DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

BLUE CROSS OF CALIFORNIA
DBA ANTHEM BLUE CROSS

MARCH 27, 2024

Behavioral Health Investigation
Anthem Blue Cross
March 27, 2024

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (Department) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the Department licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975 and regulations promulgated thereunder (collectively, Knox-Keene Act).[1] The Department is conducting focused Behavioral Health Investigations (BHI) of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with California law and to assess whether enrollees have consistent access to medically necessary behavioral health care services. The full-service commercial health plans will be investigated in phases. The investigation of Blue Cross of California DBA Anthem Blue Cross (Plan) is included in Phase Two.

On July 5, 2022, the Department notified the Plan of its BHI covering the time period of April 1, 2020 through June 30, 2022. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.[2] The investigation team interviewed the Plan and its Pharmacy Benefit Manager (PBM), CVS Health, on November 1, 2 and 3, 2022.

The BHI uncovered four Knox-Keene Act violations in the areas of Pharmacy, Quality Assurance, and Grievances and Appeals:

1. The Plan does not make its determinations on formulary exception requests and provide notification to enrollee, enrollee's delegate or prescriber on a timely basis.
2. The Plan does not ensure that a quality assurance program is established and implemented that consistently documents 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. Additionally, the Plan is operating at variance with its filed policy by not appropriately referring potential quality issues (PQIs).
3. The Plan does not consistently provide immediate notification to grievants of the right to contact the Department about expedited grievances.
4. The Plan does not maintain the required log of exempt grievances and failed to demonstrate it periodically reviews the log of exempt grievance data.

[1] The Knox-Keene Health Care Service Plan Act of 1975 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.

[2] For purposes of this Report, the term "behavioral health" or "behavioral health services" refers to mental health as well as substance use disorder conditions, and the services used to diagnose and treat those conditions.

This BHI Report also includes Plan initiatives or operations, if any, identified as potentially having a positive impact on the Plan's provision of and/or enrollee access to behavioral health services. In this case, the investigation identified no Plan initiatives or operations that result in positive impacts on the Plan's provision of and/or enrollee access to behavioral health services.

The Plan is hereby advised that the findings and violations noted in this BHI Report will be referred to the Department's Office of Enforcement. The Department's Office of Enforcement will evaluate appropriate enforcement actions, which may include corrective actions and assessment of administrative penalties, based on the Knox-Keene Act violations. In its Phase Two Summary Report, the Department will provide recommendations for any barriers to care not related to Knox-Keene Act violations.

FRAMEWORK FOR THE BEHAVIORAL HEALTH INVESTIGATIONS

I. Background

Both California and federal laws require health plans to cover services to diagnose and treat behavioral health conditions. Senate Bill (SB) 855 (Wiener, 2020) made amendments to California's mental health parity law and requires commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. Health plans must also provide all covered mental health and substance use disorder benefits in compliance with the Mental Health Parity Addiction Equity Act (MHPAEA). The MHPAEA requires health plans to provide covered benefits for behavioral health in parity with medical/surgical benefits.

Other Knox-Keene Act provisions and corresponding regulations establish standards for access to care, requiring health plans to provide or arrange for the provision of covered health care services, including behavioral health services, in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.[3] Plans must ensure enrollees can obtain covered health care services, including behavioral health services, in a manner that assures care is provided in a timely manner appropriate for the enrollee's condition.[4]

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. This included analysis of benefit classifications, cost sharing requirements and non-quantitative treatment limitations to determine if health plans were meeting parity

[3] Rule 1300.67.2.2(c)(1).
[4] Rule 1300.67.2.2(c)(2).

requirements under MHPAEA. As a result of this focused compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA. Since the initial compliance review, the Department conducts ongoing review of MHPAEA compliance when plans make changes to policies or operations, or when licensing new health plans. Additionally, the Department has incorporated into routine surveys review for compliance and the enforcement of requirements of SB 855 (Wiener, 2020) that expanded the scope of access and coverage for behavioral health benefits.

II. Methods for BHIs

The BHIs involve evaluation of health plans' commercial products regulated by the Department.[5] To evaluate the Plan's operations for the review period of April 1, 2020, through June 30, 2022, the Department requested and reviewed plan documents, files, and data, and conducted interviews with Plan and Pharmacy delegate staff. The BHI involved reviewing and assessing the Plan's operations pertaining to the delivery of behavioral health services. The BHI focused on the following areas:

- Appointment Availability and Timely Access
- Utilization Management, including Triage and Screening
- Pharmacy
- Quality Assurance
- Grievances and Appeals
- Claims Submission and Payment
- Cultural Competency, Health Equity and Language Assistance
- Enrollee and Provider Experience

To further understand potential barriers to care from the perspective of enrollees and providers, the Department sought enrollee and provider participation in separate interviews concerning their experiences with the Plan. The Department reached out to stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the DMHC Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. In connection with the Plan BHI, the Department interviewed 26 providers and 11 enrollees whose input was considered for the Plan's BHI. The interviews were conducted between December 2021 and August 2022. The 11 providers serviced Alameda, Contra Costa, Los Angeles, Marin, Riverside, Sacramento, San Diego, San Francisco, San Joaquin and Yolo Counties.

[5] The BHIs do not include plan products or plan enrollees covered by Medicare, California's Medi-Cal program, self-insured Administrative Services Organizations or non-Department regulated products.

The issues raised by interviewed enrollees included having to go out of network to obtain services when the Plan was unable to provide an appropriate contracted provider, poor communication and customer service and having inadequate behavioral health services. The providers raised issues including long wait times and difficulty reaching Plan staff by telephone, strict length of stay or time restrictions on authorizations for substance use disorder services, low reimbursement rates compared to other health plans, difficulties in obtaining an accurate account of enrollee benefits, various types of claims submission and payment difficulties and lack of or difficulties in Plan communication.

