however, the service was denied as not being a covered benefit. Medical necessity criteria are not relevant to benefit decisions made based upon whether a service is a covered benefit.

Implications: A clear and concise explanation of the Plan's reason for delaying, denying or modifying requested health care services is an essential component of a fair and reasonable authorization process. When the reasons for a denial are not clearly explained, enrollees and providers may not understand the basis of the denial and may not have the information necessary for making a decision regarding whether to file an appeal or request an independent medical review (IMR).

Corrective Action: The Plan shall submit evidence that it has taken action to ensure that all medical necessity denial letters clearly describe the reason(s) for the denial by:

1) Ensuring that the CPT code narrative and the services denied in the body of the letter are congruent, and
2) Ensuring that the Plan response letters have been modified for the denial reason, (medical necessity or benefit), and the individual circumstances of the enrollee clearly and concisely addressed.

Plan's Compliance Effort:

Commercial and Healthy Families:

1. CPT code narrative congruency: In its response, the Plan stated that denial letters for both Non-Delegated Commercial and Healthy Families have been revised to include the narrative

[4] Current Procedural Terminology (CPT) is a listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians, and other healthcare providers, patients, and third parties.

[5] Industry Collaborative Effort (ICE) is a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through education of the public. ICE volunteers include interested individuals from across the nation.

[6] The Department has worked and continues to work collaboratively with ICE on a variety of issues, including template versions of statutorily required letters. However, the Department does not formally approve or disapprove the ICE templates.

description of the CPT code found on every letter template as part of the clinical rationale. If the narrative description of the CPT code and the language used when requesting the service are different, the narrative description will be in parenthesis following the language used to request the service.

2. Individualized denial reason response letters: The Plan indicated that this deficiency relates to non-compliant denial letters issued by two of its delegated medical groups. Both delegates are using the ICE Utilization Management (UM) denial letter templates and adapting them to meet their operational needs. The template version contains three paragraphs that may accompany the denial reason. One paragraph is to be used for medical necessity or benefit coverage limitation denials and the other two paragraphs are applicable for eligibility or out of network situations and benefit coverage denials (exclusions). The template requires manual customization specific to each case and to remove the non-applicable paragraph when the denial letter is processed. In the cases reviewed, the incorrect paragraph was used, which led to lack of clarity regarding whether the denial was based on a benefit or medical necessity issue.

In order to correct the deficiency, the Plan stated in its response that:
(1) Both delegates' UM staff (UM Director and Medical Director) were verbally informed of the Department's survey results within 24 hours of the completion of the audit.
(2) An e-mailed communication was sent to all delegates with a reminder of the need for specific customization for each member's specific circumstance in each denial letter. In addition, the communication stressed the importance of customizing template letters to meet the individual member's needs.
(3) The Plan conducted its annual audit of the two delegates in the 3rd/4th quarter of 2005, during which no further file review issues related to this deficiency were found, and has scheduled a focused audit for the 2nd quarter 2006 to confirm continuing compliance.
(4) All delegates are audited at least annually for all delegated UM functions, including this deficiency. If deficiencies are noted, a follow-up audit is conducted within six months of the annual audit to re-assess compliance.

The Plan submitted the following documents:

- Sample Commercial Denial Letter
- Sample Healthy Families Denial Letter
- Draft Operation Guideline, Use of CPT Code Narrative
- Emailed Re-educational communication to delegated medical groups
- Audit results, CMGWV medical group
- Audit results, RMG medical group

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan appears to have adequately addressed this deficiency.

The Department finds that the Plan has addressed the issue with the non-compliant delegates as well as with its overall delegate network. It has re-audited the non-compliant delegates and has put in place a plan for follow-up audits with same and other delegates.

C. SURVEY CONCLUSION

The Department has completed its Routine Medical Survey of the Plan. Based on the results of this survey Final Report, there will be no Follow-Up Review of the Plan conducted.

