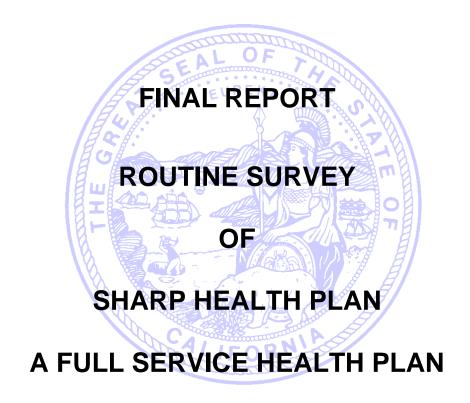


OFFICE OF PLAN MONITORING DIVISION OF PLAN SURVEYS



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Final Report of a Routine Survey Sharp Health Plan A Full Service Health Plan February 10, 2016

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EXECUTIVE SUMMARY

On June 3, 2015, the California Department of Managed Health Care (the "Department") notified Sharp Health Plan (the "Plan") that its Routine Survey had commenced, and requested the Plan to submit information regarding its health care delivery system. The survey team conducted the onsite portion of the survey from August 18, 2015 through August 21, 2015. The Department completed its investigatory phase and closed the survey on November 23, 2015.

The Department assessed the following areas:

Quality Management
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Access to Emergency Services and Payment
Prescription (RX) Drug Coverage
Language Assistance

The Department identified **four** deficiencies during the current Routine Survey. The 2015 Survey Deficiencies table below notes the status of each deficiency.

2015 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	QUALITY MANAGEMENT	
1	The Plan does not have a Public Policy Committee that complies with the required membership criteria. Rules 1300.69(a) and (d)	Not Corrected
	GRIEVANCES AND APPEALS	
2	The Plan does not include on its website, or provide a link to, prescription drug formularies or instructions on how to obtain the formulary. Section 1367.205(a)(1); Section 1367.205(c); Section 1368.016(a)(2); Section 1367.20	Corrected
3	The Plan does not consistently provide to enrollees, on the required documents and in the required format, information regarding the Department's grievance review process, including the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, and the Department's Internet address. Section 1368 02(b)	Corrected
	Section 1368.02(b)	

4	The Plan's online grievance submission process does not allow the grievant/complainant to preview and edit the grievance form prior to submission.	Corrected
	Section 1368.015(c)(2)	

SURVEY OVERVIEW

The Department evaluates each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975. At least once every three years, the Department conducts a Routine Survey of a Plan that covers major areas of the Plan's health care delivery system. The survey includes a review of the procedures for obtaining health services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the Plan in providing health care benefits and meeting the health needs of the subscribers and enrollees in the following areas:

Quality Management – Each plan is required to assess and improve the quality of care it provides to its enrollees.

Grievances and Appeals – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.

Access and Availability of Services – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

Utilization Management – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

Continuity of Care – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Access to Emergency Services and Payment – Each plan is required to ensure that emergency services are accessible and available, and that timely authorization mechanisms are provided for medically necessary care.

Prescription Drugs – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescriptions and ensure benefit coverage is communicated to enrollees.

Language Assistance – Each plan is required to implement a Language Assistance Program to ensure interpretation and translation services are accessible and available to enrollees.

The Preliminary Report was issued to the Plan on November 30, 2015. The Plan had 45 days to file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The Plan has

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¹ The Knox-Keene Act 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.

an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

This Final Report addresses the most recent Routine Survey of the Plan, which commenced on June 3, 2015 and closed on November 23, 2015.

PLAN BACKGROUND

Sharp Health Plan is a full service, non-profit HMO based in San Diego County. Its parent company is Sharp HealthCare, a San Diego based, integrated delivery system that includes IPAs, independent physicians, hospitals, ancillary providers and five medical groups. The Plan obtained its Knox-Keene license on September 17, 1992. As of December 31, 2014, the Plan has a total commercial HMO enrollment of 75,006 in its San Diego and Southern Riverside counties service areas and a Covered California enrollment of 10,202 in San Diego County.

Sharp Health Plan contracts with IPA, medical groups, independent physicians, hospitals, and ancillary providers including:

- 1. Sharp Rees-Stealy Medical Group
- 2. Rady Children's Health Network
- 3. Sharp Community Medical Group
- 4. Primary Care Associates Medical Group
- 5. Greater TriCities Independent Practice Association

Sharp Health Plan contracts with its health care providers on a capitated and fee-forservice basis for the provision of medical care services. The Plan delegates claims processing, credentialing, and utilization management functions to its delegated organizations with whom it has contracts.

