DEPARTMENT OF Managed Health Care

# OFFICE OF PLAN MONITORING
# DIVISION OF PLAN SURVEYS

# FINAL REPORT

# ROUTINE SURVEY

# OF

# BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

## A FULL SERVICE HEALTH PLAN

## OCTOBER 15, 2025

**Routine Survey Final Report**
**Blue Shield of California Promise Health Plan**
**A Full-Service Health Plan**

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## EXECUTIVE SUMMARY

On May 27, 2022, the California Department of Managed Health Care (Department) notified Blue Shield of California Promise Health Plan (Plan) that it would conduct its scheduled Routine Survey pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The survey team conducted the onsite survey from October 25, 2022 through October 28, 2022.

The Department assessed Plan operations in the following areas:

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

The Department identified **15** deficiencies during the Routine Survey. The 2022 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.

**2022 SURVEY DEFICIENCIES TABLE**

| # | DEFICIENCY STATEMENT | STATUS |
|---|---|---|
| | **QUALITY ASSURANCE** | |
| 1 | **The Plan does not consistently document that the quality of care provided is being reviewed.**<br>Rule 1300.70(a)(1). | **Not Corrected** |
| | **GRIEVANCES AND APPEALS** | |
| 2 | **The Plan's exempt grievance log does not include the name of the Plan representative who took the call and resolved the grievance.**<br>Section 1368(a)(4)(B)(i); Rule 1300.68(d)(8). | **Corrected** |
| 3 | **The Plan does not ensure all oral expressions of dissatisfaction are considered grievances and therefore does not ensure adequate consideration of enrollee grievances and rectification when appropriate.**<br>Section 1368(a)(1); Rule 1300.68(a)(1). | **Not Corrected** |

| | | |
|---|---|---|
| **4** | **When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to notify the Department of the grievance.**<br>Section 1368.01(b); Rule 1300.68(a)(1). | **Not Corrected** |
| **5** | **The Plan's written responses to grievances and appeals do not contain a clear and concise explanation of the Plan's decision.**<br>Section 1368(a)(5); Rule 1300.68(d)(3). | **Not Corrected** |
| **6** | **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 do not specify the provisions in the contract, evidence of coverage, or member handbook that excludes the service.**<br>Section 1368(a)(5); Rule 1300.68(d)(5). | **Not Corrected** |
| **7** | **The Plan does not consistently ensure adequate consideration of enrollee grievances and rectification when appropriate.**<br>Section 1368(a)(1). | **Not Corrected** |
| **8** | **The Plan does not accurately describe the issues raised in all grievances.**<br>Rule 1300.68(e)(2). | **Not Corrected** |
| **9** | **For grievances involving delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan's written responses do not clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination.**<br>Section 1368(a)(5); Rule 1300.68(d)(4). | **Not Corrected** |
| | **ACCESS AND AVAILABILITY OF SERVICES** | |
| **10** | **The Plan's provider directories do not list the providers employed by a federally qualified health center.**<br>Section 1367.27(h)(8)(C)-(D). | **Not Corrected** |

| | | |
|---|---|---|
| | **UTILIZATION MANAGEMENT** | |
| **11** | **The Plan does not make its utilization management criteria or guidelines used to authorize, modify, or deny health care services available to the public upon request.**<br>Section 1363.5(b)(5). | **Corrected** |
| **12** | **For decisions to deny or modify requests by providers based in whole or in part on medical necessity, the Plan and its delegates do not consistently include in written responses to enrollees a clear and concise explanation of the reasons for its decision, a description of the criteria or guidelines used, and/or the clinical reasons for the decision.**<br>Section 1367.01(h)(4). | **Not Corrected** |
| **13** | **The Plan does not adequately oversee its delegates.**<br>Section 1367.01(a), (h)(4), (j); Rule 1300.70(b)(2)(B), (b)(2)(G)(3). | **Not Corrected** |
| | **EMERGENCY SERVICES AND CARE** | |
| **14** | **The Plan does not provide all noncontracting hospitals in the state to which its enrollees can be transferred the necessary Plan contact information.**<br>Section 1262.8(j); Section 1317.4a(c)(1). | **Not Corrected** |
| **15** | **The Plan is operating at variance with its basic organizational documents for prior authorization for necessary medical care following stabilization of an emergency medical condition.**<br>Section 1371.4(c); Section 1386(b)(1); Rule 1300.71.4. | **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 post-stabilization procedures to ensure timely authorization of care or transfer of enrollees who are

[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.

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

The Plan, a wholly owned subsidiary of Blue Shield of California, is a nonprofit, managed care organization which offers Medi-Cal as well as CalMediConnect, during the demonstration period, in Los Angeles and San Diego Counties.

As of June 7, 2022, the Plan served 493,423 Medi-Cal and 6,667 CalMediConnect enrollees.

## SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On April 8, 2025, the Department issued the Plan a preliminary report that described each deficiency, as well as the legal and factual basis for each deficient finding. In that report, the Department instructed the Plan to perform the following within 45 days of issuance of the preliminary report:

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

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

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

## DEFICIENCIES

### QUALITY ASSURANCE

**Deficiency #1: The Plan does not consistently identify quality of care issues.**

**Statutory/Regulatory References:** Section 1370; Rule 1300.70(a)(1).

**Assessment:** Rule 1300.70(a)(1) requires the Plan to 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 where indicated.

The Plan's grievance policy states:

> A Potential Quality Issue (PQI) is a suspected deviation from expected provider quality of care, clinical care or outcome of care performance which requires further investigation. Review of the performance issue can confirm that care provided was inconsistent with professionally recognized or community standards or that no quality-of-care issue is identified. Examples of PQI include the following:
>
> - Access to care (pre or post service)
> - Referral or authorization procedures that impact care

- Communication issues that impact care
- Provider or staff behavior that impacts care
- Coordination of care
- Technical competence or appropriateness
- Facility or office environment that impacts care[2]

The Department reviewed:

- 44 exempt grievance files. Of those, 29 files contained a quality issue,[3] but none were referred as a PQI.
- 71 standard grievance and appeal selection A files.[4] Of those, 47 files contained a quality issue,[5] but seven files (15%)[6] were not referred as a PQI.
- 65 standard grievance and appeal selection C files.[7] Of those, six files contained a quality issue,[8] but three files (50%)[9] were not referred as a PQI.
- 24 expedited grievance and appeal selection B files.[10] Of those, two files contained a quality issue,[11] but one file (50%)[12] was not referred as a PQI.

**Case Examples**

- **DMHC Exempt Grievance File 7:** The enrollee complained her previous doctor had no availability and was not able to see her in person for the last two years due to the pandemic. The enrollee stated she had shooting pain and felt almost paralyzed but was not seen or sent to a specialist.

  Despite the enrollee's allegation of a lack of access to care for two years, the Plan did not refer this case for PQI review.

- **DMHC Standard Grievance and Appeal Selection A File 49:** The enrollee called to appeal a physical therapy (PT) denial. The enrollee received a letter from the provider stating her PT visits had expired. The enrollee alleged the provider incorrectly stated the enrollee had fallen due to alcohol abuse, whereas the enrollee indicated she had fallen because her cane collapsed. The enrollee requested the Plan remove this statement from her record and authorize continued PT sessions.

[2] Beneficiary Grievance Management System, page 3.
[3] DMHC Exempt Grievance File 1, 3, 7-10, 12, 15-19, 23-25, 27, 28, 30-32, 34, 36, 39-41, 43-46.
[4] Standard Grievance and Appeal Selection A files are categorized as "Grievance" by the Plan.
[5] DMHC Standard Grievance and Appeal Selection A File 2, 3, 5-8, 10-12, 14-17, 19-23, 26, 28, 29, 32, 35, 38-43, 45, 48-52, 55, 56, 58, 59, 61, 64, 65, 67-71.
[6] DMHC Standard Grievance and Appeal Selection A File 41, 42, 49, 51, 55, 56, 59.
[7] Standard Grievance and Appeal Selection C files are categorized as "Appeal" by the Plan, and do not include "RX Benefit" files.
[8] DMHC Standard Grievance and Appeal Selection C File 2, 7, 9, 19, 41, 49.
[9] DMHC Standard Grievance and Appeal Selection C File 19, 41, 49.
[10] DMHC Expedited Grievance and Appeal Selection B files are categorized as "Appeal" by the Plan.
[11] DMHC Expedited Grievance and Appeal Selection B File 1, 21.
[12] DMHC Expedited Grievance and Appeal Selection B File 21.

Despite the enrollee allegations about incorrect medical documentation and delays in care, the Plan did not refer this case for PQI review.