A P P E N D I X A

A. OVERVIEW OF THE MEDICAL SURVEY PROCESS

The medical survey is a comprehensive evaluation by the Department of a health plan's compliance with the Act and its resulting performance in meeting the health needs of plan enrollees. The survey includes an on-site meeting, a review of documents and interviews with the plan's staff. It also includes a review of the plan's oversight of the plan's provider network. Generally, the Department evaluates a plan's performance in four major areas:

(1) **Quality Management** – Each plan is required to assess and improve the quality of care it provides to its enrollees. During the medical survey, the Department evaluates a plan's quality management program, including:

- Design, implementation and effectiveness of the internal quality of care review systems;
- Overall performance of the plan in providing health care benefits;
- Overall performance of the plan in meeting the health needs of enrollees; and
- Mechanisms for credentialing and peer review.

(2) **Grievances and Appeals** – Each plan is required to resolve all grievances and appeals in a professional, fair and expeditious manner. The Department regards a plan's grievances and appeals process as a core mechanism through which enrollees can exercise their rights should there be a need to resolve problems with their plan. During the medical survey, the Department evaluates a plan's grievances and appeals system, including:

- Design, implementation and effectiveness of the Grievances and Appeals system;
- Procedures for addressing the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities such as those with visual or other communicative impairment;
- Documentation, investigation and resolution of all forms of grievances and appeals;
- Notification to enrollees, their designees and providers of the disposition of the grievances and appeals; and
- Compliance with timeliness standards.

(3) **Access and Availability of Services –** Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas and that services are available without delay that may be detrimental to enrollees' health. During the medical survey, the Department evaluates a plan's:

- Procedures for obtaining health care services;
- Procedures for monitoring and ensuring geographic access;
- Procedures for monitoring and ensuring appointment availability; and
- Overall performance in meeting established access and availability standards.

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

care. During the medical survey, the Department evaluates a plan's utilization management program, including:

- Procedures for reviewing authorization requests and regulating utilization of services and facilities;
- Compliance with notification and timeliness standards;
- Use of appropriate criteria or clinical guidelines to guide authorization decisions; and
- Use of utilization data to identify and analyze patterns and trends for potential over-utilization or under-utilization of services and to institute corrective actions as necessary.

Following a routine medical survey, the Department provides a plan with a Preliminary Report of its deficiency findings. A plan is required to respond in writing within 45 days of receipt of the Preliminary Report and to submit evidence that the deficiencies have been corrected within the same 45-day response. For those deficiencies that cannot be corrected within the 45-day response period, a plan is required to submit a CAP for Department approval. The Department then provides a Final Report to the plan and makes the report available to the public by mail or on its website (www.dmhc.ca.gov) within 180 days of the last date of the onsite survey. The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the plan's response and the Department's determination concerning the adequacy of the plan's response.

The Department conducts a Follow-Up Review and issues a report within 18 months of the date of the Final Report to determine whether uncorrected deficiencies identified in the Final Report have been corrected. The Department then provides a Follow-Up Report, which contains the Department's determination concerning the outstanding deficiencies. If deficiencies identified in the Final Report are not corrected at the time of the Follow-Up Review, a plan may be subject to disciplinary actions pursuant to Health and Safety Code 1380(i)(l). (See Appendix G for additional details on the reporting and response process.)

A P P E N D I X B

B. ENFORCEMENT ACTIONS

Below is a list of relevant Enforcement Actions taken by the Department within the past 12 months based on completed investigations where sufficient evidence was found to support allegations that the Plan has committed violations of the Act.

