DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FOLLOW-UP REPORT

ROUTINE SURVEY

OF

WESTERN HEALTH ADVANTAGE

A FULL SERVICE HEALTH PLAN

DATE OF FOLLOW-UP REPORT: NOVEMBER 30, 2017

Routine Survey Follow-Up Report
Western Health Advantage
A Full Service Health Plan
November 27, 2017

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EXECUTIVE SUMMARY

In the Preliminary Report for the Routine Survey, the Department of Managed Health Care (Department) identified three deficiencies and instructed Western Health Advantage (WHA or Plan) to implement corrective actions. By the date the Final Report was issued, three deficiencies remained uncorrected. The Plan was advised that the Department would conduct a desk level Follow-Up Survey to assess the status of those outstanding deficiencies and issue a report within 18 months of the date of the Final Report.

On January 27, 2017, the Department notified Western Health Advantage that the Follow-Up Survey had commenced, and requested the Plan to submit information regarding its uncorrected deficiencies as cited in the Final Report dated February 26, 2016.

The survey team conducted the Follow-Up Survey pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Act), codified at Health and Safety Code section 1340 *et seq*., and Title 28 of the California Code of Regulations section 1000 *et seq*.[1]

The Follow-Up Survey addressed outstanding deficiencies in the following areas:

- Quality Management
- Grievances and Appeals

The Department conducted its Follow-Up Survey and found one of the previous outstanding deficiencies to have been corrected while two of the previous outstanding deficiencies remained uncorrected.

	FOLLOW-UP SURVEY STATUS OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT ISSUED ON FEBRUARY 26, 2016	
#	**DEFICIENCY STATEMENT**	**FOLLOW-UP SURVEY STATUS**
	QUALITY MANAGEMENT	
1	**The Plan does not appropriately assign Severity Levels, and as a result, it does not assign corrective action plans, or follow-up on adverse quality of care events. Section 1386(b)(1); Section 1300.70(a)(1).**	**Not Corrected**

[1] All references to "Section" are to the Health and Safety Code unless otherwise indicated. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

	GRIEVANCES AND APPEALS	
2	**The Plan's acknowledgment letters fail to include the receipt date of the grievance.** **Section 1368(a)(4)(B)(ii); Rule 1300.68(d)(1)**	**Corrected**
3	**The Plan does not ensure adequate consideration and rectification of enrollee grievances identified as exempt grievances.** **Section 1368(a)(1); Rule 1300.70(a)(3).**	**Corrected**

SECTION I: SUMMARY OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT AND FOLLOW-UP SURVEY FINDINGS

The following details the Department's findings regarding the outstanding deficiencies. The Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health and Safety Code section 1380(i).

QUALITY MANAGEMENT

Deficiency #1: **The Plan does not appropriately assign Severity Levels, and as a result, it does not assign corrective action plans, or follow-up on adverse quality of care events.**

Statutory/Regulatory Reference(s): Section 1386(b)(1); Section 1300.70(a)(1).

Plan's Initial Compliance Effort: In the Plan's Response to the Preliminary Report, the Plan challenged some of the Department's case example findings and set forth the following corrective actions:

1) Re-training Plan physician reviewers regarding assigned Severity Levels

The Plan conducted a training session on July 30, 2015, attended by WHA's physician reviewers and Registered Nurses that included the Plan's PQI Policy and Procedure. The training included discussion of the Severity Levels and identification of communication and systems issues.

2) Revision to the Plan's PQI Management Policy and Procedure Severity Level

During the course of Department review, it was noted that WHA's PQI Policy and Procedure contained potentially confusing language regarding systems issues in the Severity Levels. Specifically, it was noted that systems issues language was included in both Severity Level I and Severity Level II. The Plan is prepared to file with the Department for review and approval a revised PQI Policy and Procedure that provides greater clarification regarding systems issues and Severity Levels.

The Plan did not provide the Department with a copy of the revised policy. Thus, the Department is unable to provide any feedback on these changes at this time. This policy will be reviewed and commented upon when the Plan files this policy with the Office of Plan Licensing.