- **DMHC Standard Grievance and Appeal Selection C File 41:** The enrollee stated she was referred to providers located too far away. The enrollee found an in-network provider, but the Plan denied authorizations for this new provider. The enrollee requested assistance in either gaining approval for this provider or finding a new in-network provider for immediate treatment, as the enrollee indicated her condition was worsening.

  Despite the enrollee alleging her condition was worsening due to access delays, the Plan did not refer this case for PQI review.

- **DMHC Expedited Grievance and Appeal Selection B File 21:** This case was forwarded to the Plan by the DMHC. The enrollee alleged she had experienced significant access delays in receiving needed specialist care, causing harm to her health. The case notes state: “Due to the delay in being able to access the out of network provider, [name] has already suffered another grand mal seizure.”

  Despite allegations of access to care delays significantly impacting the enrollee’s health condition, the Plan did not refer this case for PQI review.

**TABLE 1**
***Potential Quality Issue File Review***

| FILE TYPE | NUMBER OF FILES | REQUIREMENT | COMPLIANT | DEFICIENT |
|---|---|---|---|---|
| Exempt Grievance | 29 | The Plan must document the quality of care provided is being reviewed | 0 (0%) | 29 (100%) |
| Standard Grievance and Appeal Selection A | 47 | The Plan must document the quality of care provided is being reviewed | 40 (85%) | 7 (15%) |
| Standard Grievance and Appeal Selection C | 6 | The Plan must document the quality of care provided is being reviewed | 3 (50%) | 3 (50%) |

| | | | | |
|---|---|---|---|---|
| Expedited Grievance and Appeal Selection B | 2 | The Plan must document the quality of care provided is being reviewed | 1 (50%) | 1 (50%) |

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

> [A]cknowledges the Department's finding that the Plan did not consistently document that the quality of care provided is being reviewed. Since the conclusion of the onsite audit, the Plan has enhanced processes, conducted numerous trainings for multiple teams, and implemented an Appeals and Grievances Clinical Oversight Team (COT) to ensure the quality of care being provided is being reviewed and consistently documented…

The Plan also indicated it:

- Implemented a daily review of all cases closed as exempt grievances (February 2023).
- Began a clinical oversight process for all exempt grievances cases documented in the Call Center (May 2024).
- Provided various trainings to clinical and non-clinical AGD, CQR, and Customer Care staff (March 2022, May 2022, February 2024, June 2024, November 2024).
- Established COT and related processes (July 2022).

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)[13]

**Final Report Deficiency Status: Not Corrected**

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to demonstrate the effectiveness of its corrective actions.

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

[13] Blue Shield of California Promise Health Plan Response to the Department of Managed Health Care April 8, 2025, Preliminary Report of the October 2022 Routine Survey.

## GRIEVANCES AND APPEALS

**Deficiency #2: The Plan's exempt grievance log does not include the name of the Plan representative who took the call and resolved the grievance.**

**Statutory and Regulatory References:** Section 1368(a)(4)(B)(i); Rule 1300.68(d)(8).

**Assessment:** Section 1368(a)(4)(B)(i), Rule 1300.68(d)(8), and the Plan's grievance policy require the Plan to maintain a log of all grievances exempt from the requirement to send a written acknowledgment and response.[14] This log must contain the date of the call, the name of the complainant, the complainant's member identification number, the nature of the grievance, the nature of the resolution, and the name of the Plan representative who took the call and resolved the grievance.

The Department reviewed the Plan's Exempt Grievance Log and found it does not include the name of the Plan representative who took the call and resolved the grievance.

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

> [R]espectfully disagrees with the Department's finding that the Plan's exempt grievance log does not include the name of the Plan representative who took the call and resolved the grievance. Per the Department's Log Requirements, Plan Representative was not included in the specifications for the exempt grievance log. The exempt grievance log submitted as part of the audit was created to the specifications from the Department request. The Plan system and internal log do capture the name of representative who took the call and resolved the grievance.

The Plan provided an updated log with an additional field indicating which Plan representative took the call. The Plan stated although it did not originally include the Plan representative information based on its understanding of the Department's log file requirements, the information was present in the original log submission.

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)
- Exempt Grievance Log

**Final Report Deficiency Status: Corrected**

The Department acknowledges it did not instruct the Plan to include the names of representatives in its exempt grievance log submission. However, the Knox-Keene Act requires the Plan to maintain and periodically review a log that is compliant with the requirements set forth in Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8).

[14] Beneficiary Grievance Management System, page 8.

The Department finds the Plan's updated exempt grievance log includes the name of the Plan representative who took the call and resolved the grievance. Therefore, the Department determined this deficiency is corrected.

**Deficiency #3: The Plan does not ensure all 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 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 the 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.

To assess whether the Plan consistently identifies grievances, the Department reviewed 71 call inquiry files. Of those, 38 files (54%)[15] contained expressions of dissatisfaction, complaints, disputes, requests for reconsideration, or appeals the Plan should have processed as grievances.

**Case Examples**

- **DMHC File 44:** The enrollee's parent contacted the Plan after experiencing difficulty with her son's psychiatry authorization and referral. During the hour-long telephone call, the parent described significant trouble getting through to someone at the provider office. However, the Plan's records merely documented the customer service representative (CSR) trying to call the enrollee back with the mental health provider's phone number and provided no further details. The CSR did not recognize the enrollee's expression of dissatisfaction and did not process the case as a grievance.

- **DMHC File 45:** The Plan's documentation of the call only states the CSR was adding the phone number and best contact number for the enrollee. This call was conducted in Spanish, so the Department requested the Plan provide a transcript of the audio recording in English. The transcript indicated that the enrollee expressed multiple concerns regarding difficulty getting necessary authorizations and referrals for her son's glasses and speech therapy, including the denial of her son's special glasses. The CSR did not recognize the enrollee's expressions of dissatisfaction and did not process the case as a grievance.

[15] DMHC Call Inquiry File 4, 11-13, 15, 20, 23, 25, 30, 32, 33, 36, 38, 40, 44-47, 49-54, 56, 58, 59, 61, 62, 65-71, 76, 77.

**TABLE 2**
***Call Inquiry File Review***

| FILE TYPE | NUMBER OF FILES | REQUIREMENT | COMPLIANT | DEFICIENT |
|---|---|---|---|---|
| Call Inquiry | 71 | Expressions of dissatisfaction, complaints, disputes, requests for reconsideration, and appeals are processed as grievances | 33 (46%) | 38 (54%) |

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

> [A]cknowledges the Department's findings that the Plan did not ensure all oral expressions of dissatisfaction are considered grievances and therefore did not ensure adequate consideration of enrollee grievances and rectification when appropriate. Since the conclusion of the onsite audit, the Plan has implemented a comprehensive oversight process in order to immediately identify grievances that may have been miscategorized as inquiries. Additionally, the Plan is bolstering existing training and processes to routinely reinforce appeals and grievance knowledge throughout Customer Care.
>
> In October 2023, the Plan implemented a speech and data analytics tool to review calls categorized as inquiries. This tool searches all call inquiries for words that may indicate an expression of dissatisfaction. The Plan's Call Center Quality Assurance team reviews the report weekly to determine if a grievance was raised during any of the calls.

The Plan indicated it is developing annual and new hire AGD trainings for call center agents. Training development will be completed by July 2025, and completion of the refresher training will be completed by September 2025.

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)

**Final Report Deficiency Status: Not Corrected**

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to demonstrate the effectiveness of its corrective actions.

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, training documents, speech and data analytics tool and reports, files, and any other review deemed necessary by the Department.

**Deficiency #4:** **When the Plan has notice of a case requiring expedited review, the Plan did not immediately inform enrollees and subscribers of their right to notify the Department of the grievance.**

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

**Assessment:** When the Plan has notice of a case requiring expedited review, Section 1368.01(b), Rule 1300.68.01(a)(1), and the Plan's grievance policy require the plan to immediately inform enrollees and subscribers of their right to notify the Department of the grievance.[16]

The Department reviewed 24 expedited grievance and appeal selection B files. Of those, five files (21%)[17] did not contain documentation showing the Plan immediately informed enrollees and subscribers of their right to notify the Department of the expedited appeal. Enrollee notifications ranged from 27 hours to six days after the Plan received the grievance.

During onsite interviews, the Department reviewed File 3 with the Plan. The Plan agreed it made the required notification to the enrollee more than 27 hours after the Plan received the grievance.[18]

**TABLE 3**
***Expedited Appeal Files***

| FILE TYPE | NUMBER OF FILES | REQUIREMENT | COMPLIANT | DEFICIENT |
|---|---|---|---|---|
| Expedited Grievance and Appeal Selection B | 24 | Enrollees and subscribers are immediately informed of their right to notify the Department of the grievance | 19 (79%) | 5 (21%) |

[16] Beneficiary Grievance Management System, page 13.
[17] DMHC Expedited Grievance and Appeal Selection B File 1, 3, 20, 22, 24.
[18] DMHC Expedited Grievance and Appeal Selection B File 3, page 10.