Sharp Health Plan is affiliated with five medical groups/IPAs and 97.3% of its enrollment is assigned to fully delegated medical groups/IPAs. As part of its integrated health care delivery system, the Plan also contracts with Psychiatric Centers at San Diego (PCSD) for its behavioral health network.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On November 30, 2015, the Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to:

- (a) Develop and implement a corrective action plan for each deficiency, and
- (b) Provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions.

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

DEFICIENCIES

QUALITY MANAGEMENT

Deficiency #1: The Plan does not have a Public Policy Committee that complies with the required membership criteria.

Statutory/Regulatory Reference(s): Rules 1300.69(a) and (d).

Assessment: Rule 1300.69(a) requires that the Plan's Public Policy Committee be partially composed of enrollees:

- (a) If the plan is a corporation, either:
- (1) At least one-third of its governing board shall be subscribers and/or enrollees, or
- (2) There shall be established a standing committee which shall be responsible for participating in establishing public policy of the plan as defined in Section 1369 of the Act, and whose recommendations and reports are regularly and timely reported to the governing board. The governing board shall act upon such recommendations and such action shall be recorded in the board's minutes. The membership of the standing committee shall comply with each of the following:
- (A) At least 51% of the members shall be subscribers and/or enrollees,
- (B) At least one member shall be a member of the governing board of the plan, and
- (C) At least one member shall be a provider.

Rule 1300.69(d) requires that those enrollees "are <u>not</u> employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan" [Emphasis added.]

The Plan's bylaws confirm some of the obligations set forth in Rule 1300.69, stating: "[Public Policy] committee membership shall include the President/CEO or his/her designee, one participating network provider, and three (3) consumer representatives who are Plan members. Persons constituting the three (3) Plan Member members of the Committee shall not be employees of the Plan, providers of health care services under the Plan, sub-contractors or contractors of the Plan or persons financially interested in the Plan."

During interviews, Plan staff conveyed the following information:

- The Plan's Public Policy Committee is incorporated into its Board of Directors (BOD).
- The Plan actively recruits Plan enrollees for membership in the BOD with little success. (The Department also reviewed corroborating information: the Plan's enrollee handbook and a screenshot of the Plan's website that invites enrollee participation.)
- At least three of the five BOD members are also health plan enrollees.

Review of the Plan's BOD Member Roster and BOD Meeting Minutes from February 26, 2015 show the current BOD membership as follows:

- President and CEO of Sharp HealthCare
- President and CEO of Sharp Health Plan
- Senior Vice President of Business Development for Sharp HealthCare
- Senior Vice President and CFO of Sharp HealthCare
- Sharp pulmonology physician

The Plan's BOD membership consists primarily of executives from the Plan's parent company, Sharp HealthCare. As the Plan's parent company, Sharp HealthCare and its executives qualify as persons financially interested in the Plan. The remaining two members are employees of the Plan, specifically, a Plan executive and a Plan physician. As such, there are no members who are enrollees but not "employees of the Plan, providers of health care services under the Plan, sub-contractors, or contractors of the Plan or persons financially interested in the Plan."

Conclusion: Rule 1300.69(d) requires that a plan's Public Policy Committee be partially composed of enrollees who "are not employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan." The Plan has no enrollees meeting this regulatory requirement on its BOD, which also functions as the Plan's Public Policy Committee. Therefore, the Department finds the Plan in violation of this regulatory requirement.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan requested the Department remove this deficiency and disputed the Department's findings relying on the language in Rule 1300.69: "Unless a plan complies with the requirements of the Health Maintenance Organization Act of 1973 in affording subscribers and enrollees' procedures to participate in establishing the public policy of the plan, as defined in Section 1369 of the Act, it shall comply with the following requirements..."

The Plan asserted that it complies with the requirements of Section 1369 in "affording subscribers and enrollees' the opportunity to participate in establishing the public policy of the Plan, [thus,] it appeared that the specific provisions of Rule 1300.69 do not apply." However, in order for this exception to apply, the regulation requires the Plan

comply with the Health Maintenance Organization Act of 1973, which is federal law. Notably, Congress repealed the relevant provision(s) of the Health Maintenance Organization Act of 1973 (effective as of 1988), and the California legislature amended Section 1369 in 2005 to reflect this change. Accordingly, the exception cannot apply and the requirements of Rule 1300.69 are applicable.

