Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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November 17, 2023

SENT VIA EMAIL

Karen Wan
California Physicians' Service
DBA: Blue Shield of California
601 12th St, 23rd Floor
Oakland, CA 94607

RE: ENFORCEMENT MATTER NUMBER: 21-794 plus 1 associated case[1]

LETTER OF AGREEMENT

Dear Karen Wan:

The Office of Enforcement within the Department of Managed Health Care (Department) has concluded its investigation of California Physicians' Service (Plan), License Number 933 0043, concerning the above matter. This investigation concerned the Plan's violations of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and regulations promulgated thereunder. The relevant facts are fully set forth below.

The enrollee in these matters was diagnosed with gender dysphoria and received services (Relevant Services) from an out-of-network provider (Provider), between March 3, 2021, and July 31, 2021. Enrollee's Evidence of Coverage (EOC) provides the following:

> "Call Customer Service if you need help finding a Participating Provider who can provide the care you need close to home. If a Participating Provider is not available, you can ask to see a Non-Participating Provider at the Participating Provider Cost Share. If the services cannot reasonably be obtained from a Participating Provider, we will approve the request and you will only be responsible for the Participating Provider Cost Share."

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[1] The associated case included herein is Enforcement Matter Number 22-271.

Since the Plan was unable to identify an in-network provider to perform the Relevant Services, the Plan authorized the enrollee to receive the services from the out-of-network Provider pursuant to a Letter of Agreement (LOA).

On July 23, 2021, the enrollee filed a grievance with the Plan, regarding the Plan’s failure to pay various claims from the Provider (Provider Claims) pursuant to the authorization and LOA. This resulted in the Provider suspending services to the enrollee effective July 30, 2021. In addition, the enrollee wanted to know why they were receiving $25 checks from the Plan.

During the Office of Enforcement’s (OE) investigation, it was discovered that the enrollee was receiving the $25 checks because 13 enrollee Provider Claims for dates of services between March 3, 2021, and July 31, 2021, were initially incorrectly processed with an incorrect allowed amount and the enrollee was designated as the payee. However, in its August 10, 2021, grievance response, the Plan failed to address all of the enrollee’s concerns. The Plan only restated the enrollees’ concerns without providing an explanation or resolution to any of the issues raised.

On August 12, 2021, the enrollee filed a complaint with the Department regarding the Plan’s failure to timely and appropriately pay the Provider Claims resulting in the Provider’s refusal to provide further services to the enrollee.

The Plan’s responses dated August 18, 2021, and August 30, 2021, confirmed that the enrollee’s copayment for the Provider services should be $30, and that the claims were processed incorrectly with varying copayment amounts and allowed amounts. The Plan agreed to reprocess all claims for dates of services through July 31, 2021, with the enrollee being responsible for a copayment of $30. The Plan also informed the Department that the claims processing issues for the enrollee were resolved and the Provider agreed to resume services for the enrollee in September of 2021.

After the Department closed the enrollee’s complaint, the Plan continued to provide inconsistent information regarding their copayment responsibility for Provider services, assigning copayment responsibility of either $35 or $60 to various enrollee Provider Claims.

On November 27, 2021, the enrollee filed a second grievance with the Plan asking the Plan to clarify their financial responsibility for the Provider services. The Plan’s December 16, 2021, response stated that the enrollee is only responsible for a $30 copayment for the Provider services.

On December 12, 2021, the enrollee filed a second complaint with the Department requesting assistance in getting the Provider Claims processed correctly with a $30 copayment, as confirmed by the Plan in their December 16, 2021, grievance response. In their response to the Department’s request for information, the Plan determined that the enrollee was actually responsible for a $35 copayment amount per their EOC.

However, the Plan agreed to honor their December 16, 2021, representation of a $30 copayment. All claims from the Provider were processed and paid accordingly.
In total, the OE identified 13 enrollee Provider Claims for dates of services between March 3, 2021, and December 21, 2021, that were not processed per the authorization and LOA within 30 business days.

Through discovery, the OE also discovered that the Plan failed to timely process eight additional Provider Claims for services impacting other Plan enrollees between January 1, 2019, and July 11, 2022.

The Plan's improper adjustments and denials of the enrollee Provider Claims were in violation of California Code of Regulations, title 28, section 1300.71, subdivision (d)(1),[2] and are subject to discipline under Health and Safety Code section 1386, subdivision (b)(1).[3]

Rule 1300.71, subdivision (d)(1), states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. Section 1386, subdivision (b)(1), provides that a health plan may be subject to discipline where it is determined to be operating at variance to a document filed with the Department as required by Sections 1351 or 1352. EOC documents are required to be filed with the Department. (Health & Saf. Code, § 1351, subd. (f).)