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

> [R]espectfully disagrees with the Department's finding…The Plan implemented a process to inform members immediately of their right to contact the Department after the Department's 2019 Routine Survey of the Plan. In April 2020, AGD updated their Policy & Procedure, titled Beneficiary Grievance Management System, updated desk level procedures and retrained the Customer Care team on providing the member with their right to notify the Department at the time of the call requesting an expedited grievance…If the request is received by another method such as written correspondence, the AGD immediately makes an outbound call to inform the member.

In addition, the Plan asserted the five deficient files identified during the survey "are cases where the Plan did not receive an expedited request through the Call Center." The Plan stated "[t]hese cases were received either as a standard request and later deemed to be handled as expedited by AGD, or by fax, or email, or directly from the Department." For each of the five files, the Plan provided summaries and explained why the Department should not have found the files deficient.

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)

**Final Report Deficiency Status: Not Corrected**

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

- **DMHC Expedited Grievance and Appeal Selection B File #1:** The Plan stated:

  > The grievance request was received by the Plan on January 21, 2022, as a standard grievance request, there was no request for this to be expedited at this time. On January 27, 2022, the member called back, and Customer Care emailed the appeals and grievance intake team to review this case as an expedited request. This case was upgraded to an expedited case and DMHC rights were provided to the member and her son on January 27, 2022, at 12:06pm.

  The Department disagrees with the Plan's assertion the enrollee was immediately notified of DMHC rights when the case was "upgraded to an expedited case" on January 27. When the enrollee initially contacted the Plan on January 21, she informed the CSR she had cancer. The enrollee also indicated she was currently receiving treatment from a certain provider, had a surgical procedure scheduled in a week, and the Plan redirecting her to a new provider shortly before a scheduled procedure caused her great stress.

  Although the enrollee did not explicitly request the grievance to be expedited during the January 21 call, her initial call involved an imminent and serious threat

to her health. As such, the CSR should have expedited the grievance based on the enrollee's assertions and immediately provided her with DMHC rights. Therefore, the Plan's response does not support its assertion that no deficiency existed, or the deficiency was corrected.

- **DMHC Expedited Grievance and Appeal Selection B File #3:** The Plan stated:

  > The grievance request was received as a late transfer from our Customer Care Department. The case was originally received on May 09, 2022, at 14:07pm [sic] and DMHC rights were provided at the time of the initial call. The appeals and grievance Intake coordinator documented the date/time Customer Care provided the DMHC rights to the member incorrectly in the system of record. The date/time the Intake coordinator documented this information is when the case was transferred to appeals and grievance. This is a documentation error by the intake coordinator.

  While the Plan asserted this was a documentation error by the intake coordinator, the Plan did not provide the Department with any evidence indicating the enrollee was provided with DMHC rights on May 9 instead of May 10. Therefore, the Plan's response does not support its assertion that no deficiency existed, or the deficiency was corrected.

- **DMHC Expedited Grievance and Appeal Selection B File #20:** The Plan stated:

  > The grievance was received via email from the DMHC as an expedited request on March 7, 2022, at 4:01pm. The member was called on March 9, 2022, at 1:39pm to provide their DMHC rights. This member was already aware of their rights as the case was already accepted by the DMHC. The grievance was created to support the expedited resolution of the DMHC complaint. In this example, the member exercised their right to bypass the grievance process due to the expedited circumstances of their grievance.

  The Department disagrees with the Plan's assertion it met its obligation to immediately notify the enrollee of his DMHC rights. The Plan stated it received an email from the DMHC on March 7. However, the file shows the Plan initially received an email about this expedited grievance on March 4 at 3:30 p.m., which means the Plan waited almost five calendar days to notify the enrollee of his DMHC rights.

  The Plan attempted to justify this delay because the enrollee "was already aware of their rights" as he "exercised their right to bypass the [Plan's] grievance process." Although the enrollee filed a complaint with the Department before requesting an internal Plan expedited appeal, the Plan is still legally required to immediately notify him of his DMHC rights without exception. Therefore, the

Plan's response does not support its assertion that no deficiency existed, or the deficiency was corrected.

- **DMHC Expedited Grievance and Appeal Selection B File #22:** The Plan stated:

  > The grievance case was an expedited request from the Department of Social Services (DSS), State Hearing division received via email on November 15, 2021, at 7:35pm. The member was contacted on November 17, 2021, at 1:46pm to provide their DMHC rights. This member was aware of their rights as the case was already accepted by the DSS State Hearing Division. The grievance was created to support the expedited resolution of the State Hearing complaint.

  The Plan asserted the enrollee "was aware of their rights as the case was already accepted by the DSS State Hearing Division." However, since DSS and DMHC are separate and distinct state agencies, DSS is not obligated to inform the enrollee of his DMHC rights. The enrollee was not advised of DMHC rights until over 48 hours after the Plan received notice the complaint required expedited review. Therefore, the Plan's response does not support its assertion that no deficiency existed, or the deficiency was corrected.

- **DMHC Expedited Grievance and Appeal Selection B File #24:** The Plan stated:

  > This grievance case was received via fax on March 17, 2022, at 3:33pm. An attempt to contact the member was made on March 17, 2022, at 5:20pm to provide their DMHC rights.

  The Plan asserted an "attempt" was made to contact the enrollee. However, there was no evidence in the file or the Plan's response demonstrating how the attempt was made (e.g., voice mail, email, fax, etc.), how many attempts were made, or whether the Plan was ultimately successful in providing the enrollee with DMHC rights. Therefore, the Plan's response does not support its assertion that no deficiency existed, or the deficiency was 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 reports, policies and procedures, training documents, files, interviews, and any other review deemed necessary by the Department.

**Deficiency #5: The Plan's written responses to grievances and appeals do not contain a clear and concise explanation of the Plan's decision.**

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

**Assessment:** Section 1368(a)(5), Rule 1300.68(d)(3), and the Plan's grievance policy require the Plan to provide enrollees with written responses to grievances containing a clear and concise explanation of the Plan's decision.[19]

The Department reviewed:

- 54 standard grievance and appeal selection B files.[20] Of those, the Plan did not provide a clear and concise explanation of its decision in 16 files (30%).[21]
- 65 standard grievance and appeal selection C files. Of those, the Plan did not provide a clear and concise explanation of its decision in 24 files (37%).[22]
- 57 expedited grievance and appeal selection A files.[23] Of those, the Plan did not include a clear and concise explanation of the Plan's decision in 14 files (25%).[24]
- 24 expedited grievance and appeal selection B files. Of those, the Plan did not include a clear and concise explanation of the Plan's decision in six files (25%).[25]

**Case Examples**

- **DMHC Standard Grievance and Appeal Selection B File 17:** The denial letter responding to an appeal from a provider on behalf of an enrollee for a Breo Ellipta Aero RX prescription to treat emphysema states:

  > You or [provider], on your behalf, appealed the denial of Bre Ellipta Aero BR ACT 200/25/MCG Inhaler. [The Plan] has reviewed the appeal and has decided to uphold decision. This request is still denied. This is because a [Plan] doctor looked at the request for a medicine called Breo Ellipta. The facts sent to us show that you have a lung disorder. **You are not currently taking this medicine.** Breo Ellipta is not a covered drug listed on the plan's drug list (i.e. non-formulary). [The Plan's] Non-Formulary Medication Policy says that you must have tried and failed other drugs on the plan's drug list (formulary) before asking for a non-formulary drug. The facts show that you have not tried and failed Bevespi aerosphere which is on the plan's drug list. Your doctor did not state that you cannot take this medicine for any reason. You do not meet the guideline stated here. As such, we are not able to approve the request.

[19] Beneficiary Grievance Management System, pages 8, 12, 18, 19.
[20] Standard Grievance and Appeal Selection B files are categorized as "Appeal" by the Plan, and include "RX Benefit" files.
[21] DMHC Standard Grievance and Appeal Selection B File 6, 11, 12, 14, 16-18, 20, 21, 25, 26, 28, 29, 51, 52, 54.
[22] DMHC Standard Grievance and Appeal Selection C File 3, 4, 6, 8, 10, 13, 15, 16, 21, 24, 26, 27, 29, 32, 37, 38, 42, 46, 49-51, 54, 60, 63.
[23] DMHC Expedited Grievance and Appeal Selection A files are categorized as "Grievance" by the Plan.
[24] DMHC Expedited Grievance and Appeal Selection A File 2, 3, 5, 12, 15, 21, 22, 31, 33, 34, 36, 47, 48, 52.
[25] DMHC Expedited Grievance and Appeal Selection B File 8, 9, 13, 18, 20, 23.

