DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

WESTERN HEALTH ADVANTAGE

A FULL SERVICE HEALTH PLAN

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Final Report of a Routine Survey
Western Health Advantage
A Full Service Health Plan
February 26, 2016

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EXECUTIVE SUMMARY

On April 30, 2015, the California Department of Managed Health Care (the "Department") notified Western Health Advantage (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 July 14, 2015 through July 16, 2015. The Department completed its investigatory phase and closed the survey on November 16, 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 **three** 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 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**
	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)	**Not Corrected**
3	**The Plan does not ensure adequate consideration and rectification of enrollee grievances identified as exempt grievances.** Section 1368(a)(1) and Rule 1300.70(a)(3)	**Not Corrected**

SURVEY OVERVIEW

The Department evaluates each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975.[1] 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 December 14, 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

[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 April 30, 2015 and closed on November 16, 2015.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On December 14, 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 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)

Assessment: Pursuant to Rule 1300.70(a)(1), "[t]he [Quality Assurance] program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated." The Plan does identify quality issues and conducts clinical reviews; however, the Severity Levels, corrective actions, and follow-ups assigned from those reviews, are not always appropriate for the nature of the issue.

Background Related to Potential Quality Issues (PQI) Identification and Leveling:

The *Quality Improvement Program Description* states "WHA and contracted medical groups/IPAs are responsible of reporting, investigating, and documenting risk management and potential quality issues (PQI)." WHA screens all inquiries, grievances, and appeals for PQIs. When a PQI is identified, WHA's Quality Staff refers the case to the contracted medical group/IPA for information and initial investigation. WHA's Medical Director or Assistant Medical Director(s) review the medical group/IPA findings and assign a Severity Level to the case.

The Plan's *Potential Quality Issue Management Policy and Procedure 2015* document details the Plan's Severity Levels as follows:

Level 0: No Quality of Care Issue.

Unfounded complaint, unavoidable complication, unavoidable disease progression.

Level 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.

Level II: Minimum Adverse Effect
Includes systems issues and possibly less severe clinical judgement issues.

Level III: Moderate Adverse Effect
Includes preventable complication and/or readmission or delay in diagnosis and treatment

Level IV: Significant Adverse Effect
All serious issues of medical mismanagement

A quality of care issue with a Severity Level of II or higher requires review by the physician members of the Quality Improvement Committee (QIC). Quality issues are then elevated to the QIC for discussion and recommended corrective actions, these actions are determined on a case-by-case basis. The Plan's policies do not detail what type of corrective actions should be taken for each level assigned. In addition, Severity Levels II-IV peer review findings would be forwarded to the Quality Director at the contracted medical group/IPA, if deemed necessary by the WHA's Medical Director and the QIC. This process is documented in the Plan's *Provider Manual.*

The Department reviewed 30 potential quality issue (PQI) files randomly selected from a total universe of 148 files and found that the Plan failed to assign appropriate Severity Levels in six (6) out of 30 Potential Quality Issue (PQI) files. The following case summaries reflect the Plan's failure to appropriately assigned Severity Levels, corrective action plans, and/or conduct follow-up.

PQI Case Summaries [2]:

PQI #22: This case involved a mother who took her child with a history of known asthma to an urgent care center. The child was having a severe asthma attack. Because the registration clerk was new and had not been taught how to triage or to get someone else to conduct the triage, the child was not triaged immediately and care was delayed. When the doctor saw the patient, he realized that the child was in trouble and needed immediate medical care. The doctor wanted to call an ambulance to take the child to an emergency room as the child needed a higher level of care than what could be provided at the urgent care center. The mother was so upset she refused to wait for the ambulance.

Lack of appropriate and timely triage caused a delay in care and based on Plan policy, this case should have been elevated to a Level III severity for a delay in diagnosis and treatment. This quality issue was not elevated to the QIC for a CAP because this case was assigned a Severity Level 0. The nurse manager at the urgent care center realized

[2] The Plan challenged the Department's original finding related to the following case examples in its Response to the Preliminary Report. The Department requested the Plan provide records substantiating its challenge. Based on the information provided by the Plan, the Department made corrections and clarifications to the case examples.

this was a systems and education issue; she immediately educated everyone in the urgent care's front office on proper triage procedures, particularly when someone states they are in trouble, as this mother stated she had. Based on the Plan's description of an assigned Level 0, no corrective action would be implemented. Because this was assigned a Severity Level 0, this quality issue was not elevated to the QIC for a CAP.

