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BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF THE ACCUSATION AGAINST: Care 1st Health Plan, Respondent.	Enforcement Matter Nos.: 16-235[1] **ACCUSATION** (Health & Safety Code section 1340, *et seq.*)

I.

INTRODUCTION

The California Department of Managed Health Care (the "Department" or "Complainant") brings the present action to assess administrative penalties against CARE 1st HEALTH PLAN ("Respondent") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended ("Knox-Keene Act" or the "Act") (Health and Safety Code section 1340 et seq.) Respondent is a health care service plan licensed under and regulated by the Act.

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[1] Enforcement Matter Nos.: 16-235 (Control Case), 16-1293, 16-1769, 16-1838, 16-2074, 16-2135, 17-044, 17-045, 17-046, 17-065, 17-434, 17-435, 17-436, 17-438, 17-439, 17-440, 17-528, and 17-716.

II.

PARTIES

1. Drew Brereton ("Complainant") is the Deputy Director and Chief Counsel of the Department's Office of Enforcement ("OE"). Complainant brings this Accusation solely in his official capacity as Deputy Director and Chief Counsel of the Office of Enforcement for the Department.

2. At all times pertinent to the allegations herein, Respondent has been a full-service health care service plan as defined by Health and Safety Code section 1345, subdivision (f), and is subject to the regulatory provisions of the Act. Respondent is the holder of health care service plan license number: 933 0326 which was issued on November 1, 1995, by the Commissioner of the Department of Corporations, predecessor to the Director of the Department. Respondent's principal corporate office is located at: 601 N. Potrero Grande Drive, Monterey Park, California.

III.

JURISDICTION

3. This Accusation is brought before the Director of the Department ("Director") under the authority conferred in the Act and title 28 of the California Code of Regulations, as specified below.

4. The Department is charged with the task of regulating managed care in the State of California and ensuring that the entities which sell managed care products in California, known as health care service plans, are in compliance with their obligations under the Act. (Health & Saf. Code, §§ 1341, subd. (a), and 1345, subd. (f).)

5. The Director is responsible for the performance of all duties and responsibilities vested by law in the Department, including the administration and enforcement of the Act and the rules and regulations adopted thereunder. (Health & Saf. Code, §§ 1341, subd. (c), and 1346, subd. (a)(5).)

6. Health and Safety Code section 1386, subdivision (a),[2] authorizes the Director to take disciplinary action against a health care service plan under the appropriate circumstances. The Director is authorized to assess administrative penalties against the plan if the Director determines,

[2] For convenience, a section of the Health and Safety Code is hereinafter referred to as "Section," followed by the section number unless otherwise indicated.

after appropriate notice and opportunity for a hearing, that the plan has committed any of the acts or omissions enumerated in Health and Safety Code section 1386, subdivision (b), which constitute grounds for disciplinary action.

7. Section 1386, subdivision (b)(6), states the grounds for disciplinary action include instances where the plan has violated or attempted to violate any provision of rule of the Act or any order issued by the Director.

IV.

LEGAL AND FACTUAL BACKGROUND

A. Health Plan Grievance System Requirements

8. Section 1368 and the implementing regulations, California Code of Regulations, title 28, section 1300.68 and 1300.68.01,[3] provide the general statutory and regulatory framework for the grievance system requirements of health care service plans.

9. Section 1368, subdivision (a)(1), requires health plans to establish and maintain a grievance system under which enrollees may submit their grievances to the plan. The grievance system must ensure adequate consideration of an enrollee's grievance(s), and resolution as appropriate.

10. Rule 1300.68, subdivision (a), requires that a health plan's grievance system be established in writing and include procedures which will receive, review, and resolve grievances within 30 calendar days of receipt. Pursuant to Rule 1300.68, subdivision (a)(1), a grievance is defined as a written or oral expression of dissatisfaction regarding the plan or provider, and includes a complaint, dispute, request for reconsideration or appeal. If a plan is unable to distinguish between a grievance and an inquiry, the plan shall consider it a grievance.

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[3] For convenience, a section of title 28 of the California Code of Regulations is hereinafter referred to as "Rule," followed by the section number unless otherwise indicated.

11. Section 1368, subdivision (a)(4)(A), requires a health plan to provide an acknowledgement of an enrollee's grievance within five calendar days of receipt. Rule 1300.68, subdivision (d)(1), requires the acknowledgement to include a notice that the grievance has been received and date of receipt, and the name and contact information of the health plan representative who may be contacted about the grievance.