The letter is unclear because there is a provider note in the file indicating the enrollee was already taking Breo Ellipta, whereas the letter incorrectly states the enrollee was not currently taking Breo Ellipta.

- **DMHC Standard Grievance and Appeal Selection C File 13:** The denial letter responding to an appeal for a hyaluronic acid injection into the knee joint states:

  > You or [provider] appealed the denial of hyalgan or supartz injection dose, drain/injection joint/bursa w/us. [The Plan] has decided to uphold the decision. This request is still denied. This is because we have reviewed your request to have a medicine (hyaluronic acid) injected into your knee joint and the criteria (MCG 25th edition A-0306) show that this is not proven to help your condition. We have approved the drain/injection joint/bursa w/us under authorization number […] effective May 11, 2022, through November 7, 2022.

  The letter is unclear because it mentions both a denial and an approval of the same request, and includes medical abbreviations which would be unclear to a layperson.

- **DMHC Expedited Grievance and Appeal Selection A File 2:** The denial letter responding to an appeal for denied chemotherapy states:

  > We called the office of [Provider] and spoke with [name]. She advised us they did receive the approved authorization from [medical group]. She advised this authorization was for administering the medication. She advised the authorization in which they are not processing is the one for the chemotherapy medication. She advised she sent it to them, and the authorization was voided advising they were not at risk for the medication. We verified we are at risk for chemotherapy medications. We requested for [name] to submit the authorization to us with your medical records.

  The letter is unclear because it refers to both an approval for administering medication and a “not processing” status for chemotherapy medication. The letter also references a provider, a representative, and a medical group, but thereafter uses “they” or “them” to describe the parties, making it difficult to understand who took what actions. Additionally, the letter states the authorization was voided because one of the parties was not “at risk” for the medication, which is medical insurance terminology the enrollee is unlikely to understand.

- **DMHC Expedited Grievance and Appeal Selection B File 18:** The denial letter responding to an enrollee’s appeal requesting not to be discharged from a skilled nursing facility (SNF) so he could heal longer before discharge states:

  > This request is still denied. This is because we have reviewed the request for you to stay in the nursing facility and the records indicate

> you have completed your antibiotics. It is not clear whether the degree and type of wound care you still need can be done at a lower level of care. Your stay through May 11th is approved under authorization number […].

The letter is unclear because the Medical Director's clinical decision in the file approved the length of stay until May 16, not May 11, and supports the longer stay with the statement "It is not clear whether the degree and type of wound care you still need can be done at a lower level of care."[26] The statement from the Medical Director was included in the denial letter, but not in support of the enrollee staying longer at the SNF.

**TABLE 4**
***Expedited and Standard Grievance and Appeal Files***

| FILE TYPE | NUMBER OF FILES | REQUIREMENT | COMPLIANT | DEFICIENT |
|---|---|---|---|---|
| Standard Grievance and Appeal Selection B | 54 | Plan's written response to grievances contains a clear and concise explanation | 38 (70%) | 16 (30%) |
| Standard Grievance and Appeal Selection C | 65 | Plan's written response to grievances contains a clear and concise explanation | 41 (63%) | 24 (37%) |
| Expedited Grievance and Appeal Selection A | 57 | Plan's written response to grievances contains a clear and concise explanation | 43 (75%) | 14 (25%) |
| Expedited Grievance and Appeal Selection B | 24 | Plan's written response to grievances contains a clear and concise explanation | 18 (75%) | 6 (25%) |

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

> [A]cknowledges the Department's findings that the Plan's written responses to grievances and appeals did not contain a clear and concise explanation of the Plan's decision. Since the conclusion of the onsite

[26] DMHC Expedited Grievance and Appeal Selection B File 18, page 50.

> audit, the Plan has implemented multiple trainings, updating desk level procedures and continues to enhance monitoring to ensure a clear and concise explanation of the Plan's decision in written responses to grievances and appeals.
>
> The AGD Medical Director Leadership team has acquired new leadership and undergone reorganization in 20242025 [sic]. The Plan has instituted several processes that ensure the resolutions provided by the Medical Director reviewers include a clear and concise explanation of the rationale underlying their decisions…

The Plan also indicated it:

- Conducted various trainings for AGD staff, medical directors (June 2023, November 2024, April 2025).
- Revised and updated AGD policies and procedures and desk level procedures (November 2024).
- Will implement enhanced monitoring on a monthly basis (June 2025).
- Is working to develop a Medical Director Monitoring Program and desk level procedure (to be completed by August 1, 2025).
- Is working to develop Medical Director monitoring tools (to be completed by September 1, 2025).

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)

**Final Report Deficiency Status: Not Corrected**

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to demonstrate the effectiveness of its corrective actions.

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

**Deficiency #6:** **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 do not specify the provisions in the contract, evidence of coverage, or member handbook that excludes the service.**

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

**Assessment:** When the Plan's written responses to grievances involve the denial or modification of a request for health care services based in whole or in part that the proposed services are not a covered benefit, Section 1368(a)(5) and Rule 1300.68(d)(5) require the Plan's responses to clearly specify the provisions in the contract, evidence of coverage, or member handbook excluding the service.

The Department reviewed:

- 54 standard grievance and appeal selection B files, one of which involved a decision the requested service was not a covered benefit.[27] In this file, the Department found the Plan did not specify the provisions in the contract, evidence of coverage, or member handbook excluding the service in the Plan's written response.
- 65 standard grievance and appeal selection C files, 14 of which involved a decision the requested service was not a covered benefit.[28] Of those, the Department found the Plan did not specify the provisions in the contract, evidence of coverage, or member handbook excluding the service in the Plan's written response in seven files (50%).[29]
- 57 expedited grievance and appeal selection A files, two of which involved a decision the requested service was not a covered benefit.[30] In both files, the Department found the Plan did not specify the provisions in the contract, evidence of coverage, or member handbook excluding the service in the Plan's written response.
- 24 expedited grievance and appeal selection B files, eight of which involved a decision the requested service was not a covered benefit.[31] Of those, the Department found the Plan did not specify the provisions in the contract, evidence of coverage, or member handbook excluding the service in the Plan's written response in one file (13%).[32]

[27] DMHC Standard Grievance and Appeal Selection B File 6.
[28] DMHC Standard Grievance and Appeal Selection C File 10, 12, 15, 17, 18, 20, 35-37, 39, 41, 59, 61, 64.
[29] DMHC Standard Grievance and Appeal Selection C File 10, 17, 36, 37, 41, 59, 64.
[30] DMHC Expedited Grievance and Appeal Selection A File 6, 15.
[31] DMHC Expedited Grievance and Appeal Selection B File 2-5, 8, 10, 15, 23
[32] DMHC Expedited Grievance and Appeal Selection B File 23.

**TABLE 5**
***Standard and Expedited Grievance and Appeal Files***

| FILE TYPE | NUMBER OF FILES | REQUIREMENT | COMPLIANT | DEFICIENT |
|---|---|---|---|---|
| Standard Grievance and Appeal Selection B | 1 | Plan's written response to grievances involving a determination the requested service is not a covered benefit specifies the provision that excludes the service | 0 (0%) | 1 (100%) |
| Standard Grievance and Appeal Selection C | 14 | Plan's written response to grievances involving a determination the requested service is not a covered benefit specifies the provision that excludes the service | 7 (50%) | 7 (50%) |
| Expedited Grievance and Appeal Selection A | 2 | Plan's written response to grievances involving a determination the requested service is not a covered benefit specifies the provision that excludes the service | 0 (0%) | 2 (100%) |
| Expedited Grievance and Appeal Selection B | 8 | Plan's written response to grievances involving a determination the requested service is not a covered benefit specifies the provision that excludes the service | 7 (87%) | 1 (13%) |

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

> [A]cknowledges the Department's findings…Since the conclusion of the onsite audit, the Plan has enhanced multiple processes to ensure 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 specify the provisions in the contract, evidence of coverage, or member handbook that excludes the service.

The Plan also indicated it:

- Updated various grievance review processes (January 2025, February 2025).
- Developed a desk level procedure for medical directors (April 2025).

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)

**Final Report Deficiency Status: Not Corrected**

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to demonstrate the effectiveness of its corrective actions.

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

**Deficiency #7: The Plan does not consistently ensure adequate consideration of enrollee grievances and rectification when appropriate.**

**Statutory Reference:** Section 1368(a)(1).

**Assessment:** Section 1368(a)(1) requires the Plan to ensure adequate consideration of enrollee grievances and rectification when appropriate.

