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

AUGUST 24, 2020

Routine Survey Follow-Up Report
Western Health Advantage
A Full Service Health Plan

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EXECUTIVE SUMMARY

In the Final Report for the Routine Survey (Final Report) of Western Health Advantage (Plan), dated April 4, 2019, the California Department of Managed Health Care (Department) identified two corrected deficiencies and five uncorrected deficiencies. The Plan was advised that the Department would conduct a follow-up review (Follow-Up Survey) to assess the status of the five outstanding deficiencies and issue a report within 18 months of the date of the Final Report.[1]

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*.[2] On January 17, 2020, the Department notified the Plan of its scheduled Follow-Up Survey and requested the Plan submit information regarding its uncorrected deficiencies as cited in the Final Report.

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

Quality Assurance
Grievances and Appeals
Utilization Management
Continuity of Care

The Follow-Up Survey revealed **two** out of the previous five outstanding deficiencies remain uncorrected.

	FOLLOW-UP SURVEY STATUS OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT ISSUED ON APRIL 4, 2019	
#	**DEFICIENCY STATEMENT**	**FOLLOW-UP SURVEY STATUS**
	QUALITY ASSURANCE	
1	**The Plan failed to establish public policy participation procedures and maintain a compliant public policy body.** Section 1369; Rule 1300.69(a), (d), (h) and (i).	**Corrected**

[1] 2018 Western Health Advantage Final Report.
[2] 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	
4	**Upon receipt of an expedited grievance, the Plan does not immediately inform enrollees of their right to contact the Department.** Section 1368.01(b); Rule 1300.68.01(a)(1); Section 1386(b)(1).	**Not Corrected**
	UTILIZATION MANAGEMENT	
5	**The Plan's denial letters do not consistently include a clear and concise explanation of the reasons for the Plan's decision.** Section 1367.01(h)(4).	**Not Corrected**
6	**The Plan does not conduct adequate oversight of its delegates to ensure compliance with required utilization program standards.** Section 1367.01(a), (h)(4), and (j).	**Corrected**
	CONTINUITY OF CARE	
7	**The Plan does not ensure timely screening of children for autism spectrum disorders (ASD) in accordance with professionally recognized standards of practice.** Section 1374.72(a) and (d)(7); Section 1374.73(a)(1); Rule 1300.74.73(a)(3)(D); Section 1370; Rule 1300.70(b)(1)(A).	**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).

DEFICIENCIES

QUALITY ASSURANCE

Deficiency #1: The Plan failed to establish public policy participation procedures and maintain a compliant public policy body.

Statutory/Regulatory References: Section 1369; Rule 1300.69(a), (d), (h), and (i).

Plan's Follow-Up Compliance Effort: In its response to the Department's notice to conduct the Follow-up Survey, the Plan stated it developed procedures for permitting subscribers and enrollees to participate in establishing the Plan's public policy in Summer 2019. The Plan amended its Bylaws to include these procedures. The Plan's Board of Directors approved its amended Bylaws on May 20, 2019. The Plan also included a summary of its public policy procedures in its Evidence of Coverage documents.

The Plan began recruiting members for its Public Policy Committee (PPC) in Fall 2019. The Plan's PPC hosted its first meeting on January 21, 2020.

Supporting Documentation:

- Western Health Advantage Bylaws Amendments-Exhibit A
- Public Policy Committee Charter (May 20, 2019)
- Western Health Advantage Public Policy Committee Roster of Members
- Evidence of Coverage and Disclosure Forms
- Western Health Advantage (WHA) Advantage Magazine-(Summer 2019)
- Public Policy Committee Meeting Minutes-(January 21, 2020)
- Board of Director Meeting Minutes (February 20, 2019, May 20, 2019, February 21, 2020)

a. **Follow-Up Survey Assessment:** ***Public Policy Participation Procedure***

The Department reviewed the Plan's amended Bylaws and found they incorporate the Plan's public policy participation procedures. The Department also found evidence in meeting minutes that the Plan's Board of Directors approved the amended Bylaws on May 20, 2019. Finally, the Department found the Plan's *Evidence of Coverage (EOC) and Disclosure Form* included a description of the Plan's system for public policy participation.

b. Public Policy Body

The Department reviewed the Plan's PPC member roster and found the committee consists of three enrollees, one provider, and one member of the Plan's Board of Directors. Based on the information provided by the Plan, the Department determined that all three enrollee representatives meet the definition of "subscribers or enrollees" outlined in Rule 1300.69(d). Further, the Department also found the Plan's PPC satisfies the membership requirements of Rule 1300.69(a)(2). The Plan provided evidence the PPC held its first meeting on January 21, 2020.

