

**File #933-0043: Exhibit E-1, Attachment 1: Response to the
Final Report of the Non-Routine Survey**

blue  of california

**Response of
Blue Shield of California
to
Department of Managed Health Care
Division of Plan Surveys'
Final Report
Non-Routine Survey**

November 17, 2014

TABLE OF CONTENTS

	Page
I. INTRODUCTORY STATEMENT	1
II. BLUE SHIELD’S ANALYSIS AND RESPONSE TO THE FINAL REPORT	2
A. Blue Shield has significantly reduced provider front-office confusion and increased the accuracy of its provider lists to address the concerns raised by the Department in Deficiency Nos. 1-4	2
B. Response to “Deficiency” Nos. 1 through 3 - The Department’s survey results are not evidence that Blue Shield’s list of contracted providers was inaccurate	4
1. The Department’s survey is not evidence that Blue Shield’s online provider directory included non-contracted providers.....	5
2. The Department cites no evidence that providers who were no longer accepting new patients had notified Blue Shield of that fact.....	8
3. Online provider directories need only be updated on a quarterly basis	9
C. The Final Report violates Health & Safety Code section 1382(c) because Blue Shield has had no opportunity to research and respond to the conclusions, data, and arguments raised for the first time in the Final Report	9
1. The Department did not disclose serious flaws in its survey methodology	10
2. The Department has developed an entirely new legal theory in the Final Report not made in its Preliminary Report	10
3. The Final Report attempts to bypass significant evidentiary problems with the Department’s survey findings by relying on data that was not included in the Preliminary Report	11
D. Further response to Deficiency No. 1: The Department’s survey is not evidence that Blue Shield is acting at a variance with its provider directory	13
E. Further Response to Deficiency No. 2: Blue Shield did not violate Health & Safety Code section 1360.....	14
F. Further Response to Deficiency No. 3: The Department’s survey data do not support its finding that Blue Shield failed to comply with its statutory obligation to provide a list of contracted providers that is updated on a quarterly basis	17
G. Further response regarding Deficiency No. 4: There was a net increase in the number of contracted primary care providers in Sacramento County	18
III. CONCLUSION.....	18

I. INTRODUCTORY STATEMENT

Blue Shield of California acknowledges and shares the Department of Managed Health Care's ("Department") concern about the network confusion that Individual and Family Plan members and our network providers experienced in 2014, due in large part to the implementation of the Affordable Care Act. We have worked hard over the last year to ensure that all of our members have an improved and positive experience in 2015. We are committed to continuing to work with the Department on our shared mission of serving Covered California members across the state. At the same time, we believe that the Department's Final Report is misleading and has the potential to further confuse members by significantly overstating the severity of the issues.

Here is what is important for our members to know:

Our 2015 Networks Are Ready

- Blue Shield has undertaken a comprehensive effort to address member confusion about providers, which should lead to a much improved 2015 experience.
- Our provider directories have been updated, and we are intently focused on maintaining their accuracy through continuous updates, educational outreach for providers and staff, and technological enhancements to our systems.
- The Department has reviewed Blue Shield's networks for 2015, and we currently have over 27,000 primary care providers and specialists in our Exclusive PPO and EPO networks, with 96% confirming they are accepting new Covered California patients.

The Department's Findings Are Misleading

- The Department's report exaggerates the severity of the issues and understates the extent of our corrections. We feel this is misleading for our members. The vast majority of the issues raised in the Department's report have either been corrected by Blue Shield or were never caused by Blue Shield in the first place.
- The Department's findings are rooted in a flawed methodology that consisted of minimal survey sampling of a population that did not always have access to the most current information. The survey relied solely on what provider front office staff reported in a telephone interview rather than whether Blue Shield, in fact, had a signed network contract with the provider, which it did in almost every case.
- Finally, the Department does not take into account that a successful healthcare system depends upon the active engagement of all participants. The report identifies Blue Shield as the sole source of confusion among members and fails to acknowledge that there were multiple points of miscommunication in the system over which Blue Shield did not have control.

II. BLUE SHIELD'S ANALYSIS AND RESPONSE TO THE FINAL REPORT

A. Blue Shield has significantly reduced provider front-office confusion and increased the accuracy of its provider lists to address the concerns raised by the Department in Deficiency Nos. 1-4.

In January 2014, federal and state health care reform engendered transformative changes in California's market for health coverage. These changes have contributed to the provider confusion evidenced by the Department's survey results. While Blue Shield disagrees with many of the Department's conclusions in the Final Report, Blue Shield acknowledges a longstanding industry-wide challenge in maintaining entirely accurate physician rosters, especially in PPO and EPO environments. Physicians are independent contractors, and, as such, modify and change their group affiliations and locations frequently, in many cases without notice to health plans. Physician schedules and "open" panel status often vary by day of the week, office location, and group affiliation. Although Blue Shield's physician contracts require that physicians give Blue Shield notice of these events and changes, when physicians leave a particular practice or change the location of a practice, Blue Shield's experience is that they often do not provide the required notice.

Blue Shield acknowledges that the implementation of the Affordable Care Act, in conjunction with these longstanding industry challenges, has resulted in confusion at the provider and member level. Blue Shield has taken a variety of substantial steps to address and remedy these issues. Thus, while Blue Shield strongly disagrees with the Department's contentions, Blue Shield believes that many of the issues identified by the Department in the Final Report are the inevitable byproduct of year one of a new market for health coverage, and that, looking forward, Blue Shield's efforts to eliminate confusion and confirm provider participation in its networks will successfully resolve these issues for 2015.

As the Department acknowledges repeatedly in its Final Report, Blue Shield is engaged in a comprehensive effort to improve the accuracy of its provider databases. Recognizing that the Department's survey results indicate some degree of provider front-office confusion regarding which health plans the surveyed physicians accept, Blue Shield has also taken a number of steps to make sure physicians and their front office staff both understand our health plans and networks, and accurately communicate their network participation to members in order to avoid "downstream" confusion at the provider front-office level.

By way of background, Blue Shield originally filed its Exclusive PPO and EPO Networks with the Department in 2013. At that time, Blue Shield demonstrated that its networks met the Department's regulatory requirements for network adequacy. These networks were reviewed and approved by the Department.

