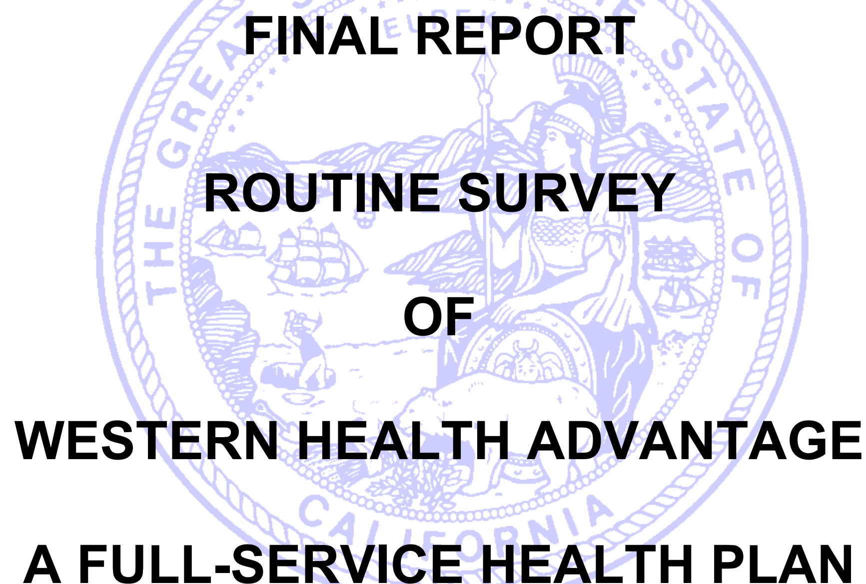
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS



FINAL REPORT

ROUTINE SURVEY

OF

WESTERN HEALTH ADVANTAGE

A FULL-SERVICE HEALTH PLAN

APRIL 14, 2026

Routine Survey Final Report
Western Health Advantage
A Full-Service Health Plan

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EXECUTIVE SUMMARY

On December 6, 2024, the California Department of Managed Health Care (Department) notified Western Health Advantage (Plan) that it would conduct its scheduled Routine Survey pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The Department's survey team conducted the onsite survey from May 6, 2025, through May 7, 2025.

The Department assessed Plan operations in the following areas:

- Quality Assurance
- Grievances and Appeals
- Access and Availability of Services
- Utilization Management
- Continuity of Care
- Emergency Services and Care
- Prescription Drug Coverage
- Language Assistance
- Behavioral Health – SB855

The Department identified **seventeen** deficiencies during the Routine Survey. The 2025 Survey Deficiencies Table below provides the status of each deficiency. The report describes each deficiency finding, Plan efforts to correct deficiencies and the Department's assessment of corrective action as well as the need for continued efforts and follow up.

2025 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	QUALITY ASSURANCE	
1	**The Plan did not consistently complete investigations involving quality of care issues within the timeframes established by its Quality Management Program.** Rule 1300.70(b)(2)(E) and (F).	**Not Corrected**
2	**The Plan did not consistently identify potential quality issues in exempt grievances.** Section 1370; Rule 1300.70(a)(1), (b)(1)(A)-(B).	**Not Corrected**
	GRIEVANCES AND APPEALS	
3	**The Plan did not consistently identify all expressions of dissatisfaction as grievances.** Section 1368(a)(1); Rule 1300.68(a)(1).	**Not Corrected**

4	**The Plan did not consistently resolve all issues raised in grievances.** Section 1368(a)(1); Rule 1300.68(a)(4).	**Not Corrected**
5	**The Plan's acknowledgment letters did not advise the complainant of the name of the Plan representative who may be contacted about the grievance.** Section 1368(a)(4)(A)(iii); Rule 1300.68(d)(1).	**Not Corrected**
6	**The Plan did not immediately notify enrollees of their right to contact the Department regarding their urgent grievance.** Section 1368.01(b); Rule 1300.68.01(a)(1).	**Not Corrected**
7	**The Plan did not correctly display the notice required by Section 1368.02(b) in the specified format.** Section 1368.02(b).	**Corrected**
	ACCESS AND AVAILABILITY OF SERVICES	
8	**The Plan did not provide an online interface for providers to submit provider directory verification or changes with an acknowledgment of receipt or a hyperlink to identify and report possible inaccurate, incomplete, or misleading information.** Section 1367.27(m)(2) and (3).	**Not Corrected**
	UTILIZATION MANAGEMENT	
9	**The Plan's denial, delay or modification communications to providers did not include a direct telephone number or extension of the healthcare professional responsible for the Plan's determination.** Section 1367.01(h)(4).	**Corrected**
10	**The Plan's delegate denial letters did not consistently include clear and concise explanations of reasons for the denials, descriptions of the criteria or guidelines used to make decisions, and the clinical reasons for the denials.** Section 1367.01(a), (h)(4) and (j).	**Not Corrected**
11	**The Plan did not disapprove requests for authorization to provide necessary post-stabilization medical care within one half-hour of the request or deem the care authorized.** Section 1371.4(a) and (j)(1); Rule 1300.71.4(b).	**Not Corrected**

	EMERGENCY SERVICES AND CARE	
12	**The Plan failed to maintain compliant emergency services and care policies and procedures.** Section 1367.01(b); 1371.4(a) and (c).	**Corrected**
	PRESCRIPTION DRUG COVERAGE	
13	**The Plan's pharmacy benefit manager did not include a copy of the form 61-211 on its website.** Section 1385.001; Rule 1300.67.241(d) and (e)(1).	**Corrected**
14	**The Plan’s formulary did not include a description of the coverage provided under the FDA-approved products through the outpatient prescription drug benefit.** Rule 1300.67.205(d)(16).	**Corrected**
15	**The Plan’s denial letters did not consistently include clear and concise explanations of reasons for denials, descriptions of criteria or guidelines used to make decisions, and clinical reasons for denials.** Section 1367.01(h)(4).	**Not Corrected**
	LANGUAGE ASSISTANCE	
16	**The Plan did not demonstrate that it informed enrollees of the timely availability of free language assistance and auxiliary aids and services.** Section 1367.042(a)(1) and (2).	**Not Corrected**
	BEHAVIORAL HEALTH – SB855	
17	**The Plan did not evidence that individuals responsible for making medical necessity decisions achieved interrater reliability testing pass rates.** Section 1374.721(e)(5) and (7).	**Not Corrected**

SURVEY OVERVIEW

The Department conducts a routine medical survey of each licensed health care service plan at least once every three years pursuant to Section 1380 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The survey evaluates the plan's health care delivery system and includes review and assessment of the plan's overall performance in providing health care benefits and meeting the health care needs of its enrollees in the following areas:

Quality Assurance – Quality assurance programs must be directed by providers, designed to monitor and assess the quality of care provided to enrollees, and ensure effective action is taken to improve the quality of care when necessary. The quality assurance program must address service elements, including accessibility, availability and continuity of care and must monitor whether the provision and utilization of services meets professionally recognized standards of practice.

Grievances and Appeals – Grievance systems must be in writing and include procedures for receiving, reviewing and timely resolving grievances. Plans must adequately consider, promptly review and appropriately document each grievance. A plan officer must have primary responsibility for the grievance system, providing continuous review to identify emergent patterns of grievances. Plans must provide information about the grievance system on its website and provide an online grievance submission process.

Access and Availability of Services – Plans must provide or arrange for the provision of health care services in a timely manner, appropriate for the enrollees' condition and consistent with good professional practice. Plan and provider processes necessary for obtaining services must be completed in a manner that ensures timely provision of care. Plans must have adequate processes to maintain and ensure the accuracy of the information in their provider directories.

Utilization Management – Each plan and any entity delegated to perform utilization management functions must ensure that decisions based on medical necessity are consistent with clinical criteria/guidelines; that utilization review and oversight operations are performed by appropriate personnel; and that enrollees and requesting providers receive timely and appropriate information concerning approvals, denials, and modifications of requested services.

Continuity of Care – Plans must furnish medical and mental health care services in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

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[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

Emergency Services and Care – Emergency medical and behavioral health services must be accessible and available, and plan determination of reimbursements made appropriately. Plans must also have post-stabilization procedures to ensure timely authorization of care or transfer of enrollees who are stabilized following emergency care and provide coverage or provision of medically necessary services when required.

Prescription Drug Coverage – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescription drugs, benefits, and services, and ensure it communicates benefit coverage information to enrollees.

Language Assistance – Each plan is required to implement a language assistance program to ensure enrollees have access to no cost interpretation and translation services.

Behavioral Health – SB 855 – Each plan is required to provide coverage for medically necessary treatment of mental health and substance use disorders that fall under any of the diagnostic categories listed in the Mental & Behavioral Disorders chapter of the most recent edition of the International Classification of Diseases (ICD) OR that are listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

PLAN BACKGROUND

As of January 14, 1997, Western Health Advantage (Plan) has been a licensed full-service health maintenance organization (HMO).

The Plan only offers HMO lines of business to enrollees in large, small and individual health plans, and enrollees in covered California and Medicare Advantage products.

The Plan's service area covers the full counties of Humboldt, Sacramento, Solano, Sonoma, Yolo, Napa, and Marin, as well as partial counties of Placer, Colusa, and El Dorado. The Plan has two provider networks (WHA Network and WHA Large). As of October 2024, commercial enrollment was 118,117 enrollees.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On December 23, 2025, the Department issued the Plan a preliminary report that described each deficiency, as well as the legal and factual basis for each deficient finding. In that report, the Department instructed the Plan to perform the following within 45 days of issuance of the preliminary report:

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

As part of the Plan's corrective action for Deficiency 11, the Director required retroactive review of the denied post-stabilization care claims identified in the deficiency, as well as all denied claims for post-stabilization care that were adjudicated on or after December 1, 2022 (the beginning of the file review period). The Plan's retroactive review was required to assess whether claims were inappropriately denied when the Plan took more than 30 minutes to approve or disapprove requests for post-stabilization care.

For each claim that should have been approved, the Director required the Plan to readjudicate the claim. As outlined in Deficiency 11 below, the Plan's corrective action was required to describe the process used to identify overpayments by enrollees or payments due to providers, and the steps taken to readjudicate the claims, as well as the anticipated time period for completion.

This Final Report describes the deficiencies identified by the Department, the Plan's 45-day response and proposed corrective actions, and the status of the deficiencies following the Department's review of the Plan's compliance efforts. Within 18 months of the issuance of this Final Report, the Department will reassess the uncorrected deficiencies for compliance, including deficiencies requiring more than 45 days to correct.

DEFICIENCIES

QUALITY ASSURANCE

Deficiency #1: The Plan did not consistently complete investigations involving quality of care issues within the timeframes established by its Quality Management Program.

Statutory and Regulatory References: Rule 1300.70(b)(2)(E) and (F).

Preliminary Assessment: Rule 1300.70(b)(2)(E) requires the plan to ensure appropriate licensed professional participation in quality assurance (QA) activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. Rule 1300.70(b)(2)(F) specifies there be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities.

The Plan's policy[2] states that review of a potential quality issue (PQI) will be completed within 60 days of receipt by the Plan and that cases scored at level 2 or greater, with corrective action plans (CAP) and/or with other interventions may be extended to 90 days.[3]

The Department reviewed 21[4] of the Plan's PQIs with severity levels of 2 to 3. In 15[5] (71%) of the 21 files, the cases were closed more than 90 days after receipt.

Case Examples

- **DMHC File 2:** The enrollee was scheduled for surgery at a hospital ambulatory surgery center and turned away over an insurance issue. The enrollee's primary insurance was with a non-contracted entity, but the enrollee had been authorized to use secondary insurance. The enrollee stated they were treated in a rude manner, and the staff violated their privacy by speaking loudly about protected health information in the waiting room.

The Plan's CAP was lengthy. The facility responded to the Plan by addressing most of the issues, some of which required further investigation. Although the Plan reviewed all issues, resolution took 208 days.

