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14 Department of Managed Health Care

15 BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE
16 OF THE STATE OF CALIFORNIA

17 In the Matter of the Investigation of:

18 CALIFORNIA PHYSICIANS' SERVICE,
19 Respondent.

20 ENFORCEMENT MATTER NOS. 14-175,
21 15-141 and 15-142
22 SETTLEMENT AGREEMENT

23 **I.**

24 **Recitals**

25 1. This Agreement ("Agreement") is made and entered into by and between the following
26 Parties: CALIFORNIA PHYSICIANS' SERVICE dba BLUE SHIELD OF CALIFORNIA ("Blue
27 Shield" or "Plan") and the California DEPARTMENT OF MANAGED HEALTH CARE (the
28 "Department").

29 2. In 2010, California created a health benefit exchange known as Covered California
30 ("Covered California" or "Exchange") to implement the federal Patient Protection and Affordable
31 Care Act ("ACA"). Blue Shield was one of the health issuers selected by Covered California to offer

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1 products through Covered California and the off-Exchange individual market under the provisions of
2 the ACA. Blue Shield offered individual PPO and EPO plans through Covered California and the
3 off-Exchange individual market (collectively “BSC IFP Plans”)

4 3. Open enrollment for new ACA plans on the Exchange and off-Exchange began on
5 October 1, 2013 for coverage starting January 1, 2014. The open enrollment period was extended
6 several times through early 2014. Blue Shield issued BSC IFP Plans to those who selected Blue
7 Shield at the time of enrollment.

8 4. Individuals who enrolled (“enrollees”) and who wished to enroll (“potential enrollees”)
9 in BSC IFP Plans could search for participating providers in a variety of ways, including by going to
10 Blue Shield's website to view Blue Shield’s online Provider Directory (“Provider Directory”) or by
11 calling Blue Shield customer service representatives, who in turn viewed and communicated the
12 information in the Provider Directory.

13 5. In the last quarter of 2013 and the beginning of 2014, the Department received
14 complaints from consumers enrolled in BSC IFP Plans who reported having difficulty finding in-
15 network physicians. In May 2014, the Department conducted an informal telephone survey of
16 randomly selected physicians who were identified by Blue Shield as contracted physicians for the
17 BSC IFP Plans, and were told by numerous physicians’ offices that the physicians did not accept
18 Covered California enrollees.

19 6. On June 10, 2014, pursuant to Title 28, California Code of Regulations section
20 1300.82.1, the Department initiated a Non-Routine Survey (“Non-Routine Survey”) of Blue Shield to
21 test claimed inaccuracies in the Plan’s Provider Directory.

22 7. Blue Shield provided the Department with its Provider Directory for the BSC IFP
23 Plans, as it appeared on the Plan’s website as of June 9, 2014, which the Department used to conduct
24 the Non-Routine Survey.

25 8. On June 10, 2014, the Department commenced the Non-Routine Survey to evaluate for
26 the BSC IFP Plans whether physicians listed in Blue Shield’s Provider Directory reported to the
27 Department’s survey vendor that they were: (1) at the location listed; (2) accepting Blue Shield plans,
28 (3) accepting BSC IFP Plans offered through the Exchange, and (4) accepting new patients with BSC

1 IFP Plans offered through the Exchange. The Department conducted this Non-Routine Survey with
2 the full cooperation of Blue Shield.

3 9. On August 29, 2014, the Department issued its Preliminary Report on the results of its
4 Non-Routine Survey. On October 17, 2014, Blue Shield provided its Response to the Preliminary
5 Report.

6 10. On November 7, 2014, the Department issued its Final Report of Non-Routine Survey
7 ("Final Report" or "Non-Routine Survey Final Report"). In that Final Report, the Department
8 identified four deficiencies, three of which it alleged had not been corrected.

9 11. On November 17, 2014, Blue Shield filed its Response to the Final Report, in which
10 Blue Shield disputed the Department's conclusion of the three deficiencies. The Final Report was
11 issued to the Department's Public File on November 18, 2014. Thereafter, the Department
12 commenced this Enforcement Action against Blue Shield.

13 12. The Final Report and Blue Shield's November 17, 2014 Response to the Final Report
14 (available online on the Department's public website) are incorporated by reference herein.

15 13. Blue Shield acknowledges the Department's Non-Routine Survey Final Report
16 concluded that 18.2% of the physicians listed in the Provider Directory as of June 9, 2014 were not at
17 the location listed in the Provider Directory; and that 8.8% of the physicians contacted stated they
18 were not accepting Covered California patients even though the Provider Directory listed them as
19 doing so.