12. Under Section 1368, subdivision (a)(5), a health plan is required to provide enrollees with written responses to grievances which contain a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision.

13. Under Section 1368.01, subdivision (a), the plan must resolve grievances within 30 calendar days of receipt. Rule 1300.68, subdivision (d)(3), requires the plan's resolution, containing a written response, be sent within 30 calendar days of receipt, and contain a clear and concise explanation of the plan's reasons for its decision.

14. Section 1368.02, subdivision (b), requires that the plan include the Department's toll-free number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. This section further requires that health plan written notices to enrollees under the grievance process include the following statement:

> The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related

to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://hmo-help.ca.gov has complaint forms, IMR application forms and instructions on line.

B. Requirements for Health Plans Once an Enrollee files a Grievance with the Department of Managed Health Care

15. Under Rule 1300.68, subdivision (g)(1)-(5), after an enrollee files a grievance with the Department, the Department will notify the Plan. Within 5 calendar days after notification, the plan must provide documents and information to the Department, including, a written response to the issues raised in the grievance; a copy of the plan's original grievance response to the enrollee; a complete and legible copy of medical records related to the grievance, or a statement that medical records were not used in the grievance resolution; a copy of the cover page and all relevant pages of the enrollee's evidence of coverage with applicable sections underlined; and all other information relied upon by the plan in responding to the enrollee's grievance.

16. Under Rule 1300.68, subdivision (g)(6), the Department may request additional information from the plan. The plan must respond to the request for additional information within 5 calendar days, and either provide the requested information or provide the Department with a description of the action being taken to obtain the information, and when the information can be expected.

17. Under Rule 1300.68, subdivision (h), the Department may determine an early review is warranted. In these cases, the Department may require a shorter time frame for the plan to respond to a request for information.

C. Disciplinary Actions In This Case

18. As set forth more specifically below, disciplinary action is appropriate in this case because Respondent violated Sections 1368, subdivisions (a)(1) and (a)(4)(A); and Rule 1300.68, subdivisions (a), (d)(1), (g), and (g)(1-6).

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19. All hearings before the Director are to be held in accordance with the Administrative Procedure Act, and the Director has all of the powers granted under that act. (Section 1397, subdivision (a).) The factors for determining an appropriate penalty for violations of the Knox-Keene Act are set forth in Rule 1300.86.

20. This Accusation is not intended to, nor does it limit the Department's authority to take any and all additional appropriate action as provided under the authority of the Knox-Keene Action and title 28 of the California Code of Regulations with regard to same or similar violations which occurred during the same time period.

D. Facts At Issue In This Case[4]

OE Matter No.: 16-235[5]

21. The enrollee in matter 16-235 complained to the Department seeking assistance in requesting reimbursement from Respondent for physical therapy sessions. On July 24, 2015, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and Respondent's response was due on July 29, 2015. Respondent timely provided its response to this notification on July 29, 2015. However, Respondent failed to include copies of telephone logs between the enrollee and Respondent, making the response incomplete. Respondent provided these documents untimely, on August 17, 2015, nineteen days late.

22. The Department also sent Respondent a request for additional information on August 18, 2015. The Plan's response was due by August 24, 2015. Respondent's response was received on August 28, 2015, four days late.

OE Matter No.: 16-1293

23. The enrollee in matter 16-1293 complained to the Department seeking assistance in obtaining authorization from Respondent for surgery. On September 9, 2015, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and Respondent's response was due on September 14, 2015. Respondent provided an untimely response to this notification on September 16, 2015, two days late.

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[4] In the interest of judicial efficiency, these matters are being prosecuted as a group. This group prosecution is not intended to represent the universe of violations during the relevant time period.

[5] Matters referred to throughout are internal Department references, and are used only for case identification.

24. In addition, Respondent's response to the Department's notification did not include the cover page and all other relevant pages (with applicable sections underlined) from the enrollee's Evidence of Coverage. Respondent's response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

25. On September 9, 2015, the Department also sent requests for additional information in the form of a Request for Health Plan Information form, which was due September 14, 2015. Respondent's response to this request was untimely received on September 16, 2015, and did not contain all the requested information, notably the dates Respondent received and resolved the enrollee's grievance. The Respondent's September 16, 2015 response also did not advise the Department of the actions it was taking to obtain the materials and of its anticipated date of response.

OE Matter No.: 16-1769

26. The enrollee in matter 16-1769 complained to the Department seeking authorization for a medication. On October 9, 2015, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and a response was due from Respondent on October 14, 2015. Respondent provided an untimely response on October 19, 2015, five days late.