PLAN BACKGROUND

The Plan obtained its Knox-Keene license in 1993 and is headquartered in Woodland Hills, California. The Plan is a full-service health care plan licensed to provide managed care health plans to large employers, small employers, individual, Medi-Cal and Medicare markets. The managed care plans include health maintenance organizations, preferred provider organizations, point-of-service plans, and specialty managed care networks. As of June 30, 2022, the Plan had 1,915,078[6] enrollees in individual, small, and large groups for its commercial lines of business. The Plan operates in all major counties in California.

[6] Source: DMHC Dashboard 2022 Q2

SECTION I: KNOX-KEENE ACT VIOLATIONS

PHARMACY

#1: The Plan does not make its determinations on formulary exception requests and provide notification to enrollee, enrollee's delegate or prescriber on a timely basis.

Statutory/Regulatory Reference(s): Section 1367.24(k); 45 C.F.R. 156.122(c)(3)(ii)

Supporting Documentation:

- Plan *CA Operations Oversight* monthly reports (January 2021 – July 2022)

Assessment: Section 1367.24(k) provides that for any individual, small group, or large health plan contracts, a plan's process for authorization of medically necessary nonformulary prescription drugs must comply with the request for exception and external exception request review processes described in federal law.[7]

The applicable federal law requires plans to have processes in place to allow enrollees or their prescriber to "request and gain access to clinically appropriate drugs not otherwise covered by the health plan (a request for exception)."[8] Plans must have processes in place to receive and timely respond to standard requests for exception and expedited requests for exception.[9] For standard requests, plans must make a determination and notify the enrollee of the decision no later than 72 hours from receipt of the request.[10] For expedited requests, plans must make a determination and notify the enrollee of the decision no later than 24 hours from receipt of the request.[11] If a plan grants an external exception review, the plan must cover the nonformulary drug for the duration of the prescription (for a standard exception request), or for the duration of the exigency (for an expedited exception request).[12]

The Department asked the Plan to provide reports pertaining to external exception request reviews. In response, Plan provided the "Grievance & Appeals" portion of 19 *CA Operations Oversight* monthly reports (Oversight Reports) for the period January 2021 through July 2022. The submitted portions of the Oversight Reports include data and information pertaining to both medical health care services and behavioral health care services. Under the heading of "Grievances & Appeals – Medical," the Oversight Reports describe the applicable timeframes and response requirements for exception

[7] 45 C.F.R. 156.122(c)(1)-(3).
[8] 45 C.F.R. 156.122(c).
[9] See 45 C.F.R. 156.122 (c)(1)-(2) (Expedited review of requests is required in exigent circumstances which exist when "an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.")
[10] 45 C.F.R. 156.122(c)(1)(ii).
[11] 45 C.F.R. 156.122(c)(2)(iii).
[12] 45 C.F.R. 156.122(c)(3)(iii).

requests, the Plan's 95% threshold goal for compliance, and data and compliance rates reported. However, the portion of the Oversight Reports pertaining to behavioral health did not include exception request information, data or compliance results. During onsite interviews, the Plan confirmed it does not collect or report compliance with the applicable federal law separately for drugs used to treat medical and behavioral health conditions. Therefore, the compliance rates reported in the Oversight Reports apply to drugs to treat both medical and behavioral health conditions.

The Oversight Reports indicate that in eight out of the 19 or 42% of the monthly reports provided, the 95% goal for responding to exception requests (standard or both standard and urgent), was not met. Specifically, during 2021, Plan data showed the 95% compliance goal was met only during the months of July, August, November, and December.

Conclusion: Based on review of the Plan's monthly Oversight Reports, the Department finds the Plan in violation of Section 1367.24(k) for failing to make timely formulary exception request determinations and notifications to the enrollee, enrollee's delegate, or prescriber on a timely basis.

QUALITY ASSURANCE

#2: The Plan does not ensure that a quality assurance program is established and implemented that consistently documents 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. Additionally, the Plan is operating at variance with its filed policy by not appropriately referring PQIs.

Statutory/Regulatory Reference(s): Rule 1300.70(a)(1), 1300.70(b)(1)(B) and Section 1386(b)(1)

Supporting Documentation:

- Plan Potential Quality Issues, Log I (April 1, 2020 – June 30, 2022)
- Plan *West Region Peer Review Subcommittee* policy (reviewed September 27, 2021)
- Plan *Member Grievance, PQI and PAE Processes* (Enterprise Grievances and Appeals Policy) (reviewed February 19, 2019, April 6, 2022)
- Plan Report *BH CA Grievance/PQI Trend Analysis* (Q4 2020)
- Plan Report *BH CA Grievance/PQI Trend Analysis* (Q3 2020)

Assessment: Rule 1300.70(a)(1) states that health plans' quality assurance programs must document that "the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated." Rule 1300.70(b)(1)(B) requires health plans to ensure "quality of care problems are identified and corrected for all provider entities."

The Department reviewed a sample of the Plan's PQI files which included two cases leveled at C-6, the Plan's highest severity rating involving events that "represent gross departure from expected standards" and are "severe enough to warrant consideration of de-credentialing the practitioner or termination of the provider's contract."[13] In accordance with the Plan's *Member Grievance, PQI and PAE Processes* policy, quality issues leveled at C-6 are to be included in a weekly report and routed to the Plan's Peer Review Sub Committee for handling.[14] Corrective action plans (CAPs) are required for cases leveled at C-6, with the corrective action to be monitored by the Plan's Peer Review Committee.[15] The Plan's *West Region Peer Review Subcommittee* policy states:

> It is the policy of the Plan to review and track the quality of care delivered to enrollees and the performance of medical personnel through an effective Peer Review Program…The PRSC[16] gathers data on identified cases, assimilates the information through a review and consultation process, assesses the information and implements corrective action commensurate with the seriousness of the quality of care issue.

