DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

WESTERN HEALTH ADVANTAGE

A FULL SERVICE HEALTH PLAN

SEPTEMBER 20, 2022

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

TABLE OF CONTENTS

EXECUTIVE SUMMARY

On January 22, 2021, 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 survey team conducted the onsite survey from June 22, 2021 through June 25, 2021.

The Department assessed Plan operations 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

The Department identified **eight** deficiencies during the Routine Survey. The 2021 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.

2021 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	QUALITY ASSURANCE	
1	**The Plan failed to maintain an active standing committee responsible for establishing the public policy of the Plan.** Section 1369; Rule 1300.69(a)(1-2) and (h).	**Not Corrected**
	GRIEVANCES AND APPEALS	
2	**The Plan does not consistently include the statement required by Section 1368.02(b) in the appropriate format on all required documents.** Section 1367.01(h)(4); Section 1368.02(b); Section 1368.015(c)(3); Rule 1300.68(d)(7).	**Not Corrected**
3	**The Plan's written responses to expedited grievances do not contain a clear and concise explanation of the Plan's decision.** Section 1368(a)(5); Rule 1300.68(d)(3).	**Not Corrected**

	ACCESS AND AVAILABILITY OF SERVICES	
4	**The Plan's provider notices do not include a statement advising that failure to respond to the notification may result in a delay of payment or reimbursement of a claim.** Section 1367.27(I)(1); Section 1367.27(I)(2)(B).	**Corrected**
	UTILIZATION MANAGEMENT	
5	**The Plan does not conduct adequate oversight of its delegates to ensure delegates consistently provide written notification to enrollees and providers that complies with all statutory requirements.** Section 1367.01(a), (h)(4) and (j); Section 1368.02(b).	**Not Corrected**
	EMERGENCY SERVICES AND CARE	
6	**The Plan does not apply the correct legal standard when evaluating the medical necessity of emergency services.** Sections 1317.1(b) and 1371.4(c).	**Corrected**
7	**The Plan failed to demonstrate it maintains a compliant post-stabilization care authorization process.** Section 1262.8(d)(1) and (2); Section 1371.4(j)(1) and (j)(2)(B); Rule 1300.71.4(b)(1) and (2).	**Corrected**
	PRESCRIPTION DRUG COVERAGE	
8	**The Informational Section of the Plan's formularies does not include notice of monthly updates.** Section 1367.205(a)(3); Rule 1300.67.205(d)(9).	**Corrected**

SURVEY OVERVIEW

The Department conducts a routine survey of each licensed health care service plan at least once every three years to evaluate the plan's health care delivery system. Surveys are conducted pursuant to Section 1380 of the Knox-Keene Health Care Service Plan Act of 1975[1] and include 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 with internet websites 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.

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.

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

[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.

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.

PLAN BACKGROUND

Licensed by the Department on January 14, 1997, the Plan is a full-service health maintenance organization (HMO). Effective July 1, 2014, the Plan became a tax-exempt nonprofit public benefit corporation under Section 501(c)(4) of the Internal Revenue Code. The sole corporate members of the Plan are Dignity Community Care and NorthBay Healthcare System.

At the end of the survey review period, December 31, 2020, the Plan's enrollment included 101,736 enrollees.[2] The Plan offers Commercial (large, small and individual), Health Benefits Exchange (Covered California) and, as of January 1, 2021, Medicare Advantage product lines.

[2] This total does not include Medicare Advantage enrollees.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On May 25, 2022, 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.

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 deficiency following the Department's review of the Plan's compliance efforts. The Department will reassess Plan compliance with all uncorrected deficiencies, including deficiencies that required more than 45 days to correct, during a follow-up survey within 18 months of issuance of this Final Report.

The following describes the Department's preliminary findings, the Plan's corrective actions, and the status of the deficiency following the Department's review of the Plan's compliance efforts.

DEFICIENCIES

QUALITY ASSURANCE

Deficiency #1: The Plan failed to maintain an active standing committee responsible for establishing the public policy of the Plan.

Statutory/Regulatory References: Section 1369; Rule 1300.69(a)(1-2) and (h).