COMPLAINT / ENFORCEMENT # CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 244662 **Enforcement Matter No**: 05-272 **Citation(s):** Section 1367.01(h)(4)	The Department determined that the Plan was in violation by not providing a clear and concise explanation of the reasons for the Plan's decision, description of the criteria or guidelines used, and clinical reasons for the decision regarding medical necessity. The enrollee, in this particular matter, initially requested the approval of a medication that required pre-authorization. The enrollee failed to obtain the requisite authorization. The Plan denied coverage, and the enrollee appealed the Plan's decisions. In the Plan's denial letter, they attached a copy of their medical policy. The attachment merely described "medical necessity" in a very broad sense. The Act requires a more detailed explanation for the denial of coverage. Under the circumstances of this situation, the attachment did not meet the requirements of the statute.	September 7, 2005
Enforcement Matter No: 05-229 **Citation(s):** Section 1367.01(h)(4)	The Department determined that the Plan was in violation by not providing a clear and concise explanation of the reasons for the Plan's decision, description of the criteria or guidelines used, and clinical reasons for the decision regarding medical necessity. If a denial is based, in part, on the enrollee's Evidence of Coverage ("EOC") or the Plan's "Medical Policy", those documents should be provided with the denial letter to meet the requirements of the statute. The Plan's determined that the enrollee did not meet conditions of coverage in accordance with the terms and conditions of the enrollees EOC for an out of network evaluation and treatment at City of Hope. The decision was based upon the enrollee's specific circumstances and upon peer reviewed criteria including the Medical Policy. These statements neither describe the criteria upon which the denial was based nor did not indicate the pertinent portions of the EOC were enclosed.	August 1, 2005

COMPLAINT / ENFORCEMENT # CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 154466 **Enforcement Matter No**: 04-217 **Citation(s):** Section 1367.01(h)(4) Section 1368.02(b)	The Plan must ensure that its medical groups, contracted to provide utilization review and management, and any part of the administration and/or resolution of an enrollee's grievance, comply with the Act. In this case Monarch HealthCare responded to an enrollee's provider's request for service. The December 24, 2003 letter denied the requested service based on a lack of medical necessity. The letter failed to provide the enrollee's parents with a clear and concise explanation of the reason for the decision. The explanation was vague as to the clinical information used in making the decision. In the same letter the statutory language requiring that a paragraph be included in any written communication to an enrollee informing them of their right to engage in the grievance process was missing the pertinent health plan telephone number.	May 24, 2005
Complaint No. 152181 **Enforcement Matter No**: 04-216 **Citation(s):** Section 1368.02(b)	The enrollee received an initial denial letter from Riverside Physician Network that failed to incorporate the pertinent plan phone number in the statutory paragraph as required. Instead the disclosure paragraph provided instruction to the enrollee to call the member services numbers listed on the back of the enrollee's identification card.	April 28, 2005
Enforcement Matter No: 05-051 **Citation(s):** Section 1368.02(b) Section 1374.30(m) Section 1368(a)(5)	In a June 2004 letter from the Grievance and Appeals Department to the enrollee, the Plan advised the enrollee to refer to the enrollee information provided on the enrollee's card. The language used is contrary to the exact wording requirements pursuant to 1368.02(b), which became law January 1, 2003. In the same letter it did not include an Independent Medical Review (IMR) application nor pre-addressed envelop as required in Section 1374.30(m). Finally, the letter did not contain the referenced attachments involving the criteria and guidelines used in making a determination of medical necessity as required in Section 1368(a)(5).	April 25, 2005

COMPLAINT / ENFORCEMENT # CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Enforcement Matter No: 04-344 **Citation(s):** Rule 1300.68(d)(3) Rule 1300.68(d)(1)	The Plan received an enrollee's complaint regarding non-payment of services on July 24, 2003. The Plan requested itemized billing information from the enrollee on August 6th and the enrollee responded with the information on August 18th. No further correspondence was received by the enrollee. The enrollee contacted the Plan in February 2004 after being referred to collections. In the letter to the enrollee dated March 22, 2004, the Plan acknowledged mishandling the enrollee's grievance by not responding timely as required.	March 30, 2005
Enforcement Matter No: 05-050 **Citation(s):** Rule 1300.68(g)	On December 6, 2004 the Department faxed the enrollee's complaint to the Plan. The Plan responded to the Department on December 14, 2004. This is in violation as the Plan failed to provide its initial response to the Department within five calendar days.	March 7, 2005
Complaint No. 193771 **Enforcement Matter No**: 04-403 **Citation(s):** Rule 1368.02(b)	The Plan failed to include the statutory paragraph outlined in Section 1368.02(b) in any written communication in response to an enrollee's grievance.	February 28, 2005
Enforcement Matter No: 03-252 **Citation(s):** Section 1368 Section 1368.01(a) Rule 1300.68 **Enforcement Matter No**: 03-254 **Citation(s):** Rule 1300.68(g)	In Metter 03-252, the Plan acknowledged it received a grievance from the enrollee on February 20, 2003 but did not provide written acknowledgement until March 4, 2003, more than five days after receiving. The Plan also failed to respond in writing within 30 calendar days of receipt. In Matter 03-254, the investigation focused on the Plans failure reply within five days of receiving a faxed copy of an enrollee grievance from the Department. The request had been made by the Department for the Plan to provide certain information in order to further process the grievance.	February 9, 2005