The Department reviewed the Plan's quarterly reporting for the review period titled *BH CA Grievance/PQI Trend Analysis*. The two PQIs leveled as C-6 were included in the quarterly Trend Analysis Reports.[17] However, no corrective actions or follow-up activities were noted in the Trend Analysis Reports.

During interviews with the Plan, the Plan confirmed there were no CAPs in place for any provider during the review period on the basis of PQIs, and explained the Plan identified an error involving an individual peer reviewer who did not refer the two C-6 cases to the Peer Review Sub Committee as required. As a result, the two cases were not reviewed by the Peer Review Sub Committee and CAPs were not developed or assigned to the involved providers. By not timely referring the cases or implementing CAPs, the Plan failed to take effective action for the identified deficiencies or ensure quality of care problems were corrected for all provider entities as required by Rule 1300.70(a)(1) and 1300.70(b)(1)(B). The Plan stated it made "enhancements to process and reporting" operations to address the issue and prevent future similar incidents.

By not referring the C-6 PQIs to the Peer Review Sub Committee, the Plan is also in violation of Section 1386(b)(1) for operating at variance with its filed policy and procedure. Health plans are subject to disciplinary action if it is determined, among

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[13] Definition per the Plan's *West Region Grievance and Appeals Policy.*

[14] Plan's *Member Grievance, PQI and PAE Processes* policy addresses processes for the Western Region.

[15] *West Region Grievance and Appeals Policy.*

[16] PRSC is the Peer Review Subcommittee.

[17] PQI #1 – Per Log I, completed on July 20, 2020 with a level of C-6. This PQI is noted in *BH CA Grievance/PQI Trend Analysis Q3 2020* on page 4 and categorized as "Care Inappropriate". PQI #2 – Per Log I, completed on December 3, 2020 with a level of C-6. This PQI is noted in *BH CA Grievance/PQI Trend Analysis Q4 2020* on page 4 and categorized as "Sexual Contact".

other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or with filed amendments or material modification filings.[18] Included in the types of documents required to be filed are plans' grievances and appeals policies and procedures.[19] As required by Section 1352, the Plan filed its *Enterprise Grievances and Appeals* policy and its *West Region Grievances and Appeals* policy with the Department.[20] The Plan's failure to refer the two C-6 PQIs to the PRSC and the failure to develop and implement CAPs and subsequent monitoring are at variance with requirements of the Enterprise Grievances and Appeals and West Region Grievances and Appeals policies.

Conclusion: Although the Plan identified quality issues, the lack of CAPs and subsequent monitoring of PQI files with the Plan's most serious PQI level demonstrate the Plan failed to take effective action and improve care for deficiencies as required, failed to correct all provider deficiencies and failed to conduct appropriate follow-up or correct quality of care issues in violation of Rules 1300.70(a)(1) and 1300.70(b)(1)(B). Additionally, by operating at variance with its filed policies and procedures, the Department finds the Plan in violation of Section 1386(b)(1).

GRIEVANCES AND APPEALS

#3: The Plan does not consistently provide immediate notification to grievants of the right to contact the Department about expedited grievances.

Statutory/Regulatory Reference(s): Section 1368.01(b) and Rule 1300.68.01(a)(1)

Supporting Documentation:

- 37 Plan Expedited Appeal files (April 1, 2020 – June 30, 2022)

Assessment: Section 1368.01(b) states:

> The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance.

Rule 1300.68.01(a)(1) states:

> Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential

[18] Sections 1386(b)(1), 1351, 1352.
[19] Sections 1351(l)
[20] See eFiling #20192783.

> loss of life, limb or major bodily function ("urgent grievances") At a minimum, plan procedures for urgent grievances shall include: (1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. Notice…may be accomplished by a documented phone call.

Therefore, upon receipt of a grievance or appeal, if the Plan determines an expedited review is required, the Plan must immediately notify the complainant, who may be an enrollee, subscriber, provider or other person submitting the complaint, of the right to contact the Department. A complainant is the same as a grievant.

The Department reviewed a random sample of Plan grievance and appeals files, of which, 37[21] were expedited appeal files. Of the 37 expedited appeals files, 29 files[22] (78%) failed to include documentation demonstrating the grievant was immediately notified of the right to contact the Department about the expedited grievance or appeal, in violation of Section 1368.01(b) and Rule 1300.68.01(a)(1). Of the 29 files[23] failing to include immediate notification, 27 of the appeals (93%) were submitted by providers following denial of requested services.

File review demonstrated the Plan has a practice of informing a requesting provider of the following at the time it notifies the provider of a utilization management denial determination:

> If you would like to request an expedited appeal for our member you may do so by calling [telephone number]. Please note, your request will be completed within 72 hours of the appeal request time. Additionally, we are required to notify our member that they can bypass the Plan's grievance process and go directly to the Department of Managed Health Care to advise them that they have filed an expedited review with the Plan. The agency can be reached at [telephone number].

Immediate notification of the right to contact the Department is required to be provided to a complainant **after** the Plan receives a grievance or appeal and determines an expedited review is required. By providing the information at the time of a service denial, rather than after the submission of a grievance or appeal and determination that the

[21] File #1, File #3, File #5, File #6, File #9, File #13, File #14, File #15, File #16, File#21, File #23, File #24, File #25, File #28, File #30, File #31, File #32, File #33, File #34, File #35, File #36, File #37, File #38, File #39, File #40, File #46, File #47, File #48, File #50, File #52, File #54, File #55, File #56, File #62, File #63, File #64, File #67.