- **DMHC File 3:** An enrollee with autism was under the care of a gastroenterologist (GI specialist) for chronic pain. The enrollee had been waiting three months for an esophagogastroduodenoscopy (EGD).[6] The lengthy wait resulted in the enrollee having two emergency room visits and medication for pain. The physician felt the EGD should be done in a hospital. The specialist did not have privileges at a hospital within the Plan's network and the physician's partner was not approved because the services would have been performed outside the Plan's network. An appeal was sent, but the enrollee had the procedure done prior to the decision, citing a delay in care.

The Plan determined there was a lack of communication and action on the part of the GI specialist causing a delay in treatment. The CAP consisted of a review and questions about the actions taken by the GI specialist's office for the EGD procedure. The case was closed 170 days after receipt.

- **DMHC File 19:** An enrollee with Type 2 diabetes, using a continuous glucose monitor, was frustrated at the difficulty with the durable medical equipment vendor to obtain a sensor for a monitor. The vendor offered one month of supplies but stated it needed a new prescription and medical records. The vendor said it needed another prior authorization (PA), although it had only been two months. The vendor tried for two months to get an updated prescription from the physician. During the investigation, it was discovered the enrollee's PA listed the wrong insurance. There were other issues causing

[2] *QI-015-POL Potential Quality Issue (PQI) Management.*
[3] *QI-015-POL Potential Quality Issue (PQI) Management*, page 3.
[4] DMHC Files: 1-21.
[5] DMHC Files: 1-3, 5, 8, 10-13, 15-20.
[6] EGD is a procedure where the gastroenterologist uses a scope to view the inside of the patient's esophagus, stomach and small intestine to diagnose and treat digestive tract issues.

further delays including getting the authorization to the vendor and with the fax machine. The enrollee did not receive the sensors for two months after the physician's request.

The CAP satisfactorily reviewed all the issues, but the case was closed 142 days after receipt.

TABLE 1

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Potential Quality Issues-B Files	21	PQI closed within 90 days	6 (29%)	15 (71%)

Preliminary Findings: Based on review of the Plan's PQI policy and PQI files, the Department determined the Plan did not meet all requirements of Rule 1300.70(b)(2)(E) and (F). The Plan did not consistently complete investigations involving quality of care issues within timeframes established by its Quality Management Program. Therefore, the Department found the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan acknowledges and agrees with the Department's preliminary finding that the Plan did not consistently complete investigations involving quality of care issues within the timeframes established by its Quality Management Program. The Plan explained that beginning in 2023, the Appeals & Grievances Department assumed responsibility for PQI that were previously managed by the Quality Department. This transition, along with an increase in both the volume and complexity of PQI, as well as staffing challenges impacted the ability to consistently complete PQI investigations within established timeframes. However, the Plan remained committed to conducting thorough and substantive investigations for each PQI by reviewing each case to identify contributing factors, assess quality-of-care concerns, and ensure appropriate provider and staff education. Where applicable, CAPs were developed and implemented. The Plan believes the CAPs submitted during the review period appropriately addressed identified quality concerns and resulted in meaningful corrective actions, even when investigation closure exceeded required timeframes.

In October 2025, the Plan successfully hired a full-time Appeals & Grievances Registered Nurse whose primary responsibility is oversight, investigation, and timely resolution of PQI in compliance with Quality Management Program timelines. Effective January 2026, the Plan implemented ongoing oversight mechanisms to monitor the performance and effectiveness of the Appeals & Grievances Nurse including PQI investigation timeliness, case volume, and closure outcomes through monthly performance reports monitored by Appeals & Grievances leadership. Any identified delays or adverse trends are escalated to management and addressed through

corrective actions. These monitoring activities will support sustained compliance and early identification of potential risks to timely PQI resolution.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by implementing new processes including oversight by Appeals and Grievance leadership to monitor the performance and effectiveness of the newly hired nurse, investigation of PQI timeliness, case volume, and closure outcomes through monthly performance reports. While the Plan's corrective actions address this deficiency, the Plan's efforts are ongoing, and the Plan needs more time to implement corrective actions. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the Plan corrected the deficiency. The assessment may include a review of PQI files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan's progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan's compliance during the Follow-Up Survey.

Deficiency #2: The Plan did not consistently identify potential quality issues in exempt grievances.

Statutory and Regulatory References: Section 1370; Rule 1300.70(a)(1), (b)(1)(A)-(B).

Preliminary Assessment: Section 1370 requires the plan to continuously review quality of care. Rule 1300.70(a)(1) requires the plan's QA program to document that the quality of care provided is being reviewed. Rule 1300.70(b)(1)(A) and (B) requires the plan to ensure "a level of care which meets professionally recognized standards of practice is being delivered to all enrollees" and "quality of care problems are identified and corrected for all provider entities."

The Plan defines a PQI as

> "[a]n issue brought forward by a Grievant related to quality of care or service, timely access to care, the quality of a practitioner's office site, or any other issue or system problem with the potential to result in delayed diagnosis or treatment, temporary or permanent harm to the Member, or failure to meet expected legal, regulatory, or community standards."[7]

Plan staff are trained to listen to words or phrases that may indicate a quality issue, such as "refusal to provide routine appointment within 10 days for [primary care physician (PCP)]," "unrelieved pain or other symptoms," or "medication problems."[8] If

[7] PQI Training; Appeals & Grievances, page 2.
[8] *Id*., page 3.

the enrollee states these words or phrases, Plan staff should refer the grievance to the appeals and grievance (A&G) nurse for a PQI review.[9]

The Department reviewed 69 exempt grievance files and found seven[10] files contained a PQI. Of the seven files, six[11] files (86%) were not referred to the A&G nurse for PQI review.

Case Examples

- **DMHC File 12:** The enrollee contacted the Plan on November 17, 2023, due to difficulties in scheduling a timely appointment with a PCP. The enrollee stated he had pain in his head and felt dizzy when looking down. He went to urgent care but was told they did not do bloodwork and was advised to see his provider. The enrollee contacted providers on the Plan's provider directory and was told either the provider was not accepting new patients or that the soonest appointment was in January. The enrollee understood he would not be seen on the same day but requested an appointment sooner than January.

There was no evidence this grievance was referred to quality review, even though the enrollee stated several key words and/or phrases including there had been a "refusal to provide routine appointment within 10 days for PCP" and that he had "unrelieved pain or other symptoms." According to the Plan's PQI training, this file should have been referred to the A&G nurse for PQI review.

TABLE 2

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievance Involving a PQI	7	Grievance referred to quality review as a PQI	1 (14%)	6 (86%)

Preliminary Findings: Based on review of the Plan's exempt grievance files and supporting documentation, the Department found the Plan did not consistently identify PQI in grievances and refer them to the A&G nurse as required by Section 1370, Rule 1300.70(a)(1), (b)(1)(A)(B), and its own PQI training. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan acknowledges the Department's finding that PQI were not consistently identified in exempt grievances in accordance with applicable statutory and regulatory requirements.

Effective immediately, the Plan will conduct monthly periodic reviews of exempt grievance files received during the prior month(s) to assess compliance with PQI

[9] *Id.*, page 4.
[10] DMHC Files: 4, 12-14, 20, 24, 50.
[11] DMHC Files: 4, 12-14, 24, 50.

identification and referral requirements. Review findings will be monitored by the Utilization Management Supervisor, in collaboration with the Appeals & Grievances Supervisor, and will be used to reinforce training, promote consistency in screening and referral practices across departments, and support continuous quality improvement. In addition, the Appeals & Grievances Department will collaborate with Member Services leadership, Training, and the Quality Assurance team to support oversight and monitoring of member inquiries including review of inquiries that may warrant processing as exempt grievances and/or referral as PQI.

To address this finding and strengthen consistent identification of PQI, the Plan is implementing the following corrective actions:

- **Enhanced PQI Screening Standards:**

  Beginning February 2026, the Plan will hold meetings to reinforce standardized PQI screening criteria to ensure exempt grievances are consistently reviewed for indicators of potential quality issues, including access to care, delays in treatment, disruptions in care, or potential clinical risk.

- **Cross-Departmental Training:**

  The Plan will implement coordinated, cross-departmental training involving Member Services and the Appeals & Grievances Department to promote a shared understanding of PQI identification requirements. The training will emphasize:

- Regulatory standards governing PQI identification and referral.
- PQI indicators encountered during member contacts and grievance intake.
- The requirement that PQI screening and referral are independent of whether a member elects to file a grievance or completes a contact.
- Clear roles and handoffs between Member Services and Appeals & Grievances to ensure timely referral for quality review.

- **Standardized Referral Process:**

  The Plan is reinforcing existing procedures to ensure exempt grievances meeting PQI criteria are consistently referred to appropriate clinical staff for quality review in accordance with the Plan's Quality Management Program.

- **Ongoing Oversight and Monitoring:**

  The Plan will conduct monthly periodic reviews of exempt grievance files to assess compliance with PQI identification and referral requirements. Review results will be used to reinforce training, promote consistency across departments and support continuous improvement.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by conducting monthly periodic review of exempt grievance files to assess compliance with PQI identification and referral requirements. While the Plan's corrective actions address this deficiency, the Plan's efforts are ongoing, and the Plan needs more time to implement corrective actions. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the Plan corrected the deficiency. The assessment may include a review of Exempt Grievance files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan's progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan's compliance during the Follow-Up Survey.

GRIEVANCES AND APPEALS

Deficiency #3: The Plan did not consistently identify all expressions of dissatisfaction as grievances.

Statutory and Regulatory References: Section 1368(a)(1); Rule 1300.68(a)(1).

Preliminary Assessment: Section 1368(a)(1) requires the plan to ensure adequate consideration and rectification of all enrollee grievances. Rule 1300.68(a)(1) and the Plan's grievance policy[12] defines a grievance as a "written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative." Rule 1300.68(a)(1) clarifies that "[w]here the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance."

The Department reviewed 71 call inquiry files and found 34[13] files (48%) contained an expression of dissatisfaction. However, the Department found no documentation the Plan identified and processed the expression of dissatisfaction as a grievance.

Case Example

- **DMHC File 16:** The enrollee called and complained about two hospitals providing conflicting information about the location to obtain a fluoroscopy procedure. The enrollee stated she was tired of the hospitals and would like to know directly from the Plan which hospital she was authorized to get the fluoroscopy. The member services representative (MSR) informed the enrollee that it is the medical group, not the Plan, that authorizes the location.

[12] *Identifying Grievances / Exempt Grievances / Appeals* (June 2024), page 1.
[13] DMHC Files: 3, 4, 8, 15-17, 22, 26, 28-32, 37-39, 42, 44, 45, 46, 48, 49, 52, 55, 60, 62, 64, 68, 70, 72, 73, 75, 77, 78.

> Another option was that the enrollee could request the provider to submit a request for a specific location. The enrollee was upset and frustrated that it was so difficult to obtain authorization for the location of this procedure. The enrollee stated, "So, [the request] go to my doctor: my regular doctor or my specialist? You realize how insane this is, right? You are my insurance. I need somebody to answer something and not get screwed and get stuck with a $5,000 bill."

The Department found no evidence in the file to demonstrate the Plan processed the enrollee's complaint through its grievance system.

TABLE 3

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Call Inquiry	71	Expression of dissatisfaction processed as a grievance	37 (52%)	34 (48%)

Preliminary Findings: Based on review of the Plan's call inquiry files, the Department found the Plan did not consistently identify and process all oral expressions of dissatisfaction as grievances, and thereby ensure adequate consideration and rectification as required by Section 1368(a)(1) and Rule 1300.68(a)(1). Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan acknowledges in part the Department's finding that the Plan did not consistently identify all expressions of dissatisfaction as grievances.

The Plan respectfully disputed findings related to File 17 and 78. The Plan contends File 17 was correctly categorized as an inquiry instead of an exempt grievance because the enrollee's sibling called about the enrollee's behavioral health benefit and there was no expression of dissatisfaction. The Plan stated File 78 was an exempt grievance because the Plan had multiple grievances on file at the time of the call.