Since the time of that approval, Blue Shield has expanded its physician network significantly. In those counties where Blue Shield has experienced attrition from the Exclusive PPO and EPO Networks, Blue Shield has added additional providers.

Blue Shield recently re-filed its Exclusive PPO and EPO Networks with the Department. Those filings were closed by the Department on September 29, 2014. In other words, the

Department has apparently concluded that Blue Shield's networks meet its regulatory requirements on a going-forward basis.

Additionally, Blue Shield recently conducted outreach to 30,599 primary care providers and specialists to confirm their continued participation in the Exclusive PPO and EPO Networks. On November 5, 2014, Blue Shield submitted to the Department the results of its provider outreach telephone survey. As Blue Shield reported to the Department, more than twenty-seven thousand primary care providers and specialists (88.4% of the sample) confirmed their participation in Blue Shield's Exclusive PPO and EPO Networks. Further, 96% of the 27,040 providers confirmed that they are accepting new Covered California patients.

As a follow-up to its survey, Blue Shield will contact providers who indicated either that they were not participating, or that they were unable to confirm their participation in the Exclusive PPO and EPO Networks. We will also send a certified letter to these providers reaffirming their participation in the networks in accordance with their contractual obligations.

Further, Blue Shield is updating the provider directory to identify providers who have advised us they are no longer accepting new patients. Blue Shield anticipates completing these updates by November 30, 2014. Blue Shield continues to update our directory to reflect recent provider demographic changes, including address and telephone number changes we learned of as a result of our provider outreach efforts.

In a continuing effort to ensure the accuracy of our provider database, Blue Shield has committed to conducting additional "secret shopper" outreach to contracted providers to validate their network participation and availability, and to update the provider directory in accordance with our findings.

Blue Shield has also agreed to keep the Department apprised of a greater than 10% change to our filed provider rosters. Specifically, Blue Shield has committed to re-filing the roster on a quarterly basis if there has been a greater than 10% change to the network since our last filing with the Department.

Finally, Blue Shield is engaged in a three-year initiative to enhance our ability to identify and correct errors in our provider databases, notwithstanding the longstanding industry challenges affecting database accuracy. Blue Shield contemplates completing the Provider Single Source of Truth ("SSoT") Program in 2015. The goal of the SSoT Program is to improve quality and customer experience by increasing both accuracy and timeliness of service to providers and members.

In addition to Blue Shield's comprehensive efforts to improve the accuracy of our provider database, Blue Shield has also taken steps to address the provider front-office confusion reflected in the Department's survey results. Throughout 2014, Blue Shield engaged in significant provider education and outreach, conducting onsite visits to targeted providers, hosting numerous educational webinars (with another eight webinars scheduled between November and December 2014), and distributing provider office manager toolkits to educate provider front-office staff regarding Blue Shield's plans and networks. Over a period of fifteen months, Blue Shield will have conducted close to 1,200 personal visits to high-volume primary

care providers and specialists. These educational efforts are designed to reduce the likelihood of any downstream communication errors causing members to receive inaccurate information from providers or their front-office staff (such as those identified on page 12 of the Final Report).

Blue Shield believes the steps we have taken to improve the accuracy both of our databases, and of the information providers and their staff give to members will correct any deficiencies identified in the Department's Final Report, and looks forward to serving our members in 2015. Blue Shield notes that we explained the substantial steps we have undertaken to the Department, and were not asked to undertake any additional or different corrective actions.

Blue Shield now addresses several fundamental problems with the Department's conclusions with respect to 2014, as reflected in the Final Report.

B. Response to "Deficiency" Nos. 1 through 3 - The Department's survey results are not evidence that Blue Shield's list of contracted providers was inaccurate.

To the extent the Final Report is premised on the Department's survey results, the survey does not constitute evidence of the statutory violations alleged in the Final Report. Indeed, the Final Report includes no evidence that the provider front-office staff surveyed by the Department (or whoever responded to the survey) were correct when they indicated that they were not contracted with Blue Shield for purposes of its Covered California products. Therefore, the survey does not support the Department's contention that Blue Shield's online provider directory listed providers who had not actually contracted with Blue Shield.¹

The Department contends that Blue Shield failed to meet its statutory obligations because: (1) 119 out of 1,360 providers listed on Blue Shield's online provider directory told the survey team that they did not accept Blue Shield's Covered California products; (2) 248 of the offices advised the survey vendor that the provider does not practice at the listed location, and (3) the survey vendor was only able to confirm that 771 providers accepted Blue Shield's Covered California products. (Final Report at 13.) None of these findings evidences a violation of Health & Safety Code sections 1367.26 (Deficiency No. 3), 1360(a) (Deficiency No. 2), or 1386(b)(1) (Deficiency No. 1).

Moreover, the Department's survey findings (which are based on a survey design identifying the caller as part of a survey team acting on behalf of the Department of Managed Health Care, rather than a design that would better replicate the experience of a member calling to schedule an appointment) are not evidence that members experienced difficulty in reaching providers or receiving care. (Final Report at 33.) Finally, the Department's survey results do not indicate one way or another whether the providers who responded to the survey had previously advised Blue Shield that they no longer practiced at a certain location or that a provider had

¹ Additionally, the survey does not support the Department's new contention in the Final Report that "California consumers could not reach and/or did not have access to providers who were represented as being part of the Plan's network during the first open enrollment period for Covered California." (Final Report at 13.) The survey was not designed to replicate the customer experience and was based on a provider database effective several months after the close of open enrollment. Additionally, Blue Shield's records demonstrate that the majority of providers who advised the survey vendor they did not accept Covered California plans had, in fact, submitted claims to Blue Shield for members in Blue Shield's Covered California plans that were processed at an in-network benefit level.

terminated his or her relationship with a contracted provider group.

1. The Department's survey is not evidence that Blue Shield's online provider directory included non-contracted providers.

Health & Safety Code section 1367.26 requires that Blue Shield provide a list of “*contracted* providers, within the enrollee's or prospective enrollee's general geographic area” that is updated on a quarterly basis. Cal. Health & Safety Code § 1367.26(a). The Department's various alleged deficiencies are based on its survey data, none of which support a finding that the directory included providers who actually were not contracted with Blue Shield. Instead, the survey data indicate: (1) that “119 of out 1,360 (8.75%) of the providers identified by Blue Shield as participating in Blue Shield's Covered California products affirmatively *told the survey team vendor* that they are not participating in, and not accepting patients enrolled in, Blue Shield's Covered California products”; and (2) that 771 out of 1,360 (56.7%) affirmatively told the survey vendor that they accepted Blue Shield's Covered California plans. (Final Report at 13.)