COMPLAINT / ENFORCEMENT # CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 96935 **Enforcement Matter No**: 03-329 **Citation(s):** Section 1374.34	The Department investigated the failure of the Plan to comply with the requirements to properly implement an IMR decision that overturned the Plan's denial decision. The health service in question included inpatient and/or residential psychiatric care for which the duration was not specified, either by the order of the patient's physician or the IMR reviewer. After the IMR decision for the Plan to cover the services, the Plan authorized coverage for a few days while the Plan conducted a concurrent review. After an additional five days of coverage was approved the Plan ended the coverage based on its concurrent review. The Department evaluated the requirements of Section 1374.34 as it applied to this case and concluded that the Plan's denial of coverage after the IMR decision was in violation.	February 7, 2005

A P P E N D I X C

C. OVERVIEW OF PLAN OPERATIONS

The table below summarizes the information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire:

PLAN PROFILE

Type of Plan	Full Service		
Number of Enrollees as of July, 2005	**Product Name**	**Product Lines**	**Enrollees**
	Blue Cross of California: CaliforniaCare, Blue Cross HMO, Blue Cross Plus	Commercial HMO/ Point of Service (POS)	1,535,740
	Blue Cross of California: Prudent Buyer, Blue Cross PPO, BC Life & Health Prudent Buyer	Commercial PPO	3,958,057
	Blue Cross of California: Senior Secure	Medicare HMO	30,723
	Blue Cross	Medi-Cal	451,807
	Blue Cross	Healthy Families	291,849
	Blue Cross	MRMIP	4,418
	Blue Cross	AIM	8,708
	Total		6,281,302
Service Area(s) *(Counties, in full or in parts)*			
Product			
HMO	Alameda Butte Contra Costa El Dorado Fresno Imperial Kern Kings Los Angeles Madera Marin Merced	Nevada Orange Placer Riverside Sacramento San Benito San Bernardino San Diego San Francisco San Joaquin San Luis Obispo	San Mateo Humboldt Santa Barbara Santa Clara Santa Cruz Solano Sonoma Stanislaus Tulare Ventura Yolo

PPO	Alameda Alpine Amador Butte Calaveras Colusa Contra Costa Del Norte El Dorado Fresno Glenn Humboldt Imperial Inyo Kern Kings Lake Lassen Los Angeles Madera	Marin Mariposa Mendocino Merced Modoc Mono Monterey Napa Nevada Orange Placer Plumas Riverside Sacramento San Benito San Bernardino San Diego San Francisco San Joaquin	San Luis Obispo San Mateo Santa Barbara Santa Clara Santa Cruz Sierra Siskiyou Solano Sonoma Stanislaus Sutter Tehama Trinity Tulare Tulare Tuolumne Ventura Yolo Yuba
Healthy Families	Alameda Alpine Amador Butte Contra Costa Calaveras Colusa Del Norte El Dorado Fresno Glenn Humboldt Imperial Inyo Kern Kings Lake Lassen Los Angeles Madera	Marin Mariposa Mendocino Merced Modoc Mono Monterey Napa Nevada Orange Placer Plumas Riverside Sacramento San Benito San Bernardino San Diego San Francisco San Joaquin	San Luis Opispo San Mateo Santa Barbara Santa Clara Santa Cruz Shasta Sierra Siskiyou Stanislaus Solano Sonoma Sutter Tehama Trinity Tulare Tuolumne Ventura Yolo Yuba

Number of Providers HMO/POS	**Primary Care**	**Specialty Care**	**Affiliated Medical Groups or IPAs**
	10,874	28,024	177
PPO	20,576	25,409	17
Healthy Families	N/A	N/A	540

The discussion below is a brief overview of the Plan's operations in each of the four program areas that were examined during the Department's Routine Medical Survey.