The Plan identified three reasons for this deficiency:

- Member-facing representatives could apply greater conformity to the grievance policies/guidance in Support Point, the Plan's knowledgebase system.
- Member-facing representatives need to better understand the definition of an inquiry versus an expression of dissatisfaction.
- Premium Billing dissatisfaction needs to be handled differently.

  The Plan's corrective actions include:

- In July 2025, the Member Services team added a Learning & Development Specialist.

- Beginning in October 2025, SupportPoint was updated to ensure that instructions are current and mirror guidance in existing policies and as provided in new hire/refresher training. This is a continual process to ensure instructions and guidance meet the need of member-facing staff.

- Member Services conducted training in October 2025 to clarify the differences between a grievance and an inquiry, how to code them in the Plan's systems, and resolution time frames.

- Premium Billing training was performed in October 2025 to ensure that inquiries about member invoices were able to be managed as a "first-touch resolution" as opposed to transferring to another department for assistance.

- Member Services Representatives' (MSR) performance is continuously monitored to review appropriate call classifications. Staff are coached via routine Quality Assurance (QA) Audits and one-on-one reviews with Supervisor.

- The QA Specialist team looks for trigger words, context and tone that would identify if a call is an expression of dissatisfaction. When the MSRs categorize the call as an exempt grievance, the supervisors review and validate the case prior to sending it to Member Relations to ensure the documentation is resolved within one business day.

- The department director reviews monthly call reports to ensure member service representatives handle calls within the department and does not transfer members to Premium Billing.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by training staff and providing oversight of the Plan's new process to ensure expressions of dissatisfaction are identified within inquiries. While the Plan's corrective actions address this deficiency, the Plan's efforts are ongoing, and the Plan needs more time to implement corrective actions.

The Department further acknowledges the Plan disputes the findings associated with Files 17 and 78. However, the Plan's documentation of the identification of grievances within these files was primarily at issue and therefore the Department finds no grounds for revising this deficiency. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the Plan corrected the deficiency. The assessment may include a review of Call Inquiry Files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan's progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan's compliance during the Follow-Up Survey.

Deficiency #4: The Plan did not consistently resolve all issues raised in grievances.

Statutory and Regulatory References: Section 1368(a)(1); Rule 1300.68(a)(4).

Preliminary Assessment: Section 1368(a)(1) requires the plan's grievance system to "provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate." Rule 1300.68(a)(4) and the plan's grievance policy[14] define "resolved" when "the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system."

The Department reviewed 69 exempt grievance files and 70 standard grievance files and found that 33[15] exempt grievance files (48%) and 23[16] standard grievance files (33%) did not demonstrate the Plan resolved all issues.

Case Examples

- **Exempt Grievance File 19:** The enrollee contacted the Plan to understand why they were charged $18.99 for a prescription. While the MSR waited for further assistance, the MSR returned to the enrollee's call to verify the prescription. The enrollee became extremely angry and disconnected the call. The file was routed to the Appeals and Grievance (A&G) Department and was closed as resolved on the same day.

The file contained no documentation the Plan contacted the enrollee for further investigation or ever conducted any research whether the enrollee had been charged incorrectly. Although the grievance was closed, there was no documentation demonstrating resolution of this grievance.

- **Standard Grievance File 43:** The enrollee contacted the Plan because over a bill received from Quest Diagnostics. The enrollee submitted a previous grievance on the same issue which resulted in the enrollee not being responsible for the bill. The Plan's resolution, again, confirmed the enrollee was not responsible for this bill and to allow 10-14 business days for the medical group and Quest Diagnostics to resolve the bill. The grievance was closed as resolved on August 30, 2024.

On September 24, 2024, the Plan emailed the medical group to request information about this bill. The email noted the issue remained "unresolved" and that "the member continues to call WHA," and that the "member submitted a new grievance due to

[14] *Exempt Grievance and Grievance Management Policy – AGP-04-POL* (June 26, 2024), page 12.
[15] Exempt Grievance Files: 1, 2, 5-7, 9-11, 14, 15, 18-20, 23, 24, 29, 30, 32, 36, 38, 41, 47, 50-52, 54-58, 62, 63, 68.
[16] Standard Grievance Files: 5, 7, 10, 12, 13, 18, 25, 27, 30, 31, 37, 41, 43-45, 47-49, 51, 54, 59-61.

receiving another bill from Quest Diagnostics" for the same date of service. The email requested the medical group to "work with Quest Diagnostics to have the account adjusted" and to "please provide confirmation that the check to Quest was cashed."

The file contained no further documentation the medical group ever responded to the Plan, including whether the check to Quest Diagnostics was cashed. There was no documentation demonstrating the Plan resolved the enrollee's grievance.

TABLE 4

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievance	69	Resolved all issues raised in the grievance	36 (52%)	33 (48%)
Standard Grievance	70	Resolved all issues raised in the grievance	47 (67%)	23 (33%)

Preliminary Findings: Based on review of the Plan's exempt and standard grievance files, the Department found the Plan did not consistently resolve all issues raised in grievances as required by Section 1368(a)(1) and Rule 1300.68(a)(4). Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan acknowledges the Department's finding. Based on the Plan's internal review of the files cited in the Preliminary Report, the Plan notes that in many instances, substantive actions were taken to address the member's concerns. These actions included claim reprocessing requests, provider and medical group outreach, escalation to delegated entities, benefit education, system corrections, and referrals to appropriate departments.

The Plan recognizes that although actions were often initiated or completed, the documentation within the grievance file did not always clearly demonstrate all issues raised by the member reached a final conclusion, as determined by the Department. In particular, the Plan understands that grievance records should clearly reflect how each issue raised was addressed and brought to closure within the Plan's grievance system.

The Plan further notes that certain grievance issues may need additional review such as claim reprocessing, provider billing adjustments, eligibility corrections, or delegated entity actions. These grievances may require coordination with external entities and systems outside of the Plan's direct control. In these circumstances, the Plan's resolution activities may include initiating corrective actions, providing direction to the responsible entity, and communicating expected next steps to the member, even though the final external action or system update may occur outside the grievance timeframe.

In addition, the Plan acknowledges that its Grievance and Appeals case management system has functional limitations that affect how multiple issues are captured and documented. The system does not allow staff to select multiple reasons, categories, or subcategories within a single case record. As a result, when a member raises more

than one distinct issue, the Plan must create separate cases to accurately capture and track each issue. In certain situations, the Plan creates a new case based on the original record. In doing so, the Plan does not alter or edit the original intake documentation or “Case Notes” associated with the initial expression of dissatisfaction. For these cases, the Plan documents the reason for creating the new case and clearly identifies the specific issue being addressed. For these cases, the Plan continues to apply the original date of dissatisfaction or appeal to ensure compliance with grievance and appeal to timeliness requirements.

The Plan acknowledges that its documentation did not always clearly explain these system driven practices within the grievance record, which may have contributed to the appearance in the Department’s review that some issues were not fully resolved within a single case file.

While the Plan maintains that staff acted in good faith to advocate for members and initiate appropriate corrective actions, the Plan agrees that enhancements are necessary to more clearly demonstrate resolution of all issues raised.

To address this deficiency, the Plan has implemented and/or will implement the following corrective actions:

- **Clarified Documentation of Resolution Activities**

  The Plan has clarified internal guidance to ensure grievance documentation reflects the Plan’s review, analysis, and intervention activities for each issue raised, including when resolution requires coordination with external entities. Internal guidance, such as workflows, job aids, and quick reference guides will be discussed and distributed to Appeals and Grievance staff during our upcoming meetings in February 2026.

- **Issue Identification and Segmentation**

  Staff are required to identify and document each distinct issue raised during a grievance. When system limitations require the creation of separate cases, staff must clearly document the relationship between cases and the specific issue addressed in each.

- **Documentation of Cloned Cases**

  The Plan has reinforced requirements to explicitly document when and why a case is cloned, to identify the issue addressed in the cloned case, and to confirm that the original date of dissatisfaction or appeal is preserved for timeliness purposes.

- **Distinction Between Plan Action and Effectuation**

  The Plan has reinforced documentation standards that distinguish between actions completed by the Plan within the grievance process and

the subsequent effectuation of those actions by providers, medical groups, or delegated entities.

- **Targeted Training**

  The Plan has initiated targeted retraining for Member Services and Appeals and Grievances staff by March 2026. Training focuses on documentation expectations for grievance resolution; appropriate characterization of Plan actions versus effectuation; identification and separation of multiple issues raised in a single grievance; and the Department's focus on member impact and clarity of documentation.

- **Enhanced Quality Oversight**

  The Plan has enhanced quality assurance reviews of grievance documentation to ensure that grievance records accurately reflect the Plan's actions and the resolution status of each issue prior to case closure. The Plan remains committed to ensuring grievances are thoroughly reviewed, appropriately addressed, and clearly documented in accordance with regulatory requirements.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by improving documentation within files to demonstrate resolution of all issues in addition to training and oversight. While the Plan's corrective actions address this deficiency, the Plan's efforts are ongoing, and the Plan needs more time to implement corrective actions. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the Plan corrected the deficiency. The assessment may include a review of Exempt and Standard Grievance files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan's progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan's compliance during the Follow-Up Survey.

Deficiency #5: The Plan's acknowledgment letters did not advise the complainant of the name of the Plan representative who may be contacted about the grievance.

Statutory and Regulatory References: Section 1368(a)(4)(A)(iii); Rule 1300.68(d)(1).

Preliminary Assessment: Section 1368(a)(4)(A)(iii) and Rule 1300.68(d)(1) require the plan to provide for a written acknowledgment advising the complainant of the name of the plan representative who may be contacted about a grievance.

The Department reviewed 31 standard grievance files[17] and found none of the letters including the name of the Plan representative who could be contacted about the grievance. The Department found the letters only provided the following general statement: “If you have any questions regarding your grievance please contact the WHA Member Services Department.”

TABLE 5

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance	31	Acknowledgment letter with name of the Plan representative who may be contacted about the grievance	0 (0%)	31 (100%)

Preliminary Findings: Based on review of the Plan’s standard grievance files and interviews with Plan staff, the Department found the Plan did not provide for a written acknowledgment advising the complainant of the Plan representative who may be contacted about the grievance as required by Section 1368(a)(4)(A)(iii) and Rule 1300.68(d)(1). Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Plan’s Compliance Effort: In its response to the Preliminary Report, the Plan respectfully disputed this finding by explaining the Plan completed a secondary review of all 31 standard grievance files and confirmed that each file included the full first and last name of the assigned Appeals & Grievances representative in the signatory section of the correspondence as detailed in the Plan’s policy under efiling 20222499.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by reviewing whether the name of the assigned Appeals & Grievance representative was included in the signatory section of the correspondence. However, the Plan’s response also discussed that in January 2025 the name of the representative was temporarily removed from Appeals & Grievance correspondence in accordance with efiling 20260556, which has now been withdrawn. While the Plan’s corrective actions address this deficiency, the Plan’s efforts are ongoing, and the Plan needs more time to implement corrective actions and to demonstrate the name of the representative is included in Appeals & Grievance correspondence. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan’s implementation of corrective action and whether the Plan corrected the deficiency. The assessment may

[17] DMHC Files: 1-31.

include a review of Standard Grievance files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan's progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan's compliance during the Follow-Up Survey.

Deficiency #6: The Plan did not immediately notify enrollees of their right to contact the Department regarding their urgent grievance.

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

Preliminary Assessment: Section 1368.01(b) and Rule 1300.68.01(a)(1) require the plan to immediately notify enrollees of their right to contact the Department regarding their urgent grievance. An urgent grievance involves an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily functions. Rule 1300.68.01(a)(1) further clarifies this immediate notice need not be in writing but may be accomplished by a documented telephone call.