There is a fundamental problem with the deficiencies identified in the Final Report: the Final Report simply assumes the accuracy of the information given by the physicians or their staff to the Department's survey team.

It is a basic proposition of law generally, and agency law specifically, that an agency that alleges that a regulated entity has violated a legal requirement must come forward with evidence of the claimed violation. *Daniels v. Dept. of Motor Vehicles*, 33 Cal. 3d 532,536 (1983). The underlying predicate for the allegation that Blue Shield's directory included inaccurate information regarding certain providers' contracted status is the Department's survey, during which a number of providers “told the survey team” that they were not participating in Blue Shield's Covered California products, when the directory listed them as participating. From this, the Department concludes that the provider directory was inaccurate. The basic problem with that conclusion is that the Department cites no evidence that those providers (or, more likely, the front-office staff who responded to the survey) were correct. If those providers were mistaken, and in reality had contracted with Blue Shield to accept members in Covered California plans, then the cited deficiencies are without foundation. The Final Report is therefore predicated *not* on any actual proof, but on a massive assumption - that turns out to be false - that the surveyed providers, in fact, had not contracted with Blue Shield to accept members in Covered California plans.

The claim that only 771 of the providers queried “were available” to Covered California members suffers from that same problem – it assumes the accuracy of the providers' representations to the Department's survey team. It also incorrectly excludes providers from Blue Shield's network who did not answer their telephones or who did not respond to a voicemail from a survey vendor (12.8% of the total), responders who did not know whether the provider queried accepted Covered California members (2.4% of the total), and providers who did not regularly practice at the listed location, but who might practice there via referral. The Department's conclusions are not predicated on any actual analysis of the contract status between those providers and Blue Shield.

The Knox-Keene provision that governs provider directories requires only that Blue Shield provide a list of “contracted providers, within the enrollee’s or prospective enrollee’s general geographic area.” Health & Safety Code § 1367.26(a). While Blue Shield obviously would like providers and their staffs to supply accurate information to patients about their contracted status, Section 1367.26 does not require a plan to be a guarantor that every provider or his/her front-office staff will not be confused.² The Knox-Keene Act simply requires plans to provide their members with lists of providers who are contracted, which Blue Shield did. Cal. Health & Safety Code § 1367.26(a). The Final Report cites no evidence whatsoever that the 119 providers referenced on page 7 of the survey report were not, in fact, contracted with Blue Shield to accept members in Covered California plans.

Furthermore, a provider’s network status is governed by the actual contracting arrangement between the provider and Blue Shield, and how Blue Shield adjudicates their claims – not by what a provider or his/her staff mistakenly may communicate. Cal. Health & Safety Code § 1373.96(m)(2) (“Nonparticipating provider” means a provider who is *not contracted* with the enrollee’s health care service plan to provide services under the enrollee’s plan contract”); Cal. Health & Safety Code § 1374.60 (defining in-network coverage or services to include “the health care services provided or offered under the requirements of this chapter that are received from a provider employed by, under contract with, or otherwise affiliated with the health care service plan and in accordance with the procedures set forth in the plan’s approved evidence of coverage”); *Coast Plaza Doctors Hosp. v. Blue Cross of California*, 173 Cal. App. 4th 1179, 1183 (2009) (hospital was “an ‘out-of-network provider’ (i.e., it did not *contract* with Blue Cross to provide services to plan participants or beneficiaries)”); *Lori Rubinstein Physical Therapy, Inc. v. PTPN, Inc.*, 148 Cal. App. 4th 1130, 1136 (2007) (“In a PPO plan, there is a designated panel of preferred providers with whom a third party payor has *contracted* to provide medical services to insureds at discounted rates. The providers agree to discount their rates in part because they are guaranteed a defined pool of patients who have an economic incentive to use a preferred provider”).

The Final Report cites no evidence that the providers surveyed by the Department were, in fact, not contracted as represented in Blue Shield’s directory; and thus it contains no evidence that Blue Shield failed to provide a proper listing of contracted providers. Thus, the non-routine survey results do not satisfy the Department’s burden of proof as to the deficiencies alleged in the Final Report.³ The Department’s burden may not be satisfied by mere hearsay evidence (like the non-routine survey). Indeed, “[t]he legislative mandate of Government Code section 11513 against sole reliance on hearsay evidence is emphatic.” *Daniels*, 33 Cal. 3d at 538.

As it turns out, many of those providers or their staff were mistaken as to their contracted

² Independent of any statutory obligations, in order to address provider and member confusion, Blue Shield has implemented several educational outreach efforts. For example, Blue Shield created and distributed a toolkit for providers, which includes a brochure for providers to distribute to Blue Shield members enrolled in IFP PPO and EPO plans. The member brochure, “Navigating Health Care, Getting the Most from your Individual or Family Plan,” provides useful information, including step-by-step instructions for how to find a doctor using Blue Shield’s Find a Provider tool, and encourages members to register on the member portal.

³ The “burden of proving the facts necessary to support the action rests with the agency making the allegation.” *Daniels*, 33 Cal. 3d at 536. The applicable standard of proof in an administrative setting is clear and convincing evidence. *Sandarg v. Dental Bd. of Calif.*, 184 Cal. App. 4th 1434 (2010).

status. Prior to the issuance of the Final Report, the Department sent Blue Shield the names of 665 providers. As Blue Shield demonstrated in previous responses to the Department, Blue Shield had active contracts with 664 of those providers (99.8%). For the one missing contract, Blue Shield received from the provider a confirmation in writing that he participates in the network. Some of these provider contracts were signed as recently as one year ago, and the providers have received multiple communications from Blue Shield since then. Thus, the results of the Department’s survey indicated a need for further provider education (which Blue Shield began in July), but they do not support the deficiencies alleged in the Final Report.