20 14. Blue Shield acknowledges that the implementation of the ACA, in conjunction with
21 longstanding industry challenges in obtaining and maintaining up-to-date, accurate provider
22 demographic information, has resulted in confusion at the provider and member level. Blue Shield
23 acknowledges that there was confusion among some of Blue Shield's contracted providers regarding
24 the BSC IFP Plans Blue Shield sold through Covered California and off-Exchange, and regarding
25 their participation in BSC's IFP Plan provider networks.

26 15. The Parties acknowledge that in September 2013, Blue Shield met with the Department
27 to discuss Blue Shield's BSC IFP Plan networks. The Parties also acknowledge that Blue Shield
28

1 originally filed its BSC IFP Plan networks with the Department in 2013, and that these filed networks
2 were reviewed and approved by the Department in July 2013.

3 16. The Parties acknowledge that since the Department approved Blue Shield's filings for
4 its networks for the BSC IFP Plans, Blue Shield continued to negotiate contracts and expand its
5 provider networks for its BSC IFP plans. The Parties acknowledge that Blue Shield re-filed its
6 exclusive PPO and EPO networks with the Department. Those filings were closed by the Department
7 on September 29, 2014.

8 17. The Parties acknowledge that at the Department's request, Blue Shield conducted
9 outreach to 30,599 primary care providers and specialists to confirm their continued participation in
10 the networks, submitting the results of its survey to the Department on November 5, 2014. As a
11 follow-up to Blue Shield's outreach survey, Blue Shield contacted the providers who had indicated
12 that they were not participating or who were unable to confirm their participation to reaffirm their
13 participation in the networks. Blue Shield further updated its Provider Directory to reflect provider
14 demographic changes identified during its provider outreach efforts. Blue Shield also reported to the
15 Department that it continues to pursue efforts to improve quality and customer experience by
16 increasing the accuracy and timeliness of information.

17 18. Additionally, the Parties acknowledge that throughout 2014, Blue Shield engaged in
18 significant provider education and outreach to address the provider front-office confusion regarding
19 provider participation in the networks, as reflected in the Department's Non-Routine Survey results,
20 conducting onsite visits to targeted providers, hosting numerous educational webinars in 2014 and
21 2015, and distributing provider office manager toolkits to educate provider front-office staff
22 regarding Blue Shield's plans and networks. Blue Shield informed the Department that it has already
23 conducted 1,772 personal visits to high-volume primary care providers and specialists as part of its
24 provider education efforts. Blue Shield maintains that all of these efforts are designed to reduce the
25 likelihood of downstream communication errors causing members to receive inaccurate information
26 from providers or their front-office staff regarding a provider's participation in Blue Shield's
27 networks.

28 19. Blue Shield informed the Department it has spent over \$14.6 million between June 2014

1 and June 2015 in efforts to improve its contracted providers' understanding of the BSC IFP Plans in
2 which they participate, to improve the accuracy of the provider information it has in its systems, and to
3 make it easier for enrollees to access accurate information regarding participating providers. Blue
4 Shield informed the Department it spent additional sums before June 2014 and after June 2015. The
5 Department acknowledges these remediation efforts.

6 20. Blue Shield acknowledges that the Final Report states during 2014, some BSC IFP Plan
7 enrollees encountered an unacceptable consumer experience when they could not reach and/or did not
8 have access to providers who were represented in the Provider Directory as being part of the Plan's
9 network.

10 21. Blue Shield has paid over \$38 million in claims adjustments between June 2014 and
11 June 2015 to enrollees who received care from providers participating in Blue Shield's full PPO
12 network, but who were not participating in the networks available to those in the BSC IFP Plans.
13 Blue Shield paid additional amounts before June 2014 and additional amounts after June 2015. The
14 Department acknowledges these restitution efforts.

15 22. Blue Shield acknowledges its obligation to maintain and update provider lists, as set
16 forth in Health and Safety Code section 1367.26.

17 23. The Department and Blue Shield acknowledge that there are state and federal legislative
18 activities underway that are directed toward establishing common requirements and standards for
19 provider network information available to health plan enrollees, and that such legislative efforts to
20 bring clarity to this area, should they result in duly-enacted or promulgated laws or regulations, will be
21 binding according to their terms.

22 II.

23 Advisements and Waivers

24 24. The Plan has carefully read, fully discussed with its counsel, and understands the effects
25 of this Agreement.