OVERVIEW OF PROGRAMS

QUALITY MANAGEMENT

- The Board of Directors ("Board") has overall authority and accountability for the Quality Improvement (QI) Program. The Board has delegated this responsibility to the Physicians Relations Committee. The Physicians Relations Committee has delegated the development, implementation, and monitoring of the QI Program to the QI Committee for the State Sponsored Business and Quality Management (QM) Committee for the Commercial Business. The Quality Medical Directors for the two business units are responsible for implementing the QI Program.

- The QI Committee and QM Committee monitor the areas listed below as relevant to their populations to assess whether quality of care and service are meeting established goals. If goals are not met, the groups conduct analyses to identify barriers and make recommendations to promote improvement.
  - Patient Safety (e.g., potential drug related morbidity and mortality, Leapfrog);
  - Appropriateness of Clinical Care, including:
    - Disease prevention (e.g., well child visits, immunizations),
    - Early detection of diseases to improve outcomes (e.g., chlamydia, cancer screening), and
    - Health management programs to help enrollees manage health-related events (e.g., pregnancy, diabetes, asthma, cardiovascular disease, depression);
  - Provider Availability;
  - Accessibility of Services;
  - Continuity and Coordination of Care;
  - Credentialing of Providers;
  - Enrollee Complaints, Grievances, and Appeals;
  - Enrollee satisfaction with services provided by the Plan and network providers;
  - Under- and over-utilization of health care services;
  - Timeliness and appropriateness of Utilization Management decisions;
  - Provider satisfaction with the Plan; and
  - Oversight of Provider Medical Groups (PMGs) and Independent Practice Associations (IPAs) that have been delegated credentialing and/or utilization management.

GRIEVANCES AND APPEALS

- For its State Sponsored Business (which includes the Healthy Families), the Plan's Vice President, Corporate Medical Director oversees the medical direction of quality of care, utilization review, and grievance management.

- For its commercial lines of businesses, the Plan's Grievance/Appeals Officer has primary responsibility for the G&A process and monitors the operation of the system on a continuous basis to identify any emergent patterns of grievances/appeals. The Plan's G&A Medical Directors are responsible for clinical review, oversight, and final decision-making on medical necessity and quality of care grievances.

- For both the Healthy Families and commercial programs, enrollees have up to 180 calendar days after an incident or dispute to submit a grievance or request for an appeal. Grievances/appeals may be submitted verbally, in writing, or electronically (i.e., by mail, telephone, fax, e-mail or online at www.bluecrossca.com). Grievance forms are posted in both Spanish and English on the Web site. Plan policies require that an acknowledgment letter be sent to the enrollee within five calendar days of receipt of a standard grievance. Standard grievances must be resolved and a resolution letter sent to the enrollee within 30 calendar days of receipt of the grievance. Urgent (expedited) grievances must be resolved and a resolution letter sent to the enrollee within 72 hours of receipt of the grievance. If not satisfied with the Plan's final appeal decision, the enrollee has the right to seek arbitration. IMR is also an option provided for health care services that are denied or modified based upon the determination that the service is either not medical necessary or is experimental/investigational.

- To address the linguistic and cultural needs of its enrollees, the Plan has employees proficient in a language other than English. When a Grievance and Appeals associate identifies an enrollee with limited or no English skills, the appropriate language interpreter is contacted to assist in communicating with the enrollee. The Plan also uses the AT&T translator line as needed, and has a TDD line for the speech and hearing impaired. Plan policy states that "Grievance and Appeals associates accommodate members' preferred languages upon request and will send appropriately translated letters."

- In its Healthy Families program, the Plan provides enrollees and providers with free face-to-face and sign language interpreter services, telephone interpreter, and TTY services. Oral and sign interpreters are provided for all languages spoken by Medi-Cal and Healthy Families enrollees.

ACCESS AND AVAILABILITY OF SERVICES

- The Plan has established standards to guide its performance in a number of areas, including:
  - The geographic availability of its providers;
  - The waiting time for emergency, urgent, preventive care and routine appointments;
  - Customer service center response times and abandonment rate; and
  - After-hours availability of providers.