27. On October 9, 2015, the Department also sent Respondent requests for additional information in the form of a Request for Health Plan Information form, which was due October 14, 2015. Respondent's response to this request was untimely received on October 19, 2015, and did not contain all the requested information, notably the dates Respondent received and resolved the enrollee's grievance. Respondent's October 19, 2015, response also did not advise the Department of the actions it was taking to obtain the missing information and its anticipated date of response.

OE Matter No.: 16-1838

28. The enrollee in matter 16-1838 complained to the Department seeking coverage for services rendered on several dates. On March 1, 2016, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and Respondent's response was due by March 7, 2016. The Department received Respondent's untimely response on March 9, 2016, two days late.

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OE Matter No.: 16-2074

29. The enrollee in matter 16-2074 complained to the Department seeking authorization from Respondent for a medication. On December 16, 2015, the Department notified Respondent of the Department's receipt of the enrollee's complaint. On December 16, 2015, the Department sent Respondent requests for additional information in the form of a Request for Health Plan Information form, which was due December 21, 2015. Respondent's response to the request for additional information did not contain all the requested information, notably the dates Respondent received and resolved the enrollee's grievance. Respondent's response also did not advise the Department of the actions it was taking to obtain the missing information and its anticipated date of response.

OE Matter No.: 16-2135

30. The enrollee in matter 16-2135 complained to the Department seeking authorization for an endoscopy and heart ultrasound. On November 25, 2015, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and a response was due from Respondent November 30, 2015. Respondent untimely provided its response to this notification on December 2, 2015.

31. The Department also sent a request for additional information on November 25, 2015, in the form of a Request for Health Plan Information form. Respondent's response was due November 30, 2015. Respondent's response to this request was untimely received on December 2, 2015, and did not contain all the requested information, notably information regarding the product name. Respondent's December 2, 2015, response also did not advise the Department of the actions it was taking to obtain the missing information and its anticipated date of response.

OE Matter No.: 17-044

32. The enrollee in matter 17-044 complained to the department seeking reimbursement from Respondent for prescriptions the enrollee paid for out-of-pocket. On November 26, 2013, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and a response was due from Respondent November 30, 2013. Respondent timely provided its response to

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the Department. However, Respondent failed to include a written response to all issues raised in the enrollee's grievance. Respondent's response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

OE Matter No.: 17-045

33. The enrollee in Matter 17-045 complained to the Department requesting a referral from Respondent to see a dermatologist. On May 11, 2016, the Department notified Respondent of the Department's receipt of the enrollee's complaint. The Department also sent Respondent a request for additional information on May 11, 2016, in the form of a Request for Health Plan Information form, which was due May 16, 2016. Respondent did not provide the Request for Health Plan Information form until May 19, 2016, three days late.

OE Matter No.: 17-046

34. The enrollee in Matter 17-046 complained to the Department seeking authorization from Respondent for a specialized steroid injection. On May 12, 2016, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and Respondent's response was due on May 17, 2017. Respondent sent a timely response to the Department on May 16, 2016. However, also on May 12, 2016, the Department sent Respondent a request for additional information, in the form of a Request for Health Plan Information form. Respondent's response was due May 17, 2017. Respondent untimely provided this document on May 18, 2017, one day late.

OE Matter No.: 17-065

35. The enrollee in Matter 17-065 complained to the Department expressing concerns with the quality of service the enrollee received from Respondent's grievance department. On July 11, 2016, the Department notified Respondent of the Department's receipt of the enrollee's grievance, and requested an expedited response, due by July 12, 2016. However, Respondents provided a response on July 14, 2016, two days late.

OE Matter No.: 17-434

36. The enrollee in Matter 17-434 complained to the Department seeking authorization from Respondent for a medication. On November 19, 2015, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and Respondent's response was due by

November 24, 2015. Respondent untimely provided its response to this notification on November 27, 2015, three days late.

37. The Department also sent Respondent a request for additional information on November 19, 2015, in the form of a Request for Health Plan Information form. Respondent's response was due on November 24, 2015. Respondent's response was both untimely received on November 27, 2015, and did not contain all of the requested information, notably the dates the grievance was received and resolved by Respondent. Respondent's November 27, 2015, response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

OE Matter No.: 17-435

38. The enrollee in Matter 17-435 complained to the Department seeking authorization from Respondent for trigger point injections. On November 2, 2015, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and Respondent's response was due November 9, 2015, Respondent untimely provided its response on November 13, 2015, four days late.