The Department reviewed 56 expedited grievance files and found 11[18] files (20%) did not document the enrollee was immediately notified of their right to contact the Department regarding their urgent grievance.

TABLE 6

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Grievance	56	Enrollee was immediately informed of their right to contact the Department regarding their urgent grievance	45 (80%)	11 (20%)

Preliminary Findings: Based on review of the Plan's expedited grievance files, the Department found the Plan did not immediately notify enrollees of their right to contact the Department regarding their urgent grievance as required by Section 1368.01(b) and Rule 1300.68.01(a)(1). Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan acknowledges the preliminary determination that in a subset of expedited grievance files reviewed, documentation did not consistently demonstrate enrollees were immediately notified of their right to contact the Department regarding their urgent grievance.

[18] DMHC Files: 2, 9, 15, 16, 18, 28, 35, 37, 41, 47, 57.

The Plan remains committed to maintaining an expedited grievance process that ensures timely communication of enrollee rights and documentation practices consistent with statutory and regulatory expectations.

Following an internal review of the files identified by the Department, the Plan determined the preliminary finding is associated with documentation clarity and workflow sequencing variations observed in certain cases. The Plan's review further indicated that in many of the cited cases, Appeals & Grievances staff initiated member outreach on the same day or shortly after receipt or a Plan decision that the case required an expedited determination. However, because regulatory compliance requires the immediate notification to the enrollee of their right to contact the Department be clearly documented in the case record, the Plan's documentation variability contributed to the Department's findings.

To address the Department's findings and to strengthen the Plan's consistency with expedited grievance notification requirements, the Plan is implementing the following corrective actions:

- **Clarification of Immediate Notification Requirements**

  Staff are being reminded that this notification must occur at the time a grievance is identified or deemed expedited, independent of written correspondence.

- **Standardization of Call Documentation**

  The Plan is implementing standardized call note expectations for expedited grievances to ensure explicit documentation that the enrollee's rights to contact the Department were communicated. This will apply to both live contact and voicemail messages. Documentation must clearly reflect the content of the notification provided.

- **Reinforcement of Intake and Routing Practices**

- o Targeted education is being provided to Member Services and Appeals and Grievance staff to reinforce early identification of expedited grievance criteria and prompt routing for review.
- o Once urgency is identified, emphasis is placed on timely Appeals and Grievance involvement.

- **Senior or Supervisory Oversight of Expedited Cases**

- o Senior staff or Supervisory review will include confirmation that immediate DMHC notification. outreach is documented prior to case closure.
- o Opportunities for clarification or correction will be addressed during case review.

- **Written Correspondence Practices**

- The Plan clarified internally that while written acknowledgment and resolution letters continue to be issued timely, regulatory compliance for "immediate" notification is met through documented verbal outreach, consistent with statute and regulation.

- Written correspondence may be sent via USPS, as overnight delivery is not required by law.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by improving documentation within files of the Plan's expedited grievance notification to enrollees in addition to training and oversight. While the Plan's corrective actions address this deficiency, the Plan's efforts are ongoing, and the Plan needs more time to implement corrective actions. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the Plan corrected the deficiency. The assessment may include a review of Expedited Grievance files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan's progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan's compliance during the Follow-Up Survey.

Deficiency #7: The Plan did not correctly display the notice required by Section 1368.02(b) in the specified format.

Statutory Reference: Section 1368.02(b).

Preliminary Assessment: Section 1368.02(b) requires the plan to publish specific information about the Department on every Plan contract, evidence of coverage, grievance procedures, complaint forms, and all written notices to enrollees required under the plan's grievance process. In each of these documents, Section 1368.02(b) mandates the plan include the following notice verbatim and display the Department's telephone number, the Department's TDD line, the plan's telephone number, and the Department's internet website address in 12-point boldface type:

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

> process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

The Department reviewed several Plan documents[19] and found the Plan did not include Section 1368.02(b) notice language verbatim.

Preliminary Findings: Based on review of the Plan's supporting documentation and letter templates, the Department found the Plan did not consistently display the required notice in the manner specified by Section 1368.02(b). Therefore, the Department finds the Plan in violation of this statutory requirement. Additionally, this deficiency is a repeat of Deficiency #2 in the 2021 Routine Survey.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan acknowledges the Department's finding regarding Grievance and Appeal templates not displaying the notice required under Section 1368.02(b). The Plan identified this issue in October 2025 during a review of Grievances and Appeals (G&A) correspondence templates in addition to the Plan documents reviewed by the Department.

On October 22, 2025, the Plan updated all applicable Grievance and Appeal templates to ensure the Section 1368.02(b) notice language is included verbatim and displayed in the required 12-point boldface type, including the Department's telephone number, TDD line, the Plan's telephone number, and the Department's website. All revised Grievance and Appeal templates were uploaded and implemented in the Plan's platform no later than November 1, 2025. These updates apply to all current and future grievance and appeal correspondence generated by the Plan.

Eighteen (18) appeals and grievances (A&G) and three (3) clinical resources (CR) template letters have been updated to comply with HSC 1368.02(b).

The 2026 Member Guidelines has been updated to comply with Section 1368.02(b). Refer to pages 17-18.

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[19] The Plan documents included the following: *Member Guidelines, Combined Evidence of Coverage and Disclosure Form; Individual, Combined Evidence of Coverage and Disclosure Form; Individual Advantage, Combined Evidence of Coverage and Disclosure Form; Large Group Combined Evidence of Coverage and Disclosure Form; Small Group, Filing a Grievance,* Pre-Service Denial Letter Template, Exper Denial LtrTemp-Terminall Ill, Second Opinion Denial Template, Appeal Request Acknowledgement letter template, Appeal Acknowledgement/Resolution – Untimely Filing letter template, Appeal Review Resolution letter template, Appeal Extension letter template, Appeal Approval Resolution letter templates, Appeal Withdrawal letter template, Expedited Grievance Request Acknowledgement letter template, Expedited Appeal Request Acknowledgement letter template, Expedited Appeal Criteria Not Met Acknowledgement letter template, Expedited Grievance Criteria Not Met Acknowledgement letter template, Grievance Acknowledgement letter template, Grievance Acknowledgement/Resolution letter template, Coverage Dispute letter template, Grievance Extension letter template, Grievance Resolution letter templates, Grievance Withdrawal letter template.

The Plan has noted inconsistent updates in the EOCs. Additional reviews and corrections will be identified for 2025/2026 EOCs.

The Plan will continue to monitor template updates through review processes to ensure ongoing adherence to Section 1368.02(b).

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department determined this deficiency is corrected.

The Department reviewed the Plan's letter templates and member guidelines submitted in support of the Plan's CAP and found that the Plan has taken sufficient corrective action to ensure the required notice is displayed correctly.

ACCESS AND AVAILABILTY OF SERVICES

Deficiency #8: The Plan did not provide an online interface for providers to submit provider directory verification or changes with an acknowledgment of receipt or a hyperlink to identify and report possible inaccurate, incomplete, or misleading information.

Statutory and Regulatory Reference: Section 1367.27(m)(2) and (3).

Preliminary Assessment: Section 1367.27(m)(2) and (3) requires the plan to provide an online interface for providers to submit provider directory verification or changes with an acknowledgment of receipt. There must also be a website hyperlink and form for enrollees, potential enrollees, other providers, and the public, to identify and report possible inaccurate, incomplete, or misleading information. The Department reviewed the Plan's online[20] Provider Directory and was unable to locate an online process for submitting inaccuracies and changes.

During interviews with Plan staff, the Plan confirmed the information technology (IT) department was working to develop an online interface to report Provider Directory changes and inaccuracies.

Preliminary Findings: Based on review of the Plan's website and interviews, the Department determined the Plan did not provide an online interface for providers to submit provider directory verification or changes and no hyperlink to identify and report possible inaccurate information as required by Section 1367.27(m)(2) and (3). Therefore, the Department found the Plan in violation of this statutory requirement.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan acknowledges the Department's finding that the Plan did not provide an online interface for providers to submit provider directory verification or changes and no hyperlink to

[20] Plan's Provider Directory (May 7, 2025).

identify and report possible inaccurate information as required by Section 1367.27(m)(2) and (3).

The Plan performs continuous provider validations and updates to its provider directory. Along with internal quarterly provider reviews the Plan works with two provider data validation vendors, IHA/Symphony and Quest Analytics / BetterDoctor to supplement provider directory activities. These validation vendors offer an online interface for providers to securely log in to change and attest to their directory information.

Western Health Advantage currently offers a secure email option through directory@westernhealth.com for providers to report directory inaccuracies. This option is available on the Plan's online provider directory by selecting the Menu and then either the "Verification Process" or "Provider Search FAQ" dropdown selections. The Plan notes that during the survey review time period to present, the Plan has not received any reports of inaccuracies to the email address. Also, the automatic acknowledgement emails generated by the secure email system were not functioning as intended but the Plan expects resolution by February 2026. The Plan updated its policy and procedure to include the quarterly review and testing of the directory@westernhealth.com email acknowledgements are successfully sent to the submitter.

The Plan expects the online interface to be operational by the end of the third quarter of 2026 which will allow providers to promptly verify or submit changes to their information. These submissions will receive an electronic acknowledgment to let the submitter know the information provided has been received and will be reviewed in accordance with applicable regulatory requirements and established provider directory review and correction procedures. This site will be tested quarterly to ensure that the automatic acknowledgements are functioning properly.

The Plan has filed policy updates to its policy PR-001-POL-Provider Directory under filing #20260557.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by providing an online interface to verify and submit changes to provider information with an acknowledgement that the Plan received the information. While the Plan's corrective actions address this deficiency, the Plan's efforts are ongoing, and the Plan needs more time to implement corrective actions. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the Plan corrected the deficiency. The assessment may include a review of the Plan's website, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan's progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan's compliance during the Follow-Up Survey.

UTILIZATION MANAGEMENT

Deficiency #9: The Plan's denial, delay or modification communications to providers did not include a direct telephone number or extension of the healthcare professional responsible for the Plan's determination.

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

Preliminary Assessment: Section 1367.01(h)(4) requires plan written communications to the requesting provider of a denial, delay, or modification of a request to include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided must be a direct number, or an extension, to allow the requesting provider to easily contact the professional responsible for the denial, delay, or modification.

The Plan's *Denial Process* policy provides provider communications to include the name, title, and direct phone number of the person making the utilization management (UM) determination to allow the requesting provider to contact the person at the Plan who made the adverse decision.[21]

The Department reviewed 27 UM files[22] and found that none of the written provider communications included the direct number or extension of the professional responsible for the denial, delay, or modification.

TABLE 7

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Utilization Management	27	Written provider communications include a direct telephone number or extension for the professional responsible for the decision	0 (0%)	27 (100%)

Preliminary Findings: Based on UM file review, the Department found the Plan's communications did not include a direct telephone number or extension of the healthcare professional responsible for the decision as required under Section 1367.01(h)(4). Therefore, the Department found the Plan in violation of this statutory requirement.

[21] *Denial Process,* Policy Statements, page 2.
[22] DMHC Files: 1, 3, 5-10, 12-27, 29-31.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan respectfully disagrees with the Department's finding that the Plan's denial, delay, or modification communications to providers did not include the name and direct telephone number of the healthcare professional responsible for the determination.

Health and Safety Code section 1367.01(h)(4) requires that written communications to the requesting provider regarding a denial, delay, or modification include the name and telephone number of the healthcare professional responsible for the determination.

When letters are generated, the notices sent to the member and the provider are copies. The name of the healthcare professional responsible for the determination is supplied to the provider in an addendum attached to the provider copy, in order to facilitate peer-to-peer reviews and communications.