- The Plan produces comprehensive annual reports that summarize and analyze the results of its internal monitoring of access and availability issues for both its Commercial Business (QI Program Annual Report) and its State Sponsored Business (Access and Availability Comprehensive Analysis). Monitoring approaches used to asses performance include:
  - Geo-Access reporting;
  - Provider ratio reports;
  - Complaint/grievance reports;
  - California Assessment of Health Plans member satisfaction survey;
  - Monitoring of customer service line performance;
  - Monitoring of high volume/high risk conditions/diseases; and
  - Telephone surveys of provider offices (to assess appointment availability and after-hours availability).

- The Plan uses a number of approaches to promote and improve access to its services, including:
  - Provider recruitment efforts;
  - Member and provider newsletter articles
  - A member information website; and
  - Provider performance bonus program.

UTILIZATION MANAGEMENT

- The Plan has a comprehensive UM Program that includes Pre-Service authorization, Concurrent Review and authorization, Post-Service Review and authorization, and Discharge Planning from inpatient care.

- The Plan has a Case Management Program that serves enrollees with extended hospital stays, hospital readmissions within 30 days of any discharge, frequent hospitalizations, high-risk pregnancies, catastrophic illnesses and injuries, organ transplant candidates, and specialty unit admissions (e.g., Neonatal Intensive Care Unit).

- The majority of UM activity is delegated to 176 Participating Medical Groups. For Healthy Families, 24% of the membership is in capitated PMGs that provide UM. Of

Healthy Families members, approximately 127,000 are in the HMO product and 165,000 are in the Exclusive Provider Organization product. The Exclusive Provider Organization members have access to the Commercial Prudent Buyer Network. In this network the enrollee is not required to have an assigned Primary Care Practitioner (PCP). Of Commercial HMO members, only 35,000 are not in a capitated PMG. These enrollees are in the Western IPA owned by the Plan. The Plan manages the UM for these enrollees. Delegated UM PMGs have 1.355 million HMO enrollees.

- For the PPO and POS enrollees, the Plan preauthorizes a small number of services, less than 100 items.

- Pharmacy benefits are managed for all enrollees, regardless of product, by a single Plan entity. A corporate national entity, the Clinical Resources Committee, develops and maintains the Plan formulary.

- The Plan also has a corporate national committee, the Health Policy and Technology Assessment Committee, also known as the Medical Policy and Technology Assessment Committee, that develops all health policy and criteria for medical necessity and benefits determinations across all products. The Plan adopted Milliman USA Health Care Guidelines in 2003. In addition, the plan uses criteria developed by the Health Policy and Technology Assessment Committee /Medical Policy and Technology Assessment Committee for services not covered by the Milliman criteria.

- The Plan has a well-developed and ongoing oversight mechanism to monitor delegated PMGs' UM Programs. The Plan reviews the description and implementation of the UM Programs of PMGs under consideration for delegation. Once contracted as delegated providers, PMGs are subject to demonstrate compliance with the terms of their agreement with the Plan. To evaluate and monitor delegated PMGs, the Plan conducts onsite audits, (at least annually and more frequently when indicated) and reviews reports of UM performance, accessibility of care, grievances and appeals, and provider and enrollee satisfaction. The Plan trends the performance of delegated groups and profiles each one relative to peers. The Plan shares and reviews the performance reports with each delegated PMG to ensure understanding of the results and to identify opportunities for improvements. It also utilizes a Bonus program that ties to PMG performance on targeted measures. According to Plan and delegated groups interviewed, the financial incentives appear to motivate increased compliance and improved performance by delegates.

A P P E N D I X D

D. LIST OF SURVEYORS

The Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Dan McCord, MBA	Sr. Health Plan Analyst, Division of Plan Survey
Terry German	Counsel, Enforcement Division
Ginger King	Associate Health Plan Analyst, Division of Plan Survey

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Erick Davis, MD, MPH, MBA	Utilization Management Surveyor
Jill Sanborn, MPH, MHS	Quality Management Surveyor
Marika Gordon, MA	Utilization/Quality Management Surveyor
Patricia Allen, M.Ed.	Access and Availability of Services Surveyor
Rose Leidl, RN, BSN	Grievance & Appeal Surveyor

A P P E N D I X E

E. LIST OF STAFF INTERVIEWED

The following key Plan officers and staff were interviewed during the onsite survey at the Plan.