[22] File #1, File #3, File#5, File #6, File #9, File #13, File #14, File #15, File #16, File #21, File #23, File #25, File #28, File 30, File #31, File #33, File #34, File #37, File #38, File #39, File #40, File #48, File #50, File #52, File #54, File #56, File #62, File #63, File #67.

[23] File #1, File #3, File#5, File #6, File #9, File #14, File #15, File #16, File #21, File #23, File #28, File 30, File #31, File #33, File #34, File #37, File #38, File #39, File #40, File #48, File #50, File #52, File #54, File #56, File #62, File #63, File #67.

grievance or appeal requires expedited handling, the Plan is in violation of Section 1368.01(b) and Rule 1300.68.01(a)(1). [24]

***TABLE* #1**
Grievances and Appeals: Immediate Notification of the right to contact the Department about expedited grievances or appeals

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Appeals	37	Immediate notification of the right to contact the Department	8 (22%)	29 (78%)

Conclusion: Based on grievance and appeals file reviews, the Department found the Plan in violation of Section 1368.01(b) and Rule 1300.68.01(a)(1) for failing to immediately notify complainants who submit urgent grievances or appeals of the right to contact the Department.

#4: <u>The Plan does not maintain the required log of exempt grievances and failure to demonstrate it periodically reviews the log of exempt grievance data.</u>

Statutory/Regulatory Reference(s): Rule 1300.68(d)(8)

Supporting Documentation:

- Plan policy *One Day Grievances (Exempt Grievances)* (reviewed March 16, 2022)
- Plan Report *CA Operations Oversight Blue Cross of CA 200C: Grievance & Appeals* (July 20, 2022)
- Anthem Blue Cross – California: Commercial Grievances & Appeals, Western Region Quality Committee Report (Q2 2020, Q3 2020)
- Anthem Blue Cross – California: Commercial Grievances & Appeals, CA Quality Management Committee Report (Q4 2020, Q1 2021, Q2 2021, Q3 2021, Q4 2021, Q1 2022, Q2 2022)

Assessment: Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response.[25] Health Plans are required to maintain a log of these exempt grievances, including the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the

[24] Although Section 1367.01(h)(4) requires health plans to "include information as to how the enrollee may file a grievance with the plan" in communications regarding decisions to deny, delay or modify requested health care services, compliance with Section 1367.01(h)(4) does not absolve the Plan of its obligation to comply with Section 1368.01(b) or Rule 1300.68.01(a)(1).
[25] Rule 1300.68(d)(8).

call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan.[26] The Plan refers to exempt grievances as "One Day Grievances."

The Plan's *One Day Grievances (Exempt Grievances)* policy states, in part:

> The Grievances and Appeals Department is responsible for compliance monitoring of the [one day grievance] cases . . . . Results of the call monitoring audits are reported to the Quality Management Committee and Member Experience leadership team. . . . The Grievances and Appeals Department provides an annual report to the Quality Management Committee. One Day Grievance data will be shared with ACE committee every 4 months monthly to monitor performance.

The Plan submitted a log of grievances (Log F) that included standard, expedited and exempt grievances. However, that log was created for purposes of the Plan's BHI in response to a Department request, and was not a log of exempt grievances required to be maintained by the Plan in compliance with the requirements of Rule 1300.68(d)(8) which specifies the Plan maintain a log of exempt grievances that contains certain data. Furthermore, the Log F submitted by the Plan did not include all information required by Rule 1300.68(d)(8), including the nature of the resolution and the name of the representative who took the call and resolved the grievance. Specifically, for grievances handled by the Plan, the Log F described the nature of the resolution in some cases as "In favor of Anthem," "Not Available." The party in whose favor the resolution was determined is not a description of the nature of the resolution. Finally, for grievances pertaining to prescription drugs handled by the Plan's PBM, rather than the name of the representative who took and resolved the grievance, the Log F included a series of letters and numbers only, such as QCPAJGH1. For all these reasons, the Log F submitted by the Plan as part of the Plan's BHI does not satisfy the requirements of Rule 1300.68(d)(8).

In addition to maintaining a log of exempt grievances, Rule 1300.68(d)(8) also requires plans to periodically review the log. Committee meeting minutes and reports submitted by the Plan failed to demonstrate that One Day (or exempt) grievances are tracked, monitored or reported by the Plan. Plan grievance and appeals performance reporting documents included data for standard and expedited grievances, but no data or tracking of exempt grievances. Similarly, the Plan's *CA Operations Oversight Blue Cross of CA 200C: Grievance & Appeals* report also included no mention of One Day grievance information, although substantial information for standard and expedited grievances was presented, and the Plan's Quality Management Committee reports included no data specific to One Day (or exempt) grievances to demonstrate they are reviewed as required by Rule 1300.68(d)(8).

[26] Id.

Conclusion: The Department finds the Plan failed to maintain a log of specific exempt grievance data or periodically review such data, in violation of Rule 1300.68(d)(8).

SECTION II: SUMMARY OF BARRIERS TO CARE NOT BASED ON KNOX-KEENE ACT VIOLATIONS

The Department identified no barriers through its investigation of the Plan.

For purposes of the BHIs, barriers to care mean those barriers, whether inherent to health plan operations or otherwise, that may create undue, unjustified, needless or unreasonable delays or impediments to an enrollee's ability to obtain timely, appropriate behavioral health. As applied to providers, barriers refer to those barriers that result in undue, unjustified, needless or unreasonable delays or impediments to a provider's ability to provide timely, appropriate behavioral health services to an enrollee.

The barriers themselves may not arise to a violation of the Knox-Keene Act and/or Rules. The barriers may be caused by a combination of factors, such as a lack of certain provider types due to market conditions (i.e., supply of providers has not kept up with demand for services), health plan acts or omissions that do not arise to a violation of the Knox-Keene Act and/or Rules, circumstances that may not be covered by the Knox-Keene Act and/or Rules, or insufficient facts to support a finding of a violation of the Knox-Keene Act. Although barriers are not enforceable under the Knox-Keene Act, the Summary Report for each phase of the BHIs will include recommendations to reduce barriers and improve access to behavioral health services.