3) Review of PQI's assigned Level 0 for accuracy of assigned Severity Levels

The Plan's Quality Management RN's conducted a random review of 55 PQI's from 2013 - 2015 to determine if cases were assigned severity levels consistent with its PQI Policy and Procedure. The Plan did not identify any deviations with the score assigned and the Plan's policy.

Department's Findings at Issuance of Final Report: Not Corrected

The Department found that the Plan reported that it conducted training regarding its Severity Level assignments, revised its PQI policy, and conducted an audit of the 2013-2015 PQIs. To assess whether the Plan's corrective actions were sufficient to correct this deficiency, the Department would conduct a file review at the Follow-Up Survey.

Plan's Follow-Up Compliance Effort: The Plan submitted a narrative description, "*Summary of Plan Actions Taken Regarding Potential Quality Issues*," which outlined corrective actions to address this deficiency. The Plan made the following policy and procedure changes in response to the Department's findings:

1) The Plan revised its *Potential Quality Issue Management (PQI)* policy and procedure

The Plan's *Potential Quality Issue Management (PQI)* policy and procedure was revised in June 2016, to provide greater clarification regarding severity levels assigned to PQIs by Plan staff, in particular, severity levels involving communication and systems issues. The revisions were approved by the Plan's Quality Improvement Committee (QIC) in its June 22, 2016, meeting. The severity levels described in the original policy were amended to remove the term *system problem* from Severity Level I for clarification and to further differentiate Severity Level I from Severity Level II. .

The following table identifies the policy changes made by the Plan.

Changes in Severity Level Descriptions

Level	Original	Revision
0	No Quality of Care Issue Unfounded complaint, unavoidable complication, unavoidable disease progression	No Quality of Care Issue Unfounded complaint, unavoidable complication, unavoidable disease progression
I	No Potential Harm to Patient Includes issues of poor documentation, poor communication, non-compliance, may reflect a healthcare system problem such as office wait time, etc.	No Potential Harm to Patient Includes issues of poor documentation, poor communication, non-compliance, may reflect a delay such as office wait time, etc.
II	Minimum Adverse Effect Includes systems issues and possibly less severe clinical judgment issues	Minimum Adverse Effect Includes systems issues and possibly less severe clinical judgment and/or process issues
III	Moderate adverse effect Includes preventable complication and/or readmission or delay in diagnosis and treatment	Moderate adverse effect Includes preventable complication and/or readmission or delay in diagnosis and/or treatment

IV	Significant adverse effect All serious issues of medical mismanagement	Significant adverse effect and/or sentinel events All serious issues of medical mismanagement

As discussed above, the Plan revised its Potential Quality Issue Management (PQI) policy and procedure to provide greater clarity regarding severity levels assigned to PQIs by Plan staff and added language to further define 'sentinel event' and the Plan's peer review processes. The Department reviewed the minutes of the June 22, 2016, QIC meeting and found relevant discussion and approval of the revisions incorporated into this policy. The Department found that while the revisions made to the descriptions of Severity Level 1 and Severity Level 2 eliminate some confusing language, no examples are given for each severity level, which would promote consistency in interpretation and application. File #9 demonstrates this need. (See case summaries below.)

2) The Plan trained its clinical staff on the PQI policy revisions, including changes in severity levels

The Plan trained staff on the Plan's revised PQI policy to ensure consistent understanding and implementation of the changes in severity levels. The Plan submitted a document, *Potential Quality Issue Training Information,* in which the Plan affirms staff training at various times in 2016. The document stated:

> WHA's new Medical Director received training regarding WHA's Potential Quality Issue (PQI) Policy including severity levels, communication, and systems issues during his initial orientation in March 2016.
>
> WHA physician reviewers received training on PQI Severity levels, communication and systems issues on June 2016 after the PQI policy revisions were approved. In addition, all of WHA's physician reviewers and licensed nurses receive training on severity levels, communication and system issues periodically during the newly established weekly PQI Team meetings.
>
> WHA's Quality Improvement Committee physician members also received training on severity levels in June 2016 during review of WHA's PQI Management policy.