26 25. The Plan is fully aware of its rights in this matter, including the right to a hearing on any
27 Accusation related to these Enforcement Matters, the right to be represented by counsel at its expense,
28 the right to confront and cross-examine witnesses against it, the right to present evidence and to testify

1 on its behalf, the right to issuance of subpoenas to compel the attendance of witnesses and the
2 production of documents, the right to require the Department to meet its burden of proof to establish
3 violations, the right to reconsideration and court review of an adverse decision, and all other rights
4 accorded by the California Administrative Procedure Act and other applicable laws.

5 26. By entering into this Agreement, the Plan voluntarily, knowingly, and intelligently
6 waives the procedural rights set forth above with respect to these Enforcement Matters.

7 **III.**

8 **Reservation**

9 27. The Plan and Department's recitals herein may not be used as an admission against the
10 Plan in any other civil or criminal proceedings; but, may be used by the Department in future
11 administrative proceedings in considering penalties against the Plan for future, unlawful inaccuracies
12 with its Provider Directory that are not encompassed by, or addressed in or as a result of this
13 Agreement.

14 **IV.**

15 **Agreement**

16
17 WHEREAS, this Agreement is entered into based on the Recitals, Advisements and Waivers,
18 and Reservation set forth above, which are incorporated herein by this reference.

19 WHEREAS, the Parties desire to enter into this Agreement and thereby resolve the deficiencies
20 set forth in the Non-Routine Survey Final Report, as well as the deficiencies that could have been
21 raised in these Enforcement Matters.

22 WHEREAS, by entering into this Agreement, Blue Shield does not admit any liability or
23 violation of the Act or any other law or regulation, but admits that the Department found deficiencies,
24 as set forth in the Final Report. Blue Shield disputes the Non-Routine Survey Final Report but will
25 not take any further action in these Enforcement Matters to contest the deficiencies stated in the Final
26 Report, and agrees that such deficiencies may be considered by the Department in assessing
27 administrative or other penalties should the Department establish that the Plan engaged in future
28 similar conduct regarding inaccuracies in its Provider Directory. Notwithstanding these contentions,

1 the Parties agree that it is in the best interests of the BSC IFP Plans' past, present and future enrollees
2 to enter into this Agreement.

3 WHEREFORE, the Department and Blue Shield mutually agree to enter into this Agreement,
4 as follows:

5 A. By entering into this Agreement, the Parties hereby settle Enforcement Matters 14-175,
6 15-141 and 15-142 and all issues, accusations and claims that the Department may have against Blue
7 Shield, including without limitation, any alleged violation of the Knox-Keene Act, relating to or
8 arising from Blue Shield's actions as specified in the Department's Non-Routine Survey Final Report
9 as issued to public file on November 18, 2014. However, nothing in this Agreement is intended to
10 affect or limit an enrollee's right to file, consistent with the timeframes in the Act, a grievance with
11 Blue Shield, or a complaint with the Department, or request for reprocessing of claims as it relates to
12 the accuracy of its Provider Directory.

13 B. The Department, through its Director, has determined (in accordance with the factors
14 set forth in California Code of Regulations, title 28, section 1300.86 et seq.) that an administrative
15 penalty in the amount of \$350,000 shall be assessed against Blue Shield. Blue Shield agrees that
16 within 10 days of the execution of this Agreement by Blue Shield, it will pay to the Department the
17 \$350,000 (three-hundred fifty thousand dollar) administrative penalty.

18 C. Blue Shield agrees to undertake all corrective actions described on page 18 of the Non-
19 Routine Survey Final Report as well as the corrective actions described in Exhibit A to this
20 Agreement, titled Corrective Action, and incorporated herein by reference.

21 D. Blue Shield acknowledges the Department's authority to conduct an additional, follow-
22 up survey, pursuant to section 1382 of the Health and Safety Code and Title 28 of the California Code
23 of Regulations, sections 1300.81, 1300.82, and 1300.82.1. The Parties agree that the Department shall
24 conduct a Follow-Up Survey ("Follow-Up Survey") to the Non-Routine Survey in accordance with
25 those statutes and regulations. The Follow-Up Survey shall be performed by an independent Auditor
26 and the Department has stated its intention to begin in October 2015. The Auditor will develop the
27 methodology and approach of the Follow-Up Survey subject to final approval by the Department. All
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1 expenses for conducting the Follow-Up Survey shall be charged against the Plan and paid in
2 accordance with Health & Safety Code section 1382(b).