SECTION III: CONCLUSION OF THE BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified four Knox-Keene Act violations and no barriers to care not based on Knox-Keene Act requirements.

The Plan was afforded an opportunity to respond to any factual errors in this Report and submit a CAP reasonable calculated to correct the identified Knox-Keene Act Violations.

Within seven calendar days from issuance of this Report, the Plan is required to submit a corrective action plan (CAP) that is reasonably calculated to correct the four identified Knox-Keene Act violations, as needed.

The Plan must submit its Response, if any, and CAP via the Department's Web portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

Once logged in, follow the steps shown below to view and submit the documents required:

- Click the e-Filing link.
- Click the Online Forms link.

- Under Existing Online Forms, click the Details link for the DPS Routine Survey Document Request titled, DPS 2021 Mental Health Investigation– Document Request.

This Report, along with the Plan's submitted CAP will be sent to the Office of Enforcement for review and appropriate enforcement action, which may include corrective actions and assessment of administrative penalties. A copy of the Report that includes any appropriate factual corrections, along with the CAP will be posted to the Department's website.

APPENDIX A

APPENDIX A. INVESTIGATION TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Holly Pearson	Assistant Chief Counsel
Tammy McCabe	Attorney IV
Laura Biele	Supervising Health Care Service Plan Analyst
Lezlie Micheletti	Health Program Specialist II
Jamie Gordon	Health Program Specialist II
CONSULTANT TEAM MEMBERS: THE INS COMPANIES, INC.	
Heather Harley	Project Manager
JoAnn Baldo	Investigator
Anita Edington	Investigator
Katie Dublinski	Investigator
Donna Lee Williams	Investigator
Trisha Crissman	Investigator
Art Kusserow	Investigator
Mary Kay Lucas	Investigator
Beth Ann Middlebrook	Investigator
Henry Harbin	Investigator

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: ANTHEM BLUE CROSS	
Karen Armstrong	CA Strategy and Governance Director
Myron Arthur	Director, Quality Accreditation
Tim Burg	Director of Behavioral Health Services
Katie Burkhardt	Director, Pharmacy Operations
Stephanie Cala	Director, Performance Enhancement Claims
Allison Chamberlain	Program Director IngenioRx
Misty Colopy	Director, Customer Service
Mark Cortez	Business Change Director
Sara Esparza	Operations Expert
Kayla Fisher	Medical Director BH
Randee Hegner	Manager I, Utilization Management
Thai Hoang	Director, Health Care Management
Heather Terry Holt	Process Expert II
Michael Janesin	Business Change Director
David Larsen	Director I, Customer Care
Joseph Karam, MD	Medical Director Lead, Grievance & Appeals
Jennifer Macasieb	Director II, Medical Management
Jacob Moussai	Medical Director BH
Patrick O'Connor	Legal Counsel Senior
Mike Piellucci	RVP I Provider Solutions
Mike Poindexter	Manager BH Services
David Pryor, MD	RVP Clinical Quality
Joy Rannebeck	Payment Innovation Manager
Kerry Regev	Manager, Behavioral Health Services
Carl Reinhart	Director, SIU
Valerie Ridge	Program Director
Irma Rochin-Campos	Business Change Director
Brandie Rogers	Operations Expert
Jasmine Ross	Customer Care Rep III
Omar Sawari	Director Sr. Digital Operations
JoEllen Scheid	Manager II, Credentialing
Soley Scriuba	Process Improvement Coordinator
April Stachowiak	Director, Regulatory/Grievance & Appeals
Grace Ting	Health Services Director
Josh Vinson	Compliance Manager IngenioRx
Erica Weis	RVP Network Strategy
Jeff White	Staff VP Clinical Pharmacy Services
Daidre Williams	Director, Special Programs

PLAN STAFF INTERVIEWED FROM: ANTHEM BLUE CROSS (continued)	
Melissa Wynn	Behavioral Health Appeals Coordinator
John Yao	Chief Medical Officer
Jack Zabounian	Program Director Grievances & Appeals
Terry German	Managing Associate General Counsel
Deborah Rothman	Associate General Counsel Senior
Sussan Cirino	Compliance Director
Piya Gasper	Director II, Compliance
Jeannie Hoover	Compliance Director
John Mastijasevic	Director I, Compliance
Jim Vagenas	Compliance Director
DELEGATE STAFF INTERVIEWED FROM: CHIPA	
Sarah Batres	Operations Analyst
Lourdes Basmajian	Director, Grievances & Appeals
Anthony Holston	Director, Grievances & Appeals
Katy Susienka	Director, Clinical Services
DELEGATE STAFF INTERVIEWED FROM: CVS	
Valencia Grace	Customer Care Associate
Ashley Marken	Manager, Client Operations
Kara Smith	PharmD Executive Director
Daniel Wellons	Customer Care Associate
Heather Gerard	Director, Claims
Ashleigh Schardt	Process Expert, Claims

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management – Anthem Blue Cross	30	UM10576093 UM26085257 UM17005371 UM10632191 UM12566630 UM18523310 UM9600423 UM9634319 UM26800791 UM22581003 UM14955002 UM30939020 UM24107771 UM31561561 UM30240252 UM16603857 UM10447789 UM16394451 UM25606678 UM10170651 UM28492288 UM29250171 UM15229187 UM11949233 UM14122321 UM15528830 UM23398893 UM22271660 UM15622300 UM18284623
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Utilization Management – CHIPA	60	062121 00031 00016 2 4 040721 00028 00003 1 5 062121 00031 00016 2 4 091420 00029 00035 1 1 031121 00024 00024 1 2 043020-8-49-2-1 070620 00025 00026 3 9 032322 00015 00015 2 2