In addition to attesting in its narrative description to staff training at various times in 2016, the Plan submitted copies of PQI review agenda and meeting minutes detailing Plan training sessions regarding PQI severity level review.

3) The Plan conducted PQI file reviews to determine the accuracy of Plan staff Severity Level assignment using the revised descriptions

The Plan's quality management licensed nurses conducted quarterly file reviews on all 77 PQI files processed from January through September 2016. The fourth quarter

review was in process at the time of the Plan's narrative response to the Department and was not available for review. The purpose of the file reviews was to measure compliance with the Plan's revised PQI policy in terms of assigning appropriate severity levels.

The Plan's file review findings were included in the document, *2016 PQI File Review Audit Results*, which the Plan submitted to the Department. The Plan assigned 96%, 100%, and 100% compliance scores for the first, second, and third quarters, respectively. The Plan stated that cases were brought to the weekly PQI Team meeting for further review if the final severity level was in question or if the file documentation showed inconsistencies with the revised policy.

4) The Plan implemented weekly PQI review meetings

Per Plan Policy, *Potential Quality Issue (PQI) Management*, PQI cases are referred to Plan medical directors for determination of severity levels. In the Plan document, "*Summary of Plan Actions Taken Regarding Potential Quality Issues*," the Plan affirmed that all PQIs are now subsequently reviewed and discussed by a PQI Team, which meets weekly and is composed of three physicians, four registered nurses, and one licensed vocational nurse. The Plan stated that members of the team receive periodic training on severity levels, communication, and systems issues as part of the weekly meetings. The Plan states that this new model allows for greater interactive peer review, inter-rater reliability, and consensus regarding severity levels, corrective actions, and follow-up.

The Department noted during the course of the Follow-Up Survey PQI file review that the PQI team began reviewing PQI cases and assigning Severity Levels in June 2016. Active discussions of file review results, PQI cases, PQI dispositions, and Severity Levels are evident in selected (by the Plan) minutes of the PQI Team meetings conducted in June, October, and November 2016—these minutes are in document titled *Selection of PQI Weekly Meeting Minutes/Audit Result Discussions/Trainings*.

The Department notes that review of PQI cases by the PQI Team is not described in Plan policy, *Potential Quality Issue (PQI) Management*. The policy is limited to a description of PQI case review by the medical directors and referral to the QIC, as follows:

> 4.2 WHA's Chief Medical Officer ("CMO") has overall responsibility for the grievance program and has delegated the review of PQIs to WHA's Medical Director and Assistant Medical Director (hereafter referred to as "Designated Physician"). The latter shall review medical records and other case documentation prior to determining the severity level of an issue. If indicated, the opinion of an appropriate physician specialist shall be sought and/or the case shall be referred to WHA's Quality Improvement Committee ("QIC") for review by Contracted Medical Group ("CMG")/Independent Practice Association ("IPA") physician peers. QIC physicians shall make recommendations for corrective action as needed and shall determine the final severity level for the case.

The QIC minutes for meetings conducted from April 2016 to November 2016 document PQI case discussions, confirmation or revisions of Severity Levels, assignment of corrective actions plans, and follow-up activities that are consistent with the Plan's PQI policy.

File Review

During the Follow-Up Survey, the Department reviewed a random selection of 38 PQI files from a universe of 80 of such files for the follow-up review period April 1, 2016 to December 31, 2016. Despite the corrective actions discussed above, the Department found that the Plan failed to assign appropriate severity levels in accordance with its policy in 6 of the 38 PQI files (16%).[2]

PQI Case Summaries

The following cases were assigned inappropriate Severity Levels:

- File #4: The enrollee complained that she had an incisional infection from surgery. Her PCP refused to see her saying that the surgeon should address the problem. The surgeon required another referral since the problem arose nearly 90 days after the surgery. There is no documentation that the PCP submitted another referral. The Plan noted that additional information was required to determine the conclusion of the case but the file contains no further information regarding the outcome of the case—there is no any indication that the enrollee was ever seen by either the PCP or the surgeon. Plan reviewers felt there was a communication issue between the PCP and the surgeon and assigned this case a Severity Level 1 (no potential harm to patient; issues of poor communication).