During the audit period, all provider denial, delay, or modification letters included the name and title of the physician reviewer in the signatory section of the letter, clearly identifying the healthcare professional responsible for the determination. In addition, each letter included a standardized addendum titled "ADDENDUM FOR REQUESTING PHYSICIAN ONLY," which expressly provided the reviewing physician's name and a telephone number for physician-to-physician discussion and requests for the criteria used to make the determination. These addenda were included as part of the written provider communication and were directed specifically to the requesting physician. The telephone number provided connected requesting providers to Western Health Advantage's physician peer-to-peer line dedicated to utilization management discussions and physician review.

The Plan submitted a spreadsheet report cross-referencing each reviewed utilization management letter with the specific page of the corresponding addendum which demonstrated that the reviewing physician's name and telephone number was included in each letter reviewed during the audit period.

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department determined this deficiency is corrected.

The Department reviewed the Plan's spreadsheet report and corresponding addendum and determined the reviewing physician's name and telephone number was included in each letter and therefore the Plan's denial, delay and/or modification communications to providers include a direct telephone number or extension of the healthcare professional responsible for the Plan's determination.

Deficiency #10: The Plan's delegate denial letters did not consistently include clear and concise explanations of reasons for the denials, descriptions of the criteria or guidelines used to make decisions, and the clinical reasons for the denials.

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

Preliminary Assessment: Section 1367.01(a) requires the plan and "any entity with which it contracts for services that include utilization review or utilization management functions" to comply with Section 1367.01. Section 1367.01 (h)(4) further requires written communication regarding decisions to deny, delay, or modify health care services requested by providers to include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. In addition, Section 1367.01(j) mandates the plan to evaluate its delegates' compliance with these requirements as part of the plan's quality assurance program.

The Department reviewed the Plan's *Denial Process*[23] policy which provides the Plan will ensure that providers and enrollees receive timely written communications that clearly document reasons and rationale for denial decisions, cite specific reasons and criteria used to make the decision, and that such decisions are stated in a clear, concise, and understandable language.

The Plan delegates UM functions to Meritage Medical Network, Hill Physicians Medical Group, Mercy Medical Group, Woodland Clinic, Providence Medical Group, NorthBay Healthcare, University of California Davis Medical Group, Optum and Magellan.

The Department reviewed 65 UM Medical Necessity Files from the Plan's delegates and found in 24[24] files (37%), the written notifications did not include clear and concise language and that 10[25] (42%) of the 24 files did not include a description of the criteria or guidelines used for the denial. Finally, in five[26] (21%) of the 24 files, the letters did not include sufficient clinical reasons for the medical necessity decisions.

Case Examples

- **DMHC File 6:** The Plan's written denial communication to the enrollee stated in relevant part:

  Per the health plan genetic testing is covered if you have had genetic counseling prior to testing. Our Medical Director denied the request as not medically necessary. Your child's records do not show he has been seen by a genetic counselor. The request cannot be approved at this time.

  The Department determined this denial letter did not include a description of the criteria and/or guidelines used by the Plan to deny the request.

- **DMHC File 688:** The Plan's written denial communication to the enrollee states in relevant part:

  The requested Dexamethasone injection and Triamcinolone Acetonide injection does not meet medical necessity criteria based on the medical information provided. This decision was based on your Evidence of

[23] *Denial Process*, Policy Statements, page 2.
[24] DMHC Delegate UM Files: 1, 3-10, 13, 684, 688, 690, 17, 18, 20, 23, 26, 694, 32, 671, 672, 697, 700.
[25] DMHC Delegate UM Files: 3-7, 9, 10, 13, 17, 18.
[26] DMHC Delegate UM Files: 6, 9, 684, 688, 697.

Coverage, page 34, section 2. . . Specifically, there is no documentation of a trial of oral corticosteroids.

The Department determined this letter was not clear and concise as it contained complex medical terminologies. The letter also did not include a clinical reason with specific clinical information relating to the enrollee's medical condition.

TABLE 8

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Delegate UM Medical Necessity	65	Written responses to enrollees are clear and concise	41 (63%)	24 (37%)
Delegate UM Medical Necessity	24	Written communications include a description of the criteria or guidelines used in making the decision	14 (58%)	10 (42%)
Delegate UM Medical Necessity	24	Written include the clinical reason for the denial	19 (79%)	5 (21%)

Preliminary Findings: Based on the review of the Plan's delegate UM files, the Department found the Plan's delegate's denial written communications did not consistently include clear and concise explanations of reasons for the denials, descriptions of criteria or guidelines used to make the decisions, and clinical reasons as required by Section 1367.01(a), (h)(4) and (j). Therefore, the Department found the Plan in violation of these statutory requirements.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan acknowledges and agrees with the Department's preliminary finding that the Plan's delegates' utilization management denial, delay, or modification letters did not consistently include clear and concise explanations of the reasons for the determinations, descriptions of the criteria or guidelines used to make decisions, and the clinical reasons for the determinations, as required by Health & Safety Code Sections 1367.01(a), 1367.01(h)(4), and 1367.01(j).

The Plan requested clarification of the specific delegate files numbers used in this deficiency.[27]

[27] Mercy Medical Group Files 1-41, Hill Physicians Medical Group Files 659-678 and North Bay Healthcare Files 684-703.

The Plan formally notified all delegated entities performing utilization management functions of the Department's findings and the applicable statutory requirements. Delegates were instructed that denial letters must clearly explain the reason for the determination using plain, non-technical language; explicitly identify the criteria or clinical guideline relied upon and explain the clinical rationale in a manner understandable to members and providers. The Plan summarized its training efforts to delegates: **Targeted Training and Education for Delegates**

The Plan will implement targeted enhancements to denial letter standards and will conduct focused discussions with its delegated entities to improve clarity, readability, and compliance of denial language.

- Reinforcement of the requirement to explicitly identify applicable criteria or clinical guidelines
- Utilization of relevant Evidence of Coverage language to ensure consistency with plan benefits and coverage terms
- Guidance on providing plain-language explanations of medical or clinical terminology, including brief definitions when such terminology is necessary
- Ongoing delegate education through oversight communications, training sessions, and routine engagement

Ongoing and Planned Corrective Actions

- Delegate Oversight and Monitoring

The Plan will continue to incorporate targeted audits of delegate denial letters into its quality assurance and delegate oversight processes. Audit results will be documented, trended, and addressed through corrective action plans as appropriate.

- Joint Operations Committee (JOC) Oversight

Beginning in early March 2026, compliance for this Deficiency will be a standing agenda item at Joint Operations Committee meetings with delegated entities. JOC discussions will include review of denial letter content, readability expectations, and ongoing compliance monitoring.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by providing delegate training and oversight to ensure the delegates' denial letters are clear and concise and contain descriptions of criteria or the guidelines used to make the decision. While the Plan's corrective actions address this deficiency, the Plan's efforts are ongoing, and the Plan needs more time to implement

corrective actions. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the Plan corrected the deficiency. The assessment may include a review of delegate UM Medical Necessity files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan's progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan's compliance during the Follow-Up Survey.

Deficiency #11: The Plan did not disapprove requests for authorization to provide necessary post-stabilization medical care within one half-hour of the request or deem the care authorized.

Statutory and Regulatory References: Section 1371.4(a) and (j)(1); Rule 1300.71.4(b).

Preliminary Assessment: Section 1371.4(j)(1) and Rule 1300.71.4(b) require the plan to approve or disapprove a provider's request for authorization of post stabilization care within 30 minutes of the request. When the plan fails to provide authorization within the required timeframe, the necessary post stabilization care is deemed authorized, and the plan must reimburse the provider for the care rendered to the enrollee.

The Plan's *Out of Area Emergency Hospital Admissions* policy states that for an out-of-network hospital, the Plan will triage and determine within 30 minutes whether post-stabilization care will be approved or the transfer process will be initiated.[28]

The Department reviewed 29 post-stabilization files and found in 25[29] (86%) of the files, the Plan failed to respond to the provider within 30 minutes of receiving the request for post-stabilization care.

Case Examples

- **DMHC File 3:** The case notes indicate the facility notified the Plan on August 22, 2024, at 3:35 p.m. by fax[30].

  The Plan's Clinical Resources Department responded to the facility by fax on August 22, 2024, at 5:37 p.m. (with a second fax attempt on August 30,

[28] *Out of Area Emergency Hospital Admissions*, page 3
[29] DMHC Files: 3, 4, 6, 7, 9, 11-30.
[30] The Department's file review found the majority of facility requests for post-stabilization care were made by fax. File review also demonstrated the Plan's practice was to respond to these requests and that there was no delay by the Plan due to the facility sending requests via fax.

2024). The Plan's response letter[31] outlined its post-stabilization process[32]. The letter explains in relevant part,

"When possible, all post-stabilization care must be provided within WHA's network as soon as medically appropriate" and that "WHA requires post-stabilization care to be authorized in advance."

The letter also requests the facility to provide clinical notes and regular updates to the Plan and concludes, "Failure to provide timely information may result in a denial of services."

On September 17, 2024, the Plan issued by fax the Medical Director's written denial determination to the facility. This denial was based on the facility's failure to provide clinical information to the Plan after three requests. The Plan's denial letter states,

"WHA requires all post-stabilization care and transfers of stable members to be authorized in advance. Coverage of services for this inpatient hospital stay on August 22, 2024, has been denied and is the financial responsibility of [facility]. This determination was made based upon the lack of clinical information you provided and in relation to the member's health plan guidelines for acute care services."

The Department determined the Plan failed to approve or disapprove of the facility's August 22, 2024, notification within 30 minutes.

In addition, the Department's review of this file did not find evidence the Plan considered the treating physician's determination whether this enrollee was clinically stable[33]. Rather, as noted above, the Plan's denial was ultimately based on the facility not providing "clinical information." However, Section 1317.1(j) (incorporated by reference in Section 1371.4) makes clear the determination of stabilization is to be made in the opinion of the "treating physician and surgeon, or other appropriately licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon...." Additionally, Rule 1300.71.4(b) specifies the 30-minute contact and response time requirements only commence "when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and cannot be safely discharged...." This file contained no evidence that the Plan's denial determination considered the opinion of the treating provider with regard to whether this enrollee was medically stable consistent with Section 1317.1(j) and Rule 1300.71.4(b).

Finally, it was not clear whether the Plan appropriately reimbursed the facility for medical services. The Department's review found the facility billed $41,422.78 for

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[31] The Department's file review found the identical letter in all files which explained the Plan's post-stabilization process.
[32] The letter specifies an admission date of August 21, 2024.
[33] The Department's file review found the Plan established August 21, 2024, as the date of the enrollee's admission into the hospital. Also, a Plan case note dated August 26, 2024, stated the enrollee was an inpatient at the facility on August 22 and that August 22 was the date of discharge.

services on August 21, 2024, and the Plan's Evidence of Benefits (EOB) dated November 12, 2024, established the Plan paid $8,257.93.

- **DMHC File 12:** The case notes indicate the facility notified the Plan on January 3, 2023, at 3:11 p.m. by fax.

  The Plan's Clinical Resources Department responded to the facility by fax on January 3, 2023, at 4:35 p.m. [34] As in DMHC File #3, the Plan's letter provides an explanation of the Plan's overall post-stabilization process.

  On January 13, 2023, the Plan issued by fax the Medical Director's written denial determination to the facility. This denial was based on the facility's failure to provide adequate notice and clinical information to the Plan after three requests. The Plan's denial letter states:

  "Western Health Advantage ("WHA" or the "Plan") has reviewed the documentation submitted regarding this member's medical condition. WHA Medical Director has determined that this observation/inpatient admission to [facility] from 1/1/2023-1/6/2023 is denied due to the delay of notification of admission and the inadequate clinical documentation provided by [facility]. Because of the delayed notification for this admission, WHA was not provided the opportunity to determine members stability in order to have member transferred back into the service area. WHA requires all post-stabilization care to be authorized in advance. Clinical records also had been requested three times since WHA was notified of the admission and the documentation received was not adequate to support reasoning for the prolonged observation status and delayed inpatient admission. Coverage of services for this entire observation/inpatient hospital stay, beginning 1/1/2023-1/6/2023 has been denied and is the financial responsibility of [facility]. However, the ER services on 1/1/2023 are approved and covered. Again, this determination was made based upon the lack of timely notification and the lack of adequate clinical documentation provided. This is in relation to the member's health plan guidelines for acute care inpatient services."