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management – CHIPA (continued)		032122 00034 00001111 032122 00034 00001111 110420 00021 00017 1 1 081420 00024 00044 1 6 050420 00021 00001 1 2 121320 00001 00004 5 6 021721 00023 00026 1 1 032822 00018 00015 1 4 060820 00026 00042 4 1 062221 00020 00039 1 1 011721 00002 00040 4 3 060220 00022 00015 1 5 092021 00030 00017 1 1 111020 00029 00017 1 1 102221 00011 00020 1 1 042020 00009 00043 4 6 110220 00033 00034 5 1 051420 00015 00007 3 4 082120 00017 00017 1 1 042722 00027 00021 1 5 081621 00027 00030 1 1 050520 00011 00049 3 1 020722 00019 00019 1 3 083120 00014 00042 1 1 121521 00009 00045 1 1 040821 00006 00007 1 2 052220 00005 00039 1 1 051122 00023 00026 1 2 111620 00037 00044 2 1 110920 00013 00004 2 1 043020 00004 00019 1 1 090320 00019 00012 2 1 060522 00002 00041 1 5 030620 00026 00029 2 4 051120 00014 00049 1 1 050520 00015 00007 1 1 031822 00025 00006 1 3 051021 00034 00002 1 1 060822 00012 00005 1 6 121620 00021 00043 7 3 081721 00014 00025 1 1 061222 00001 00045 1 1 050220 00002 00006 3 8 051222 00028 00029 1 7 061320 00002 00022 1 7

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management – CHIPA (continued)		061220 00007 00019 1 1 052220 00006 00014 1 1 090320 00013 00039 1 1 072721 00030 00009 1 3 030422 00024 00016 2 5 041522 00010 00045 1 3 100821 00022 00004 1 1
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Utilization Management – Rx Denials	30	77979728 82784040 64032407 55763634 58639686 80848676 78456429 54816186 82998377 70810713 61893298 68073138 72322923 56187457 83382721 63881763 78394222 80767895 73430597 55026067 80435603 57882813 60899935 71534334 81727814 62266416 65707620 74937474 68561987 56723203

Type of Case Files Reviewed	# of Files	Case ID Number
Benefit/Coverage Experimental/ Administrative Denials of Behavioral Health Services	35	UM19455472 UM27867067 UM28639996 UM11803131 UM19111678 UM10926509 UM26790559 UM12568821 UM12564541 UM13182797 UM12446347 UM18117922 UM9217089 UM19655549 UM17779685 UM29459646 UM30412202 UM21966569 UM8372911 UM16717139 UM29307904 UM15699288 UM25480650 UM22866637 UM12502252 UM24633586 UM13990152 UM22300080 UM16190147 UM11240014 UM13091597 UM20241845 UM10267185 UM9722998 UM28096052

Type of Case Files Reviewed	# of Files	Case ID Number
Benefit/Coverage Experimental/ Administrative Denials of Behavioral Health Services - Rx	31	78848698 74543018 79877922 77022716 83202537 76506961 73499132 78890520 76080402 80639201 76325498 83011666 78960941 77230684 69564144 77798279 78768926 82777879 80746635 81497675 77258831 81913455 76901004 82031032 79086299 74812004 74042646 81292618 82155246 81499829 79082921
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Provider Complaints	30	REQ-COMM-191879 REQ-COMM-96428 REQ-COMM-360438 REQ-COMM-121835 REQ-COMM-83322 REQ-COMM-84061 REQ-COMM-173483 REQ-COMM-156383 REQ-COMM-381088 REQ-COMM-635055 REQ-COMM-642618

Type of Case Files Reviewed	# of Files	Case ID Number
Provider Complaints (continued)		REQ-COMM-415763 REQ-COMM-194304 REQ-COMM-206847 REQ-COMM-194062 REQ-COMM-105311 REQ-COMM-186548 REQ-COMM-249548 2020224430218 REQ-COMM-112846 REQ-COMM-150965 REQ-COMM-599589 REQ-COMM-136299 REQ-COMM-148804 REQ-COMM-410577 REQ-COMM-84242 REQ-COMM-500720 REQ-COMM-585724 REQ-COMM-220280 REQ-COMM-154741
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Claims for Behavioral Health Services – Anthem Blue Cross - Paid	30	05_LFHP_Q421 01_LFHP_Q122 01_LFHP_Q421 01_LFHP_Q221 02_LFHP_Q121 02_LFHP_Q122 02_LFHP_Q221 03_LFHP_Q122 03_LFHP_Q220 03_LFHP_Q221 04_LFHP_Q121 04_LFHP_Q420 04_LFHP_Q220 05_LFHP_Q121 05_LFHP_Q122 05_LFHP_Q220 06_LFHP_Q121 06_LFHP_Q122 06_LFHP_Q220 07_LFHP_Q121 07_LFHP_Q122 07_LFHP_Q220 08_LFHP_Q121

Type of Case Files Reviewed	# of Files	Case ID Number
Claims for Behavioral Health Services – Anthem Blue Cross – Paid (continued)		08_LFHP_Q122 08_LFHP_Q220 08_LFHP_Q221 09_LFHP_Q121 08_LFHP_Q421 09_LFHP_Q220 09_LFHP_Q421
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Claims for Behavioral Health Services – Anthem Blue Cross - Denied	30	01_LFHD_06_42 01_LFHD_Q121 01_LFHD_Q122 01_LFHD_Q220 02_LFHD_Q221 02_LFHD_Q121 02_LFHD_Q122 02_LFHD_Q222 03_LFHD_06_42 03_LFHD_Q221 03_LFHD_Q122 03_LFHD_Q220 04_LFHD_Q220 04_LFHD_Q121 04_LFHD_Q122 08_LFHD_Q320 05_LFHD_Q121 05_LFHD_Q122 06_LFHD_06_42 06_LFHD_Q121 06_LFHD_Q122 07_LFHD_Q121 07_LFHD_06_42 07_LFHD_Q122 08_LFHD_Q121 08_LFHD_Q122 09_LFHD_Q221 09_LFHD_Q420 09_LFHD_Q421 09_LFHD_Q220