Follow-Up Report Deficiency Status: Corrected

The Department finds the Plan established public policy participation procedures, amended its Bylaws to incorporate such procedures, and included a description of its system for public policy participation into its EOC. The Department also determined the Plan established a public policy body, which includes membership meeting the requirements of Rule 1300.69(a)(2).

Based upon the corrective actions undertaken, the Department determined the Plan corrected this deficiency.

GRIEVANCES AND APPEALS

Deficiency #4: Upon receipt of an expedited grievance, the Plan does not immediately inform enrollees of their right to contact the Department.

Statutory/Regulatory References: Section 1368.01(b); Rule 1300.68.01(a)(1); Section 1386(b)(1).

Plan's Follow-Up Compliance Effort: In its response to the Department's notice to conduct the Follow-Up Survey, the Plan stated its "Member Relations Unit ("MRU") (the Plan unit responsible for handling of expedited grievances and appeals) were given handouts and quarterly training and/or discussions regarding expedited grievances and appeals, and WHA's duty to immediate inform our members of their rights to contact the Department." The Plan indicated it provided training beginning in February 2019 and conducted quarterly refresher trainings thereafter. The Plan explained its MRU conducted quarterly audits of all expedited grievances and appeals through 2019. The Plan indicated audit results were shared with MRU staff.

Supporting Documentation:

- MRP-04-POL *Exempt Grievance and Grievance Management Policy* (January 1, 2020)
- MRP-01-POL *Appeal Management – Member (Expedited) Policy* (January 1, 2020)
- 30 Expedited Grievance Files (April 1, 2019 through January 31, 2020)

- Western Health Advantage "Team Huddle" Meeting Minutes (January 23, 2019, February 14, 2019, March 21, 2019, June 7, 2019, August 22, 2019, October 17, 2019 and February 11, 2020)
- Expedited Grievance and Appeal Flowchart (February 14, 2019)
- 2019 MRU Audit Tool for Grievance and Appeals

Follow-Up Survey Assessment: The Department reviewed the Plan's *Exempt Grievance and Grievance Management Policy*, which affirms that enrollees "will immediately be informed of their right to submit Expedited Grievances to the DMHC"[3] as required by Section 1368.01(b) and Rule 1300.68.01(a)(1). It also states:

> WHA shall provide immediate telephonic or verbal notification to the Member regarding their right to contact the DMHC about their Expedited Grievance without the Member having first participated in WHA's Grievance process prior to applying to the DMHC.[4]

The Department also reviewed the Plan's *Appeal Management – Member (Expedited) Policy* and found it states:

> Upon receipt of an expedited grievance, WHA will immediately notify the member of his/her right to contact DMHC in writing or through a documented telephone call. Within twenty-four hours, or by the end of the first business day following receipt of the expedited grievance request, the member will be sent an Acknowledgment Letter via regular mail, unless it replaces the documented telephone call, then it will be sent via Federal Express overnight.[5]

Because the policy appears to permit the Plan to notify the enrollee of the right to contact the Department by the end of the next business day, the Department determined the *Appeal Management – Member (Expedited) Policy* fails to comply with the immediate notification requirement mandated by Section 1368.01(b) and Rule 1300.68.01(a)(1).