Assessment: Section 1369 requires that every plan establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan. The Plan permits such participation through its Public Policy Committee (PPC). The Plan's public policy participation procedures are further detailed in the *Public Policy Committee Charter*.

The PPC *Charter* specifies that the public policy body is required to meet quarterly.[3] Despite this requirement, however, the Department found the PPC only met once during the survey review period of February 1, 2019 through January 31, 2021. The Department review PPC meeting minutes for the survey review period and only found evidence the committee met on January 21, 2020. The Plan provided no further evidence demonstrating its PPC met quarterly as required by its *Public Policy Committee Charter.*

[3] *Public Policy Committee Charter*, page 2.

During interviews with Plan staff, the Plan's Chief Experience Officer (CEO) noted that the PPC was initially formed in 2019. Prior to 2019, the Plan fulfilled its obligation to permit public policy participation through its Board of Directors. The Plan's CEO stated that, following its meeting in January 2020, the PPC did not hold any further meetings. He indicated the PPC was scheduled to meet in July 2021.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated that, "[d]ue to pandemic impacts on committee and staff members, the Public Policy committee did not meet the required or anticipated number of times in 2021. The committee will follow approved policy and meet the required number of times in 2022."

Supporting Documentation:

- Corrective Action Plan Response Form (July 1, 2022)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is not corrected. While the Department acknowledges the Plan has taken steps towards resolving this deficiency, 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 committee meeting minutes, interviews with Plan staff, and any other review deemed necessary by the Department.

GRIEVANCES AND APPEALS

Deficiency #2: The Plan does not consistently include the statement required by Section 1368.02(b) in the appropriate format on all required documents.

Statutory/Regulatory References: Section 1367.01(h)(4); Section 1368.02(b); Section 1368.015(c)(3); Rule 1300.68(d)(7).

Assessment: Based on review of the Plan's grievance forms, *Evidence of Coverage (EOC)* documents, grievance letter templates, and pre-service denial letter template, the Department found the Plan failed to publish Section 1368.02(b)'s notice language in the required format.

Section 1368.02(b) requires the Plan to publish specified notice language in "on every plan contract, on every evidence of coverage, on copies of the plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances." Section 1368.02(b) further requires that the Plan's telephone number and the Department's telephone number, TDD line,

and internet website "be displayed by the plan in each of these documents in 12-point boldface type."

a. Grievance Forms

The Department reviewed the Plan's grievance form contained within its *Provider Manual*[4] and posted on its website.[5] The Department also reviewed the Plan's online grievance portal. The Department determined all three grievance forms failed to include Section 1368.02(b)'s required notice language verbatim as required by Section 1368.015(c)(3). The Plan improperly included the following sentence to the notice language in the forms: "If you believe your health coverage has been, or will be improperly cancelled, rescinded, or not renewed, you may also call the Department for assistance."

b. EOC

The Department also reviewed the Plan's *EOCs*[6] and found the Plan failed to include Section 1368.02(b)'s required notice language verbatim. The Plan improperly capitalized the words grievance, complaint, and coverage decisions. The Plan added "(DMHC)" to the first sentence. The Plan also failed to include its telephone number in the second sentence by instead directing enrollees to contact the Plan "at one of the number listed below." The Plan omitted a comma in the fourth sentence of the notice language.

Additionally, the Department found the Plan failed to comply with Section 1368.02(b)'s formatting requirements. The Plan bolded the last two sentences of the notice language. Section 1368.02(b) mandates that only the Department's telephone number, the Department's TDD line, the Plan's telephone number, and the Department's website be displayed in boldface type.

c. Grievance Letter Templates

The Department reviewed the Plan's grievance template letters and found they also failed to include Section 1368.02(b)'s required notice language verbatim. The Plan improperly included the following sentence with the notice language: "If you believe your health coverage has been, or will be improperly cancelled, rescinded, or not renewed, you may also call the Department for assistance."[7] Additionally, the Plan added the following phrase "or where the Department determines that an earlier review is