The Department determined the Plan failed to approve or disapprove of the facility's January 3, 2023, notification within 30 minutes.

The Plan's denial was based on a lack of timely notification and inadequate clinical documentation. However, this file contained no evidence the Plan considered the treating physician's determination whether the admitted enrollee was ever clinically stable. In fact, the clinical information in the Plan's internal case notes are contradictory to the Plan's conclusion (in the letter above) that the enrollee only received emergency services on January 1. The Plan's internal case notes dated January 4th and 5th establish this enrollee was likely receiving emergency services after January 1. The January 4, 2023, case note states, "Members pain is not completely under control, and he is struggling with his oral intake. The surgeon wants to monitor him over night, and they are working on stabilizing him to discharge tomorrow." The January 5, 2023, case note states, "Per CM [name], member is not ready for discharge, member is having

[34] The letter specifies admission dates of January 1, 2023 through January 6, 2023.

chills and fever of 103.1 and they are trying to rule out if he has an infection and a DVT. Surgeon is planning to come see him. Will call and follow up with CM around 2 pm." The Plan's final case note dated January 6, 2023, at 11:40 a.m. states the enrollee was discharged earlier that morning, the request for transfer was closed, and clinical notes were requested. Therefore, the Plan's case notes establish the treating physician did not make a determination about the stability of this enrollee's medical condition until January 6. As noted above, Section 1317.1(j) clarifies the enrollee's treating physician is responsible for determining whether the enrollee's condition is stable.

Finally, it was not clear whether the Plan appropriately reimbursed the facility for medical services provided to the enrollee. The Department's review found the facility billed over $100,000 for services and the Plan's Evidence of Benefits (EOB) established the Plan paid $1,882.

TABLE 9

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Post-Stabilization	29	Plan responded to the provider within 30 minutes of receipt of request.	4 (14%)	25 (86%)

Preliminary Findings: Based on the review of the Plan's post-stabilization files, the Department finds the Plan did consistently approve or disapprove of requests for post-stabilization care within 30 minutes of receipt and may have failed to pay claims for post-stabilization care rendered.

Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

As part of the Plan's corrective action for this Deficiency, the Director requires retroactive review of the denied post-stabilization care claims identified, as well as all denied claims for post-stabilization care that were adjudicated on or after December 1, 2022 (the beginning of the file review period). The retroactive review shall assess whether claims were inappropriately denied when the Plan took more than 30 minutes to approve or disapprove requests for post-stabilization care.

For each claim in which it is determined that the claim should have been approved, the Director requires the Plan to readjudicate the claim. The Plan's corrective action shall describe the process the Plan shall use to identify overpayments made by enrollees or payments due to providers, and the steps the Plan will take to readjudicate the claims, as well as the anticipated time period for completion.

The corrective action plan (CAP) should also include a spreadsheet that identifies the total number of claims reviewed (i.e., both the inappropriately denied claims identified in the deficiency, as well as all denied post-stabilization claims adjudicated on or after

December 1, 2022), total number of reviewed claims that were overturned/readjudicated, and the total amount to be paid by the Plan. For each overturned/readjudicated claim, the spreadsheet shall include the following details:

- Claim Number (unique claim number for each claim)
- Enrollee ID #
- Date(s) of Service
- Name of Provider/Hospital
- Original Amount Billed (prior to readjudication)
- Place of Service Code (e.g., ER is place of service 23)
- Requested Treatment
- Enrollee Medical Condition/Diagnosis
- Denial Codes
- Denial Reason
- Original Processed/Adjudicated Date (prior to readjudication)
- Original Amount Paid (prior to readjudication)
- New Claim Number, if any (after readjudication)
- Date Readjudicated
- Type of Documents that Provide Evidence of Readjudication (i.e. Explanation of
- Benefits (EOB) or Explanation of Payment (EPP)
- Amount Paid by the Plan (after readjudication)
- Date of payment
- Name of payee

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan reviewed its post-stabilization processes, statutory interpretation, and corrective actions.

The Plan clarified that its post-stabilization letter does not serve as an approval or a denial of post-stabilization services, nor was it intended to function as such. The post-stabilization letter is a procedural notification used to acknowledge that emergency services have been provided and to notify non-contracting providers that once a member is clinically stabilized, prior authorization is required for post-stabilization services. The letter is also used to request the clinical documentation necessary for the Plan to determine whether stabilization has occurred, whether continued post-stabilization services are medically necessary, and the appropriate next steps, including transfer, discharge, or continued inpatient care. Absent receipt of medical records or other information from a treating physician sufficient to establish stabilization and ongoing medical necessity, the Plan is unable to render clinically appropriate approval or disapproval determination.

The Plan acknowledges, however, the Department's concern regarding timeliness and recognizes that prospective utilization management may be deemed unavailable when notice, documentation, or timing does not permit real-time review.

The Plan recognizes the Department's concern that denials should not be based solely on missing documentation. At the same time, the Plan cannot approve post-stabilization services without sufficient clinical information to establish stabilization and medical necessity. Accordingly, the Plan's retrospective review balanced these considerations. Where medical records were subsequently received, and/or the Plan considered the opinion of the treating physician and surgeon, and retrospective review demonstrated that post-stabilization medical necessity criteria were met, the Plan modified approvals

and authorized payment. Where retrospective review demonstrated that services did not meet post-stabilization medical necessity criteria, or where services were otherwise non-covered or outside the Plan's financial responsibility, the Plan upheld the original denial or modification. The Plan stated that its approach ensures that payment determinations are based on affirmative medical necessity findings rather than solely on administrative or documentation deficiencies. In addition, the Plan provided a further explanation of its corrective actions as follows:

Retrospective Review

The Department identified 25 post-stabilization cases as deficient. The Plan conducted a comprehensive retrospective review of these 25 cases, limited solely to the Department-identified population. As a result of this review, nine[35] of the 25 cases were identified as requiring reprocessing and payment, either in full or in part, based on retrospective determination that post-stabilization services met medical necessity criteria. The remaining sixteen cases were determined to have been appropriately denied or appropriately modified based on retrospective review demonstrating one or more of the following: medical records sufficient to establish stabilization and post-stabilization medical necessity were never received; medical necessity review supported a different level of care (e.g., observation rather than inpatient); the requested services were not a covered benefit; or financial responsibility appropriately resided with a delegated medical group pursuant to contractual risk arrangements.

In addition to completing the retrospective review of the 25 post-stabilization cases identified by the Department as deficient, the Plan implemented corrective actions consistent with the full scope of the Department's findings. The Plan acknowledges the Department's request that, as part of corrective action for this Deficiency, the Plan will conduct retroactive review not only of the denied post-stabilization care claims identified in the deficiency, but also of all denied claims for post-stabilization care adjudicated on or after December 1, 2022. Accordingly, the Plan has identified an additional 35 denied post-stabilization claims adjudicated on or after December 1, 2022, that fall within the Department's expanded review scope. The Plan has initiated retrospective clinical review of these claims to assess whether any were inappropriately denied, including evaluation of whether post-stabilization services would have met medical necessity criteria had timely review been possible. The Plan proposes to complete review of the additional 35 cases and to submit its findings to the Department, including identification of any claims requiring reprocessing and payment, consistent with the Department's instructions.

In addition, the Plan's internal review identified 79 post-stabilization cases adjudicated between December 1, 2024, and December 31, 2025, that resulted in a denial or modification. Due to the volume and the need to obtain and review clinical documentation, the Plan will complete retrospective review of these additional 79 cases and submit its findings.

The Plan will also implement workflows and desktop procedures to create operational improvements that will be designed to support sustained compliance. These actions

[35] DMHC Files: 9, 12, 19, 20, 21, 22, 24, 26, 28.

include reinforcing that post-stabilization letters are procedural notices and documentation requests rather than approval or denial determinations; enhancing internal guidance regarding escalation and case management when clinical documentation is not received; strengthening tracking and escalation processes for post-stabilization notifications to support earlier clinical engagement; and standardizing retrospective review criteria to ensure consistent assessment of stabilization, medical necessity, and appropriate level of care.The Plan will submit to the Department any materials supporting implementation of these corrective actions, including updated workflows, internal guidance, and training documentation.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by reviewing the Plan’s post-stabilization process, the content of letters, and readjudicating post-stabilization files. While the Plan’s corrective actions address this deficiency, the Plan’s efforts are ongoing, and the Plan needs more time to implement corrective actions. Therefore, the Department cannot consider this deficiency corrected at this time.

Additionally, the Department further acknowledges that while the Plan has begun the process of readjudicating files, the process of identifying all relevant claims is not complete, and the Plan needs additional time to complete this review. To assess the Plan’s compliance, the Plan shall submit a supplemental response consisting of the results of the Plan’s re-review of the 79 post-stabilization cases.

At the Follow-Up Survey, the Department will assess the Plan’s implementation of corrective action and whether the Plan corrected the deficiency. The assessment may include a review of Post-Stabilization files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan’s progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan’s compliance during the Follow-Up Survey.

EMERGENCY SERVICES AND CARE

Deficiency #12: The Plan failed to maintain compliant emergency services and care policies and procedures.

Statutory and Regulatory References: Section 1367.01(b); 1371.4(a) and (c).

Preliminary Assessment: Section 1367.01(b) requires the plan to have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees.

The Plan’s *Emergency & Urgent Care Services* included the following language regarding a prudent layperson standard as it relates to an emergency condition:

> A prudent layperson is considered to be a person who is without medical training and who draws on his or her own practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.[36]

The Knox Keene Act's standard for the determination of an emergency condition with respect to the enrollee is based on the enrollee's subjective belief[37] which does not include the prudent layperson standard contained in the Plan's policy.

Preliminary Findings: Based on the review of the Plan's policy, the Department found the Plan's policy was not compliant with the subjective standard to determine emergency medical conditions. Therefore, the Department found the Plan in violation of these statutory requirements.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it acknowledges the deficiency identified by the Department regarding the inclusion of a prudent layperson standard in the Emergency & Urgent Care Services policy. The Plan's prior policy language improperly applied a prudent layperson standard rather than the Knox-Keene Act's required subjective standard.

Under e-file 20260557, the Plan updated page 4 of its 2026 Emergency Services and Care policy and procedure to remove all references to the prudent layperson standard.

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department determined this deficiency is corrected.

The Department reviewed the Plan's revised Policy and determined the prudent layperson standard language in the Policy was removed.

PRESCRIPTION DRUG COVERAGE

Deficiency #13: The Plan's pharmacy benefit manager did not include a copy of the form 61-211 on its website.

Statutory and Regulatory References: Section 1385.001; Rules 1300.67.241(d) and (e)(1).

Preliminary Assessment: Section 1385.001 and Rules 1300.67.241(d) and (e)(1) require the plan and its contracted pharmacy benefit manager (PBM) to make the Prescription Drug Prior Authorization or Step Therapy Exception Request form (Form 61-211) electronically available on their website.

[36] *Emergency & Urgent Care Services*, Definitions, page 4.
[37] See guidance in the Department's All Plan Letter 17-017 dated December 19, 2017.

Although the Plan's website electronically posts Form 61-211, the website for the Plan's Pharmacy Benefits Manager (PBM) did not list Form 61-211.

Preliminary Findings: Based on the review of the PBM's website, the Department found the Plan's PBM did not include a copy of the form 61-211 on its website during the survey review period. Therefore, the Department found the Plan in violation of these statutory and regulatory requirements.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan explained prior authorization (PA) is not delegated to its PBM and that all PA requests are reviewed directly by the Plan and that the PBM has a copy of the PA form on the OptumRx (ORx) website under the State-Specific Information section[38].