3 E. Except as stated in Section A, above, this Agreement shall not affect or limit the
4 Department's disciplinary authority or discretion regarding the Follow-Up Survey and any associated
5 results, conclusions, investigations, findings, disciplinary and administrative action. Blue Shield
6 reserves all defenses and rights with respect to any associated results, conclusions, investigations,
7 findings, disciplinary and administrative action by the Department.

8 F. The Parties agree that if Blue Shield discovers that it is in material breach of its
9 obligations under this Agreement, it will promptly notify the Department of the breach and what
10 actions Blue Shield has taken or will take to cure the breach. Alternatively, if the Department
11 discovers that Blue Shield has breached the Agreement, the Department will notify Blue Shield of the
12 breach. The Parties agree that in either of these circumstances the Department will allow Blue Shield
13 a reasonable opportunity to cure the breach, prior to commencement of an enforcement action (unless
14 the Department determines that the nature of the breach is likely to result in immediate serious harm
15 and requires immediate enforcement action). If Blue Shield fails to cure the breach, the Department
16 reserves the right to take actions pursuant to the Act.

17 G. In the event of any future litigation (administrative or civil) between the Department
18 and the Plan, the Plan agrees it will not object to the admissibility of corrective actions taken by the
19 Plan in 2014 to improve or correct Provider Directory accuracy on the basis of California Evidence
20 Code section 1151 (subsequent remedial measures). The Plan reserves its right to object to the
21 admissibility of corrective actions taken on all other grounds.

22 H. This Agreement is the entire agreement between the Parties and supersedes any prior
23 negotiations, representations, or agreements, whether written or oral, which related to the subject
24 matter of this Agreement.

25 I. This Agreement may not be altered, amended or otherwise changed or modified, except
26 in writing signed by both of the Parties.

27 J. This Agreement may be executed in counterparts and each counterpart or facsimile
28 copy thereof will have the same force and effect as the original.

1 K. Once executed by the Parties, this Agreement shall become the final agreement
2 between the Parties.

3 L. Each signatory below warrants and represents that he or she has authority to sign on
4 behalf of, and to bind, his or her respective entity.

5 M. All corrective actions required by this Agreement shall remain in effect for a period of
6 two years from the Effective Date of this Agreement, unless otherwise noted. To the extent that this
7 Agreement imposes more restrictive requirements than any federal or state legislation or regulation
8 (related to the obligations of health plans to establish and maintain accurate provider directories)
9 enacted after the effective date of this Agreement, the Parties agree that Blue Shield will continue to
10 meet its obligations under this Agreement, unless the Parties determine that federal law would preempt
11 such obligation(s).

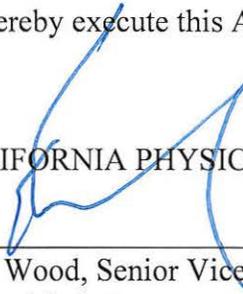
12 N. This Agreement shall take effect upon execution by both Parties.

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14 **IT IS SO AGREED**

15 **IN WITNESS WHEREOF**, the Parties hereby execute this Agreement by the signatures of
16 their respective duly authorized officials.

17 Dated: October 19, 2015

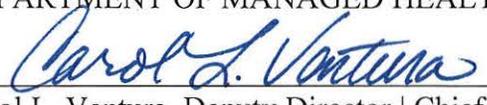
CALIFORNIA PHYSICIANS' SERVICE



Ken Wood, Senior Vice President for Consumer and
Senior Markets
California Physicians' Service

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21 Dated: *October 30* 2015

DEPARTMENT OF MANAGED HEALTH CARE



Carol L. Ventura, Deputy Director | Chief Counsel
Department of Managed Health Care

1 **Exhibit A – CORRECTIVE ACTION**

2
3 1. This Exhibit (“Exhibit A”) is incorporated by reference in and made a part of the
4 Agreement.

5 2. Blue Shield agrees to all corrective actions described herein.

6 3. Blue Shield informed the Department that it paid over \$38 million in claims
7 adjustments between June 2014 and June 2015 to enrollees who received care from providers
8 participating in Blue Shield’s full PPO network, but not participating in the networks for the BSC IFP
9 Plans. Those claims adjustments included adjustments made as a result of member calls to Blue
10 Shield’s Customer Service Department, appeals and grievances, and a targeted reprocessing of high-
11 dollar value claims that was undertaken without regard to demonstrated inaccuracies in Blue Shield’s
12 provider directory. Blue Shield’s processing of the targeted claims adjustments included identifying
13 the relevant time period, the pool of impacted individuals, notice to these individuals, and the
14 processing of their claims, and/or grievances and appeals. Blue Shield informed the Department that it
15 paid additional amounts before June 2014 and continues to adjust claims and make additional
16 payments related to dates of service in 2014 and 2015, including in response to member calls to Blue
17 Shield’s Customer Service department or appeals and grievances.