The Department reviewed:

- 37 exempt grievance files. Of those, the Plan did not adequately consider and rectify the grievances in six files (16%).[33]
- 71 standard grievance and appeal selection A files. Of those, the Plan did not adequately consider and rectify the grievances in 17 files (24%).[34]

[33] DMHC Exempt Grievance File 1, 5, 7, 11, 31, 36.
[34] DMHC Standard Grievance and Appeal Selection A File 3, 5, 8, 9, 25, 28, 32, 36, 37, 41, 51, 54, 66-68, 70, 71.

- 51 standard grievance and appeal selection C files. Of those, the Plan did not adequately consider and rectify the grievances in 12 files (24%).[35]
- 57 expedited grievance and appeal selection A files. Of those, the Plan did not adequately consider and rectify the grievances in 25 files (44%).[36]

**Case Examples**

- **DMHC Exempt Grievance File 31:** Notes from the Plan's CSR state:

  > Member called in upset regarding an issue the member had with a nurse last night. The member also stated that she is being hurrased [sic] by a few ppl in her apt. building and has already place [sic] a police report. The member primeraly [sic] states that she needs a PCP and that she does not have one. I tried to assit [sic] the member but was not successful. I reached out to management and was advised to connected [sic] member to a supervisor per member's request on the medicare dept.
  >
  > I called our medicare dept and talked to [name] who then conferenced the call with her supervisor [name] call dropped, per [name] [name] will call member back, no further action.

  The Plan closed this file with no evidence it investigated or rectified the enrollee's grievance regarding the nurse or with finding a PCP.

- **DMHC Standard Grievance and Appeal Selection C File 41:** The enrollee's appeal details from the Plan's CSR state:

  > Member is requesting assistance with approving her authorizations for Oncology, Pulmonology, and Colorectal Surgery to [provider]. Member states that she was referred to providers that are too far from her and plus she has also confirmed with [provider] that they are in network with BSC PHP and [IPA]. Member states she does not understand why her authorizations were denied to [provider] and is requesting assistance in approving her referrals to [provider] or assistance in finding a new PCP/IPA that is in network with [provider] to receive the immediate treatment that she needs as her condition is worsening.

  The Plan only addressed the authorizations for pulmonology in the resolution letter, and did not address the enrollee's concerns about her PCP:

  > You appealed the modification of Pulmonology Office Visit. Blue Shield of California Promise Health Plan has reviewed the appeal and has decided to uphold decision. This request is still denied. This is because

[35] DMHC Standard Grievance and Appeal Selection C File 1, 2, 6, 7, 10, 14, 15, 33, 38, 41, 42, 49.
[36] DMHC Expedited Grievance and Appeal Selection A File 1, 3-6, 9, 12, 15-17, 20, 24, 28, 33, 35-37, 41, 43, 44, 47, 52, 53, 56, 57.

> we are looking at your request to be sent to [provider]. You are required to follow your Health Plan rules. These rules state that you must see network Providers for your care. Your case is not an emergency. Similar care is available in the network. You have been referred to a network Provider for care. Your request is still denied.

The Plan's investigation and rectification of the enrollee's grievance was also inadequate, confusing, and incomplete. Even though the enrollee made it clear the assigned in-network provider was too far away, the Plan did not consider or address this issue. The Plan also did not find a new PCP for the enrollee.

- **DMHC Expedited Grievance and Appeal Selection A File 17:** The enrollee reported transportation service issues and her inability to obtain gurney transportation. The Plan's response affirmed the transportation issue details. The Plan also stated they were aware of the enrollee's next scheduled trip, and indicated the vendor's "management is aware of the situation and they are working on the issue."

  The Plan closed the file without rectifying the enrollee's grievance regarding her inability to obtain necessary transportation services.

**TABLE 6**
***Exempt, Standard, and Expedited Grievance Files***

| FILE TYPE | NUMBER OF FILES | REQUIREMENT | COMPLIANT | DEFICIENT |
|---|---|---|---|---|
| Exempt Grievance | 37 | The Plan ensures adequate consideration and rectification of enrollee grievances | 31 (84%) | 6 (16%) |
| Standard Grievance and Appeal Selection A | 71 | The Plan ensures adequate consideration and rectification of enrollee grievances | 54 (76%) | 17 (24%) |
| Standard Grievance and Appeal Selection C | 51 | The Plan ensures adequate consideration and rectification of enrollee grievances | 39 (76%) | 12 (24%) |

| | | | | |
|---|---|---|---|---|
| Expedited Grievance and Appeal Selection A | 57 | The Plan ensures adequate consideration and rectification of enrollee grievances | 32 (56 %) | 25 (44%) |

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

> [A]cknowledges the Department's findings that the Plan did not consistently ensure adequate consideration of enrollee grievances and rectification when appropriate. Since the conclusion of the onsite audit, the Plan has implemented additional oversight, updated processes, and conducted multiple trainings…

The Plan also indicated it:

- Created a report to capture all exempt grievances filed by CSRs. The report is audited daily to ensure all grievances were considered, documented, resolved appropriately and categorized accurately (February 2023).
- Retrained AGD staff (June 2023, April 2025).
- Updated and developed various desk-level procedures (November 2024, January 2025, March 2025, April 2025).
- Implemented enhanced monitoring for clear and concise explanation of the resolution via quality team on a monthly basis (June 2025).

**Supporting Documentation:**
- Plan response to the Preliminary Report (May 23, 2025)

**Final Report Deficiency Status: Not Corrected**

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to demonstrate the effectiveness of its corrective actions.

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

**Deficiency #8: The Plan does not accurately describe the issues raised in all grievances.**

**Regulatory Reference:** Rule 1300.68(e)(2).

**Assessment:** Rule 1300.68(e)(2) and the Plan's grievance policy require the Plan's grievance system to track and monitor grievances and describe the issues raised in grievances.[37]

The Department reviewed:

- 44 exempt grievance files. Of those, the Plan did not accurately describe the issues raised in 22 files (50%).[38]
- 54 standard grievance and appeal selection A files. Of those, the Plan did not accurately describe the issues raised in nine files (17%).[39]
- 57 expedited grievance and appeal selection A files. Of those, the Plan did not adequately describe the issues raised in 22 files (39%).[40]

**Case Examples**

- **DMHC Exempt Grievance File 1:** The enrollee complained about his inability to obtain an appointment, among other things. The Plan categorized it as a "Delay in Service." However, the enrollee also described feeling disrespected by the office's actions, and stated the office was unprofessional. The Plan did not capture the quality of service allegations.

  During interviews with Plan staff to discuss this file, the Plan stated it did not track and trend exempt grievances like other "formal" grievances.

- **DMHC Standard Grievance and Appeal Selection A File 41:** The enrollee complained about excessive wait times to see his doctor. The enrollee also complained authorizations were not being submitted timely. The enrollee discussed changing their PCP. The resolution letter stated the enrollee "declined to file a grievance." The letter focused on asking the enrollee to change their PCP as a resolution.

  The Plan categorized the grievance as "Customer Service/Plan Administration." However, the Plan did not categorize the significant access issues the enrollee reported at the PCP's office for tracking and monitoring and did not investigate these issues due to the enrollee declining to file a grievance.

- **DMHC Expedited Grievance and Appeal Selection A File 3:** The enrollee complained about transportation services needed to obtain chemotherapy. The enrollee stated she had multiple issues with the Plan's transportation service over a two-month period, including cancelled trips.

[37] Beneficiary Grievance Management System, page 5.
[38] DMHC Exempt Grievance File 1, 3, 4, 7-10, 16, 18-20, 24, 25, 28, 31, 34, 37, 38, 40, 43, 44, 46.
[39] DMHC Standard Grievance and Appeal Selection A File 6, 8, 10, 14, 22, 25, 38, 41, 50.
[40] DMHC Expedited Grievance and Appeal Selection A File 1, 3, 6, 11, 22, 23, 28, 31-33, 37, 38, 43, 44, 46, 47, 49, 52-56.

The Plan categorized the grievance as “Customer Service/Transportation.” However, the Plan did not add the “Access to Care” category, which is indicated by the enrollee’s allegations regarding canceled trips and issues with transportation services.

**TABLE 7**
***Exempt, Standard, and Expedited Grievance Files***

| FILE TYPE | NUMBER OF FILES | REQUIREMENT | COMPLIANT | DEFICIENT |
|---|---|---|---|---|
| Exempt Grievance | 44 | The Plan accurately describes all grievance issues for tracking and monitoring | 22 (50%) | 22 (50%) |
| Standard Grievance and Appeal Selection A | 54 | The Plan accurately describes all grievance issues for tracking and monitoring | 45 (83%) | 9 (17%) |
| Expedited Grievance and Appeal Selection A | 57 | The Plan accurately describes all grievance issues for tracking and monitoring | 35 (61%) | 22 (39%) |

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

> [A]cknowledges the Department’s findings that the Plan did not accurately describe the issues raised in all grievances. Since the conclusion of the onsite audit, the Plan has implemented additional oversight, updated processes, and conducted multiple trainings…

The Plan also indicated it:

- Created a report to capture all exempt grievances filed by CSRs. The report is audited daily to ensure all grievances were considered, documented, resolved appropriately and categorized accurately (February 2023).
- Updated and developed various desk-level procedures (December 2023, November 2024, January 2025, March 2025, April 2025).
- Implemented enhanced monitoring for clear and concise explanation of the resolution via quality team on a monthly basis (June 2025).