The Plan explained that members and providers submit PA requests through the Health Plan's website which is the primary and preferred process for PA submissions and allows the Plan to conduct timely reviews, accurate routing, and consistent processing.

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department determined this deficiency is corrected.

The Department reviewed the link to the PBM's website and determined there is a copy of the PA form.

Deficiency #14: The Plan's formulary did not include a description of the coverage provided under the FDA-approved products through the outpatient prescription drug benefit.

Statutory and Regulatory Reference: Rule 1300.67.205(d)(16).

Preliminary Assessment: Rule 1300.67.205(d)(16) requires the plan's informational section of the formulary to include a description of the coverage provided under the outpatient prescription drug benefit for drugs, devices, and FDA-approved products. The description must include a detailed explanation of the requirements and process to acquire those drugs, devices, and FDA-approved products, through the outpatient prescription drug benefit.

The informational section of the Plan's *4-Tier Preferred Drug List* and *3-Tier Preferred Drug List* did not include a description or a detailed explanation of the requirements and process to acquire FDA-approved products[39].

The Plan's website also did not include a description of the coverage provided under the outpatient prescription drug benefit for drugs, devices, and FDA-approved products.

Preliminary Findings: Based on the review of the Plan's formulary and website, the Department found the Plan did not include a description of the coverage provided under

[38] The form is located at: https://business.optum.com/en/pharmacy-services/electronic-prior-authorization.html
[39] *4-Tier Preferred Drug List* and *3-Tier Preferred Drug List*, page 3

the FDA-approved products required by Rule 1300.67.205(d)(16). Therefore, the Department found the Plan in violation of this regulatory requirement.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan explained the full informational section of the Preferred Drug Lists includes sections describing how to obtain prescriptions, the prior-authorization process, and how to obtain medications through retail and mail-order options on page 5 of the formulary informational section. The drug list contains tiering information and coverage limitations. Enrollees are referred to their Evidence of Coverage and Copayment Summaries for plan-specific information.

The Plan explained that both the *4-Tier and 3-Tier Preferred Drug Lists* (PDLs) comply with the requirements set forth in California Health & Safety Code Sections 1367.002, 1367.25, and 1367.51 as they relate to preventive medications and supplies. Specifically, the Plan demonstrated that both the PDLs on pages 8 and 9 met applicable statutory requirements for coverage of preventive medications, including contraceptives, HIV medications, diabetes-related drugs and supplies, and COVID-19 products consistent with Sections 1367.002 and 1367.51.

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department determined this deficiency is corrected.

The Department reviewed the Plan's *4-Tier Preferred Drug List* and *3-Tier Preferred Drug List* and determined it contained a description and detailed explanation of the requirements and process to acquire FDA-approved products required by Rule 1300.67.205(d)(16).

Deficiency #15: The Plan's denial letters did not consistently include clear and concise explanations of reasons for denials, descriptions of criteria or guidelines used to make decisions, and clinical reasons for denials.

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

Preliminary Assessment: Section 1367.01(h)(4) requires plan responses regarding decisions to deny, delay, or modify health care services requested by providers to be in writing, to include a clear and concise explanation of the reasons, a description of the criteria or guidelines used, and clinical reasons for the decisions regarding medical necessity.

The Department reviewed 70 Pharmacy Step Therapy Exception Request files and found in 39[40] files (56%), the Plan did not include a clear and concise explanation of the reasons for the Plan's denial and that 31 (44%)[41] of the 70 files did not include a description of the criteria or the clinical reasons for the decisions.

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[40] DMHC Files: 1,2,4, 8, 9, 13, 14, 17, 20, 21, 24, 26, 28, 30-33, 36, 37, 41, 42, 45-47, 49-54, 58, 60, 62, 67-69, 75-77.
[41] DMHC Files: 1-11, 13-18, 20, 21, 23-33, 35.

Case Examples

- **DMHC File 8:** The Plan's denial letter to the enrollee stated in relevant part:

  WHA covers Repatha for the treatment of patients at least 10 years of age with heterozygous familial hypercholesterolemia (HeFH); AND (1) prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist; AND (2) diagnosis of HeFH is confirmed by medical record documentation; AND (3) prior to treatment with Repatha, patient has an LDL-C level greater than 190 mg/dL (for patients 16 years of age or greater) or greater than 155 mg/dL (for patients less than 16 years of age); AND (4) one of the following documented in medical records: (4a) Patient has a genetic mutation in the LDL receptor, ApoB, or PCSK9 gene, (4b) Patient has physical signs of HeFH (i.e., tendon xanthomas, corneal arcus and age less than 45 years, tuberous xanthomas, or xanthelasma), (4c) Dutch Lipid Clinic Network diagnostic criteria for familial hypercholesterolemia score is greater than 8 (i.e., definite familial hypercholesterolemia), (4d) Simon Broome diagnostic criteria for familial hypercholesterolemia corresponds to definite familial hypercholesterolemia; AND (5) one of the following documented in medical records: (5a) Patient has received two high-intensity stating therapies (i.e., atorvastatin 40 mg - 80 mg; rosuvastatin 20mg - 40mg) for at least 12 consecutive weeks each. . .

The Department found the language in this letter to the enrollee was not clear and concise as it contained numerous complicated and unexplained medical terminologies. The Plan's letter also failed to specify the criteria relied upon by the Plan and did not include the specific clinical reasons for the medical necessity denial.

- **DMHC File 47:** The Plan's denial letter to the enrollee stated:

  Western Health Advantage (WHA) and Optum Rx manage your WHA prescription drug coverage benefit. Your plan may have drug coverage requirements or limitations on the amount of medication covered during a specific period. However, your provider can request coverage if a drug or its usage falls outside the plan specifications. In these cases, a qualified healthcare professional at WHA will review the request for medical necessity. After reviewing the medical information sent to WHA, we regret to inform you that the authorization request for IBRANCE 125 MG CAPSULE is denied. We are unable to provide coverage for this medication at this time due to the following reason(s)…

The Plan's denial letter was not clear and concise as it contained vague references to coverage limitations. The Plan's letter also did not specify the actual criteria relied upon for the Plan's denial or clarify the specific clinical reasons as it relates to the enrollee's condition for the Plan's medical necessity denial.

TABLE 10

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Rx Step Therapy Exception Requests	70	Enrollee letter includes a clear and concise explanation	31 (44%)	39 (56%)
Rx Step Therapy Exception Requests	70	Enrollee letter includes a description of the criteria or guidelines used	39 (56%)	31 (44%)
Rx Step Therapy Exception Requests	70	Enrollee letter includes the clinical reasons for the decisions regarding medical necessity	39 (56%)	31 (44%)

Preliminary Findings: Based on the results of the file review, the Department found the Plan's denial letters did not consistently include clear and concise explanations of reasons for denials, descriptions of criteria or guidelines used to make decisions, or the clinical reasons for denials. as required under Section 1367.01(h)(4). Therefore, the Department found the Plan in violation of this regulatory requirement.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan acknowledges the Department's preliminary finding that denial letters did not consistently include clear and concise explanations of reasons for denials, descriptions of criteria or guidelines used to make decisions, and clinical reasons for denials.

Beginning in 2025, the Plan implemented enhancements to the content of denial letters to improve readability and comprehension. These enhancements included explicitly identifying the criteria or clinical guidelines used to support the decision, defining medical or clinical terminology in plain language, and monthly audits to review the denial language readability standards.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by implementing enhancements to improve the content and readability of pharmacy denial letters. While the Plan's corrective actions address this deficiency, the Plan's efforts are ongoing, and the Plan needs more time to implement corrective actions. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the Plan corrected the deficiency. The assessment may

include a review of Pharmacy Step Therapy Exception Request files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan's progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan's compliance during the Follow-Up Survey.

LANGUAGE ASSISTANCE

Deficiency #16: The Plan did not demonstrate that it informed enrollees of the timely availability of free language assistance and auxiliary aids and services.

Statutory and Regulatory Reference: Section 1367.042(a)(1) and (2).

Preliminary Assessment: Section 1367.042(a)(1) and (2) requires the plan to notify enrollees that language assistance services, including oral interpretation and translated written materials, as well as appropriate auxiliary aids and services, will be available in a timely manner.

The Plan's *Notice of Language Assistance* (NOA)[42] which is provided annually to enrollees in various documents and posted on the Plan's website[43] did not include information that language assistance services are available in a timely manner.

The Department requested the Plan to submit evidence it notified enrollees of the timeliness of language assistance services during the survey review period. In response, the Plan provided the same NOA previously provided to the Department in the *Combined Evidence of Coverage and Disclosure Form* (EOC), and listed on the Plan's website.[44]

The Department reviewed 31 standard grievance files[45] and 28 expedited grievance files[46] and found that none of these files included the notice that language assistance services, including oral interpretation and translated written materials, would be available in a timely manner.

[42] The Department reviewed the NOA within the Plan's 2022 through 2024 *Combined Evidence of Coverage and Disclosure Forms* (EOC) for the Plan's Large Group, Small Group, Individual, and Covered California product offerings and found that none of these EOCs provided information to enrollees on the timeliness of language assistance services.
[43] Plan's *Notice of Language Assistance* Webpage (April 3, 2025).
[44] Plan Response to Department request #23.
[45] DMHC Standard Grievance Files: 1-31.
[46] DMHC Expedited Grievance Files: 1-23, 25-29.

TABLE 11

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance	31	Notice of availability of timely language assistance services	0 (0%)	31 (0%)
Expedited Grievance	28	Notice of availability of timely language assistance services	0 (0%)	28 (0%)

Preliminary Findings: Based on review of Plan's EOCs, website, and grievance files, the Department determined the Plan did not inform enrollees of the timely availability of free language assistance and appropriate auxiliary aids and services in compliance with the requirements of Section 1367.042(a)(1) and (2). Therefore, the Department found the Plan in violation of this statutory requirement.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan acknowledges the Department's preliminary finding that the Plan's Notice of Language Assistance ("NOLA") did not include information that language assistance services are available in a timely manner. Under e-filing #20260551, the Plan corrected the NOLA to include language referencing that services are available in a "timely manner."

The Plan will distribute the updated notice to applicable internal stakeholders and external partners for inclusion in letters and member-facing materials. The Plan will monitor letters and member-facing material to ensure updates are applied and republish the form on the Plan's website.

Final Report Deficiency Status: Not Corrected

Based on the corrective actions proposed and undertaken, the Department determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards correcting this deficiency by updating the Plan's NOLA to add clarification that language assistance services are available in a "timely manner," the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of Standard and Expedited Grievance files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

BEHAVIORAL HEALTH – SB855

Deficiency #17: The Plan did not evidence that individuals responsible for making medical necessity decisions achieved interrater reliability testing pass rates.

Statutory and Regulatory References: Sections 1374.721(e)(5) and (7).

Preliminary Assessment: Section 1374.721(e)(5) and (7) require the plan to ensure proper use of criteria by conducting interrater reliability (IRR) testing in utilization review decision making to discuss medical necessity decisions. Section 1374.721(e)(5) and (7) specifies the plan's IRR pass rates must be at least 90 percent. If this threshold is not met, the plan must immediately provide for the remediation of poor IRR and IRR testing for all new staff before they can conduct utilization review without supervision.

The Department reviewed the Plan's *Inter-Rater Reliability Testing & Oversight* policy, which states all licensed clinical UM reviewers who make authorization decisions are tested at least annually for consistency of their interpretation and application of the appropriate UM criteria and other related processes involved in UM decision-making.[47] The policy further includes the requirements of the Mental Health/Substance Use Disorder (MH/SUD) reviewer including prescription drugs.[48]

The Department reviewed the Plan's *Interrater Reliability Testing Results* and the *Interrater Reliability Testing Results for ASAM / BHIRR National* which lists the names and results of the test takers in 2023 and 2024.