Although the Plan disputed the Department's findings, it provided a copy of the *Public Policy Participation Procedures*, as submitted with the Plan's original application for licensure in 1992. This document states in part:

The corporation shall have a Public Policy Advisory Committee (the "Committee"). The composition, duties, responsibilities and transactions of this Committee shall be such as to comply with all requirements pertaining to public policy committees contained in the Act.

Committee membership shall include the President/CEO or his/her designee, one participating network provider, and three (3) consumer representatives who are Plan members. Persons constituting the three (3) Plan Member members of the Committee shall not be employees of the Plan, providers of health care services under the Plan, sub-contractors or contractors of the Plan or persons financially interested in the Plan. Factors to be considered in selecting the Plan Member representatives shall include attributes of the Plan Member population such as ethnic background, demographic information, occupation and geographic location.

The Plan also reported that "[a]Il five Board members are enrollees in the Plan" and that only one is an employee of the Plan. Thus, the Plan asserts that it meets the requirements of Rule 1300.69(a)(1), which requires that "[a]t least one-third of its governing board shall be subscribers and/or enrollees." However, the Plan failed to provide amended *Public Policy Participation Procedures* and Bylaws indicating that it was pursing compliance through the composition of its Board of Directors rather than a standing public policy committee, as set forth under Rule 1300.69(a)(2) and the *Public Policy Participation Procedures* provided by the Plan.

The Plan's response also stated that while it had established procedures regarding the membership and duties, it had "not had any requests from Plan Members to participate in the Committee. In a good faith effort to hold regular meetings as an avenue to permit subscribers and enrollees to participate in establishing the public policy of the Plan, the Plan holds regular meetings with its Board of Directors (Board) where such issues are discussed."

The Plan has identified additional methods of potentially obtaining enrollee participation in a Public Policy Committee, but has not yet established a Public Policy Committee with the required ratios to report to the Board as required by the *Public Policy Participation Procedures*. The Plan provided the following corrective actions in an effort to recruit enrollees:

 The Plan's Annual Member Resource Guide mailing issued to members on February 5, 2016 includes information about the Public Policy Committee. The

- language will be included in future iterations of the Annual Member Resource Guide to ensure that members receive regular notice of opportunities to participate in the Committee.
- In the event that there are not a sufficient number of enrollees who contact the Plan as a result of these outreach efforts by March 1, 2016, the Plan will contact employer groups and other plan sponsors to request assistance in identifying Committee members.

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

The Department rejects the Plan's request to remove this deficiency. The Plan's rationale that by creating procedures affording subscribers and enrollees' the opportunity to participate in establishing the public policy, the Plan is no longer subject to the provisions of Rule 1300.69 regarding Committee membership, is not valid.

The Department finds that the Plan is not operating in accordance with the *Public Policy Participation Procedures* by discussing and establishing the public policy of the Plan in the Board of Directors' meetings. The *Public Policy Participation Procedures* requires the Plan comply with Rule 1300.69(a)(2) by having a standing Public Policy Advisory Committee.

The Plan has set forth corrective actions it intends to take to recruit enrollee. Thus, additional time to allow for implementation is necessary. The Department will assess the Plan's efforts to create a Public Policy Committee whose membership meets the requirements of Rule 1300.69 at the Follow-Up Survey.

GRIEVANCES AND APPEALS

Deficiency #2: The Plan does not include on its website, or provide a link to, prescription drug formularies or instructions on how to obtain the formulary.

Statutory/Regulatory Reference(s): Section 1367.205(a)(1); Section 1367.205(c); Section 1368.016(a)(2); Section 1367.20.

Assessment: The Plan is required to "[p]ost the formulary or formularies for each product ... on the plan's Internet Web site *in a manner that is accessible* and searchable by potential enrollees, enrollees, and providers" under Section 1367.205(a)(1). [Emphasis added.] Section 1368.016(a)(2) requires plans that provide mental health services to "include on its Internet Web site, or provide a link to ... prescription drug formularies or instructions on how to obtain the formulary" "Formulary" is defined as "the complete list of drugs preferred for use and eligible for *coverage* ..." by Section 1367.205(c). [Emphasis added.]

The Department reviewed the Plan's website prior to and during the onsite survey but was unable to locate the Plan's full commercial formulary. The Plan provided a

demonstration of the website during the onsite survey. The commercial formulary, a link to the formulary, or any information on how enrollees can obtain the formulary, as required by Section 1368.016(a)(2) and Section 1367.205(a)(1), was not located on the Plan's website.