18 4. Blue Shield agrees that it shall continue to adjust claims for additional enrollees who
19 paid a provider in excess of the amount they would have paid if the claim had been processed at a
20 participating provider benefit level as a result of inaccuracies in its Provider Directory during the 2014
21 and 2015 benefit years, as set forth below.

22 5. Blue Shield shall identify and provide written notice of this settlement to BSC IFP Plan
23 members who submitted claims for services rendered in 2014 by providers participating in Blue
24 Shield’s Full PPO network but not in the PPO or EPO networks available to members in BSC IFP
25 Plans, and whose claims have not already been reprocessed at the participating provider benefit level.
26 Blue Shield shall not send notice to current or former members whose claims were not payable for
27 reasons unrelated to the provider’s network participation (for example, lack of eligibility). This
28

1 written notice, which is subject to final approval by the Department, shall be sent no later than
2 December 31, 2015.

3 6. The notice shall advise recipients that if they received covered services from a provider
4 outside of their plan's network as a result of misinformation from Blue Shield regarding the provider's
5 participation status, and paid the provider out of pocket for care, they may submit a written claims
6 submission form to a designated address within 30 days to request reprocessing of the claim. The
7 claims submission form shall require members to attest:

- 8 a. that they received covered services from a specific provider who was
9 represented in Blue Shield's Provider Directory or by Blue Shield as
10 participating in the network for their 2014 BSC IFP Plan, or who erroneously
11 informed the member the provider participated in their 2014 BSC IFP Plan
12 network;
- 13 b. to the approximate time frame and source of the misinformation;
- 14 c. that they saw the provider on a given date of service as a result of Blue Shield's
15 misinformation; and,
- 16 d. that they either paid the provider for the services at issue, or that the provider is
17 actively pursuing payment.

18 The member's claims submission form shall include an Explanation of Benefits or claim number so
19 Blue Shield can identify, research, and reprocess the member's disputed claim(s). Additionally, if the
20 member has not yet paid the provider, but attests that the provider is actively pursuing payment, the
21 submission shall include the provider's most recent communication seeking additional payment.

22 7. If the member submits all of the information required in Paragraph 6, and Blue Shield
23 either confirms the misinformation alleged in the member's claims submission form, or otherwise
24 accepts the attestation for purposes of this Agreement only, Blue Shield shall reprocess the claim at
25 the participating provider benefit level.

26 8. Following reprocessing of the claim, Blue Shield will send an adjusted Explanation of
27 Benefits to the provider and the member, and a notice to the member that the claim has been adjusted.
28 The notice shall invite members who have already paid the provider more than the member

1 responsibility amount on their adjusted Explanation of Benefits but do not receive a refund from their
2 provider to contact Blue Shield. At the member's request, Blue Shield would then contact the
3 provider in order to facilitate a refund to the member.

4 9. The Parties agree that Blue Shield shall complete the steps set forth in Paragraphs 5
5 through 7 related to claims of 2014 Provider Directory inaccuracies by October 1, 2016. Blue Shield
6 further agrees to provide the Department with a final report documenting the number of claims
7 identified and adjusted as a result of these efforts, and the adjusted amounts paid, within 60 days of
8 completion.

9 10. Nothing in the paragraphs above precludes an enrollee from filing a grievance related
10 to 2014 Provider Directory inaccuracies with Blue Shield's Appeals and Grievance Department. The
11 grievance will be directed to and reviewed by appropriately qualified and trained personnel
12 responsible for resolving such grievances consistent with this Agreement.

13 11. To the extent a current or former member of a BSC IFP Plan advises Blue Shield's
14 Customer Service Department that he or she was misinformed by Blue Shield regarding a provider's
15 participating status in connection with a service rendered in 2015, the Customer Service Department
16 will be empowered to resolve the member's issue and authorize a one-time payment of the claim at the
17 participating provider benefit level without requiring the member to file an appeal or grievance. If the
18 member expresses dissatisfaction with the resolution of the issue at the Customer Service level, the
19 member will be advised of the right to initiate an appeal or grievance. If the BSC IFP Plan member
20 submits an appeal or grievance and it is established that Blue Shield or Blue Shield's Provider
21 Directory provided misinformation regarding the provider's participating status, Blue Shield's
22 Appeals and Grievance Department shall authorize payment of the claim.