File Review

To assess compliance, the Department reviewed 42 expedited grievance files randomly selected from a universe of 99 files during the survey review period of April 1, 2019 through January 31, 2020.[6] The Department found 27 files[7] (64%) failed to demonstrate compliance with the obligation to provide immediate notification as required by Section 1368.01(b) and Rule 1300.68.01(a)(1). The Plan provided notice to the enrollee by a documented telephone call more than 24 hours after receipt of the expedited grievance

[3] *Exempt Grievance and Grievance Management Policy*, page 5.
[4] *Ibid*, page 8.
[5] *Appeal Management – Member (Expedited) Policy*, page 5.
[6] The Department found File #12 and File #34 did not meet criteria for expedited processing and were processed as standard grievances. The Department excluded these files and replaced them with File #43 and File #44 respectively.
[7] File #2, File #3, File #4, File #5, File #7, File #8, File #9, File #10, File #11, File #15, File #16, File #17, File #18, File #19, File #22, File #24, File #25, File #27, File #28, File #30, File #32, File #35, File #36, File #37, File #38, File #40, and File #44.

in 12 files.[8] The Department also determined the Plan failed to provide the enrollee with proper notice of the right to contact the Department regarding the expedited grievance without first participating in the Plan's grievance process in five files.[9] In each of those files, the Plan informed the enrollee only that they could contact the Department if they did not agree with the Plan's resolution of the expedited grievance. Finally, the Department noted the Plan accomplished notice of the right to contact the Department through a written acknowledgement letter sent to the enrollee by FedEx Priority Overnight in 10 files.[10] While the files documented when the Plan generated these written notices, the Department found no evidence documenting when the FedEx received the acknowledgment letter from the Plan or delivered the notice to the enrollee. As a result, the Department determine these 10 files failed to demonstrate compliance with the immediate notification requirement in Section 1368.01(b) and Rule 1300.68.01(a)(1).

Case Examples

- **File #4:** The Plan received an expedited appeal from a provider on the enrollee's behalf by fax on July 25, 2019 at 8:51am.[11] The file documents the Plan first attempted to contact the enrollee by telephone on July 26, 2019 at 5:11pm, more than 32 hours after receipt of the expedited appeal.[12] After the Plan was unable to contact the enrollee by telephone, the Plan sent the enrollee a written acknowledgement letter by FedEx Priority Overnight.[13] The file reflects the Plan generated the written notice on July 26, 2019 at 5:20pm. However, the Department found no evidence documenting when FedEx received the acknowledgement letter from the Plan or when FedEx delivered it to the enrollee.

- **File #15:** The Plan received an expedited appeal from a provider on the enrollee's behalf by fax on October 2, 2019 at 9:11am.[14] The file documents the Plan contacted the enrollee by telephone and left a voicemail at 12:44pm that same day. The file states the Plan "[l]eft a message advising the member that we have received an expedited appeal submitted on her behalf" and "advised if the member disagrees with the decision the member may contact DMHC ... to file a complaint."[15] The Department found such notice failed to inform the enrollee of their right to contact the Department without waiting for the Plan's grievance process to conclude as provided by Rule 1300.68.01(a)(4). The Department also noted the file also failed to comply with the Plan's own *Exempt Grievance and Grievance Management Policy*, which requires the Plan provide notice to the enrollee "regarding their right to contact the DMHC about their Expedited

[8] File #2, File #3, File #4, File #8, File #10, File #16, File #24, File #28, File #30, File #36, File #40, and File #44.
[9] File #9, File #15, File #17, File #22, and File #37.
[10] File #5, File #7, File #11, File #18, File #19, File #25, File #27, File #32, File #35, and File #38. The Plan also contacted the enrollee by telephone in five of these files, but the Department found no evidence documenting that the Plan notified the enrollee of their right to contact the Department during these telephone calls. See File #11, File #18, File #19, File #27, and File #38.
[11] File #4, page 22.
[12] *Ibid*, page 17.
[13] *Ibid,* pages 17-18, 58.
[14] File #15*,* page 21.
[15] *Ibid,* page 14.