39. The Department also sent Respondent a request for additional information on November 2, 2015, in the form of a Request for Health Plan Information form. Respondent's response was both untimely received on November 13, 2015, and did not contain all of the requested information, notably the dates the grievance was received and resolved by Respondent. Respondent's November 13, 2015, response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

OE Matter No.: 17-436

40. The enrollee in Matter 17-436 complained to the Department seeking authorization and coverage from Respondent for a glucose monitor. On October 5, 2015, the Department notified Respondent of the Department's receipt of the complaint, and Respondent's response was due by October 12, 2015. Respondent untimely provided its response to this notification on October 13, 2015, one day late.

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41. The Department also sent Respondent a request for additional information on October 5, 2015, in the form of a Request for Health Plan Information form. Respondent's response was both untimely received on November 13, 2015, and did not contain all of the requested information, notably the dates the grievance was received and resolved by Respondent. Respondent's November 13, 2015, response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

OE Matter No.: 17-438

42. The enrollee in Matter 17-438 complained to the Department seeking authorization from Respondent for a new patient office visit with a general surgeon. On July 7, 2015, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and Respondent's response was due by July 13, 2015. Respondent untimely provided its response on July 14, 2015, one day late.

OE Matter No.: 17-439

43. The enrollee in Matter 17-439 complained to the Department seeking approval from Respondent for brachytherapy. On June 22, 2015, the Department notified Respondent of the Department's receipt of the enrollee's complaint. Respondent timely provided a response to the Department on June 29, 2015. However, Respondent's response did not include the cover page and all other relevant pages (with applicable sections underlined) from the Evidence of Coverage ("EOC"). The missing information was not provided to the Department until July 1, 2015, two days late. Respondent's June 29, 2015, response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

OE Matter No.: 17-440

44. The enrollee in Matter 17-440 complained to the Department seeking authorization from Respondent for a medication. On December 18, 2013, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and Respondent's response was due by December 23, 2013. Respondent provided an untimely response on January 2, 2014, ten days late.

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OE Matter No.: 17-528

45. On September 25, 2016, the enrollee in Matter 17-528 submitted a grievance dated September 16, 2016, via facsimile to Respondent.

46. Respondent's grievance system failed to identify the September 25, 2016, communication from the enrollee as a grievance and failed to investigate and resolve it accordingly.

47. Respondent failed to send the enrollee written acknowledgment of receipt of the grievance within five days of Respondent's receipt of the grievance.

48. The enrollee complained to the Department seeking assistance with the grievance and requesting Respondent provide a referral to an in-network dental provider or authorization to see an out-of-network provider.

49. On September 27, 2016, the Department notified Respondent of the Department's receipt of the enrollee's complaint. In its response to the Department, Respondent stated that it did not respond to the enrollee's grievance because it felt it had already addressed most of the enrollee's concerns. This is an insufficient reason to fail to acknowledge and ignore the enrollee's grievance.

50. On September 27, 2016, the Department also sent Respondent a request for additional information in the form of a Request for Health Plan Information form. Respondent's response to this request was timely. However, Respondent's response to the request did not contain all the requested information, notably the product name, the coverage type and the dates the grievance was received and resolved by Respondent. Respondent's response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

51. On October 17, 2016, the Department sent Respondent another request for additional information seeking among other things, contact information for providers. The request for additional information was due on October 24, 2016. Respondent's response failed to include provider contact information until October 28, 2016, four days late. Respondent's response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

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52. On November 3, 2016, the Department sent Respondent another request for additional information. The Department requested Respondent inform the Department whether a specific provider was willing to enter into a single case agreement with Respondent. The response was due November 7, 2016. Respondent did not provide this information in its response to the Department until November 8, 2016, one day late. Respondent's response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

OE Matter No.: 17-716

53. The enrollee in Matter 17-716 complained to the Department for reimbursement from Respondent for services received from an out-of-network urgent care center, and to address a quality of service complaint regarding Respondent's reimbursement process. On September 19, 2016, the Department notified Respondent of the Department's receipt of the enrollee's complaint, and Respondent's response was due on September 26, 2016. Respondent's untimely response was received on September 28, 2016, two days late. Respondent did not provide information regarding the enrollee's quality of service complaint until October 6, 2016, ten days late. Respondent's September 28, 2016, response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

54. On September 19, 2016, the Department also sent Respondent a request for additional information in the form of a Request for Health Plan Information form. Respondent's response to this request did not contain all the requested information, notably it did not include the product name. Respondent's response did not inform the Department of steps Respondent was taking to obtain this information or its anticipated date of response.