[4] *Provider Manual,* page 102.
[5] https://www.westernhealth.com/pdfs/member-downloads/grievance-form/, page 4.
[6] To assess for compliance with this requirement, the Department reviewed the 2021 version of the Plan's *EOC* for all lines of business.
[7] The Department found non-compliant notice language in the following grievance letter templates: Appeal 24-Hour Expedited Acknowledgment, Appeal 72-Hour Expedited Acknowledgment, Grievance 24-Hour Expedited Acknowledgment, Grievance 72-Hour Expedited Acknowledgment, Grievance Acknowledgment, and Appeal Acknowledgment.

warranted." [8] Finally, the Department also found the Plan improperly underlined the Department's website in violation of Section 1368.02(b) and Rule 1300.68(d)(7).[9]

d. Pre-Service Denial Notice Template and Letters

Finally, the Department reviewed the Plan's *Pre-Service Denial Letter Template* and found it failed to include Section 1368.02(b)'s required notice language verbatim as required by Section 1367.01(h)(4). The Plan included "Western Health Advantage" in the first sentence. The Plan also replaced "department" with "DMHC" throughout the notice language. Finally, the Plan's notice failed to include the correct telephone and website address for the Department.

Additionally, the Department reviewed 25 Utilization Management (UM) files[10] and 30 Pharmacy files[11] and found the written notice in all of the files failed to include the statement required by Section 1368.02(b) in the appropriate format.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan acknowledged "that the letters/notices identified did not consistently apply the statement required under 1368.02(b)." The Plan explained "that a previous redlined version was inadvertently saved for Grievance and Appeal letters." The Plan indicated it revised all templates to comply with Section 1368.02(b) and saved them into its UM and grievance systems. The Plan also stated that it "continues to review all applicable documents to ensure that the correct statement . . . is used consistently."

Supporting Documentation:

- Corrective Action Plan Response Form (July 1, 2022)
- Pre-Service Denial Letter Template (UM) (June 2022)
- Expedited 24-hr Grievance Request Acknowledgement Letter Template
- Expedited 72-hr Grievance Criteria Not Met Acknowledgement Letter Template
- Grievance Acknowledgment Letter Template
- Grievance Acknowledgment/Resolution Letter Template
- Coverage Dispute Letter Template
- Grievance Extension Letter Template

---

[8] The Department found non-compliant notice language in the following grievance letter templates: Appeal 24-Hour Expedited Acknowledgment, Appeal 72-Hour Expedited Acknowledgment, Grievance 24-Hour Expedited Acknowledgment, Grievance 72-Hour Expedited Acknowledgment, and Grievance Acknowledgment.

[9] The Department found the Plan impermissibly underlined the Department's website in the following grievance letter templates: Appeal 24-hour Expedited Acknowledgment Letter Template, Appeal 72-hour Expedited Acknowledgment Letter, Appeal Acknowledgment Letter Template, Appeal Acknowledgment-Resolution Letter Template, Appeal Notice of Extension Letter Template, Appeal Overturned Approval Letter Template, Appeal Overturned Approval Medical Group Letter Template, Appeal Withdrawal Letter Template, Grievance 24-hour Expedited Acknowledgment Letter Template, Grievance 72-hour Expedited Acknowledgment Letter, Grievance Acknowledgment Letter Template, Grievance Acknowledgment-Resolution Letter Template, Grievance Coverage Dispute Acknowledgment-Resolution Letter Template, Grievance Notice of Extension Letter Template, Grievance Resolution-PQI Other Issues Letter Template, Grievance Resolution Letter Template, and Grievance Withdrawal Letter Template.

[10] Utilization Management Files # 4, 7-11, 13-15, 17, 22-31, 34-36, 38-39.

[11] Pharmacy Files # 1, 2, 4-13, 15-19, 21, 23-26, 28-30, 68-72.