Blue Cross of California WellPoint- State Sponsored Business and Commercial	
Laura Linebach, RN	Director, Quality Management (State Sponsored Business)
Lakshmi Dhanvanthari, MD	Quality Medical Director (State Sponsored Business)
Delia Boral, RN, MBA	Director, Medical Management (State Sponsored Business)
Christina Underwood	Supervisor, Medical Management (State Sponsored Business)
Mary Spitzer, RN	Quality Improvement Director
Michael Belman, MD	Staff Vice President, Quality Medical Director
Peter Lee	Director, Healthplan Informatics
Karla Enrequez	Credentialing Manager
Richard Lehrfeld, MD, JD	Medical Director, Grievance and Appeals
Ron McGinnis	Director, Grievance and Appeals
Theresa Peterson	Manager, Grievance and Appeals
Anne Lauer, RN	Clinical Research Manager
Julie Theodore, RN	Director, Quality Operations
Pat Sabella	Director, Medical Management, CM
Amy Barker	Manager, Provider Services
Susan James	Manager, Network Services
Suzanne Zelazny, RN	Manager, Medical Group Oversight
Keith Wolfe	Director, Network Services
Vickie Carrillo, RN	Director, Health Care Management
Cheryl Sparks	Supervisor, Medical Management
Minga Williams	Manager, Customer Care Operations
Donald Wentzel	Medical Director, UM
Ann Hill	Pharmacy Operations
Joe Cherian	Associate Clinical Pharmacist
Mauricio Viola	Pharmacy Regulatory Specialist

A P P E N D I X F

F. LIST OF PROVIDERS INTERVIEWED

The following are provider representatives who were interviewed during the on-site survey.

Dr. Jeffrey Klein	Medical Director, Regal Medical Group
Pat Hipsman	UM Director, Regal Medical Group
Mary Inglis	QM Director, Regal Medical Group
Don Miller	Credentialing Director, Regal Medical Group
Dr. Jeffrey London	Medical Director, Community MG of the West Valley
June Bardwell	QM Director, Community MG of the West Valley
Pat Rumpza	UM Director, Community MG of the West Valley
Claudia Kanzanjian	Compliance Director, Community MG of the West Valley
Renee Salazar	Credentialing Director, Community MG of West Valley

A P P E N D I X G

G. LIST OF ACRONYMS

Acronyms	Definition
CAP	Corrective Action Plan
EOC	Evidence of Coverage
HMO	Health Maintenance Organization
G&A	Grievances and Appeals
IMR	Independent Medical Review
IPA	Independent Practice Association
PCP	Primary Care Practitioner
PMG	Provider Medical Group
POS	Point of Service
PPO	Preferred Provider Organization
QI	Quality Improvement
QM	Quality Management
UM	Utilization Management

A P P E N D I X H

H. APPLICABLE STATUTES AND REGULATIONS

The following are the specific citations used in this Routine Medical Survey Report as the basis for the deficiencies:

GRIEVANCES and APPEALS

Deficiency #1: The Plan does not adequately address the linguistic and cultural needs of its enrollee population. [Rule 1300.68(b)(3)]

Citation:
Rule 1300.68(b)(3)
The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

Deficiency #2: The Plan does not consistently:

- **Provide a clear and concise explanation for its decision in its grievance resolution letters.**
- **Provide the exact provision of the contract or the Evidence of Coverage (EOC) that excludes the coverage in its appeal resolution letters for benefit denials.**
- **Provide the name and telephone number of the contact person in its grievance acknowledgment letters.**

[Section 1368(a)(4) & (5), Rule 1300.68(d)(3)]

Citations:
Section 1368(a)(4)&(5)
Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