Type of Case Files Reviewed	# of Files	Case ID Number
Claims for Behavioral Health Services – CHIPA - Paid	30	8196 3719 12150 10893 10360 9593 2743 14049 10647 12216 2287 2839 9040 6193 12713 6007 10674 3059 4121 8757 1129 3233 4426 6005 4931 5675 8740 3713 6526 2190
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Claims for Behavioral Health Services – CHIPA - Denied	30	8196 3719 12150 10893 10360 9593 2743 10647 12216 2287 2839 9040

Type of Case Files Reviewed	# of Files	Case ID Number
Claims for Behavioral Health Services – CHIPA – Denied (continued)		6193 12713 6007 1067 3059 4121 8757 1129 3233 4426 6005 4931 5675 8740 3713 6526 2190 5457
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Potential Quality Issues	33	REQ-COMM-157854 REQ-COMM-125857 REQ-COMM-197463 REQ-COMM-227175 REQ-COMM-82577 REQ-COMM-453497 REQ-COMM-295267 REQ-COMM-194505 REQ-COMM-133063 REQ-COMM-142906 REQ-COMM-90233 REQ-COMM-88245 REQ-COMM-579394 REQ-COMM-94203 REQ-COMM-184438 REQ-COMM-178463 REQ-COMM-227106 REQ-COMM-641597 REQ-COMM-229457 REQ-COMM-728084 REQ-COMM-131093 REQ-COMM-86395 REQ-COMM-263290 REQ-COMM-255469

Type of Case Files Reviewed	# of Files	Case ID Number
Potential Quality Issues (continued)		REQ-COMM-561844 REQ-COMM-230588 REQ-COMM-192088 REQ-COMM-196619 REQ-COMM-173809 REQ-COMM-180822 REQ-COMM-713103 REQ-COMM-213460 REQ-COMM-226917
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Enrollee Requests for Out of Network Coverage for Behavioral Health Provider	43	UM23664106 UM21552530 UM16603223 UM18574279 UM28526911 UM31019914 UM29956013 UM22456732 UM16475534 UM23445082 UM17940438 UM31398547 UM21443239 UM26248016 UM29314478 UM26860567 UM25773241 UM10546378 UM12950608 UM14623442 UM31027726 UM19652575 UM17776210 UM16172562 UM28471147 UM18703153 UM20167952 UM14739868 UM9948530 UM10323052 UM10645916 UM14388490 UM23450262

Type of Case Files Reviewed	# of Files	Case ID Number
Enrollee Requests for Out of Network Coverage for Behavioral Health Provider (continued)		UM7059399 UM22578742 UM20375154 UM18064229 UM11234572 UM20562759 UM16429874 UM25660250 UM20143818 UM14955809
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Grievances and Appeals	69	REQ-COMM-213919 REQ-COMM-513882 REQ-COMM-380600 REQ-COMM-569943 REQ-COMM-116122 REQ-COMM-246376 REQ-COMM-168185 REQ-COMM-82154 REQ-COMM-489051 REQ-COMM-216445 REQ-COMM-564041 REQ-COMM-401760 REQ-COMM-281993 REQ-COMM-95002 REQ-COMM-240720 REQ-COMM-193054 REQ-COMM-158357 REQ-COMM-458045 REQ-COMM-600273 REQ-COMM-517183 REQ-COMM-638250 REQ-COMM-279778 REQ-COMM-210191 REQ-COMM-149988 REQ-COMM-257150 REQ-COMM-230771 REQ-COMM-226085 REQ-COMM-441509 REQ-COMM-541401 REQ-COMM-137974 REQ-COMM-393305 REQ-COMM-169775

Type of Case Files Reviewed	# of Files	Case ID Number
Grievances and Appeals (continued)		REQ-COMM-223222 REQ-COMM-695395 REQ-COMM-170514 REQ-COMM-172363 REQ-COMM-287445 REQ-COMM-430132 REQ-COMM-399205 REQ-COMM-232285 REQ-COMM-191539 REQ-COMM-474237 REQ-COMM-397471 REQ-COMM-205779 REQ-COMM-242939 REQ-COMM-161866 REQ-COMM-145659 REQ-COMM-650332 REQ-COMM-147367 REQ-COMM-503720 REQ-COMM-175688 REQ-COMM-415466 REQ-COMM-78730 REQ-COMM-304908 REQ-COMM-195139 REQ-COMM-466664 REQ-COMM-199880 REQ-COMM-130477 REQ-COMM-396587 REQ-COMM-208011 REQ-COMM-167881 REQ-COMM-500518 REQ-COMM-290896 REQ-COMM-417831 REQ-COMM-375326 REQ-COMM-132223 REQ-COMM-88585 REQ-COMM-413884 REQ-COMM-185830

Type of Case Files Reviewed	# of Files	Case ID Number
Enrollee Inquiries	97	1041034686 1141241976 1076770756 1083940929 1129826229 1110973628 1099046420 1056699470 1067839747 1111939656 1069134838 1106056813 1053963460 1053396890 1099380736 1114832190 1158181504 1096380406 1029362313 1085622141 1045912517 1154324357 1087814312 1149135438 1036743886 1105910007 1041712835 1082948143 1050062904 1131615866 1153150254 1142243110 1054287226 1103938125 1071873585 1083320146 1052152093 1029048524 1045046009 I-25696088 I-28757952 I-41955143 I-28424539 I-64214238 I-34474703