The real evidence of whether these providers are available to Covered California members is not a phone call from a survey vendor, but whether the providers in fact are contracted and treated by Blue Shield as in-network providers (i.e., that any claims are paid at an in-network level to these providers for Blue Shield’s Covered California enrollees, holding the members harmless outside of any deductible or copayment obligations.) Blue Shield has reviewed its records to determine whether providers who advised the survey vendor that they were not participating in the Covered California network were, in fact, providing services to Blue Shield’s Covered California enrollees. As set forth below, 67.3% of 162 providers who told the Department that they do not participate in Blue Shield’s Covered California network have submitted at least one claim, and received payment at the in-network level, for Blue Shield’s Covered California members.

Blue Shield has adjudicated over ten thousand of these providers’ claims for services rendered to Covered California members at an in-network benefit level. These facts directly contradict the Department’s conclusion that the providers are “not participating” in Blue Shield’s Covered California networks and/or unavailable to its members. To our knowledge, Blue Shield’s payments to the providers (in addition to any deductibles and copayments made by the enrollee) were accepted by the providers as payment in full. Therefore, the vast majority of these “non-participating” providers are, in fact, seeing Covered California enrollees, submitting claims for reimbursement to Blue Shield, and getting paid at the in-network benefit level.

**Paid In-Network Covered California Claims for Providers deemed
“not participating” in Blue Shield’s Covered California networks in DMHC Survey**

Covered CA Claim Processed	Group/ Solo Practitioner	Count of Billing Providers	Percentage of Billing Providers	Claim Count
Yes	Group ¹	66	40.7%	9,300
	Solo Practitioner	43	26.5%	799
Yes Total		109	67.3%	10,099
No	Group ¹	26	16.0%	
	Solo Practitioner	27	16.7%	
No Total		53	32.7%	
Grand Total		162		10,099

¹ Individual physician results are not available for Group billing provider numbers.

Covered California is new for providers, and some confusion remains in the marketplace about what it is, what it does, and what its name is. Indeed, when Blue Shield contracted with our provider network for this new marketplace, it was called the California Health Benefits Exchange – it had not yet been rebranded as “Covered California”. Therefore, Blue Shield’s provider contracts do not reference Covered California. In addition to confusion resulting from the renaming of the Exchange, many consumers and providers do not understand that Blue Shield (and not Covered California) is a member’s health plan, even when the member has enrolled through the exchange. The solution to this problem is to continue to educate providers, members and the overall marketplace, as Blue Shield has done.⁴

In sum, the survey results do not constitute evidence that Blue Shield represented that providers were contracted for Covered California plans when, in fact, they were not.

2. The Department cites no evidence that providers who were no longer accepting new patients had notified Blue Shield of that fact.

The Department also alleges that Blue Shield failed to meet its statutory obligation “where its online Provider Directory failed to accurately report the status of providers who had closed their practices or were not otherwise accepting new patients.” (Final Report at 16.) However, Blue Shield has no statutory obligation to update the provider list to reflect providers who have closed their practices or otherwise are not accepting new patients *unless the provider tells Blue Shield first*. Cal. Health & Safety Code 1367.26(b) (the list “shall indicate which providers *have notified the plan* that they have closed practices or are otherwise not accepting new patients at that time.” (emphasis added).)⁵

As Section 1367.26(b) makes clear, the onus is on the provider to tell Blue Shield when he or she is no longer accepting new patients or has closed a practice. Blue Shield’s provider contracts require that providers supply this information, and Blue Shield makes every effort to stay abreast of these types of changes. Nonetheless, the Department’s survey results do not give rise to a statutory violation because there is no evidence that any of the providers who had closed a practice or were no longer seeing new patients had *notified Blue Shield* they were not accepting new patients or had closed their practices.

There is no legal basis for the Department’s attempt on pages 16-17 of the Final Report to shift the burden of proof to Blue Shield to demonstrate that it complied with the statute. The Department has no evidence suggesting that Blue Shield had previously been informed by providers that they were not accepting new patients, had closed a practice, or had experienced a

⁴ As discussed below, Blue Shield had no opportunity to research whether providers who did not answer the phone were accurately included in the list of providers who were unavailable to Covered California members, because the Department did not provide their names to Blue Shield. Moreover, in its Preliminary Report, the Department failed to advise Blue Shield that this category included providers who failed to return voicemails left by the survey team. If the Department’s survey vendor reached a physician’s voicemail, there is no basis for concluding that the provider is not available to members of Blue Shield’s Covered California plans simply because the office did not respond to a survey vendor’s message.

⁵ The statute also states that a provider list shall “indicate it is subject to change without notice,” that a plan may satisfy its obligation to provide a list of contracted providers by directing the enrollee or prospective enrollee to the provider listings on the website, and that plans shall update their lists at least quarterly. Cal. Health & Saf. Code §§ 1367.26(c) and (d).

change in address or telephone number, and, therefore, no evidence of any statutory violation. As discussed in Section II(C)(3), below, the Department's efforts to burden-shift are even more problematic here, because the Final Report is based on arguments and conclusions that were not included in the Department's Preliminary Report. *Daniels*, 33 Cal. 3d at 536 (burden of proof rests with the agency).

3. Online provider directories need only be updated on a quarterly basis.

Finally, the Knox-Keene Act only mandates quarterly updates to Blue Shield's online provider directory. *See*, Cal. Health & Safety Code § 1367.26(d) ("A plan may. . . satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its Internet Web site. Plans shall ensure that the information provided is updated at least quarterly.") As a result, the Final Report suffers from two additional flaws.

First, the Final Report is premised on the unfounded assumption that Blue Shield must provide real-time updates to the online provider directory. While Blue Shield strives to ensure that our online directories are as accurate as possible, the statutory obligation is to perform quarterly updates.

Second, even assuming the providers who responded that they do not accept Blue Shield's Covered California plans were correct, the survey does not indicate *when* those providers terminated their affiliation with a contracted provider group or Blue Shield. If the provider was contracted with Blue Shield in the quarter preceding the June 2014 provider list given to the Department, then there is no statutory violation. Again, the Department makes no findings to support its evidentiary burden.

C. The Final Report violates Health & Safety Code section 1382(c) because Blue Shield has had no opportunity to research and respond to the conclusions, data, and arguments raised for the first time in the Final Report.