This case should have been assigned a Severity Level 2 based on the PCP's refusal to see the enrollee and referring the enrollee back to the surgeon without taking the necessary actions to enable that referral. The non-action of the PCP in this case could have harmed the enrollee. Severity Level 2 includes "systems issues" and possibly "clinical judgment and/or process issues." Per Plan policy, PQI cases assigned a Severity Level 2 through 4 on initial review require QIC peer review and a corrective action plan (CAP) as determined by the Chief Medical Officer, designated physician, and/or QIC. Because the Plan assigned this case a Severity Level 1, no CAP was assigned and the case was not reviewed by the QIC.

- File #9: The enrollee's mother complained on July 13, 2016, that no provider appointments were available until September 2016 to administer a vaccine, which the enrollee needed for school. When the provider's office was informed that the child's mother complained to the Plan, an appointment was made for the administration of the vaccine prior to the start of school. The Plan assigned this case a Severity Level 0 (no quality of care issue; unfounded complaint).

This case should have been assigned at least a Severity Level 1 based on a possible access issue to the provider. The case also could have been assigned a Severity Level

[2] File #4, File #9, File #11, File #25, File #27, File #30.

2 (systems issue and possible judgement/process issue) because it should not have been necessary for the enrollee's mother to file a complaint to the Plan in order to get an appointment for a child's immunization within the timeframe required by Rule 1300.67.2.2 (c)(5)(C) – i.e., "within ten business days of the request for appointment...." If this case were assigned a Severity Level 2, the provider office would have received at least an educational letter regarding Plan access standards and the Plan could follow up with the provider to evaluate adherence to such standards.

PQIs involving communication Issues

- File #11: The enrollee complained that her PCP did not address/suggest a treatment plan for her syncope (fainting) following several episodes resulting in car accidents, loss of driver license, and hospitalization. The PCP's last notes relate to the enrollee's visit in October 2016, following discharge from the hospital. The notes do not include any mention of syncope. Upon investigation, the Plan learned that the enrollee had an extensive inpatient workup for syncope and was evaluated by specialists. The Plan assigned this case a Severity Level 0 (no quality of care issue; unfounded complaint). The reviewer's notes do not go beyond a simple statement that the case had no quality issue; the notes do not document that the possible communication issue was recognized or assessed.

This case should have been assigned a Severity Level 1, which includes issues of "poor documentation, poor communication." While the medical management of the enrollee during the PCP visit was appropriate, there is no documentation that any communication occurred between the PCP and the enrollee regarding her syncopal episodes, the findings of the specialists during hospitalization, or the plan of treatment for the syncope. The Plan did not recognize the possibility of communication issues between the PCP and the enrollee.

- File #25: The enrollee's mother complained that the pediatrician's office staff was unprofessional—yelling at each other and telling the mother that she was a bad parent because she refused to immunize her child. She also alleged that the provider's office gave her a one-day notice to find another provider. Upon investigation, the Plan learned that the enrollee was given 30 days to find a new provider. The Plan noted that the provider gave the enrollee notice to find another provider not because of the conflict over immunization but because the office no longer accepts the enrollee's insurance.

The Plan reviewer assigned a Severity Level 0 (no quality of care; unfounded complaint) to the case and did not comment about the communication problems with the provider's office staff. This case should have been assigned a Severity Level 1, which includes issues of "poor communication."

- File #27: This enrollee**,** who experienced a non-displaced fracture of a small wrist bone, complained that the orthopedist was condescending and dismissive of the symptoms, advising the enrollee to continue using an over-the-counter wrist brace. The enrollee went to a different orthopedist, who placed a cast on the wrist. The Plan reviewer determined that the standard of care for a wrist fracture includes use of a brace *or* application of a cast and assigned this case a

Severity Level 0 (no quality of care; unfounded complaint). The Plan reviewer failed to address/comment on the potential communication issue between the first orthopedist and the enrollee.

This case should have been assigned a Severity Level 1, which includes issues of "poor communication," based on the enrollee's accusations about the orthopedist's attitude and potential failure to fully discuss the standard treatment options.