Here, the Plan had entered into a LOA with the Provider to provide Relevant Services to the enrollee. The Plan also authorized the enrollee to receive services from the Provider at the in-network level of benefits due to a lack of access to an in-network provider. However, the Plan acted at variance with the enrollee's EOC by failing to process the services per the authorization and LOA. 13 enrollee Provider claims were identified during OE's investigation that were not processed per the authorization and LOA. These claims were processed with the incorrect allowed amount and the enrollee as the designated payee, instead of the Provider.

This improper processing of the claims was a violation of Rule 1300.71, subdivision (d)(1). The Plan is further subject to discipline under Section 1386, subdivision (b)(1), for failure to pay for benefits as covered under an enrollee's EOC.

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[2] All references to "Rule" are to title 28 of the California Code of Regulations unless otherwise indicated.

[3] All references to "Section" are to the Health and Safety Code unless otherwise indicated.

The Plan violated Section 1368, subdivision (a)(1), when it failed to adequately consider and resolve the enrollee's grievances.

A plan shall maintain a grievance system that provides reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate. (Health & Saf. Code, § 1368, subd. (a)(1).)

The Plan failed to adequately consider and resolve the enrollee's July 23, 2021, grievance when it provided no resolution for the Plan's failure to pay the Provider Claims according to the LOA and authorization. In addition, the Plan also failed to address or adequately consider the enrollee's request regarding clarification as to why they were receiving $25 checks from the Plan. The Plan only restated the enrollees' concerns but did not provide an actual response or resolution to the issues raised. Since the Plan failed to adequately consider and resolve the grievance, it violated Section 1368, subdivision (a)(1).

The Plan failed to timely reimburse claims in violation of Section 1371, subdivision (a)(1).

The Plan must reimburse claims as soon as practicable but no later than 30 working days after receipt of the claim by the health plan, or if the health plan is a health maintenance organization, 45 working days after receipt of the claim by the health plan. (Health & Saf. Code, § 1371, subd. (a)(1).)

During OE's investigation, it determined that the Plan failed to timely process eight additional Provider Claims for services impacting other Plan enrollees in a timely manner. The Plan's failure to process multiple Provider Claims in a timely manner is a violation of Section 1371, subdivision (a)(1).

Past Corrective Action Plan

The Plan has voluntarily taken the following corrective actions to address the issues identified in this matter prior to the signing of this Agreement as follows:

1. The Plan provided feedback to the LOA claims processor who erroneously processed the enrollee's claims regarding how to process claims subject to multiple LOAs.
2. The Plan updated its desk level procedures for LOA claims processors to reinforce that all active LOAs between a provider and the Plan must be reviewed during claims processing.
3. The Plan instructed its vendors to conduct a refresh training on the issue of appropriately reviewing all relevant LOAs on file for out-of-network providers during claims processing.

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4. The Plan’s Appeals and Grievance Department leadership provided specific feedback relating the inadequate consideration and resolution of the enrollee’s grievance to the grievance coordinator who handled the enrollee’s July 23, 2021, grievance.
5. The Plan’s Appeals and Grievance Department conducted an all-coordinator communication and refresher on the need to take action and fully resolve an enrollee’s grievance, even if the enrollee does not articulate a specific desired outcome in their grievance.
6. The Plan’s LOA negotiating team and claims operations team completed an end-to-end LOA process review. The claims operation team did not identify any additional corrective actions beyond items 1-5 stated herein. The LOA negotiations team identified a need for a written Desk Level Procedure (DLP) and has already created the DLP.

The Plan has acknowledged its failure to comply with the Knox-Keene Act and title 28 of the California Code of Regulations in this enforcement matter. The Department has determined that an administrative penalty of $200,000 is warranted. The Department agrees the payment of the penalty will settle all issues, accusations, and claims pertaining to this enforcement matter. This agreement and the violations set forth herein may not be used as an admission against the Plan in any civil or criminal proceedings; however, they may be considered and used in any future action or proceeding by the Department involving the Plan.

In summary, the statute(s) and/or regulation(s) prosecuted herein are:

- California Code of Regulations, title 28, section 1300.71, subdivision (d)(1);
- Health and Safety Code section 1386, subdivision (b)(1);
- Health and Safety Code section 1368, subdivision (a)(1); and
- Health and Safety Code section 1371, subdivision (a)(1).

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This agreement contains the entire understanding among the parties and supersedes any prior understandings and/or written or oral agreements among them respecting the subject matter within.

Sincerely,

Dated: December 12, 2023

/Original Signature/
Sonia R. Fernandes
Deputy Director | Chief Counsel
Office of Enforcement

Accepted by California Physicians' Service

Dated: November 30, 2023

/Original Signature/
Karen Wan
Associate General Counsel
California Physicians' Service

NXN:jeh