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)

**Final Report Deficiency Status: Not Corrected**

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to demonstrate the effectiveness of its corrective actions.

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

**Deficiency #9:** **For grievances involving delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan's written responses do not state the criteria, clinical guidelines, or medical policies used in reaching the determination.**

**Statutory and Regulatory References:** Section 1368(a)(5); Rule 1300.68(d)(4).

**Assessment:** Section 1368(a)(5) and Rule 1300.68(d)(4) require the Plan to provide enrollees with written responses to grievances. For grievances involving the delay, denial, or modification of health care services based in whole or in part on medical necessity, the Plan's responses must describe the criteria, clinical guidelines, or medical policies it used in making its determination.

The Department reviewed:

- 54 standard grievance and appeal selection B files, 49 of which were denials for services the Plan did not consider medically necessary.[41] Of those, the Department found the Plan did not describe the criteria, clinical guidelines, or medical policies it used to make these determinations in 10 files (20%).[42]
- 65 standard grievance and appeal selection C files, 39 of which were denials for services the Plan did not consider medically necessary.[43] Of those, the Department found the Plan did not describe the criteria, clinical guidelines, or medical policies it used to make these determinations in 12 files (31%).[44]

[41] DMHC Standard Grievance and Appeal Selection B File 1-5, 7, 8, 11-32, 34-37, 39-54.
[42] DMHC Standard Grievance and Appeal Selection B File 5, 8, 16, 18, 20, 24, 26, 32, 35, 46.
[43] DMHC Standard Grievance and Appeal Selection C File 1-3, 5, 7, 9, 13, 14, 16, 19, 21, 22, 24-26, 28-33, 38, 40, 42, 43, 45-52, 54, 55, 58, 62, 63.
[44] DMHC Standard Grievance and Appeal Selection C File 3, 7, 22, 30, 33, 38, 42, 43, 49, 51, 55, 62.

- 24 expedited grievance and appeal selection B files, nine of which were denials for services the Plan did not consider medically necessary.[45] Of those, the Department found the Plan did not describe the criteria, clinical guidelines, or medical policies it used to make these determinations in four files (44%).[46]

**Case Examples**

- **DMHC Standard Grievance and Appeal Selection B File 8:** The file includes a denial of a medication deemed not medically necessary. The Plan's written denial response states:

  > You or [provider], on your behalf, appealed the denial of Otezla Tablet 30mg. [The Plan] has reviewed the appeal and has decided to uphold [sic] decision. This request is still denied. This is because we are looking again at your request for Otezla. Health Plan rules require you to try and fail treatment with both Humira and Enbrel. Your records do not show you have tried Enbrel. Your request remains denied.

  The Plan denied the medication based upon "health plan rules," but did not describe the criteria, clinical guidelines, or medical policies it used to make its determination in the written response.

- **DMHC Standard Grievance and Appeal Selection C File 33:** The file includes a denial of an appeal for a walker with a seat. The Plan's written denial response states:

  > You or [provider], on your behalf, appealed the denial of a new walker with seat. [The Plan] has reviewed the appeal and has decided to uphold [sic] decision. This request is still denied. This is because we are looking at your request for a new walker. Medi-Cal rules allow a new one every five years. You received your last one in 2020. Your records do not show why you should receive a new one sooner that [sic] rules allow.

  The Plan denied the walker based upon "Medi-Cal rules," but did not describe the criteria, clinical guidelines, or medical policies it used to make its determination in the written response.

[45] DMHC Expedited Grievance and Appeal Selection B File 3, 9, 12, 13, 17-19, 22, 24.
[46] DMHC Expedited Grievance and Appeal Selection B File 9, 17, 19, 22.

**TABLE 8**
***Standard and Expedited Grievance and Appeal Files – Medical Necessity***

| FILE TYPE | NUMBER OF FILES | REQUIREMENT | COMPLIANT | DEFICIENT |
|---|---|---|---|---|
| Standard Grievance and Appeal Selection B | 49 | Written responses to grievances involving the denial or modification of health care services based in whole or in part on medical necessity must describe the criteria used for its decision | 39 (80%) | 10 (20%) |
| Standard Grievance and Appeal Selection C | 39 | Written responses to grievances involving the denial or modification of health care services based in whole or in part on medical necessity must describe the criteria used for its decision | 27 (69%) | 12 (31%) |
| Expedited Grievance and Appeal Selection B | 9 | Written responses to grievances involving the denial or modification of health care services based in whole or in part on medical necessity must describe the criteria used for its decision | 5 (56%) | 4 (44%) |

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

> [A]knowledges the Department's findings…Since the conclusion of the onsite audit, the AGD Medical Director Leadership team has acquired new leadership and undergone reorganization in 2024 through 2025. It has instituted several processes that ensure the resolutions provided by the Medical Director reviewers include a clear and concise explanation of the rationale underlying their decisions…

The Plan also indicated it:

- Developed various desk level procedures for medical directors and nurses (July 2024, April 2025).
- Provided various trainings to medical directors, clinical AGD nurses, (October 2024, April 2025, May 2025).
- Is working to develop a Medi-Cal Medical Director Monitoring Program and desk level procedure (to be completed by August 1, 2025).
- Is working to develop Medi-Cal Medical Director monitoring tools (to be completed by September 1, 2025.

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)

**Final Report Deficiency Status: Not Corrected**

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to demonstrate the effectiveness of its corrective actions.

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

## ACCESS AND AVAILABILITY OF SERVICES

**Deficiency #10: The Plan's provider directories do not list the providers employed by a federally qualified health center.**

**Statutory Reference:** Section 1367.27(h)(8)(D).

**Assessment:** Section 1367.27(h)(8)(D) requires the Plan to list the names of providers employed by contracted federally qualified health centers (FQHCs).

The Plan's Medi-Cal Provider Directory for Los Angeles County lists contracted FQHCs on page 2,963. However, this directory does not list the providers employed by FQHCs. Similarly, the Plan's Medi-Cal Provider Directory for San Diego County lists contracted FQHCs on page 16, but also does not list the names of providers employed by these FQHCs.

The Plan demonstrated its online provider directory at the survey, and when searching for FQHCs, their website displayed an "Oops! Page not found" error. The Department re-visited the online directory in March 2025, and the search function identified

contracted FQHCs. However, the online directory did not list any providers employed by FQHCs.

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

> [R]espectfully disagrees with the Department's findings…The ability to search for Federally Qualified Health Centers (FQHC) in Find a Provider on the Plan's provider directory is available and has been since the audit period. The search functionality for providers employed by the clinics is also available. Both can be searched by specialty or name and will show the affiliation via the clinic location along with the associated medical group affiliations.

The Plan also provided screenshots of "a step-by-step example of how to conduct this search."

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)
- FQHC Provider Directory Search Screenshots

**Final Report Deficiency Status: Not Corrected**

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

The Plan's first screenshot shows a search for FQHCs in the Plan's provider directory and a listing for Chinatown Service Center Family Health Clinic. This listing clearly indicates this facility is a FQHC. However, this search function is not at issue, as this deficiency pertains to the provider directories not listing providers employed by FQHCs, not whether facilities are listed as FQHCs.

The Plan's second screenshot shows a search for a specific provider name. Search results included her credentials, specialty, address, phone number, and facility affiliations, but did not include a FQHC designation. It is unknown how the Plan knew this provider is employed by a FQHC, as the Plan searched for the provider's name, not for a list of FQHC providers.

The Department also searched for the same provider and the provider's information did not list her FQHC affiliation. In addition, the Plan's response did not mention its San Diego County provider directory.

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 provider directories, interviews, and any other review deemed necessary by the Department.

## UTILIZATION MANAGEMENT

**Deficiency #11: The Plan does not make its utilization management criteria or guidelines used to authorize, modify, or deny health care services available to the public upon request.**

**Statutory Reference:** Section 1363.5(b)(5).

**Assessment:** Section 1363.5(b)(5) requires the Plan to make available to the public upon request the criteria or guidelines the Plan uses to determine whether to authorize, modify, or deny health care services.