To assess compliance, the Department reviewed the Plan's 11[49] MH/SUD Utilization Management Review – C files and found in 5[50] (45%) of the 11 files, the Plan did not provide evidence the reviewer passed the IRR testing requirement during the year of the denial. The Department also reviewed the Plan's 8[51] MH/SUD Denial Appeal files and found that in 2[52] (25%) of the 8 files, the Plan did not provide evidence the reviewer passed the IRR testing requirement during the year of the appeal.

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[47] *Inter-Rater Reliability Testing & Oversight,* Policy Statements, page 1.
[48] *Inter-Rater Reliability Testing & Oversight, Procedure*, Additional Requirements, page 3.
[49] DMHC MH/SUD UM-C Files: 1-7, 9-12.
[50] DMHC MH/SUD UM-C Files: 1-5.
[51] DMHC MH/SUD Appeals: 1-6, 9, 10.
[52] DMHC MH/SUD Appeals: 1, 3.

TABLE 12

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
MH/SUD Utilization Management Review – C	11	Plan's Reviewer Passed IRR Testing	6 (55%)	5 (45%)
MH/SUD Denial Appeals	8	Plan's Reviewer Passed IRR Testing	6 (75%)	2 (25%)

Preliminary Findings: Based on the review of the Plan's files, the Plan did not provide evidence that individuals responsible for making medical necessity decisions achieved IRR testing pass rates as required under Sections 1374.721(e)(5) and (7). Therefore, the Department found the Plan in violation of these statutory requirements.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan explained it delegates mental health / substance use disorder Utilization Management and Appeals to U.S. Behavioral Health Plan, California d/b/a OptumHealth Behavioral Solutions of California ("USBHPC").

USBHPC respectfully disagrees with the Department's file review findings and submitted documentation for 2023 and 2024 which included unredacted names of the individuals responsible for making the medical necessity determinations.

USBHPC acknowledges the Medical Director's inter-rater reliability (IRR) score for MH/SUD Appeal File 1 was inadvertently omitted and provided documentation of the Medical Director's 2023 IRR score.

USBHPC also completed a validation of the IRR testing results for all cases and determined that certain providers fell within the 2022 IRR testing period rather than the applicable 2023–2024 testing range. USBHPC submitted the relevant 2022 IRR testing results for review. The Plan also provided a summary of the corrective actions taken by USBHPC as follows:

USBHPC's Action Taken:

The Plan has developed an enhanced process for retaining and documenting individual employee Inter-Rater Reliability test scores to demonstrate compliance. The process includes multiple tabs that illustrate the quality process for collecting employee data and test scores and was distributed on April 25, 2025. USBHPC's April 2025 enhancements have resulted in:

- Improved clarity and usability: the tracker now provides more specific, detailed data, giving a clearer and more comprehensive picture of IRR status across staff.

- Better visibility into testing needs: enhancements make it easier to identify IRR tests to be completed and whether completion dates fall within annual or off-cycle windows.
- Strengthened compliance: the additional detail supports managers in confirming that staff remain compliant with IRR requirements.
- Improved reporting accuracy: more precise data fields have reduced ambiguity and improved the quality of IRR reporting.
- Enhanced audit readiness: clearer visibility and cleaner data improve preparedness for external reviews.
- More timely updates: the managers can more easily identify gaps, or overdue requirements.

Final Report Deficiency Status: Not Corrected

The Department finds the Plan acknowledged this deficiency and has taken steps toward correcting it by working with USBHPC to clarify the timing of IRR testing requirements and reporting of IRR data. While the Plan’s corrective actions address this deficiency, the Plan’s efforts are ongoing, and the Plan needs more time to implement corrective actions. Therefore, the Department cannot consider this deficiency corrected at this time.

At the Follow-Up Survey, the Department will assess the Plan’s implementation of corrective action and whether the Plan corrected the deficiency. The assessment may include a review of MH/SUD Utilization Management and Appeal files, reports and reporting tools, policies and procedures, interviews, and any other review deemed necessary by the Department.

Based on the Plan’s progress with corrective actions, the Department has deemed the deficiency not corrected and will reevaluate the Plan’s compliance during the Follow-Up Survey.

SECTION II: SURVEY CONCLUSION

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 Survey Web Portal, eFiling application. Please click on the following link to login: DMHC Web Portal.

Once logged in, follow the steps below to submit the Plan's response to the Preliminary 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**, 2025 Routine Survey – Document Request**.

The Department's 2025 routine survey of the Plan is complete. Where indicated, the Plan shall submit a supplemental response through the Department's Survey Web Portal. In addition, the Department may request subsequent supplemental responses to assess progress with the Plan's corrections actions.

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).

The Department will conduct a Follow-Up Survey of the Plan to assess outstanding deficiencies and will issue a Report within 18 months of the date of this Final Report.

Plan Response to The Final Report

APPENDIX A: SUPPORTING DOCUMENTATION

SUPPORTING DOCUMENTATION	
Quality Assurance	
Deficiency #1	• *QI-015-POL Potential Quality Issue (PQI) Management* (June 28, 2023) • 21 Potential Quality Issues – B (SL 2-3) Files (December 1, 2022 through November 30, 2024) • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Deficiency #2	• PQI Training; Appeals & Grievances (November 6, 2023) • 69 Exempt Grievance Files (December 1, 2022, through November 30, 2024) • Western Health Advantage Member Guidelines (January 1, 2026) • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Grievances and Appeals	
Deficiency #3	• *Identifying Grievances / Exempt Grievances / Appeals* (June 2024) • 71 Call Inquiry Files (December 1, 2022, through November 30, 2024) • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Deficiency #4	• *Exempt Grievance and Grievance Management Policy – AGP-04-POL* (June 26, 2024) • 69 Exempt Grievance Files (December 1, 2022, through November 30, 2024) • 70 Standard Grievance Files • (December 1, 2022, through November 30, 2024) • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Deficiency #5	• 31 Standard Grievance Files (December 1, 2022, through November 30, 2024) • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Deficiency #6	• 56 Expedited Grievance Files (June 1, 2023, through November 30, 2024) • All Other GA Log with 16 Identified (undated)

Deficiency #7	• *Member Guidelines* (January 1, 2024; January 1, 2025) • *Combined Evidence of Coverage and Disclosure Form; Individual* (2024) • *Combined Evidence of Coverage and Disclosure Form; Individual Advantage* (2024) • *Combined Evidence of Coverage and Disclosure Form; Large Group* (2024) • *Combined Evidence of Coverage and Disclosure Form; Small Group* (2024) • *Filing a Grievance* (December 2024) • Pre-Service Denial Letter Template (June 2023) • Exper Denial LtrTemp-Terminall Ill (May 2024) • Second Opinion Denial Template [undated] • Appeal Request Acknowledgement letter template [undated] • Appeal Acknowledgement/Resolution – Untimely Filing letter template [undated] • Appeal Review Resolution letter template [undated] • Appeal Extension letter template [undated] • Appeal Approval Resolution letter templates [undated] • Appeal Withdrawal letter template [undated] • Expedited Grievance Request Acknowledgement letter template [undated] • Expedited Appeal Request Acknowledgement letter template [undated] • Expedited Appeal Criteria Not Met Acknowledgement letter template [undated] • Expedited Grievance Criteria Not Met Acknowledgement letter template [undated] • Grievance Acknowledgement letter template [undated] • Grievance Acknowledgement/Resolution letter template [undated] • Coverage Dispute letter template [undated] • Grievance Extension letter template [undated] • Grievance Resolution letter templates [undated] • Grievance Withdrawal letter template [undated] • Member Guidelines 26WHA_MGB_E_1225 • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)

Access and Availability of Services	
Deficiency #8	• Plan's Provider Directory (May 7, 2025) • 10_Link to submit PR directory changes • 10_PR- 001-POL Provider Directory Policy2-3-2026 redline • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Utilization Management	
Deficiency #9	• *Denial Process* (June 2024) • 27 Utilization Management Files (December 1, 2022, through November 30, 2024) • UM Log File 10A Post Stabilization Denials (February 4, 2026) • 12_DMHC - Exhibit 12-A_02.02.2026 • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Deficiency #10	• *Denial Process* (June 2024) • 65 Delegate UM Files (June 1, 2023 through November 30, 2024) • *Western Health Advantage Utilization Management Emergency & Urgent Care* (February 2026) • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Deficiency #11	• *Out of Area Emergency Hospital Admissions* (June 2024) • Plan Response to Department Request #65 29 Post Stablization Files (December 1, 2022 through November 30, 2024) • 14_UM_LF10A_Post Stabilization Denials_Prelim Review_Filtered for DMHC Cases_Retroactive Review_02.04.2026 • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)

Emergency Services and Care	
Deficiency #12	• *Utilization Management Program Description* (March 2024) • *Emergency & Urgent Care Services* (June 2024) • *Out of Area Emergency Hospital Admissions* (June 2024) • Plan Response to Department Request #60 • 15_ER_Emergency & Urgent Care Services 2026_redlined_02.02.2026 • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Prescription Drug Coverage	
Deficiency #13	• Plan Response – Hyperlink on Plan's Website [undated] • Plan Response – Hyperlink on PBM Website [undated] • Plan's PBM Website (June 6, 2025) • Nondiscrimination Notice (February 2026) • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Deficiency #14	• *4-Tier Preferred Drug List* (November 1, 2024) • *3-Tier Preferred Drug List* (November 1, 2024) • Plan's Formulary Webpage (June 6, 2025) • BH 2022 IRR Test score (2022) • BH BH004 3 & 5 2023, 2024 with Test and Score Unredacted (2023 through 2024) • BH MHSUD Appeal case file 1 MD 2023 IRR with Test and Score (2023) • BH USBHPC IRR External Sample (No Date) • *BH USBHPC IRR Process Guide* (No Date) • BH USBHPC 2025 WHA Med Survey Deficiencies email (February 3, 2026) • 2025 Western Health Advantage Routine Survey Preliminary Report Response (April 25, 2025) • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)

Deficiency #15	• *Provider Manual* (May 2024) • 70 Pharmacy Step Therapy3 Exception Request Files (December 1, 2022 through November 30, 2024) • 18_Pharmacy Desktop Procedure - PA Review • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)
Language Assistance	
Deficiency #16	• Plan's *Notice of Language Assistance* Webpage (April 3, 2025) • Plan Response to Department Request #23 • *Combined Evidence of Coverage and Disclosure Form Covered California* (2022, 2023 and 2024) • *Combined Evidence of Coverage and Disclosure Form Individual* (2022, 2023 and 2024) • *Combined Evidence of Coverage and Disclosure Form Large Group* (2022, 2023 and 2024) • *Combined Evidence of Coverage and Disclosure Form Small Group* (2022, 2023 and 2024) • *Combined Evidence of Coverage and Disclosure Form Individual* (2022, 2023 and 2024) • *Combined Evidence of Coverage and Disclosure Form Covered California* (2022, 2023 and 2024) • 31 Standard Grievance Files (December 1, 2022 through November 30, 2024) • 28 Expedited Grievance Files (December 1, 2022 through November 30, 2024) • 19_NOND-NOLA_E_2026-Feb-clean • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)

Behavioral Health – SB855	
Deficiency #17	• Inter-Rater Reliability Testing & Oversight (June 2024) • WHA Interrater Reliability Testing Results – 2024 [undated] • WHA Inter-Rater Reliability Testing Results for ASAM / BHIRR National – 2023-2024 [undated] • 11 MH/SUD Utilization Management Review Decisions – Pull C (December 1, 2022, through November 30, 2024) • 8 MH/SUD Denial Appeals Files (December 1, 2022, through November 30, 2024) • BH004_3 & 5_2023 & 2024 Test with Score • MHSUD Appeal File 1_MD_2023 IRR test and score USBHPC_IRR_Process_Guide USBPPC_IRR_External_Sample • 2022 IRR Testing • 20_USBHPC-2025 WHA Med Survey Deficiencies_email • 20_WHA_DMHC Preliminary report_USBHPC response • 2025 Routine Medical Survey_WHA CAP Responses_Final (undated)