- Grievance Resolution PQI Letter Template
- Grievance Resolution Letter Template
- Grievance Withdrawal Letter Template
- Westernhealth.com

Final Report Deficiency Status: Not Corrected

Based on the corrective actions proposed, the Department has determined that this deficiency is not corrected. While the Department acknowledges the Plan has taken steps towards correcting this deficiency, additional time is necessary before the Department is able to assess whether the Plan's remedial measures resolve this deficiency, including confirming whether the Plan's relevant files utilize the updated letter templates.

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 letter templates, files, and any other review deemed necessary by the Department.

Deficiency #3: The Plan's written responses to expedited grievances do not contain a clear and concise explanation of the Plan's decision.

Statutory/Regulatory References: Section 1368(a)(5); Rule 1300.68(d)(3).

Assessment: Section 1368(a)(5) and Rule 1300.68(d)(3) require the Plan provide a written response to expedited grievances that contains a clear and concise explanation of the Plan's decision.

The Department reviewed 32 expedited grievance files randomly selected from the universe of such files processed during the survey review period of February 1, 2019 through January 31, 2021.[12] The Department determined that, in 14[13] cases (44%), the Plan's grievance resolution letter failed to provide a clear and concise explanation of its decision. The Department found the Plan's resolution letters contained medical jargon that would be difficult for a layperson to understand. The following resolution letters exemplify the issue:

- **Expedited Grievance File #7:** The letter stated in part:

  WHA covers Dupixent with a prior authorization for the treatment of moderate-to-severe atopic dermatitis for patients 6 years and older, when all of the following are met as a condition for coverage: prescribed by or in collaboration with a dermatologist; AND chart note(s) document a diagnosis of moderate-to-severe atopic dermatitis with description of medications tried and reason(s) for failures; AND an Investigator's Global Assessment (IGA)

[12] The Department reviewed one file that was miscategorized as an expedited grievance. The grievance was originally submitted as an expedited grievance, but the Plan subsequently determined it did not meet criteria for expedited processing. Therefore, the Department excluded Expedited Grievance File #13.
[13] Expedited Grievance File numbers: 7, 10, 11, 12, 18, 19, 20, 22, 25, 26, 27, 28, 29, and 32.

score of 3 or 4; AN exacerbating factors that could contribute to the patient's atopic dermatitis have been evaluated and addressed (e.g., non-compliance with therapy, environmental triggers, allergy patch testing, etc.); AND the patient has tried and failed daily treatment with all of the following: at least one medium to very high potency topical corticosteroid for 1 month or more, and at least one topical calcineurin inhibitor (e.g. pimecrolimus cream, tacrolimus ointment) for 6 weeks or more, and at least one oral disease-modifying antirheumatic drug (DMARD) (e.g. cyclosporine, methotrexate azathioprine); AND the patient will not use Dupixent in combination with other biologics (e.g. Xolair, Remicade, Enbrel, Nucala, etc.); AND the patient does not have a parasitic infection.

- **Expedited Grievance File #12:** The letter stated in part:

  WHA covers testosterone cypionate agents above a quantity of 4 mL per 28 days for the treatment of hypogonadism (testosterone deficiency) in males, or hormone therapy for transgender males, when confirmed by medical records including lab documentation of morning serum testosterone concentrations; AND for hypogonadism, other reasons for androgen deficiency (e.g. adrenal insufficiency, hypopituitarism) have been ruled out; AND if age-related hypogonadism, documentation of sexual dysfunction symptoms (e.g. disturbances in potency, decreased morning erections, reduced sexual libido and activity); AND the quantity requested does not exceed the requirement for a 30-day supply.

TABLE 1
Clear & Concise Explanation in Expedited Grievance Resolution Letters

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Grievances	32	Reason for denial in clear and concise language	18 (56%)	14 (44%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated its "Appeals & Grievances Manager will review written expedited grievance responses on a weekly basis to ensure clear and concise explanation of the Plan's decision. Medical jargon will be identified, removed, and replaced with a clear account of our findings and the resolution to the expedited grievance."

Supporting Documentation:
- Corrective Action Plan Response Form (July 1, 2022)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions proposed, the Department has determined that this deficiency is not corrected.

The Department finds that the Plan's remedial measures 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 expedited grievance files, interviews with Plan staff, and any other review deemed necessary by the Department.