In addition to the evidentiary and methodological flaws discussed above, the Department's Final Report suffers from serious legal deficiencies that violate Blue Shield's statutory and due process rights. Specifically, the Department is violating its own statutes by releasing its Final Report without having given Blue Shield the opportunity to respond to the newly-asserted arguments, facts, and data included in it. Under California Health & Safety Code section 1392, the Department is entitled to conduct a non-routine survey of Blue Shield. Although the Department's report shall be open to public inspection, the statute mandates that "*no examination shall be made public, unless the plan has had an opportunity to review the examination report and file a statement or response within 45 days of the date that the department provided the report to the plan.*" Cal. Health & Safety Code § 1382(c) (emphasis added). Thus, the statute requires that Blue Shield be given adequate time to review the report and respond to it before the report can be made public. After Blue Shield has had the opportunity to respond, the Department can review Blue Shield's response, and issue a final report that "excludes any survey information, legal findings, or conclusions determined by the director to be in error." *Id.* However, the Department is without authority to blindside Blue Shield with new arguments, data, and facts that were not included in its Preliminary Report, much less to make those conclusions public without giving Blue Shield a full 45 days to respond to them. The

Department bypassed these statutory requirements with respect to its Final Report.

There are three primary areas where the Department has issued a “final” and public report based on information and conclusions that were not in its Preliminary Report. We discuss each of them in turn, below.

1. The Department did not disclose serious flaws in its survey methodology.

First, the Final Report identifies flaws in the Department’s survey methodology that were not disclosed in the Preliminary Report issued to Blue Shield. These flaws pervade the Final Report, and undermine the credibility of the Department’s conclusions. Specifically, the Final Report discloses *for the very first time* that the category of providers who did not answer the phone (12.8% of the total sample) actually includes providers with functioning voicemail systems who “did not return messages left by the survey vendor.” (Final Report at 6 and 13.)

There is a significant difference between a phone call that goes unanswered after numerous tries (the category of “No Answer” calls described in the Department’s Preliminary Report), and a phone call that reaches a voicemail system advising that the caller has reached a practicing physician’s office (the category of “No Answer” calls disclosed for the first time in the Final Report). It is not reasonable to conclude (as the Department apparently has) that a provider who does not respond to a voicemail left by a *survey vendor* is “not available” to a *potential patient*. The Department’s survey methodology was not designed to replicate the consumer experience in this (or any other) respect.

Because the Department did not disclose in its Preliminary Report that a significant percentage of the providers the Department categorized as being unavailable to Covered California members might simply have been providers whose offices did not elect to return a message left by a survey team, Blue Shield had no opportunity to identify and contact those providers to confirm that they accepted its Covered California plans. This is exactly the type of situation Health & Safety Code section 1382(c) was designed to avoid.

2. The Department has developed an entirely new legal theory in the Final Report not made in its Preliminary Report.

Second, Deficiency No. 1 is premised on a novel legal theory that was not advanced in the Department’s Preliminary Report. The Department contends that Blue Shield is operating “at a variance” with something that is not specified. (Final Report at 13 (“Deficiency #1: Blue Shield operated at a variance when its internet website and online Provider Directory informed enrollees that numerous physicians were participating in Blue Shield’s Covered California products, when they were not.”))

The Department goes on to argue that Blue Shield might have been operating at a variance with the Provider Directory filed as Exhibit I to Blue Shield’s application for licensure (Final Report at 13.) But Blue Shield is required to amend a provider network roster (Exhibits I-1, I-2, and I-3) “when 10 percent or more of the names contained in the list of a service area have been changed.” California Code of Regulations, tit. 28, § 1300.52(f). If that regulation requires that a network roster need only be amended when 10% or more of the names have changed, then there is no basis for the Department’s conclusion that *any variance* from the filed roster

constitutes a violation of Health & Safety Code section 1386(b)(1). Further, other than Deficiency No. 4, the Final Report is not based on Exhibit I at all; instead, it is rooted in survey results related to a different document – the online provider directory.

Tacitly recognizing this gap in its logic, the Department asserts, in the alternative, that Blue Shield was operating at a variance with the online provider directory. (Final Report at 13.) However, an online directory is not subject to Health & Safety Code section 1386(b)(1) because it is neither a governing basic organizational document filed with the Department pursuant to sections 1351 or 1352, nor a “published plan.”⁶ Tellingly, the Department has omitted from the Final Report any argument as to why the online provider directory falls within the scope of the statute.

While the Department has statutory authority to *exclude* legal findings or conclusions that are determined to be in error, it has no authority to make new legal findings in the Final Report, as it did here. Cal. Health & Safety Code § 1382(c) (“after reviewing the plan's response, the director shall issue a final report that excludes any survey information, legal findings, or conclusions determined by the director to be in error.”) Because the Department came up with a new Deficiency No. 1 in the Final Report, it deprived Blue Shield of the 45-day statutory period to respond to the Department’s new arguments.

3. The Final Report attempts to bypass significant evidentiary problems with the Department’s survey findings by relying on data that was not included in the Preliminary Report.

Third, the Final Report violates Health & Safety Code section 1382(c) by citing to information Blue Shield provided to the Department on August 29 that was not referenced in the Preliminary Report. Blue Shield has had no opportunity to respond to the Department’s conclusions to the extent they are premised on this data. (Final Report at pp. 13-14, 16.) The Department’s actions are particularly egregious because it contends that Blue Shield failed to address this data in its response to the Preliminary Report. For instance, the Department states on pages 16 through 17 of the Final Report that Blue Shield failed to assert that the lag between the information in the provider directory, receiving new information from a provider or medical group, and performing mandated quarterly updates to the directory, contributed to inaccuracies in the database with respect to providers who had disaffiliated with medical groups contracting with Blue Shield, changed an address or phone number, or retired, moved out-of-state, or died. However, these provider listings were not discussed in the Preliminary Report at all. Thus, Blue Shield had no reason or opportunity to demonstrate that the lag actually was responsible for any inaccuracies because the Department did not raise that issue in its Preliminary Report.