Grievance without the Member having first participated in WHA's Grievance process prior to applying to the DMHC."[16]

- **File #18:** The Plan received an expedited appeal from a provider on the enrollee's behalf by fax on May 10, 2019 at 9:50am.[17] The file documents the Plan contacted the enrollee by telephone and left a voicemail at 1:53pm that same day.[18] However, the Department found no evidence in the file demonstrating the Plan included information about the right to contact the Department in its voicemail. The file reflects the Plan generated a written acknowledgment letter at 2:12pm[19] and sent the written notice to the enrollee by FedEx Priority Overnight.[20] However, the Department found no evidence documenting when FedEx received the acknowledgement letter from the Plan or when FedEx delivered it to the enrollee.[21]

TABLE 1
Expedited Grievance Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Grievance Files	42	Upon receipt of an expedited grievance, immediately informs the enrollee of their right to contact the Department.	15 (36%)	27 (64%)

Follow-Up Report Deficiency Status: Not Corrected

Through review of the Plan's expedited grievance files, the Department determined the Plan fails to consistently provide immediate notification to enrollees of the right to contact the Department as required by Section 1368.01(b) and Rule 1300.68.01(a)(1). Based on the corrective actions undertaken, the Department finds the Plan did not correct this deficiency.

UTILIZATION MANAGEMENT

Deficiency #5: The Plan's denial letters do not consistently include a clear and concise explanation of the reasons for the Plan's decision.

[16] *Exempt Grievance and Grievance Management Policy,* page 8.
[17] File #18, page 20.
[18] *Ibid*, page 16.
[19] *Ibid*, page 17.
[20] *Ibid,* page 53.
[21] The Department also observes FedEx Priority Overnight delivers the next business day. Because the Plan sent its letter on a Friday afternoon, it is likely the enrollee received notice of the right to contact the Department the following Monday, which is three days after the Plan received the expedited grievance.

Statutory/Regulatory Reference: Section 1367.01(h)(4).

Plan's Follow-Up Compliance Effort: In its response to the Department's notice to conduct the Follow-Up Survey, the Plan indicated it updated its template denial letters. The Plan also conducted training for all staff responsible for drafting denial letters on January 24, 2019. As part of the training, participants received a handout providing guidance on denial letter language. Following the training, the Plan's Clinical Resource Manager "reviewed a high number of letters prior to letters being sent out ... to ensure new requirements were being implemented." Finally, the Plan continued to monitor letters for appropriate language and performed additional training for staff when it identified problems.

Supporting Documentation:

- *Prospective Review* Policy (Revised June 2019)
- *Denial Language* Email (April 9, 2019)
- *Denial Letter Mandatory Training – Handout*
- *Pharm Letter* Email (August 2, 2019)
- Sample Denial Language for Diclofenac 3% Gel
- Pharmacy Denial Language Sample #1 – Emgality
- Pharmacy Denial Language Sample #2 - Vraylar
- *Denial Process* Policy (Revised June 2019)
- 69 Medical Necessity Denial Files (January 1, 2019 through November 30, 2019)

Follow-Up Survey Assessment: The Department reviewed Plan's *Prospective Review* policy and found it states:

> Specific criteria used to make denial, delay, or modification decisions regarding a specific request for service are included in all written notification letters using clear and simple language.[22]

The Department also found evidence the Plan provided guidance and training to staff on ensuring written notification letters are clear and concise. On April 9, 2019, the Plan sent an email to Utilization Management (UM) and Pharmacy staff with a reminder that denial letters could not contain the language, "not medically necessary or not a covered benefit" and requested staff to be diligent in checking all denial letters. The Plan also created a handout for staff on denial letter language.

During interviews, Plan staff stated that updates were made to UM and Pharmacy denial letter templates. The Plan indicated that it provided training to all staff members involved in the denial letter process in January and April of 2019. The Plan's Clinical Resource Manager performed spot checks on denial letters after the January 2019 training.

[22] *Prospective Review*, page 4.

File Review

To assess compliance, the Department reviewed 69 medical necessity denial and modification files[23] randomly selected from the universe of such files for the survey review period of April 1, 2019 through January 31, 2020. The Department determined that in 33[24] (48%) out of the 69 files, the Plan's notification letter failed to include a clear and concise explanation of the Plan's decision. The Department found one letter included conflicting reasons for the denial, stating the request was "disapproved as not medically necessary or not a covered benefit."[25] Similarly, the Department also found a number of letters included confusing explanations of what treatment or service was being denied. Further, the Department determined the Plan frequently explained its denial decision using medical terminology that a layperson may not understand. Finally, the Department observed several letters included long run-on sentences that were difficult to follow.