The Plan has a "Pharmacy" tab on its website home page that takes the user to another Plan web page containing the hyperlink:

"Visit our <u>Drug List</u> to find out if your medication is covered by Sharp Health Plan."

This hyperlink leads to a Plan web page titled "Drug List," containing two hyperlinks. The first hyperlink labeled: "You can access the Sharp Health Plan Drug List and search for a specific drug by name," leads to a searchable formulary in which an enrollee can determine if a specific drug is covered and into what tier the drug falls. The second hyperlink labeled "Download the Sharp Advantage formulary here" leads to another Plan web page labeled, "Group Medicare Plan," where the full Medicare formulary is available. The Department and Plan were unable to locate the full drug formulary for commercial enrollees on the Plan's website.

Section 1367.205(a)(1) requires the Plan post the complete list of drugs preferred for use and eligible for coverage "in a manner that is accessible…" on its website. Because enrollees can only search for one drug at a time on the commercial formulary, and the program does not allow the user to access the entire formulary, the Plan does not meet the statutory requirements of Section 1367.205(a)(1).

During the onsite survey, the Pharmacy Director provided the Department with a hard copy of the Sharp Health Plan Drug Listing and the Sharp Heath Plan Covered California Drug Listing. The Pharmacy Director stated that the Plan was in the process of uploading these formularies to the Plan's website, but that this task was still in "production."

Conclusion: Section 1367.205(a)(1), Section 1367.205(c), and Section 1368.016(a)(2) require that the Plan's drug formulary or listings, be posted on its website and that they be both accessible and searchable. The Plan has not posted its enrollee drug formulary on its website nor does it provide a link to this formulary or instructions on how to obtain the listing. Therefore, the Department finds the Plan in violation of the requirements of Section 1367.205(a)(1) and Section 1368.016(a)(2).

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan requested the Department remove this deficiency and disputed the Department's findings, asserting that the regulations "do not define 'accessible' or any specific detail or requirements as to how the formulary must be displayed to satisfy these requirements." The Department rejects this request as "Formulary" is defined as "the complete list of drugs preferred for use and eligible for

coverage ..." by Section 1367.205(c). [Emphasis added.] The complete list of drugs is required to be posted on the Plan's website, pursuant to Section 1367.205(a)(1).

Upon the Department's request, the Plan also submitted corrective action. The Plan submitted screen shots of the public website https://www.sharphealthplan.com/ showing a hyperlink to "Search the Drug List" which now allows the user to download the Plan's entire drug formulary lists applicable for Medicare members and for on and off exchange commercial enrollees, as well as information regarding medication tiers, step therapy, and information on how to Request Authorization for a Formulary or Non-Formulary Drug.

Final Report Deficiency Status: Corrected

The Department finds that the Plan now has the entire drug formulary in a single document for each applicable product line and a function to search for drugs individually.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been fully corrected.

Deficiency #3: The Plan does not consistently provide to enrollees, on the required documents and in the required format, information regarding the Department's grievance review process, including the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, and the Department's Internet address.

Statutory/Regulatory Reference(s): Section 1368.02(b)

Assessment: Section 1368.02(b) requires the Plan to include a Department specified statement² regarding the Department's grievance review process on enrollee documents as follows:

² 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 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 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://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

[O]n 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.

Section 1368.02(b) further requires:

The Department's telephone number, the Department's TDD line, the plan's telephone number, and the Department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type ... [Emphasis added.]

Plan policies on Member Grievances, Member Appeals, and Independent Medical Review all confirm this requirement, stating:

The following statement is included in all written communication to a Member regarding an Appeal, in 12-point font. '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 **1-800-359-2002** and use your health plan's grievance process before contacting the department'..."

The Plan does not consistently provide the required information on pertinent enrollee documents, including display of Department-specific information (toll-free telephone number, TDD line, and Internet address) in 12-point, boldface, regular type. The Department reviewed a sample of the Plan's 2014 and 2015 Evidence of Coverage (EOC) and Member Handbooks to ascertain if the required information was correctly posted. The appropriate information was present in all of the reviewed EOCs and Member Handbooks; however, in the Annual Member Mailing 2015, the required information was not included.