Blue Shield believes that the lag in receiving accurate information from providers in time

⁶ The various sections of the Health & Safety Code mandating that Blue Shield provide a list of contracted providers to enrollees and prospective enrollees do not ever refer to the provider list as “the plan” or a component of the plan. Instead, it is referred to as a “list of providers,” “list of contracting providers,” or “provider list.” *See*, Health & Safety Code §§ 1367.26; 1368.016(a)(4); *see also*, *Pang v. Beverly Hospital, Inc.*, 79 Cal. App. 4th 986, 994 (2000) (“[s]tatutes must be harmonized, both internally and with each other”). In short, there is no legal authority for shoe-horning the Department’s claims regarding the accuracy of Blue Shield’s online provider directory into Health & Safety Code section 1368.

for the mandated quarterly updates is an important factor in any discrepancies, and negates the Department's claims. By way of example, the Final Report refers to 26 provider listings corresponding to providers who were no longer in practice because they were deceased, had retired, or moved out-of-state.⁷ (Final Report at 16-17.) Blue Shield has reviewed our records regarding those particular listings. Of the twenty-six listings, only a single provider or provider's office affirmatively notified Blue Shield that the provider had moved, retired, or died. That notice (that the provider had retired) was provided to Blue Shield on June 14, 2014 (*i.e.*, approximately a week after the effective date of the provider directory used in the Department's survey.) Blue Shield has confirmed that we removed the retired physician from our provider directory within 30 days. Because Blue Shield's obligation is to update its provider database on a quarterly basis only after a provider has notified Blue Shield that the provider has closed the practice or is no longer accepting patients, Blue Shield's data indicates that we have complied with our statutory obligations.

Similarly, in the Final Report, the Department cites 152 provider listings corresponding to providers who had either terminated their contract with Blue Shield, or disaffiliated with a medical group that remained contracted with Blue Shield (in fact, nearly all of these provider listings fall into the latter category of providers who had terminated their relationship with a contracted medical group), and 139 provider listings where the provider was still participating in the Exclusive PPO or EPO Networks, but had changed addresses or phone numbers.⁸ As described in Section II(A), above, Blue Shield has taken steps to improve the accuracy of our databases, even where providers fail to provide timely notification of a move, practice closure, or disaffiliation with a contracted provider group. Indeed, Blue Shield has updated the provider database to reflect any new information for the provider listings discussed above. The problem, as more fully discussed in Section II(A), is not that Blue Shield failed to update the directories with pertinent information, but that providers, for one reason or another, do not consistently give Blue Shield the information we need to keep our directories entirely accurate. Physicians are independent contractors, and, as such, modify and change their group affiliations and locations frequently, in many cases without notice to health plans.

For example, if a provider ceases to practice with a medical group that is contracted with Blue Shield, neither the provider nor the group will necessarily tell Blue Shield. Here, all but three of the providers (of the 152 provider listings cited in the Department's Final Report) terminated their affiliation with a medical group that remained contracted with Blue Shield – they did not terminate a direct contract with Blue Shield. Because Blue Shield's contract is with the group – and not with the individual provider – Blue Shield has no independent way of learning that the provider has left the medical group. Similarly, Blue Shield is dependent on the provider to advise us of an address or telephone number change.

These are longstanding industry-wide challenges to maintaining entirely accurate physician rosters. Although Blue Shield's physician contracts require that physicians give notice of these events and changes, when physicians leave a particular practice or change the location of

⁷ Provider listings may reflect multiple listings for a single provider. The 26 deceased, retired, or relocated out-of-state provider listings correspond to 16 individual providers.

⁸ These listings correspond to 107 unique providers who had terminated their relationship with a medical group that contracts with Blue Shield or who had terminated a separate contract with Blue Shield, and 94 unique providers who had changed an address or telephone number but remained contracted with Blue Shield.

a practice, Blue Shield's experience is that they often do not provide the required notice. Because this data was not included in the Preliminary Report, the Department has not given Blue Shield any opportunity to assess whether a lack of information from the providers at issue, combined with the quarterly update cycle contemplated by Health & Safety Code section 1367.26, contributed to the discrepancies described in the Final Report.

The Department's additions to the Final Report should not have been made public in the absence of a 45-day review and response period. Moreover, they pervade the Final Report. Indeed, the Department's arguments regarding the providers discussed above appear to have largely supplanted the arguments in the Department's Preliminary Report.

Blue Shield addresses additional problems with the alleged "deficiencies" identified in the Final Report in turn.

D. Further response to Deficiency No. 1: The Department's survey is not evidence that Blue Shield is acting at a variance with its provider directory.

(Cal. Health & Safety Code section 1386, subd. (b)(1).)

Deficiency No. 1 is flawed for all of the reasons identified above. Additionally, even if a provider directory were subject to Health & Safety Code section 1386 (it is not), the Final Report contains no evidence that *Blue Shield* operated at a variance with the list of contracted providers, as the statute requires. *See*, Cal. Health & Safety Code § 1386.

The Department's Final Report concludes that *providers*, or their front-office staff, may be operating at a variance with Blue Shield's provider directory. But Health & Safety Code section 1371.25 confirms that "[a] plan . . . and providers are each responsible for their own acts or omissions, and are not liable for the acts and omissions of. . . others." Blue Shield cannot be held responsible for inaccurate information disseminated by a provider's staff.

There is no evidence in the Final Report that Blue Shield has treated the 119 providers who told the Department's survey vendor they do not accept Blue Shield's Covered California plans as if they were out-of-network. On the contrary, if a provider is contracted in the Exclusive PPO or EPO Networks, Blue Shield covers the provider's service at an in-network benefit level, regardless of whether the provider (or front-office staff) thinks he or she is participating. If a Blue Shield member sees that provider, Blue Shield will pay claims in accordance with the member's contract and the provider's contracted rate. *See*, Cal. Code Regs. tit. 28, § 1300.71 (governing reimbursement to participating providers). Indeed, 67.3% of the providers the Department concludes are not available to members of Blue Shield's Covered California plans have submitted claims for services provided to Covered California enrollees since January 1, 2014, and these claims have been adjudicated by Blue Shield at an in-network benefit level.

In other words, it is the provider's *actual* contracted status – as evidenced by how Blue Shield treats that provider and adjudicates his or her claims (including any member liability) - that controls whether that provider is within Blue Shield's network. "Deficiency" No. 1 fails for that additional reason.