V.

FIRST CAUSE FOR DISCIPLINE

(Failure to Adequately Consider and Rectify the Enrollee's Grievance)

[Section 1368, subdivision (a)(1); Rule 1300.68, subdivision (a)]

55. Complainant re-alleges all matters set forth in paragraphs 1-54 and incorporates them herein.

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56. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Section 1386, subd. (b)(6).)

57. Health plans are required to establish and maintain a grievance system for enrollees to submit their grievances to the plan. The grievance system must include reasonable procedures according to the Department's regulations. The grievance system must be such that is ensures adequate consideration of an enrollee's grievances, and resolution as appropriate. (Section 1368, subd. (a)(1).)

58. The grievance system must be established in writing and include procedures which will receive, review and resolve grievances within 30 calendar days of receipt. (Rule 1300.68, subd. (a).)

59. A grievance is defined as "a written or oral expression of dissatisfaction regarding the plan or provider, including quality of care concerns. Where a plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. The Department considers a complaint to be the same as a grievance. (Rule 1300.68, subd. (a)(1)-(2).)

60. In Matter 17-528, discussed above, Respondent failed to classify the enrollee's written or oral expressions of dissatisfaction, or complaints as grievances, failing to initiate the grievance system, and thereby failing to adequately consider the enrollee's grievances. In so doing, Respondent deprived the enrollee of the enrollee's consumer protections under the Knox-Keene Act and title 28 of the California Code of Regulations. The Respondent is therefore subject to discipline for a violation of Rule 1300.68, subdivision (a).

VI.

SECOND CAUSE FOR DISCIPLINE

(Failure to Timely Provide Written Acknowledgement of a Grievance)

[Section 1368, subdivision (a)(4)(A); Rule 1300.68, subdivision (d)(1)]

61. Complainant re-alleges all matters set forth in paragraphs 1-60 and incorporates them herein.

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62. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Section 1386, subd. (b)(6).)

63. Health plans are required to provide written acknowledgement of each grievance received from an enrollee within five calendar days of the receipt of the grievance. (Section 1368, subd. (a)(4)(A).) This acknowledgement must advise the complainant that the grievance has been received and the date of receipt, and it must identify and provide the name and contact information of the health plan representative who may be contacted about the grievance. (Rule 1300.68, subd. (d)(1).)

64. In Matter 17-528, discussed above, Respondent received the enrollee's expressions of dissatisfaction which constituted grievances for the purpose of rule 1300.68, subdivision (a)(1). Respondent thereafter failed to timely provide written acknowledgement of enrollees' grievances within five calendar days, or at all. Respondent's failure to provide acknowledgement of receipt of the grievances is a violation of Section 1368, subdivision (a)(4)(A) and Rule 1300.68, subdivision (d)(1). Respondent is therefore subject to discipline pursuant to Section 1386, subdivision (b)(6).

VII.

THIRD CAUSE FOR DISCIPLINE

(Failure to Timely Provide Information to the Department)

[Rule 1300.68, subdivision (g)(1)-(5)]

65. Complainant re-alleges all matters set forth in paragraphs 1-64 and incorporates them herein.

66. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Section 1386, subd. (b)(6).)

67. After an enrollee files a grievance with the Department, the Department shall notify the Plan. Within 5 calendar days after notification, the Plan shall provide documents and information to the Department. This information includes, a written response to the issues raised in the grievance; a copy of the Plan's original grievance response to the enrollee; a complete and legible copy of medical records related to the grievance, or a statement that medical records were not used in the grievance resolution; a copy of the cover page and all relevant pages of the enrollee's evidence of coverage with

applicable sections underlined; and all other information relied upon by the plan in responding to the enrollee's grievance. (Rule 1300.68, subd. (g)(1)-(5).)

68. In Matters 16-235, 17-044, 17-439, and 17-716, discussed above, the Department notified the Respondent that the Department had received a complaint from an Enrollee. Upon notification by the Department, Respondent was obligated to provide certain documents to the Department within five calendar days. In each of these matters, Respondent failed to provide some, or all of the required documents within 5 calendar days of receipt of notice from the Department (or shorter in the case of an expedited or early review matter) in violation of Rule 1300.68, subdivision (g)(1)-(5). Respondent is therefore subject to discipline pursuant to Section 1386, subdivision (b)(6).