- File #30: The enrollee complained that her provider was not addressing her concerns, which were muscle aches and weakness following a stroke that occurred a year and a half previously, as well as a cough and low-grade fever that she experienced more recently. The enrollee also complained that the provider dismissed her from his practice. In response to the Plan's inquiry, the provider stated that the enrollee had viral bronchitis and that he had focused on the enrollee's blood pressure, diabetes, and health maintenance. The provider also stated that the enrollee was non-compliant with the treatment plan and recommendations, which was his reason for dismissing the enrollee from his practice. (Note: Providers have the right to dismiss patients from practice for non-compliance.) The Plan assigned this case a Severity Level 0 (no quality of care issues; unfound complaint) and did not document that it had assessed the possible communication issues.

This case should have been assigned a Severity Level 1 (communication issues) based on the enrollee's perception that the provider was not addressing her problems and the provider's acknowledgment of those not being the focus during the office visit.

TABLE 1
Potential Quality Issues

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
PQI Files	38	Appropriate Severity Level	32 (84%)	6 (16%)

Follow-Up Report Deficiency Status: Not Corrected

To address this deficiency, the Plan made policy and procedure changes, including revising its PQI policy; conducted staff training; implemented weekly PQI meetings and implemented quarterly PQI file audits to ensure staff compliance with the new policy and evaluate the accuracy of the assignment of severity levels by its staff. However, the Department's review of PQI files revealed that the Plan did not consistently assign appropriate severity levels in accordance with its PQI policy, and as a result it did not consistently implement corrective actions and follow-up, when appropriate, to ensure the quality of care of its enrollees, which is in violation of Rule 1300.70(a)(1). Based upon the corrective actions undertaken and the results of the Department's file review, the Department has determined that this deficiency has not been corrected.

GRIEVANCES AND APPEALS

Deficiency #2: The Plan's acknowledgment letters fail to include the receipt date of the grievance.

Statutory/Regulatory Reference(s): Section 1368(a)(4)(A)(ii); Rule 1300.68(d)(1).

Plan's Initial Compliance Effort: The Plan reported that it was in the process of a two-phase project to implement automation to ensure better quality control, outcomes for members, more detailed data reporting and a decreased margin of error. The Plan's response stated:

> During its investigation, the Plan discovered that each of the fifteen (15) letters that the Department found lacked the date of receipt of the Member's grievance were template letters used when a Member's issue has to do with a potential quality issue ("PQI Template Letter"). Further investigation determined that a change to the PQI Template Letter had occurred that inadvertently removed the date of receipt of the grievance from the PQI Template Letter. The Plan has corrected the PQI Template Letter to ensure that it again includes the date of receipt of the grievance. Still further, the Plan has undertaken an audit of a random sampling of MRU staff acknowledgment letters … The Plan will undertake this audit for three (3) months.

Department's Findings at Issuance of Final Report: Not Corrected

The Department found that the Plan had taken steps to correct this deficiency; however, file review would be necessary to confirm the use of the corrected template in acknowledging grievances that contain potential quality issues. The Department would review a selection of grievance files and the Plan's audit results to assess compliance at the Follow-Up Survey.

Plan's Follow-Up Compliance Effort: Since the Final Report, the Plan stated it hired outside consultants tasked with improving the Member Relations Unit (MRU)[3] processes and procedures including job aids, process improvements, and training manuals. Additionally, the Plan hired MRU Coordinator staff to focus on the administrative aspects of the department allowing MRU staff to focus its efforts on the processing and management of grievances. The Plan transitioned its grievance and appeals software tracking program to automate letters and correspondence, as well as automatically populate elements into template letters such as grievance receipt dates. Additionally, once fully implemented, staff will only be allowed to utilize the templates in the system unless prior management approval is obtained. The MRU also holds regular team meetings to address issues, training, and ensure compliance.

To ensure that the MRU was utilizing the correct PQI acknowledgment letter template, the Plan performed several audits of PQI acknowledgment letters:

[3] The Member Relations Unit is responsible for grievance and coordinating appeals.