Case Examples

- **File #28:** The denial letter used medical terminologies that would likely be unclear to a layperson, stating:

  The prescribing provider's request is disapproved as not medically necessary as you have Chronic Hepatitis-C Genotype 1A, but Fibrosis score results by Fibroscan Ultrasound or Biopsy were not provided, and NS5A resistance testing results were not provided. Epclusa, Harvoni and Vosevi are the preferred agents for Chronic Hepatitis-C Stage 2, 3 or 4 Fibrosis when approved under prior authorization.

  WHA covers Epclusa (Sofosbuvir-Velpatasvir) for the treatment of Chronic Hepatitis-C, Genotype 1, 2, 3, 4, 5, or 6 infection in patients without cirrhosis or with compensated Cirrhosis or in combination with Ribavirin in patients with decompensated Cirrhosis. Patients must have compensated liver disease by Fibroscan Ultrasound or Biopsy documenting Stage 2, stage 3, or Stage 4 Fibrosis. Acitest-Fibrotest is not accepted as documentation. Resistance testing must be included with the prior authorization request for Genotypes 1 and 3.

- **File #34:** The denial letter included long run-on sentences that were difficult to follow. The Department observed one sentence in the letter included 226 words spanning 23 lines of text. The same sentence also included several conjunctions,

[23] The Department determined a number of files did not involve a decision based, in whole or in part, on medical necessity. The following files were excluded and replaced: File #9, File #12, File #15, File #22, File #27, File #30, File #36, File #37, File #41, File #42, File #49, File #52, File #54, File #55, File #58, File #62, File #72, File #75, File #83, File #85, File #86, File #88, and File #89.
[24] File #1; File #2; File #3; File #4; File #5; File #7; File #11; File #13; File #17; File #18; File #20; File #21; File #25; File #28; File #29; File #31; File #32; File #34; File #39; File #40; File #48; File #50; File #53; File #57; File #64; File #70; File #73; File #74; File #79; File #80; File #81; File #84 and File #93.
[25] File #13.

such as “AND” and “OR.” Finally, the letter also included medical terminology that would likely be difficult for a layperson to understand, stating:

WHA covers Ajovy for injection for patients with a prior authorization for migraine headache prevention therapy when chart note documentation is provided supporting all of the following are met as a condition fox coverage: patient is ≥18 years of age; AND patient has ≥4 migraine headaches per month (prior to initiating a migraine-preventative medication); AND patient has tried at least two standard prophylactic pharmacologic therapies, each from a different pharmacologic class (e.g., angiotensin receptor blocker, angiotensin converting enzyme inhibitor, anticonvulsant, (β-blocker, calcium channel blocker, tricyclic antidepressant, other antidepressant), and meets ONE of the following criteria: A}: The patient has had inadequate efficacy to bath of those standard prophylactic pharmacologic therapies, according to the prescribing physician; OR B) The patient has experienced adverse events} severe enough to warrant discontinuation of both of those standard prophylactic pharmacologic therapies, according to the prescribing physician; OR C) The patient has had inadequate efficacy to one standard prophylactic pharmacologic therapy and has experienced adverse event{s) severe enough to warrant discontinuation to another standard prophylactic pharmacologic therapy, according to the prescribing physician; AND A} patient has not received a Botox injection in the past 8 weeks and B) patient will not be initiating Botox injection therapy; AND patient has tried and failed Aimovig and/or Emgality; AND Ajovy will not be used in combination with another CGRP receptor antagonist (e.g. Aimovig or Emgality). Ajovy has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions: Acute treatment of migraine, cluster headache, hemiplegic migraine. Initial approval is considered for 3 months. Renewal consideration is for 1 year if chart note documentation provided denotes a positive clinical response to Ajovy therapy.