PQI #23:[3] This case involved a woman who was carrying twins and had undergone a C-section. The woman was moved off the OB floor, and then was left in the same gown for 72 hours and never offered the opportunity to bathe. The Plan's clinical reviewer indicated in review notes that there had been communication issues, but this was assigned a Severity Level 0, even though Plan policies specify communication issues are to be assigned a Severity Level I. Under the Plan's policy, this should have been assigned a Severity Level II because this incident involved a systems issue due to the lack of care provided once the patient was transferred off the OB floor. However, because this was assigned a Severity Level 0, this quality issue was not elevated to the QIC for a CAP.

PQI #13: This case involved a 24-year-old with multiple medical problems who required hip surgery. The patient was in so much pain that she was kept overnight in the post-acute care unit where her pain was managed overnight by the anesthesiologist. The patient was not seen by a medical doctor before she was discharged. Nor was a pain assessment conducted prior to her being discharged. This enrollee had a history of multiple medical problems and it appears that this enrollee was a special needs individual. Additional caution and care would seem appropriate.

On the way home from the hospital, the patient was in so much pain that her mother had to bring her back to the emergency room. The patient's mother was upset regarding her care and having to pay for a co-pay for the emergency room visit and filed a grievance. She contested the co-pay for the emergency room visit because she had to return due to pain. She stated that if the daughter had been cared for appropriately when she was first discharged that she would not have had to come back.

The Plan found that there was no duty to reimburse the co-pay, but failed to recognize a communication and/or systems issue. Without a pain assessment documented before the enrollee left the hospital and after being awakened to be readied for discharge, it is difficult to know what the enrollee was experiencing. Without a discharge note, it is impossible to know what the discharge events were. This incident was assigned a Severity Level of 0 by the Plan, but should have been assigned a Level II Severity level,

[3] *In the Plan's Response to the Preliminary Report, the Plan asserted that this case was rated appropriately because the failure to provide new gowns and bathe patients over a 72-hour period "does not in and of itself constitute a quality of care issue because there is no medical evidence this poses a risk of harm to the patient." However, this takes a narrow view of the Plan's obligation set forth under Rule 1300.70(a)(1) and Rule 1300.70(b)(1)(A)-(B) and (D), which requires that the Plan ensures that the* level of care provided is consistent with professionally recognized standard of practice and care. The Plan does not assert that the level of care here was consistent with professionally recognized standard of practice and care, only that there was no threat of a negative outcome as a result of substandard care.

based on the Plan's policy for system issues. Because this was assigned a Severity Level 0, this quality issue was not elevated to the QIC for a CAP.

PQIs Involving Communication Issues:

PQI #13: This case involved a nurse who became ill at work; she was previously hospitalized out of the country. She was seen at an urgent care center, given a breathing treatment and went home. She awoke short of breath that night and went into the emergency room. The emergency room physician diagnosed the enrollee with anxiety and possible bronchitis. Several days later, a CT revealed significant emphysema. Chronic Obstructive Pulmonary Disease was included in the differential diagnosis in the emergency room physician's documentation. However, the enrollee complained that the emergency room physician told her she was "just anxious" and treated her as though she was having an anxiety attack, despite her difficulty breathing. This appeared rude and dismissive to the enrollee.

This was reviewed by the Plan and given a Severity Level of 0. While no ultimate harm came to the patient, there was communication issues between the enrollee and emergency room physician. Based on the Plan's *Potential Quality Issue Management Policy and Procedure* this case should have been assigned a Level I.

PQI #18: This case involved a patient who had had a rotator cuff repair. She only saw the Physician Assistant post-op, but was upset by the swelling and pain and wanted to have the doctor call her back. She stated that when she tried to make an appointment with the doctor she was told she could see the Physician Assistant. She was upset and kept calling for an appointment. During a verbal exchanged with staff, the patient used profanity, as result, the doctor asked the patient to find another orthopedist. The Plan's clinical reviewer noted in the file that there were communication issues. The Plan assigned a Severity Level 0 to this case. There was no harm to the patient, but this should have been elevated to a Severity Level I for a communication issue, per Plan policy.