E. Further Response to Deficiency No. 2: Blue Shield did not violate Health & Safety Code section 1360.

(Cal. Health & Safety Code section 1360, subd. (a).)

Blue Shield disagrees with the Department’s assertion that Blue Shield’s online provider directory is a “solicitation,”⁹ and that – to the extent it contains inaccuracies – it violates Health & Safety Code section 1360(a).

The Department has never characterized an online provider directory as a solicitation, and for good reason.

First, Health & Safety Code section 1345 (l) defines solicitations as: “any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.” In turn, section 1360 prohibits “the use of any solicitation, which is untrue or misleading.”

A provider directory is an informational tool for current members that must also be provided (upon request) to potential enrollees. The fact that it is available to potential enrollees does not mean that the provider directory has been “disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.” Cal. Health & Safety Code § 1345(l). *See, Samura v. Kaiser Foundation Health Plan, Inc.*, 17 Cal. App. 4th 1284, 1300-1301 (1993) (“The statute does not apply to communications between Health Plan and its members. . . . Moreover, we construe the statute as applying only to the deceptive ‘use’ of documents in advertising or solicitation. . . .”) The provider directory requested by the Department was effective June 9, 2014 – *i.e.*, more than two months after open enrollment for 2014 had closed, and more than five months before open enrollment for 2015 begins. In other words, it was not “disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan,” and, therefore, does not constitute a solicitation. Cal. Health & Safety Code § 1345(l).

Regulatory guidance as to the meaning of “untrue, misleading, or deceptive” information confirms Blue Shield’s position. For example, the Department’s own regulations provide that “[A]n advertisement or other consumer information is untrue, misleading, or deceptive if:”

- it represents that reimbursement is provided in full for covered services, when it is not;
- it represents that reimbursement is provided for customary charges, unless the actual experience of the plan is that there is no balance billed for covered services; or
- it represents that the plan is licensed by the Department without an accompanying statement that licensure does not assure financial soundness or the quality or extent of services.

⁹ Indeed, the Department did not even reach this conclusion in the Preliminary Report. This is yet another argument raised for the first time in the Final Report in violation of Blue Shield’s statutory and due process rights.

Cal. Code Regs. tit. 28, § 1300.61.3. Blue Shield’s online provider directory does not make any of the representations described as “untrue, misleading, or deceptive” in the regulation. Moreover, physician directories are not listed anywhere in the “Advertising and Disclosure” section of title 28 of the California Code of Regulations, confirming Blue Shield’s position that they are not “solicitations” under the Knox-Keene Act.

Second, the Department’s conclusion is flawed because provider directories are specifically governed by section 1367.26 of the Health & Safety Code, and not by section 1360. As the statute expressly confirms, there is no guarantee that a provider directory will be 100% accurate at all times. Cal. Health & Safety Code § 1367.26(c). Instead, directories are a snapshot of the network – at a point in time. Due to the nature of providers and provider practices, the provider directory is subject to change on a frequent basis. With a statewide provider network of more than ten thousand physicians and ancillary providers in Blue Shield’s EPO network, and approximately fifty thousand physicians and ancillary providers in Blue Shield’s Exclusive PPO Network, there are bound to be frequent changes to the demographic and participation status of the providers.

Blue Shield has never taken the position that a particular provider or group will always be part of a provider network or listed in its directory – we can only state that at a point in time, the provider or provider group was participating. The Legislature recognized this fact when it enacted Health & Safety Code section 1367.26 (the statute specifically governing provider directories.) Thus, while Section 1367.26 acknowledges that provider lists are “subject to change without notice” (subsection (c),) it only requires updates on quarterly basis (subsection (d).) Additionally, the statute recognizes that a plan cannot be expected to update its provider lists without first having received pertinent information from the provider. *See*, Cal. Health & Safety Code 1367.26(b) (the list “shall indicate which providers *have notified the plan* that they have closed practices or are otherwise not accepting new patients at that time.” (emphasis added).) Under the Department’s theory, however, a provider directory that complies with Section 1367.26 (the statute specifically governing provider directories) might nonetheless violate Section 1360’s prohibition on misleading solicitations. This would result in the more general sections of the Knox-Keene Act encompassed in Section 1360 swallowing the more specific provisions of Section 1367.26, in violation of basic principles of statutory construction. *See*, *Sterling Park, L.P. v. City of Palo Alto*, 57 Cal. 4th 1193, 1200 (2013) (citing the “rule of statutory construction that a special statute dealing expressly with a particular subject controls and takes priority over a general statute.”)

Maintaining current provider data is an industry-wide challenge. It is dependent upon providers sending changes as they occur to several health plans using health plan-specific methods and formats. Nonetheless, in order to improve Blue Shield’s provider data quality, we have proactively contacted providers to verify provider demographics, and remind them of their contractual obligation to notify Blue Shield of any change to their practice in a timely manner.

Third, Blue Shield clearly notifies enrollees of the dynamic nature of the provider directory. The Disclosure document provided to prospective enrollees prior to enrollment includes the following statement cautioning members about relying on the directory:

Blue Shield provider network, including facilities

We update our provider directories periodically to reflect changes in our provider networks. It is the Member's obligation to verify whether the provider chosen is a Participating Provider or an MHSA Participating Provider prior to obtaining coverage.

Disclosure Form January 2015, p. 6.

Further, when enrollees or prospective enrollees search Blue Shield's online provider directory, the following notices pop up onto the screen:

Please select plans carefully. When making appointments, confirm that your provider accepts your health plan – failure to do so could result in higher costs or denied claims.

In addition, the following acknowledgement displays when an individual attempts to search the full provider directory online:

I understand that some of these doctors and hospitals do not offer in-network services for medical plans purchased either through Covered California or directly from Blue Shield. I understand that Blue Shield of California is not responsible for paying any fees to providers who do not accept the medical coverage I have purchased.