TABLE 2
Medical Necessity Denial and Modification Files

FILE TYPE	NUMBER OF FILES	ELEMENT STATEMENT	COMPLIANT	DEFICIENT
Medical Necessity Denial and Modification Files	69	Letter includes a clear and concise explanation of the reason(s) for the Plan’s decision.	36 (52%)	33 (48%)

Follow-Up Report Deficiency Status: Not Corrected

Through review of the Plan’s medical necessity denial and modification files, the Department determined the Plan fails to consistently provide a clear and concise explanation of the reasons for its decision in the written notice sent to enrollees, as

required by Section 1367.01(h)(4). Based on the corrective actions undertaken, the Department finds the Plan did not correct this deficiency.

Deficiency #6: The Plan does not conduct adequate oversight of its delegates to ensure compliance with required utilization program standards.

Statutory/Regulatory References: Section 1367.01(a), (h)(4), and (j).

Plan's Follow-Up Compliance Effort: In its response to the Department's notice to conduct the Follow-Up Survey, the Plan provided a summary of its corrective actions, which stated:

> On February 1, 2019, Delegates who had not previously been subject to full oversight audits due to either being Deemed due to accreditation with NCQA and/or successful DMHC oversight audits ([Human Affairs International of California (HAI-CA)], Landmark Healthcare and Express Scripts, Inc.), were notified of our Corrective Action Plan from DMHC and WHA's intent to conduct full audits starting in late in 2019 and beyond. Prior to this change, these delegates provided regular performance reports and statistics like all other delegates. Additionally, regular meetings were held with Magellan Health to discuss performance statistics, improvement projects, and quality activities.

The Plan conducted audits of all three delegates in late 2019.

Supporting Documentation:

- Delegation Oversight Utilization Management (UM) Policy (January 2019)
- Magellan Behavioral Health UM Audit Summary Sheet 2019
- Landmark Healthcare UM Audit Summary Sheet 2019
- Express Scripts UM Audit Summary Sheet 2019
- Utilization Management Committee Meeting Minutes (August 28, 2019, September 25, 2019, December 4, 2019, February 26, 2020)
- WHA Delegated Medical Groups DO Audit 2019 (Hill Physicians Medical Group Audit, Mercy Medical Group Audit, Meritage Medical Group Network Audit, NorthBay Medical Group Audit, UC Davis Medical Group Audit, Woodland Clinic Medical Group Audit)

Follow-Up Survey Assessment: The Department reviewed the Plan's *Delegation Oversight Utilization Management* policy, which the Plan revised to state:

> Contracted entities delegated by WHA to perform UM activities that are NCQA accredited, if any, still need to undergo a comprehensive delegation oversight audit that includes file review to ensure compliance with requirements beyond or in addition to NCQA requirements.[26]

[26] *Delegation Oversight Utilization Management,* page 2.

The Plan's policy also outlines components of its audit process, including:

> Review of chart files for compliance with WHA's policies and NCQA/regulatory standards include but are not limited to:
>
> - appropriate staff making decisions (e.g., MDs only for denials);
> - turnaround times (issuing letters, making decisions, notifying affected parties);
> - Information provided in denial notice explaining appeal rights, including the right to request expedited appeal to the DMHC and plan simultaneously.
> - Name and phone number of health care professional responsible for the denial, delay or modification.[27]

The Department reviewed the Plan's 2019 audit results of HAI-CA, Landmark, and Express Scripts and found evidence the Plan conducted a full oversight audit of each delegate. The full oversight audit, including delegate file review, assessed compliance with specific Knox-Keene requirements, including:

- Use of qualified licensed healthcare personnel to make denials of coverage for reasons of medical necessity, and the inclusion of the reviewer's name and contact information, as required by Section 1367.01(e) and (h)(4).
- Telephone access or the equivalent to request authorizations, as required by Section 1367.01(i).
- Timely response to provider requests for authorization, as required by Section 1367.01(h)(1) through (4).
- The inclusion of CA Health and Safety Code Section 1368.02(b) in denial letter communications, as required by Section 1367.01(h)(4).

a. Medical Groups and IPAs

The Department also reviewed the Plan's 2019 audit results for its six delegated medical groups and found evidence the Plan assessed delegates' compliance with all required Knox Keene requirements for denial letters including:

- The person making the denial decision is a licensed or otherwise qualified healthcare professional, as required by Section 1367.01(e).
- The reviewing healthcare professional's name is included in the denial letter, as required by Section 1367.01(h)(4).
- The reviewer's contact phone number is included in the denial letter; as required by Section 1367.01(h)(4).