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

Deficiency #3: In its benefit denial letters, the Plan does not consistently provide the provision of the benefit contract or EOC that includes the coverage. The EOC language does not consistently support the denial decision. [Section 1368(a)(5)]

Citation:
Section 1368(a)(5)
If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

ACCESS and AVAILABILITY

Deficiency #4: The Plan does not have an adequate system for monitoring and evaluating appointment wait times and the provision of after-hour services including a system for addressing problems that develop. [Rule 1300.67.2(f)]

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

UTILIZATION MANAGEMENT

Deficiency #5: The Plan does not consistently include a clear reason in letters to enrollees for medical necessity denials. [Section 1367.01(h)(4)]

Citation:
Section 1367.01(h)(4)
Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers

initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding clinical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan**.**

A P P E N D I X I

I. THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

The following provides detail on the required survey activities and the order in which they are undertaken by the Department as well as instructions to plans for instituting corrective actions and preparing their responses to the Preliminary Report and the Final Report. The table below summarizes the survey activities and the corresponding timeframes.

MEDICAL SURVEY PROCESS

SURVEY ACTIVITY	TIMEFRAME
Notification Letter and Request for Documents	Prior to on-site visit
Routine Survey On-Site Visit Conducted	At least once every three years
Preliminary Report due from the Department to the Plan	Within 60-80 days from last day of on-site visit
Response due from Plan to the Department [Section 1380(h)(2)] *(Include evidence that each deficiency has been fully corrected)*	45 calendar days from date of receipt of Preliminary Report
Final Report due from the Department to the Plan	Within 170 days from the last day of the on-site visit
Response from Plan to Department on any matters in Final Report	Within ten calendar days from receipt of Final Report. Response is included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the on-site visit
Follow-Up Review Conducted	Anytime within 16 months of date Final Report issued to the Public File
Follow-Up Report due from the Department to the Plan	No later than 18 months from the date of the Final Report issued to the Public File
Response from Plan to Department on any matters in Follow-Up Report	Within ten calendar days from receipt of Follow-Up Report. Response is included in Public File with Follow-Up Report
Follow-Up Report due to the Public File [Section 1380(i)(2)]	No later than 18 months from the date of the Final Report issued to the Public File

Survey Preparation
The Department conducts a routine medical survey of each licensed health care service plan at least once every three years in order to evaluate the plan's compliance with the Act. Prior to the visit, the Department supplies the Plan with a Pre-On-Site Visit Questionnaire and a list of materials that the Plan is required to submit to the Department prior to the on-site visit. These materials are reviewed by the survey team to provide them with an overview of plan operations, policies and procedures in preparation for the visit. The Plan is also advised of the materials (e.g., case files, reports) the surveyors will review during the on-site visit so that these will be readily available for the survey team.

On-Site Visit
During the on-site visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

Preliminary Report
Within 60-80 days of the onsite visit, the Department provides the Plan with a Preliminary Report, which details its survey findings and the required corrective actions.

Plan's Response to the Preliminary Report
In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, only specific areas found by the Department to be in need of improvement are included in these Reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

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

(1) The Plan's response to the Department's findings of deficiencies;

(2) The Plan's response to the Department's specified corrective actions, which include a corrective action plan (CAP);

(3) Whether the CAP is fully implemented at the time of the Plan's response. If the CAP is fully implemented, the Plan should provide documents or other evidence that the deficiencies have been corrected; and

(4) If the CAP cannot be fully implemented by the time the Plan submits its response, the Plan should submit evidence that remedial action has been initiated and is on the way to achieving compliance. Please include a time-schedule for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

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

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department's web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report. This report will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the on-site survey. The Final Report to the public will be placed on the Department's website: http//www.dmhc.ca.gov/library/reports/med_survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.

Follow-Up Review

The Department will conduct a Follow-Up Review of the Plan and issue a Follow-Up Report within 18 months of the date of the Final Report to determine whether all deficiencies that were not corrected at the time of the final report have been corrected [see Health and Safety Code

Section 1380(i)(2)]. Please note that the Plan's failure to correct deficiencies identified in the survey report may be grounds for disciplinary action against the plan as provided by Health & Safety Code section 1380(i)(1).