23 12. Consistent with this Agreement, nothing in this Corrective Action shall affect or limit
24 an enrollee's right to file, per the timeframes in the Act, a grievance with the Department, or a request
25 for reprocessing of claims as it relates to the accuracy of Blue Shield's Provider Directory.

26 13. Blue Shield will begin implementing the following corrective actions with respect to
27 providers participating in its PPO network for BSC IFP Plans by no later than December 31, 2015.
28

- 1 a. Conduct outreach, either directly or through use of external vendors, at least
2 annually to verify the participation status and demographic information of each of
3 the providers listed in its Provider Directory (the "Verification Processes").
4 Outreach under the Verification Processes shall be conducted by electronic or
5 written communications and/or by telephone. Blue Shield shall document all
6 efforts undertaken in its Verification Processes for each provider listed on its
7 Provider Directory.
- 8 b. Conduct quarterly mail or fax campaigns in 2016 to remind/inform providers that
9 they are part of the Plan's Covered California IFP network and remind them of their
10 contractual obligations to notify the Plan of updates and changes in status. The
11 Plan shall notify the Department's Office of Plan Licensing through the eFiling web
12 portal within 10 days of the completion date. Blue Shield shall include an
13 explanation on its provider website of how medical groups and providers can
14 confirm which networks they participate in.
- 15 c. Blue Shield's customer service representatives shall route provider data issues to
16 the Provider Information and Enrollment team for research, and, if validated,
17 updates to the Provider Directory. Blue Shield shall update its Provider Directory,
18 as warranted, within 30 business days.
- 19 d. Conduct ongoing updates to provider information when a request is received by
20 email, fax or other written request by the provider, return mail from a provider,
21 online change form and manual and automatic updates by a provider data vendor.
22 Blue Shield shall update its Provider Directory, as warranted, within 30 business
23 days.
- 24 e. Explore opportunities to compare and control provider data across multiple source
25 systems.
- 26 f. Make quarterly comparisons of its provider rosters with the most recent roster filed
27 with the Department for each network. When the comparison indicates a 10%
28 change in the network for a product in a region, the Plan shall file an amendment to

1 the plan application with the Department consistent with subdivision (f) of Section
2 1300.52 of Title 28 of the California Code of Regulations.

- 3 g. Conduct educational webinars to educate providers on changes to BSC IFP Plans
4 (including Covered California products) for the coming year in 2015, 2016, and
5 2017. The webinars will be recorded and available on Blue Shield's provider portal
6 throughout the year and will be made available to the Department.
- 7 h. Distribute provider office manager toolkits including information regarding BSC
8 IFP Plans, confirming network participation, making in-network referrals, and the
9 importance of keeping information updated and the process for doing so.
- 10 i. Conduct a monthly audit of 500 randomly selected providers' information, and
11 make associated updates to the Provider Directory, as needed. Blue Shield shall
12 update its Provider Directory, as warranted, within 30 business days.
- 13 j. Appropriately train all personnel or vendors who administer or maintain the
14 Provider Directory about the policies and procedures required by this Agreement.
- 15 k. Establish a customer service IFP Resolution Team to support IFP members with
16 provider issues, questions, and needs. Member calls will be routed to this line when
17 a customer service agent cannot resolve provider issues for the member.
- 18 l. Train all IFP customer service agents on using the Find a Provider tool to respond
19 to member queries.
- 20 m. Implement a Help Desk to support IFP customer service agents with questions
21 related to finding a provider. The Help Desk will provide technical support and
22 service, including assistance in setting up appointments for members, as needed.
- 23 n. Continue to execute and implement any and all remediation processes identified in
24 the Plan's Response to the Department's Non-Routine Survey and other filings with
25 the Department to the extent they are consistent with the all corrective actions set
26 forth in this Agreement.

27 14. If the commitments required in this Corrective Action Plan require changes to plan
28 documents that are required to be filed with the Department by the Act, the Plan shall submit the

1 revised documents to the Department's Office of Plan Licensing through the Department's eFiling
2 web portal within thirty (30) calendar days after the execution of this Agreement. The filing shall
3 highlight as well as underline the changes to the text, if applicable, as required by California Code of
4 Regulations, title 28, section 1300.52(d).

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