Fourth, the Department's conflation of "provider directories" and "solicitations," is also misguided because it constitutes an underground regulation with which Blue Shield was never given the opportunity to comply. The California Administrative Procedure Act ("APA"), which expressly governs the Department's rulemaking, provides that "[n]o state agency shall issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation as defined in [Government Code] Section 11342.600, unless [it] has been adopted as a regulation and filed with the Secretary of State. . . ." Cal. Gov't. Code § 11340.5(a).¹⁰ Generally applicable administrative interpretations of a statute "typically constitute regulations and [] an unwritten policy, generally applied, amounts to a regulation." *Capen v. Shewry*, 155 Cal. App. 4th 378, 383 (2007). Blue Shield was not made aware of any agency interpretation suggesting that provider directories are considered "solicitations" subject to Health & Safety Code section 1360 prior to receiving the Department's Final Report. Moreover, numerous published decisions have noted "the problem of house rules of the agency, which are promulgated without public notice, opportunity to be heard, filing with the Secretary of State, and publication in the California Code of Regulations." *See, e.g., Union of American Physicians and Dentists v. Kizer*, 223 Cal. App. 3d

¹⁰ The APA requires that all covered regulations be adopted in compliance with exacting "basic minimum procedural requirements" [Gov't Code § 11346(a)], including (1) public notice of the proposed regulatory action, (2) publication of the complete text including a statement of reasons, (3) opportunity for interested parties to comment and receive responses thereto, and (4) review by the Office of Administrative Law for consistency with statutory law, clarity and necessity. Cal. Gov't Code §§ 11346.4; 11346.5; 11346.2 (a)-(b); 11346.8, subd. (a); 11346.9; 11347.3(b); 11349.1; and 11349.3. Any regulation not issued in substantial compliance with these "basic minimum procedural requirements" is an underground regulation and is invalid. Gov't Code § 11350; Cal. Code Regs., tit. 1, § 250.

490, 497, 499-500 (1990) (holding that DHS’s statistical sampling and extrapolation procedures for audits, and its claims documentation requirements, constituted unenforceable “underground” regulations.) The Department’s newly-asserted interpretation of section 1360 is therefore inconsistent with the Department’s obligations under the APA.

F. Further Response to Deficiency No. 3: The Department’s survey data do not support its finding that Blue Shield failed to comply with its statutory obligation to provide a list of contracted providers that is updated on a quarterly basis.

Cal. Health & Safety Code section 1367.26

For the reasons discussed above, the Final Report is not supported by evidence that Blue Shield violated Health & Safety Code section 1367.26, which mandates that Blue Shield provide enrollees with a list, electronically or otherwise, of contracting providers that has been updated on a quarterly basis.

First, the survey results are not evidence that providers who claimed they did not accept Blue Shield’s Covered California plans did not actually have contracts with Blue Shield. In fact, Blue Shield has produced the contracts for the providers listed by the Department,¹¹ with the exception of one who has since confirmed participation in Blue Shield’s Covered California networks.

Second, as discussed in Section II(B)(3), Health & Safety Code section 1367.26 contemplates quarterly – not instantaneous – updates to a provider list. The Legislature understood that there will always be a lag between the information in the provider directory and the actual availability of contracted providers to see enrollees. Blue Shield has no obligation to provide real-time updates to its online provider directory. *See*, Cal. Health & Safety Code § 1367.26(d). And the survey results do not indicate whether providers who claimed they did not accept Blue Shield’s Covered California plans – even if they provided the Department’s survey vendor with accurate information – had terminated their relationship with a contracting medical group within the last quarter. This is the Department’s burden, and it has not met it.

Third, the statute recognizes that online provider lists will not always be accurate. In fact, they are “subject to change without notice.” Cal. Health & Safety Code § 1367.26(c).

Fourth, as discussed in Section II(A)(2), plans are dependent upon the information supplied to them by providers. The Legislature recognized that the onus was on the providers – and not on Blue Shield in the absence of receiving information from providers – to provide current information regarding closure of a practice or the provider’s ability to see new patients. Cal. Health & Safety Code § 1367.26(b). The Final Report does not contain any evidence that the providers who claimed they were not taking new patients, who had moved, or who had

¹¹ Again, Blue Shield notes that the names of one substantial category of providers (12.8% of the survey results) were not provided to Blue Shield. Because of this lack of identifying information, Blue Shield is unable to provide further information on the providers who did not answer the telephone or return a voicemail.

closed their practices had previously advised Blue Shield of that fact.¹² Again, the Department has failed to satisfy its burden in this regard.

G. Further response regarding Deficiency No. 4: There was a net increase in the number of contracted primary care providers in Sacramento County.

Cal. Health & Safety Code section 1300.52, subd. (f)¹³

Blue Shield appreciates the Department's finding that it has corrected Deficiency No. 4. Blue Shield further responds simply to note that while it is correct that 62 providers at 95 locations in Sacramento County have left the network since Blue Shield filed the initial provider roster, Blue Shield has also added approximately 250 primary care providers at 380 locations in Sacramento County to the network since that time, for a net increase of 188 primary care providers. Thus, in Sacramento County, although the net change to the Exclusive PPO Network exceeded 10%, that change has only been favorable to Blue Shield's enrollees.

Blue Shield has expanded the provider network since our participation in Covered California began in 2013, and continues to do so, for the benefit of our enrollees. Blue Shield's mission is to ensure all Californians have access to quality health care at an affordable price. To further that mission, Blue Shield works tirelessly to expand our networks into outlying areas where access is an issue, and balances this expansion with making those services affordable for all Californians. From 2013 to 2014, Blue Shield expanded our networks fairly significantly. Blue Shield recently filed the refreshed network rosters for both the Exclusive PPO and EPO Networks, in filings that were closed by the Department on September 29, 2014.

III. CONCLUSION

For the foregoing reasons, Deficiency Nos. 1-3 are without merit. Additionally, the Department has violated Blue Shield's statutory and due process rights by making public a report that contains new information and assertions to which Blue Shield has not had an adequate opportunity to respond. Finally, in light of the significant steps Blue Shield has taken to reduce provider front-office confusion and improve the accuracy of the provider database, Blue Shield believes that each of the concerns identified in the Final Report has been or is in the process of being corrected.

¹² As the Department knows, Blue Shield's provider manual requires providers to immediately notify Blue Shield when the provider makes a change in the group or practice affiliation, office address, billing information or telephone number.

¹³ Blue Shield assumes the Department's reference to non-existent Health & Safety Code section 1300.52, subd. (f) is a typographical error, and that it intended to refer to California Code of Regulations, Title 28, section 1300.52(f) instead. (Final Report at 17.)