- In September and October of 2016, the Plan audited all PQI acknowledgment letters dated December 1, 2015 to March 31, 2016. Out of the 20 standard PQI grievance files reviewed, the Plan found 13 compliant acknowledgment letters (65%) and 7 deficient acknowledgment letters (35%). Based on the audit results, the Plan confirmed that some MRU staff were still using the noncompliant template.

- In January of 2017, the Plan audited all PQI acknowledgment letters dated April 1, 2016 to December 31, 2016. Out of the 41 standard PQI grievance files reviewed, the Plan found 36 compliant acknowledgment letters (88%) and 5 deficient acknowledgment letters (12%). The audit results showed that the five deficient letters were from earlier in the year and that from October 2016 to December 2016, all of the Plan's acknowledgment letters were compliant and included the receipt date of the grievance.

- From January 1, 2017 to March 31, 2017 the Plan audited 25 grievance files and found all compliant with acknowledgement letters including the receipt date of the grievance.

- From April 1, 2017 through June 30, 2017 the Plan reviewed 15 grievance files and found that all were 100% compliant.

At its January 26, 2017 meeting, the team reviewed the January 2017 audit outcomes and the manager reiterated the importance of reviewing and confirming that the receipt date of the grievance is included in all letters.

Follow-Up Report Deficiency Status: Corrected

The Department randomly selected 30 files for review from the Plan's universe of 1,131 of standard grievance files for the follow-up review period April 1, 2016 to December 31, 2016. The Department found that in all 30 grievance files reviewed, the Plan's acknowledgment letter included the receipt date of the grievance.

Based upon the corrective actions undertaken, the Plan's audit findings, and file review results, the Department has determined that this deficiency has been corrected.

Deficiency #3: The Plan does not ensure adequate consideration and rectification of enrollee grievances identified as exempt grievances.

Statutory/Regulatory Reference(s): Section 1368(a)(1); Rule 1300.70(a)(3).

Plan's Initial Compliance Effort: The Plan's response to this deficiency addressed each of the six non-compliant files individually, explaining that for the first two (2) case examples cited, the Member Services Representative who took the call, was either a new employee not following policy, or had miscoded the grievance in the Plan's Facets

system, which is used to record grievances. The Plan stated remedial training was provided where applicable for the Representatives. Further, the Plan indicated that as part of its two-phase grievance and appeal improvement project, described in the Plan's Compliance Efforts in Deficiency #2, the Plan would revise its coding and conduct department training that includes accurate coding of grievance and appeals.

In response to the auto-assign issue identified in the first deficiency, beginning in May 2015, the Plan began quarterly mailings to adult Members assigned to pediatricians as their PCP to encourage these Members to transition from pediatric to adult PCP care, if medically appropriate. The letter provides these Members with instructions on how to initiate a PCP change, e.g., online through the Plan Member portal or by contacting Member Services.

For the third case example cited, the Plan stated, "The Member Relations staff person that reviewed the grievance has been individually coached," and that a PQI training and checklist have been implemented. The Plan also provided factual clarification that had been included in the case example.

For the fourth case example cited, the Plan indicated that it inadvertently failed to produce all files associated with this case.[4] The Plan asserted that it identified this case internally as having incomplete and inaccurate information and a second case was opened to document the issue and the resolution. The second case was not provided to the Department, but the Plan asserted that it referred the matter as a potential quality issue for investigation. Further, the representative who took the call was coached on taking "accurate and thorough notes." The Plan indicated that the member made a retroactive PCP change to a provider that she had already scheduled an appointment with for later that month.

The Plan also investigated the non-compliant cases not detailed as case examples. Both of these cases concerned long wait time for appointments, including one from a new Plan enrollee. The representatives assigned both enrollees to a new PCP and the Plan stated it did not identify the need for further review because there was "no imminent threat of serious injury or damages to the Member." The Plan also argued that the PCP was "contractually bound to meet the applicable timely access standards" and the regulation allows that the "the applicable waiting period for a particular appointment maybe extended if the … treating licensed health care provider … has determined and noted in the relevant medical record that a longer waiting time will not have a detrimental impact on the health of the enrollee."