ACCESS AND AVAILABILTY OF SERVICES

Deficiency #4: The Plan's provider notices do not include a statement advising that failure to respond to the notification may result in a delay of payment or reimbursement of a claim.

Statutory/Regulatory References: Section 1367.27(I)(1); Section 1367.27(I)(2)(B).

Assessment: Section 1367.27(I)(1) requires the Plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in its provider directory. As part of this obligation, Section 1367.27(I)(1) requires the Plan send notices to all contracted providers at least annually. Section 1367.27(I)(2) mandates that the Plan's provider notices include all of the following:

(A) The information the plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group.
(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim....
(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface....

The Plan contracts with a vendor, BetterDoctor, to help ensure the accuracy of its provider directory. Per the Plan's *Master Agreement* and *Scope of Work* with BetterDoctor, the vendor is responsible for sending provider notices to verify information contained in the provider directory, as required by Section 1367.27(I)(1). As part of this responsibility, BetterDoctor developed set of provider notice templates, titled *Standard Outreach Template*, which includes four emails, four faxes, three post mails, and telephone outreach.

The Department reviewed BetterDoctor's *Standard Outreach Templates* and found the provider notices fail to comply with Section 1367.27(I)(2)(B). BetterDoctor's notices do not include a statement that failure to respond to the notification may result in a delay of payment or reimbursement of a claim. The Department also reviewed screenshots of BetterDoctor's web portal and similarly found it does not include a statement that failure to respond to the notification may result in a delay of payment or reimbursement of a claim as required by Section 1367.27(I)(2)(B).

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it updated its *Standard Outreach Templates* and *Provider Manual* to advise providers that failure to respond to the notification may result in a delay of payment or reimbursement

of a claim. The Plan also explained that Quest Analytics' (formerly known as BetterDoctor) contact script was revised to similarly advise providers that failure to respond to the validation request may result in a delay of payment or reimbursement of a claim.

Supporting Documentation:

- Corrective Action Plan Response Form (July 1, 2022)
- *2022 Provider Manual* (June 2022)
- Quest Analytics Example Phone Call Scripts Call to Online Portal Workflow (June 20, 2022)
- Supplemental CAP Response for Deficiency #4 (August 9, 2021)

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is corrected. The Department reviewed the Plan's *Provider Manual* and Quest Analytics' contact scripts and found they advise the provider that failure to respond may result in delay of payment or reimbursement of a claim as mandated by Section 1367.27(l)(2)(B).

UTILIZATION MANAGEMENT

Deficiency #5: The Plan does not conduct adequate oversight of its delegates to ensure delegates consistently provide written notification to enrollees and providers that complies with all statutory requirements.

Statutory/Regulatory References: Section 1367.01(a), (h)(4) and (j); Section 1368.02(b).

Assessment: Section 1367.01(a) requires that the Plan and "any entity with which it contracts for services that include utilization review or UM functions ... or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section." Section 1367.01(h)(4) sets forth requirements related to written communications sent to enrollees, including the requirement that notices include information as to how the enrollee may file a grievance with the Plan. Section 1367.01(j) requires the Plan maintain quality assurance processes to evaluate compliance with these requirements.

Additionally, Section 1368.02(b) requires the Plan to publish specified notice language on all written communications to an enrollee that offer the enrollee the opportunity to participate in the Plan's grievance process. Section 1368.02(b) further requires that the Plan's telephone number and the Department's telephone number, TDD line, and internet website "be displayed by the plan in each of these documents in 12-point boldface type."

To assess for compliance with these requirements, the Department reviewed 61[14] UM medical necessity modification and denial files randomly selected from the universe of such files for three of the Plan's delegates during the survey review period of February 1, 2019 through January 31, 2021. The Department found that none (0%) of the 61 delegate written notices included grievance notice language that complied with all requirements outlined in Section 1368.02(b).