The Plan's utilization management (UM) policy, UM program, and provider manual indicate criteria or guidelines will be available to the public upon request.[47] However, the Clinical Guidelines and Shared Decision-Making Aids section of the Plan's website states: "Providers and members have the right to request a copy of a guideline that Blue Shield Promise has used to make a treatment authorization decision."[48] This statement is inconsistent with Section 1363.5(b)(5), which requires the Plan to make criteria and guidelines available to the public, not just providers and members.

During interviews, the Department asked the Plan how it discloses the criteria or guidelines used for treatment decisions to the public upon request, since the public is not mentioned on the Plan's website. The Plan's Director of Utilization and Medical Review stated, "if it's missing, then we need to add it."

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

> [A]cknowledges the Department's findings…Since the conclusion of the audit, the Plan has updated the public facing website in order to make it clear its utilization management criteria or guidelines used to authorize, modify, or deny health care services are available to the public upon request. This update is evidenced at the following link: Clinical Guidelines and Shared Decision-making Aids | Blue Shield of CA Promise Health Plan

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)
- Plan's Website[49]

**Final Report Deficiency Status: Corrected**

The Plan updated the Clinical Guidelines and Shared Decision-Making Aids section of the Plan's website to now state, "Providers, members, *or the public* have the right to

[47] Utilization Management Standards for Medical Decision-Making Process, page 1. Utilization Management Program, page 50. Medi-Cal Provider Manual, page 29.
[48] Link to Plan's website.
[49] Link to Plan's website.

request a copy of a guideline that Blue Shield Promise has used to make a treatment authorization decision" [emphasis added].[50] Therefore, the Department determined this deficiency is corrected.

**Deficiency #12:** **For decisions to deny or modify requests by providers based in whole or in part on medical necessity, the Plan and its delegates do not consistently include in written responses to enrollees a clear and concise explanation of the reasons for its decision, a description of the criteria or guidelines used, and/or the clinical reasons for the decision.**

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

**Assessment:** Section 1367.01(h)(4) requires the Plan's communications to providers and enrollees regarding decisions to deny, delay, or modify requested health care services based upon medical necessity to be in writing. These written communications must include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

The Department reviewed 70 UM denial, delay, and modification files. Of those, 53 files (76%)[51] did not include a clear and concise explanation, description of criteria or guidelines, and/or clinical reasoning.

**Case Examples**

- **DMHC File 4:** The enrollee was referred for an acute inpatient hospitalization. The denial letter included medical terminology a layperson would not easily understand, such as "Acute Inpatient Hospitalization, H44104462 Medical Surgical Level of Care and Cellulitis." The letter did not include the discharge date, thus making the dates the Plan denied care unclear. Additionally, the letter indicated the Plan relied on "standard rules," without defining those rules or explaining why it used them.

- **DMHC File 11:** The enrollee was referred for an acute inpatient hospitalization. The denial letter included medical terminology a layperson would not easily understand, such as "Acute Inpatient hospitalization H38693757 for Telemetry Level of Care, tracheostomy and bronchoscopy." The letter also did not include the discharge date, thus making the dates it denied care unclear. Additionally, the letter indicated the Plan relied on "standard rules," without defining those rules or explaining why it used them.

The Plan delegates UM functions to several medical entities. The Department reviewed 62 UM denial, delay, and modification files for the following delegates: Thrifty

[50] Link to Plan's website.
[51] DMHC Files 1, 2, 4, 5, 7, 8, 11, 12, 15-17, 20-24, 26-28, 31, 35, 37, 39-41, 44-52, 54, 57-63, 66, 69, 70, 72-74, 76, 79-82.

Management, MedPoint Management Services, and Network Medical Management. Of those, 20 files (32%)[52] did not include a clear and concise explanation, description of criteria or guidelines, and/or clinical reasoning.

**Case Examples**

- **DMHC Delegate File 10:** The enrollee was referred for an infusion treatment for iron deficiency. The denial notice stated:

  > . . . After a review of medical guidelines by our Medical Director, it was decided that two infusion treatments (to put fluids or drugs directly into your blood) of Injectafer iron supplement are not medically needed.

  The letter did not describe the criteria or guidelines used and the clinical reasons for the medical necessity determination.

- **DMHC Delegate File 16:** The enrollee was referred to a dermatologist with a diagnosis of acne and follicular disorder. Based on the medical records, the enrollee had tried and failed conservative treatments, making a request to a specialist necessary. The denial stated:

  > . . . RE: OFFICE O/P EST LOW 20-29 MIN DESTRUCT B9 LESION 1-14 [REQUESTING PROVIDER] has asked Blue Shield of California Promise Health Plan (Blue Shield Promise) to approve removal of acne. This request is denied. This is because We cannot approve your request for removal of acne. The records received from your child's doctor show that they have sebaceous hyperplasia (enlarged skin oil seen on the forehead or cheeks of the middle-aged and older people). We do not see that your child has acne that needs removal.

  This letter is unclear because it uses medical terminology a layperson would not easily understand, such as “RE: OFFICE O/P EST LOW 20-29 MIN DESTRUCT B9 LESION 1-4.”

[52] DMHC Delegate Files 10, 14, 16, 17, 20, 23, 35, 43, 44, 46-48, 52, 62-65, 68, 102, 104.

**TABLE 9**
***Utilization Management Medical Necessity Denial, Delay, and Modification Files***

| FILE TYPE | NUMBER OF FILES | REQUIREMENT | COMPLIANT | DEFICIENT |
|---|---|---|---|---|
| Utilization Management Denial, Delay, and Modification | 70 | Response includes a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and/or the clinical reasons | 17 (24%) | 53 (76%) |
| Delegate Utilization Management Denial, Delay, and Modification | 62 | Response includes a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and/or the clinical reasons | 42 (68%) | 20 (32%) |

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

> [A]cknowledges the Department's findings…Since the time of the on-site review, the Plan has undergone significant reorganization, introducing new leadership and a revamped post-service team. This new leadership has established a revised Medi-Cal hierarchy of criteria for the UM and AGD teams. As part of this restructuring, training has been implemented to ensure proper understanding and application of the Medi-Cal criteria and to enhance the clarity and conciseness of resolution reviews for Medical Directors, Pharmacists and Nurses.

The Plan stated its "Delegation Oversight team has several measures in place to ensure compliance," including an annual audit tool, training and education, ongoing monitoring process, and annual audit and oversight by UM Delegation Oversight team.

The Plan also indicated it:

- Conducted various trainings for the Post-Service Team, pharmacists, clinicians, new hires, medical directors (November 2022, May 2024, February 2025).
- Provided updated training materials to medical director reviewers (April 2025)
- Audits its UM teams monthly.

- Will revise and update the Post-Service monitoring process and tool (by August 2025).

In addition, the Plan asserted nine of the 20 deficient delegate files included the required information.[53]

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)

**Final Report Deficiency Status: Not Corrected**

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to demonstrate the effectiveness of its corrective actions.

The Plan's assertion that nine delegate files include "reason & criteria" is unsubstantiated. Although the Plan identified the page numbers where the reason and criteria can be found in each file, the Plan provided no explanation to support its assertions. Nevertheless, even if the Department found the nine enrollee letters compliant, 11 deficient letters remain, which would not correct this deficiency.

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

**Deficiency #13: The Plan does not adequately oversee its UM delegates.**

**Statutory and Regulatory References:** Section 1367.01(a), (h)(4), (j); Rule 1300.70(b)(2)(B), (b)(2)(G)(3).

**Assessment:** Section 1367.01(a) requires the Plan and its UM delegates to comply with Section 1367.01. Section 1367.01(j) requires the Plan, as part of its quality assurance program required by Section 1370, to establish a process to assess and evaluate its compliance with Section 1367.01. Rule 1300.70(b)(2)(B) requires the Plan to have an oversight mechanism to ensure delegated functions are adequately performed.

The Department selected the following delegates in order to assess the Plan's delegation oversight: MedPoint Management Services, Thrifty Management, and Network Medical Management.

[53] DMHC Delegate Files 10, 14, 23, 35, 48, 52, 68, 102, 104.

### *1. Delegation Oversight Policies and Procedures*

The Department reviewed the Plan's *Utilization Management Program*, which outlines the Plan's activities for delegation oversight. The policy describes specific responsibilities agreed upon by the Plan and its delegates. The Plan's oversight included reviewing, monitoring, and evaluating delegates through quarterly and annual audit reviews.[54]

Additionally, the Department reviewed the Plan's *Utilization Management Delegation Oversight Evaluation and Scoring* policy, which describes the Plan's annual audit assessment process for its delegates.

Despite these policies, the Department found no evidence the Plan conducted quarterly and annual audits of its delegates.

### *2. Reporting to Committees*

The Department attempted to review the Plan's Delegation Oversight Committee (DOC) meeting minutes, but the Plan redacted these minutes. These minutes thus provided no evidence of the Plan overseeing its delegates.