Conclusion: Section 1368.02(b) requires the Plan to include a Department specified statement in a given format on Plan contracts, on EOCs, on copies of Plan grievance procedures, on Plan complaint forms, and on all written notices to enrollees required under the Plan's grievance process, including any written communications that offer the enrollee the opportunity to participate in the Plan's grievance process. Section 1368.02(b) further requires the Department's telephone number, the Department's TDD line, the Plan's telephone number, and the Department's Internet address be displayed in each of these documents in 12-point, boldface, regular type. In a review of Plan documents, the Department determined that the required information was not included in the Annual Member Mailing. Therefore, the Department finds the Plan in violation of this statutory requirement.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan disputed the Department's finding of non-compliance of the requirements of Section 1368.02(b) for failing to include the mandated Department informational paragraph in the *Annual Member Resource Guide* sent to enrollees, which includes information on the Plan's grievance procedures. The Plan maintained that the *Annual Member Resource Guide* "did not qualify as one of the written notices described in Section 1368.02(b)" because the information it contained regarding the procedure and process to resolve grievances was for purposes of satisfying the requirements of Section 1368(a)(2). Given that the *Annual Member Resource Guide* contains information about the procedure and process for resolving grievances, this document is a "written [notice] to enrollees required under the grievance process of the plan" and it is a "copy of plan grievance procedures;" therefore, under Section 1368.02(b) the mandated paragraph must be included.

Further, the information contained in the *Annual Member Resource Guide* regarding grievance procedures and process essentially offers enrollees the opportunity to participate in the Plan's grievance process, thus it does qualify as a "written [communication] to an enrollee that offer the enrollee the opportunity to participate in the grievance process," as specified by Section 1368.02(b).

Upon the Department's request, the Plan also submitted corrective action. In the Plan's response, it submitted a copy of the *Annual Member Resource Guide* that was mailed to Plan enrollees on February 5, 2016, which did include the informational paragraph required by Section 1368.02(b).

Final Report Deficiency Status: Corrected

The Department finds that the Plan included the paragraph mandated by Section 1368.02(b) in the 2016 Annual Member Mailing. Based upon the corrective actions undertaken, the Department has determined that this deficiency has been fully corrected.

Deficiency #4: The Plan's online grievance submission process does not allow the grievant/complainant to preview and edit the grievance form prior to submission.

Statutory/Regulatory Reference(s): Section 1368.015(c)(2).

Assessment: Section 1368.015(c)(2) requires that each plan's website give enrollees the opportunity to "preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal." The Plan's Member Appeals and Member Grievance policies state that "The Member may submit his/her Appeal by calling a Plan Customer Care Representative at 858-499-8300 or toll-free at 1-800-359-2002, by writing a letter to the Plan outlining details of the Appeal, by completing an online Grievance/Appeal Form ..."

The Department reviewed the Plan's website prior to and during the onsite survey. The Plan also conducted a demonstration of its website during the onsite survey. The Department was not able to confirm during any of these reviews that the Plan's online grievance form allows enrollees to preview and edit their online grievance prior to submittal. When questioned about this website limitation, Plan staff stated that they believed their current form met the requirement because the enrollee could see and edit the information on the form during data input.

Conclusion: Section 1368.015(c)(2) requires the Plan to provide the enrollee an opportunity to preview and edit an online grievance prior to submittal. The Plan's website does not provide the required preview function for the grievance information prior to submission. Therefore, the Department finds the Plan in violation of this statutory requirement.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan disputed the Department's deficiency finding, stating: "Members have the ability to scroll back to the top of their grievance and preview the entirety of the written statement they have typed in the box and/or make edits before clicking the 'submit' button." The Department rejects the Plan's request to remove this deficiency. This interpretation does not give full effect to the language in the statute.

Upon the Department's request, the Plan also submitted corrective action. In its response, the Plan submitted a screen shot of the online grievance form, showing the addition of the 'preview form' function. The Department reviewed the online grievance form, located at https://www.sharphealthplan.com/members/file-a-grievance-or-appeal#Fileacomplaintonline, and verified the online grievance form now allows a grievant to preview the form prior to submittal.

Final Report Deficiency Status: Corrected

The Department finds that the Plan added an online grievance preview function that allows enrollees to preview the online grievance form prior to submittal. Based upon the corrective actions undertaken, the Department has determined that this deficiency has been fully corrected.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Survey. The Department will conduct a Follow-Up Review of the Plan and issue a Report within 14-16 months of the date of this Final Report.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal

Once logged in, follow the steps shown below to submit the Plan's response to the Final Report:

- Click the "eFiling" link.
- Click the "Online Forms" link
- Under Existing Online Forms, click the "Details" link for the DPS Routine Survey Document Request titled, 2015 Routine Full Service Survey - Document Request.
- Submit the response to the Final Report via the "DMHC Communication" tab.