VIII.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Timely Provide Additional Information to the Department)

[Rule 1300.68, subdivision (g)(6)]

69. Complainant re-alleges all matters set forth in paragraphs 1-68, and incorporates them herein.

70. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Section 1386, subd. (b)(6).)

71. In addition to the information specified in Rule 1300.68, subdivisions (g)(1)-(5), the Department may request additional information from the plan. Within 5 calendar days of receipt of the request for additional information, the plan must forward the requested information to the Department. (Rule 1300.68, subd. (g).) If the information cannot be timely forwarded to the Department, the plan response must provide a description of the actions being taken to obtain the information, and when the information is expected to be received. (Rule 1300.68, subd. (g)(6).) A request for additional time to respond is not sufficient without a description of actions being taken to obtain the information.

72. In Matters 16-235, 16-1293, 16-1769, 16-2074, 16-2135, 17-045, 17-046, 17-065, 17-434, 17-435, 17-436, 17-528 and 17-716, discussed above, the Department sent requests for additional documents or information to Respondent. Respondent failed to provide responsive documents and

information in response to the Department's request for additional information within 5 calendar days, or to provide a response to the Department describing the actions being taken to obtain the information and when the information was expected, in violation of Rule 1300.68, subdivision (g)(6). Respondent is therefore subject to discipline pursuant to Section 1386, subdivision (b)(6).

IX.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Provide Timely Information to the Department after Notification that the Department has Received an Enrollee Grievance)

[Rule 1300.68, subdivision (g)]

73. Complainant re-alleges all matters set forth in paragraphs 1-72, and incorporates them herein.

74. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Section 1386, subd. (b)(6).)

75. A plan must provide information to the Department in a timely manner, after notice from the Department that the Department has received an enrollee grievance. (Rule 1300.68, subd. (g).) To be considered timely, the plan's response must be provided to the Department within five (5) calendar days. (Rule 1300.68, subd. (g).)

76. In Matters 16-1293, 16-1769, 16-1838, 16-2135, 17-434, 17-435, 17-436, 17-438, 17-440, and 17-716, discussed above, the Department determined that the case qualified for earlier review; however, the plan failed to expedite its response and did not provide the requested information to the Department by the requested response date. Respondent's failures to timely respond to the Department's expedited requests are violations of Rule 1300.68, subdivision (h). Respondent is therefore subject to discipline pursuant to Section 1386, subdivision (b)(6).

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X.

SIXTH CAUSE FOR DISCIPLINE

(Unfair Competition)

[Section 1386, subdivision (b)(7)]

77. Complainant re-alleges all matters set forth in paragraphs 1-76, and incorporates them herein.

78. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Section 1386, subd. (b)(6).)

79. The Department may discipline its licensees for "any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code." (Section 1386, subd. (b)(7).)

80. "[U]nfair competition shall mean and include any unlawful, unfair or fraudulent business act or practice..." (Bus. & Prof. Code, § 17200.) (Unfair Competition Law or UCL.)

81. An unlawful business practice or act under the UCL means an act of practice, committed pursuant to business activity, which is at the same time forbidden by law. Conduct by a health care service plan in violation of the Knox-Keene Act is therefore considered unfair competition under the UCL.

82. As a health care service plan, Respondent's business activities include establishing and maintaining a grievance system which shall ensure adequate consideration of enrollee grievances and rectification where appropriate. (Section 1368, subd. (a)(1).) Establishing and maintaining a grievance system provides an essential consumer protection for a plan's enrollees. Any failure of the grievance system deprives consumers of these protections.

83. In each of the 18 cases brought forth here, Respondent failed to act in a manner consistent with maintaining a grievance system to ensure adequate consideration of its enrollees' grievances. As such, Respondent has engaged in conduct that meets the definition of an unlawful business practice within the meaning of the UCL. Because the actions of respondent and/or its delegates constitute unfair competition, as defined in the UCL, Respondent is subject to disciplinary action by the Department. (Section 1386, subd. (b)(7).)

PRAYER

WHEREFORE, Complainant prays that a decision be rendered by the Director of the Department of Managed Health Care assessing an administrative penalty against the Respondent, in the amount of $135,000 for the violations of the Knox-Keene Act and the accompanying rules and regulations it has committed as alleged in this Accusation.

WHEREFORE, Complainant also prays for such other and further relief, as the Director deems proper.

Dated: December 8, 2017

DREW BRERETON
Deputy Director | Chief Counsel
Office of Enforcement