Follow-Up Report Deficiency Status: Corrected

[27] Ibid, page 4.

The Department finds that the Plan has taken appropriate actions to update its policy and ensure specific Knox-Keene requirements are included in the delegation oversight audit conducted on all delegated entities (specialty providers and medical groups).

Based upon the corrective actions undertaken, the Department determined the Plan corrected this deficiency.

CONTINUITY OF CARE

Deficiency #7: The Plan does not ensure timely screening of children for autism spectrum disorders (ASD) in accordance with professionally recognized standards of practice.

Statutory/Regulatory References: Section 1374.72(a) and (d)(7); Section 1374.73(a)(1); Rule 1300.74.73(a)(3)(D); Section 1370; Rule 1300.70(b)(1)(A)**.**

Plan's Follow-Up Compliance Effort: In its response to the Department's notice to conduct the Follow-up Survey, the Plan stated it revised its Preventive Health Guidelines to include ASD screenings. The Plan explained it included an article on *Primary Care Screening for ASD* in its 2019 Spring and 2020 Winter *Provider Insider Newsletter* issues. Finally, the Plan indicated it added review of medical group policies for an ASD screening process as an element in its Annual Medical Group Oversight audits. The Plan stated it would begin auditing for this element in 2021.

Supporting Documentation:

- Provider Web Portal Screenshot-Preventative Guidelines for Autism Spectrum Disorders
- Preventative Health Guidelines (Released April 2019)
- "Primary Care Screening for ASD" Article for 2019 Spring and Winter Provider Insider Newsletter
- Quality Improvement Committee Meeting Minutes (April 24, 2019)
- Delegation Oversight UM Audit Tool
- Delegation Oversight Utilization Management

Follow-Up Survey Assessment: The Department reviewed the Plan's Follow-Up compliance efforts to ensure the timely screening of children for autism spectrum disorders (ASD) in accordance with professionally recognized standards of practice.

The Department reviewed the Plan's revised *Preventative Health Guidelines* policy, which now require screening for autism during well child visits. The Plan also provided evidence its Quality Improvement Committee (QIC) approved these revised guidelines on April 24, 2019.

The Department also reviewed the Plan's *Delegation Oversight Utilization Management* policy, which the Plan revised to include assessment of delegated medical groups to ensure they maintain procedures for ASD screening. During interviews, the Plan explained it would use these revised audit measures starting in 2021.

Finally, the Plan submitted evidence it undertook measures to educate providers about timely screening for ASD through its Provider Web Portal and quarterly *Provider Insider* newsletter.

Follow-Up Report Deficiency Status: Corrected

The Plan established procedures for ensuring timely screening of children for ASD in accordance with professionally recognized standards of practice as defined in Rule 1300.70(b)(1)(A).

Based upon the corrective actions undertaken, the Department determined the Plan corrected this deficiency.

SECTION II: SURVEY CONCLUSION

Issuance of this Follow-Up Report concludes the Routine Survey of the Plan. The Department finds that the Plan has corrected three of the five the deficiencies that remained uncorrected upon issuance of the Final Report on April 4, 2019.

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. Please click on the following link to login: **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**, 2018 Routine Full Service Survey - Document Request.**
- Submit the response to the Follow-Up Report via the Department Communication tab.

If the Plan's corrective actions result in revisions to documents and/or information previously submitted to the Department's Office of Plan Licensing, or new documents required to be filed as an Amendment or Notice of Material Modification, please submit those documents to the Department's eFiling Web Portal using the File Documents link. Please indicate in the Exhibit E-1 that the filing is in response to the survey. All applicable documents must be submitted as an Amendment or Notice of Material Modification, as applicable (see Section 1352 and Rule 1300.52.4).

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