PQI #19: The enrollee's wife filed a complaint after her husband attended a new patient exam appointment with his new primary care provider. The office had not scheduled sufficient time for a new patient exam, so the patient was told to come back again for a full physical. The patient was also upset at some of the perceived comments made during the visit. The Plan's clinical reviewer noted in the file that there were communication issues. The Plan assigned a Severity Level 0 to this case. There was no harm to the patient, but this should have been elevated to a Severity Level I for a communication issue, per Plan policy.

Conclusion: The Department finds the Plan is not in compliance with the requirements of Rule 1300.70(a)(1) because the Plan did not consistently assign appropriate Severity Levels, nor did it consistently implement appropriate corrective actions and follow-up to ensure the quality of care of its enrollees. Additionally, because the Plan did not follow its established Quality Improvement Program and policies and procedures for assigning appropriate Severity Levels to its PQIs, the Department has determined that the Plan is also in violation of Section 1386(b)(1), for operating in variance of established policies.

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: 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 2015 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.

Final Report Deficiency Status: Not Corrected

The Department finds that the Plan has 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 are sufficient to correct this deficiency, the Department will conduct a file review at the Follow-Up Survey.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully 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)(B)(ii); Rule 1300.68(d)(1)

Assessment: Section 1368(a)(4)(A)(ii) and Rule 1300.68(d)(1) state that each plan shall respond to grievances with a written acknowledgement letter that advises the complainant of the date of receipt and provides the name, telephone number and address of the Plan representative who may be contacted about the grievance.

The Department reviewed 68 standard grievance files, from a universe of 1,697 files, occurring during the period of May 1, 2013 through May 1, 2015. The Department's review revealed that 15 (22%) of the acknowledgement letters did not include the date of receipt of the grievance in the body of the acknowledgement letter.

Failure of the Plan to include the date of the receipt in its acknowledgement letter violates Section 1368(a)(4)(A)(ii) and Rule 1300.68(d)(1). Including the date of receipt of a grievance in an acknowledgement letter is a component of a fair and reasonable grievance system and helps the complainant track the timelines of the Plan's resolution. Therefore, the Department finds the Plan in violation of these statutory requirements.

TABLE 1
Standard Grievance

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievance File	68	Acknowledgement letter includes receipt date of Grievance	53 (78%)	15 (22%)

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 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 acknowledgement letters … The Plan will undertake this audit for three (3) months.

Final Report Deficiency Status: Not Corrected

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

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully 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) and Rule 1300.70(a)(3)

Assessment: Section 1368(a)(1) requires the plan "ensure adequate consideration and rectification of enrollee grievances." Rule 1300.70(a)(3) requires plans to monitor whether the provision and utilization of services meets professionally recognized standards of practice. The Department reviewed 51 exempt grievance files out of a total universe of 22,122 files for a period of May 1, 2013 through May 1, 2015. This review found that in six files (12%) the Plan failed to ensure that it adequately considers and rectifies enrollee grievances. In in all six exempt grievance files the Plan failed to elevate the complaint for further investigation and follow up, where applicable.

Grievance Case Summaries:

File #20: A 41-year-old male enrollee called to change his primary care provider because he had been inappropriately assigned to a pediatrician as his primary care provider. A Plan representative changed the enrollee's primary care provider effective April 1, 2015 to new provider. The Plan representative advised member that "*per EOC WHA doesn't allow retro PCP* changes [advised] in meanwhile per facets he has emergency room and urgent coverage." [Emphasis added.]