The Plan's Response also stated:

> [A]ll Member Services Representatives received a refresher training in October 2015 on network access issues and taking action when a Member indicates that they are having difficulty getting an appointment. The Plan is in phase one of creating a new software program for its G&A system. Every aspect of the Plan's G&A processes is being re-examined and re-tooled to provide better customer service, more accurate information, a more robust

[4] The failure to produce all documents requested for inspection constitutes a violation of Section 1381.

reporting mechanism, and efficiencies. One of the tasks of this project is review and changes to the G&A codes. Once this list is completed, all Member Services Representatives and Member Relations staff will be trained on how to accurately code a G&A. The Plan will submit the updated code list to the Department for approval once a final draft is completed. The Plan's PQI clinical reviewers prepared a PQI checklist for the Member Relations Unit. All MRU staff received refresher training on proper PQI referrals and have implemented use of the PQI checklist in their procedures.

Department's Findings at Issuance of Final Report: Not Corrected

The Department founds that while the Plan took steps to correct the deficiency related to Member Services Representatives' failure to follow Plan policies, grievance miscoding, and PQI identification, the Plan had not completed the Grievance and Appeals Program software changes, nor implemented training on the use of and accurately coding all issues in a grievance for further action. The Department would assess the Plan's progress in revising the grievance and appeals process for grievance coding, identifying and investigating potential quality issues in grievances, and staff training at the Follow-Up Survey.

Plan's Follow-Up Compliance Effort:

On February, 13, 2017, the Plan submitted a narrative description, "*Summary of Plan Actions Taken Regarding Grievances*," outlining its corrective actions taken to address this deficiency. The Plan reported that it made the following changes in response to the Department's findings:

a. Plan Operational Technology Updates and Fixes

The Plan implemented a new software program that is intended to benefit the MRU and other Plan departments, including the Member Services Unit (MSU) (the Plan's customer service call center), Premium Accounting, and Eligibility. The software system is now the main program being utilized by Western Health Advantage for providing customer service and all calls and other contacts which are documented through the system. Also the Plan implemented a new call center phone system software program that uses smart functionality to identify a caller and route the calls to the most suitable department and/or staff person to assist with any issue.

The Plan's narrative defining the Plan's compliance effort since the Final Report stated that all member calls are categorized, including whether the issue is an inquiry, exempt grievance, urgent grievance, a standard grievance, appeal, or urgent appeal. Member calls determined to be a grievance or appeal are further coded and defined to ensure they are tasked accordingly within the Plan to assist the caller, but also to ensure that data and statistics on the member calls, types of calls, and grievance issues can be tracked and trended and continual training can be provided, where needed.

As described in its initial response to the Department's survey findings, the Plan revised and enhanced its grievance and appeal coding system to ensure appropriate

categorization of member grievance issues. The Plan's MSU staff first broadly identifies the enrollees grievance issue which then guides the staff through subcategories of codes for greater specificity e.g., Category=Access; Subcategory=Long Wait Appointment. As part of the Plan's follow-up compliance effort, revised codes were submitted to the Department for review. Included in the Plan's narrative response the Plan stated: "the codes are listed in buckets of categories but that they also have a number of "dependencies" that must be chosen, e.g., what is the provider type, is it a Plan partner, which partner, did the issue occur at a hospital, which hospital, was it an out-of-network or in-network hospital, etc."

In addition to the operational updates noted above, the Plan implemented a software program for its MSU staff that provides call center staff with scripts and process flows to assist members. This system has been updated to include information on differentiating an exempt grievance from a grievance, among many, many other issues. As part of its compliance effort, the Plan submitted to the Department sample scripts and process flows including: Grievance Checklist; Appeals and Grievances Checklist Attachment; Case Creation, Notes, and Coding; Complaints and Grievances Overview, Grievance Timeline Example; Handling Exempt Grievance and Grievance Calls, and Identifying Complaints and Grievances.