Type of Case Files Reviewed	# of Files	Case ID Number
Enrollee Inquiries (continued)		I-34714899 I-34796820 I-35344066 1086795488 1084791905 1149667515 1039578956 1092549196 I-29586198 1074233843 I-29307016 1113059653 1155098356 1092016676 1090322723 1087836303 1108170069 1090524690 1116296811 1089032077 1062585312 1041644817 I-28890523 1058174887 1072194039 1156547285 1044669218 1104235113 1157365093 1029473941 1097610069 1113802761 1040875500 1065174240 1055093742 1085068815 1034589666 1154432742 1064433777 1052187051 1044047206 1130212167 1069780425 I-56852383

Type of Case Files Reviewed	# of Files	Case ID Number
Enrollee Inquiries (continued)		I-28357606 I-57882340 I-26810861 I-26562385 I-67978715 I-32919921 I-25593439 1113010959

Anthem Blue Cross Corrective Action Plan Response

Anthem Blue Cross
Behavioral Health Investigation Report
Corrective Action Plan Response

April 8, 2024

Blue Cross of California dba Anthem Blue Cross ("Plan" or "Anthem") submits the following revised Corrective Action Plan ("CAP') in response to the Department's revised Behavioral Health Investigation Report ("Report") dated March 27, 2024. The deficiencies and Plan responses have been renumbered to reflect the updates that were made in the Report.

I. Knox Keene Violations

Deficiency No. 1: The Plan does not make its determinations on formulary exception requests and provide notification to enrollee, enrollee's delegate or prescriber on a timely basis.

Plan Response: The Plan has taken the following measures and steps to improve the process and timeliness of external exception reviews for non-formulary drugs:
In Q2 2023 the Plan added a new internal shared mailbox as a centralized location for all non-formulary requests. In Q3 2023, the Plan also added additional staff and coverage to handle these requests 7 days a week to monitor, triage, task to Independent Review Organizations and fulfill notifications to providers and members within the regulatory timeframe of 24- or 72-hours.

The Plan will also make systematic enhancements to ensure all 24- or 72-hour turnaround requirements are met. These enhancements will be put in place to capture all external exception non-formulary requests to Grievances & Appeals with a systematic approach with automation where they are prioritized into their own workbaskets for improved monitoring and urgent handling for timely resolution.

The Plan will also enhance reporting to capture all external exception requests separately for drugs used to treat medical and behavioral health conditions. These reporting changes will be implemented by Q2 2024.

Deficiency No. 2: The Plan does not ensure that a quality assurance program is established and implemented that consistently documents 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. Additionally, the Plan is operating at variance with its filed policy by not appropriately referring PQIs.

Plan Response: The Plan implemented a corrective action plan that was completed on September 26, 2023:
A California licensed psychiatrist reviewed available information pertaining to cases initially leveled as C3, C4, C5 or C6 cases to confirm the correct level had been assigned and to bring cases provided for the 2022 DMHC Behavioral Health Investigation forward to the CA Peer Review Subcommittee (PRSC) for review as needed. Cases identified for review were brought forward to the CA Peer Review Subcommittee in January 2023. The "West Region" Peer Review Subcommittee policy was updated as the "CA" Peer Review Subcommittee (PRSC) policy, filed with DMHC, and approved on October 10, 2023 (BCC FN 20232520-2). The new PRSC policy:

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

Deficiency No. 3: The Plan does not consistently provide immediate notification to grievant of the right to contact the Department about expedited grievances.

Plan Response: The Plan no longer uses the utilization management denial determination to provide the immediate notification of the right to contact the Department at the time of the service denial. The Plan took this approach to proactively provide information about the grievance process during the initial denial notification to providers/members and their right to contact the Department about expedited grievances. In October 2023, the Plan changed the process to ensure that the notification to the complainant, who may be an enrollee, subscriber, provider, or other person submitting the complaint, is provided after the Plan receives a grievance or appeal of an expedited review request.

Additional actions taken include: 1) communication to all Behavioral Health Grievance and Appeal associates of the requirements of notification of DMHC rights for expedited cases, 2) use of best practices to make the appropriate call, and 3) confirmation of the notification prior to assignment of expedited review. These metrics are measured and monitored weekly so immediate intervention or remediation can be made by the Plan if needed.

Deficiency No. 4: The Plan does not maintain the required log of exempt grievances and failed to demonstrate it periodically reviews the log of exempt grievance data.

Plan Response: The Plan maintains exempt grievance data. The data is reviewed, tracked, monitored, and reported on. The following corrective actions have been implemented to address the issues identified in the Report:

- Timeliness and quality of exempt grievance data is continuously reviewed by the California grievance officer. Additional elements including the nature of the grievance and resolutions will be reviewed and reported to the Plan's Management Oversight Committee through its subcommittees beginning in June 2024 to identify any emergent patterns and ensure performance improvement.
- Current reporting capabilities were reviewed, and the Plan is working to ensure all requirements are met:
    - System reporting enhancements of Plan exempt grievance data will be available beginning in May 2024.
    - Enhanced reporting of the Plan's Pharmacy Benefit Manager (PBM) exempt grievance data will be phased in beginning June, 2024 with tracking and trending of the data through a combination of auditing and reporting until completion of system reporting enhancements targeted for Q4 2024.
- Additional measures were integrated within the standardized reporting template to ensure consistent reporting and tracking of exempt grievances.
- Additionally, the Plan's Pharmacy Benefit Manager (PBM) system captures the name of the representative who took and resolved the grievance. When Log F was created for the purpose of the Behavioral Health Investigation, the name of the representative was replaced with the associate's employee ID. For future logs, the PBM will provide the associate's full name instead of employee ID.