The Plan did not investigate why a 41-year-old man was assigned to a pediatrician for a primary care provider at the time of the phone call. Upon inquiry by the Department, the Plan researched this issue and found that two years earlier the member's medical group terminated the contract and the enrollee was auto-assigned to a pediatrician. Based on notes from the Customer Service Representative, (CSR) it appeared the member requested a retroactive effective date and was advised that the Plan could not provide a

retroactive effective date. However, pursuant to the terms of the *Evidence of Coverage*, enrollees are entitled to a retroactive effective date when the enrollee is auto assigned to a provider. To receive a retroactive effective date the enrollee must notify the Plan within 45 days of desired effective date, and have not received any services from the provider. The Plan's notes did not include whether the CSR pursued this line of inquiry. Further, had the Plan investigated this issue further, the member may have been able to access primary care services for the remainder of the month, March 19, 2015 through March 31, 2015. Instead, the member was only able to access emergency and urgent services during this timeframe.

File #19: An enrollee requested to change her primary care provider "because current primary care provider never able to see her." The Department's review of the grievance found that the Plan changed the primary care provider but failed to investigate the access issue and failed to code the grievance as an access issue. Per Plan policy regarding identifying complaints, grievance and appeals, the issue should have been documented in the Plan's "Facets" system as an access issue as "member requesting to change PCP or complaining about their PCP because they are not able to get a non-urgent appointment for >10 business days." As such, per Plan's policy regarding identifying complaints, grievance and appeals, the Plan should have immediately referred to the issue to the Plan's Member Relations Unit (MRU) for investigation. Additionally, there was no evidence or documentation of Plan elevation of the access issue to the Plan's quality improvement and/or potential quality issue staff.

File #36: An enrollee called the Plan because her 8-year-old daughter was given a durable medical equipment prescription for crutches and the enrollee was unable to fill the prescription. The enrollee informed the Plan that primary care provider did not know if crutches were a covered benefit; therefore, he did not submit an authorization request for the crutches. Rather, the primary care provider simply gave her a prescription for crutches during the office visit. When the enrollee contacted the primary care provider's office later that day, she was advised the doctor left for two days. The enrollee stated that she could not wait for a doctor to submit the physician's authorization request for two days and that she has been carrying her child around.

In response to the compliant, the Plan contacted the PCP's office to facilitate an urgent prior authorization. However, the Plan failed to address the potential quality issue related to the doctor not submitting a request for authorization, there was no evidence or documentation that the issue was elevated to the Plan's quality improvement and/or potential quality issue staff to educate the provider on benefits and submission of requests for durable medical equipment.

File # 35: An enrollee, a new patient with the Plan, could not get an appointment with her new provider for two months. Subsequently, the enrollee called to make an appointment for a rash on her face and was told she could not get an appointment until December 18, 2013 (27 days later). The Plan referred her to urgent care to seek care for the rash on her face, but the enrollee stated she did not want to go to urgent care. As a resolution, the Plan changed the enrollee and her daughter to a new medical group. However, it was unclear whether the new provider was able to see her in a timely manner. The Plan failed to address the two-month waiting time for appointments with the new primary care provider and the 27-day wait time for appointment for the rash.

The issue of delay in care should have immediately referred to the Plan's Member Relations Unit (MRU) or another department for investigation and follow-up. While the issue was elevated to potential quality issue staff, it was determined that it did not qualify as a potential quality issue. Therefore, it does not appear the enrollee's issue in the delay of access to care was investigated or addressed.

Failure of the Plan to adequately review and rectify all of the issues contained in the grievance file violates Section 1368(a)(1) which requires the Plan's grievance system to ensure adequate consideration of enrollee grievance and rectification when appropriate. Additionally, failure to monitor the provision and utilization of services including accessibility, availability and continuity of care violates the requirements of Rule 1300.70(a)(3). Therefore, the Department finds the Plan in violation of these statutory requirements.

TABLE 2
Exempt Grievance

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Exempt Grievance	51	Failure to adequately consider and rectify grievances	45 (88%)	6 (12%)

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'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 will 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 go about initiating 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 have 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 asserts 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 asserts 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 both concerned long wait time for appointments, including one from a new Plan enrollee. The Member Relations 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 argues that because the PCP is “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 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.

Final Report Deficiency Status: Not Corrected

The Department finds that while the Plan has taken steps to correct the deficiency related to Member Services Representatives’ failure to follow Plan policies, grievance

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

miscoding, and PQI identification, the Plan has not completed the Grievance and Appeals Program software changes, nor implemented training on the use of accurately coding all issues in a grievance for further action. The Department will 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.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not 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, **DMHC 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.