b. Increased and Improved Training

The Plan has implemented new and continuing training to relevant staff regarding how to properly recognize and categorize a grievance. The Plan's recent trainings of MSU staff regarding grievances occurred in four sessions on: Session I – October 11, 2016; Session II – October 19, 2016; Session III – November 2, 2016; and Session IV – November 9, 2016. The Plan has submitted to the Department the PowerPoints and handouts utilized in the trainings as well as the sign-in sheets of staff that attended. Additionally, the Plan submitted to the Department the following documents: Sample Staff Meeting Agendas that Highlight a Grievance/Appeal Training or Discussion; PowerPoints and Handouts from the Four Sessions Mentioned Above; Two Additional PowerPoint Trainings Provided Earlier in the Year; and Staff Sign-In Sheets from Trainings.

c. Updates and Improvements to Policies and Procedures

As part of the Plan's compliance narrative, both the MRU and the MSU have commenced revising Plan policies and procedures including new and updated job aids and reference documents. As part of their Follow-Up compliance effort, the Plan submitted sample draft procedures for the grievance process, information requests, returned mail, eligibility disputes, PQI screenings and processing, and the appeals process.

The MRU also revised its Grievance and Appeals Management Policy and Procedure. A redlined and clean version of the draft proposed changes was reviewed and approved by the Department's Division of Licensing during the follow-up review period. The initiated revisions to its Complaint and Grievance Identification Policy and Procedure, which will include a broader range of examples of inquiries versus grievances and exempt grievances for identification purposes. As a part of the Plan's

compliance effort, the Plan submitted its Quality Improvement Committee meeting minutes for August 24, 2016 which denoted review and approval of revised grievance policies and procedures. However, the Department could find no evidence of review and approval of revised policies by the Plan's Board of Directors'.

Finally, upon Department approval of revised policies, the Plan stated that a comprehensive training program will be rolled out to include the MSU and the MRU Departments to ensure all staff understand their responsibilities and resources and an effort to provide customer care to its members.

d. Staffing Changes and Outside Consultants Hired

In May of 2016, the Plan hired a new MSU manager to improve MSU staffing levels, productivity, and efficiency, through institution of a metric based system that tracks multiple aspects and implementation of improved and continuous training. The hiring process for MSU staff is currently being revised to include longer more robust training prior to new staff taking member calls and other member contacts. The new hiring training process is anticipated to be rolled out in the second quarter of 2017.

The MSU manager is now able to more accurately track staff performance, compare it to peers and against baseline standards. As part of its compliance effort, the Plan submitted a copy of its Customer Service Call Evaluation Form by which MSU staff is evaluated in addition to audit findings of staff from April 2016 to December of 2016. One of the many components by which MSU staff is evaluated is whether they have correctly categorized a contact with the call center as an inquiry versus a grievance and whether the grievance was accurately coded—this includes determining the difference between an exempt grievance and a standard grievance.

File Review

The Department requested the Plan's exempt grievance log and randomly selected 30 files for review from a universe of 5,414 of such files for the follow-up review period April 1, 2016 to December 31, 2016. The Department found that all 30 (100%) of grievance files reviewed, the Plan did adequately consider and rectify the enrollee grievance.

Follow-Up Report Deficiency Status: Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been corrected. The Plan has made numerous efforts to enhance its grievance and appeals process including operational and technology upgrades and ongoing training. Additionally, exempt grievance file review by the Department has found the Plan to be compliant with adequately considering and rectifying enrollee grievances. Finally, the Department's Division of Licensing reviewed and approved the Plan's revised grievance policies and procedures to ensure compliance with the Act.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Survey of the Plan.

In the event the Plan would like to append a brief statement to the Follow-Up Report as set forth in Section 1380(i)(3), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, **DMHC Web Portal**.

Once logged in, follow the steps shown below to submit the Plan's response to the Follow-Up 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 Follow-Up Report via the "DMHC Communication" tab.

As a reminder, any amendments and modifications made to the Plan's licensing documents as a result of this Routine Survey must be submitted to the Department via the web portal using the "File Documents" link. The Plan should indicate in its Exhibit E-1 Summary of eFiling Information that this policy is being filed as a result of a deficiency identified by the Division of Plan Surveys.

Any uncorrected deficiencies identified in this Report will be referred to the Department's Enforcement Division for potential further action.