### *3. UM File Review*

The Department reviewed 62 UM denial, delay, and modification files and found the delegates did not consistently include in enrollee letters a clear and concise explanation of the reasons for its decision, a description of the criteria or guidelines it used, and/or the clinical reasons for the decision.[55]

The Department found no evidence the Plan identified these compliance issues or initiated corrective actions during the survey review period.

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

> …Delegation Oversight department conducts audits of Plan delegates on an annual basis and as needed. The Plan meticulously analyzes quarterly reports and conducts quarterly denial reviews to ensure adherence to all regulatory standards. Furthermore, all audits are presented and discussed at the Plan's Delegation Oversight Committee meetings on a monthly basis, ensuring continuous oversight and compliance.

The Plan also provided updated DOC meeting minutes and documentation including "additional evidence of quarterly audits."

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)

[54] Utilization Management Program, pages 17, 18.
[55] See Deficiency #12.

- Delegation Oversight Committee Meeting Minutes (June 15, 2021, September 21, 2021, October 19, 2021, November 16, 2021, December 14, 2021)
- Utilization Management Program 2020 Audit Tool & Guidelines
- 2020 File Review Worksheet (August 11, 2020)

**Final Report Deficiency Status: Not Corrected**

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

While the Plan sent additional documentation relating to delegation oversight, including audit reports and assessments, the documentation did not demonstrate the Plan adequately oversees its delegates. The Department acknowledges the Plan sent updated DOC meeting minutes with fewer redactions. The updated 2021 and 2022 minutes were not as redacted as the updated 2020 minutes, but the unredacted portions were mostly related to the review and approval of monthly delegation oversight logs. The minutes contained no documentation of the "meticulous analysis" of quarterly reports, quarterly denial reviews, or presentations and discussion of audits.

In DOC meeting minutes, issues requiring follow-up were identified with MedPoint Management Services[56] and Network Medical Management.[57] However, the minutes did not contain any discussion demonstrating effective action was taken, or evidence these issues were resolved. In addition, none of the DOC meeting minutes mentioned Thrifty Management.

Furthermore, although the Department found issues with the Plan delegates' written responses to enrollees for decisions to deny or modify provider requests based in whole or in part on medical necessity,[58] the Plan did not identify any issues. For example, in 2020 and 2021, the Plan found Thrifty Management letters 100 percent compliant for clear and concise responses and the inclusion of criteria and guidelines used to make the decision.[59] The Plan did not provide evidence this audit was performed in 2022.

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

[56] BSC/PHP Delegation Oversight Committee Meeting Minutes: June 15, 2021, page 7; October 19, 2021, pages 9-10; November 16, 2021, page 6.
[57] BSC/PHP Delegation Oversight Committee Meeting Minutes: September 21, 2021, pages 9-10; October 19, 2021, page 2; November 16, 2021, pages 2-3; December 14, 2021, page 2.
[58] See Deficiency #12.
[59] 8_5 2020 Audit_Thrifty_Preferred_Audit_Tool, tab UM 7; 8_5 2021 Audit_Thrifty_Preferred_Audit_Tool, tab UM 7.

## EMERGENCY SERVICES AND CARE

**Deficiency #14: The Plan does not provide all noncontracting hospitals in the state the necessary contact information to request authorization for medically necessary post-stabilization care.**

**Statutory References:** Section 1262.8(j); Section 1317.4a(c)(1).

**Assessment:** Section 1371.4(a) requires the Plan to provide 24-hour access for enrollees and providers, including noncontracting hospitals, to obtain timely authorization for medically necessary post-stabilization care. Sections 1262.8(j) and 1317.4a(c)(1) require the Plan to provide all noncontracting hospitals in the state with specific contact information they need to contact the Plan about post-stabilization care. This contact information must be updated as necessary, but no less than once a year.

During interviews, the Plan's UM Director stated the Plan relies on its website and the phone number on the back of the enrollee card as the method for noncontracting facilities to contact the Plan.

The Department determined the Plan's notification efforts do not satisfy the requirements of Section 1262.8(j) and Section 1317.4a(c)(1). Making the information available on the Plan's website puts the onus on each noncontracting hospital to search and obtain the Plan's contact information. Section 1262.8(j) and Section 1317.4a(c)(1) places the obligation on health plans to provide noncontracting hospitals with the information annually.

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

> [A]cknowledges the Department's findings…Originally, the contact information necessary to meet this requirement is posted on the Plan's website…The Plan's website provides all professional and institutional providers with contact information from Blue Shield Promise. The contact telephone number is available 24/7 for hospital admissions, which includes authorization requests for medically necessary post-stabilization care to comply with Section 1262.8(j); Section 1317.4a(c)(1).
>
> In addition to posting the contact information on the Plan's website, the Plan mailed a notice to all contracted and noncontracted acute care hospitals in California on May 21, 2025. Subsequent notices will be distributed to California's acute care hospitals at least annually. The notice provides hospitals with the Plan's contact information necessary for authorization requests for medically necessary post-stabilization care. Noncontracted hospitals are required to obtain authorization for post-stabilization care from the Plan.

The Plan indicated it updated its emergency care services policy and procedure in May 2025 to include information on the annual mailing process.

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)
- Admission Notification and Post-Stabilization Authorization Requirement for Acute Care Hospitals within California Letter Template (May 2025)
- *Emergency Care Services* (March 2024)

**Final Report Deficiency Status: Not Corrected**

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

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan did not provide evidence to demonstrate implementation of its corrective actions. The Plan provided a letter template with telephone and fax numbers for noncontracting hospitals "to notify Blue Sheld Promise of the patient's admission and request authorization for post-stabilization care." However, it is unknown whether this letter was the notice mailed to "noncontracted acute care hospitals in California on May 21, 2025." In addition, it is unknown which noncontracting hospitals received this notice, or whether the Plan will be mailing these notices annually.

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, mailed notices, interviews, and any other review deemed necessary by the Department.

**Deficiency #15: The Plan is operating at variance with its basic organizational documents for prior authorization of medically necessary care following stabilization of an emergency medical condition.**

**Statutory and Regulatory References:** Section 1371.4(a); Section 1386(b)(1); Rule 1300.71.4.

**Assessment:** Section 1371.4(c) specifies the Plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition. If the Plan requires prior authorization for post-stabilization care, Rule 1300.71.4 establishes requirements the Plan must follow when responding to requests for medically necessary health care services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred.

Under Section 1386(b)(1), operating at variance with the Plan's basic organizational documents constitutes grounds for disciplinary action.

The Plan's *Emergency Care Services* policy indicates the Plan shall approve or disapprove a request for post-stabilization inpatient services made by a contracting or non-contracting provider within 30 minutes of the request.[60]

[60] Emergency Care Services Policy, page 5

However, in response to the Department's request for a log of all post-stabilization care denials, the Plan stated it "did not have any post stabilization denials from June 1, 2020 through May 31, 2022. The Plan does not require prior authorization for post stabilization."[61] This response is inconsistent with the Plan's policy, which requires prior authorization for post-stabilization care.

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

> [A]cknowledges the Department's finding the Plan is operating at variance with its basic organizational documents for prior authorization for necessary medical care following stabilization of an emergency medical condition, based on a statement made during audit interviews…
>
> During the audit interview, Utilization Management leadership inadvertently conveyed that prior authorization was not required for post-stabilization services. The Plan confirms that Plan Policy and Procedures for Emergency Care Services accurately reflects the regulatory requirements:
>
> - Prior authorization is not required for urgent or emergent care.
> - However, for post-stabilization services, authorization is required.
> - In compliance with federal and state regulations, if a facility notifies us regarding a post-stabilization request, we are required to make a decision within 30 minutes; otherwise, the request is approved.

The Plan stated its UM system, AuthAccel, "is fully capable of pulling reports related to post-stabilization authorization requests and decisions as needed for internal review or regulatory reporting."

The Plan also indicated "[t]he statement during the audit interview was an isolated instance of miscommunication" and its policies and procedures for post-stabilization "have been consistently applied."

**Supporting Documentation:**

- Plan response to the Preliminary Report (May 23, 2025)

**Final Report Deficiency Status: Not Corrected**

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

The Plan's initial failure to provide the Department with a log of all post-stabilization care denials and the Plan representative's misstatement during interviews led the Department to believe the Plan does not require authorization for post-stabilization services. Although the Plan now asserts authorization is required for post-stabilization

[61] Plan Response to Department Request for Log #9: Post Stabilization Denials.

services, the Plan has not provided the Department with a denial log, AuthAccel reports, or evidence of how it “consistently applies” its post-stabilization policies and procedures.

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

## SECTION II: SURVEY CONCLUSION

The Department's 2022 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, **2022 Routine Full Service Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.