Both Meritage Medical Network and Woodland Clinic Medical Group's enrollee letters failed to include Section 1368.02(b)'s required notice language verbatim. The delegates impermissibly included the Plan's name in the second sentence and replaced "department" with "DMHC" throughout the paragraph. Additionally, for notices issued in 2020, both delegates replaced "department's internet website" with "DMHC's Internet website." These letters also failed to include the Department's updated telephone number and internet website address.

St. Joseph Heritage Medical Network's enrollee letters included incorrect telephone and TTD numbers for the Plan. Additionally, the delegate's letters failed to include Section 1368.02(b)'s required notice language verbatim. For letters issued in 2020, the delegate impermissibly replaced "internet website" with "Internet Web site." The letters also failed to include the Department's updated telephone number and internet website address.

To assess whether the Plan is monitoring for compliance with these requirements, the Department reviewed the Plan's delegate audit tool. The Plan's file audit tool included elements such as "DMHC language is present and correct for date letter was issued", "Correct DMHC phone number", "Correct DMHC website address", "Correct Plan phone number", and "Correct Plan hearing impaired phone number" for assessment of the delegate files. However, the Department reviewed the Plan's 2019 and 2020 annual delegate audit findings and found that the Plan found all three delegates compliant for these elements.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated notified all delegates on May 26, 2022 to ensure they are using the required notice language verbatim. The Plan explained that it required all delegates to review their letters and confirm appropriate changes were made if needed to comply.

The Plan also indicated its oversight audit nurse and UM review nurses were educated on the relevant requirements and provided with a copy of the notice language on May 26, 2022. The Plan stated "[a] Any future delegate and internal file audits will be evaluated using the corrected language."

Supporting Documentation:

- Corrective Action Plan Response Form (July 1, 2022)
- Pre-Service Denial Letter Template (UM) (June 2022)

Final Report Deficiency Status: Not Corrected

[14] The Department determined Delegate Files #4, #23, and #27 did not involve a medical necessity decision. These files were excluded from review.

Based on the corrective actions undertaken, the Department has determined that this deficiency is not corrected. While the Department acknowledges the Plan has taken steps towards resolving this deficiency, additional time is necessary for the Department to assess whether the Plan's remedial measures resolve this deficiency.

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 delegate audit results and UM files, interviews with plan staff, and any other review deemed necessary by the Department.

EMERGENCY SERVICES AND CARE

Deficiency #6: The Plan does not apply the correct legal standard when evaluating the medical necessity of emergency services.

Statutory/Regulatory References: Sections 1317.1(b) and 1371.4(c).

Assessment: Section 1371.4(c) permits the Plan to deny payment for emergency services only if the enrollee did not require emergency services and reasonably should have known that an emergency did not exist. The Department cited Section 1371.4(c) in All Plan Letter APL 17-017, which reiterates the appropriate standard for health plans to follow when providing reimbursement for emergency services. Furthermore, APL 17-017 discusses how the enrollee's "reasonable belief" standard of Section 1371.4(c) is a subjective standard based on the enrollee's state of mind.

Section 1317.1(b) defines an "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following, including: (1) Placing the patient's health in serious jeopardy; (2) Serious impairment to bodily functions; (3) Serious dysfunction of any bodily organ or part. Sections 1317.1 and 1371.4(c) contemplate that an emergency medical condition exists from the subjective viewpoint of the enrollee.

Based on review of the Plan's policies, the Department determined the Plan applies the "prudent layperson" standard when determining whether to reimburse for emergency services rather than the subjective standard required by Section 1371.4(c).

For example, the Plan's *Out-Of-Area Emergency Hospital Admissions* policy states:

> *Emergency Services* – means hospital and health care services to treat a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a **prudent layperson**, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious danger to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; or 2) serious damage

> to bodily functions; or 3) serious dysfunction of any bodily organ or part.[15] (**Emphasis added**.)

Similarly, the Plan's *Emergency & Urgent Care Services* policy outlines the following:

> *Emergency services* - are those services required for an "acute medical condition" in which the **prudent layperson** could reasonably expect the absence of immediate medical attention to result in serious jeopardy or harm. (**Emphasis added**.)
>
> *Prudent Layperson* - "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."
>
> *Emergency Services* - are those Covered Services provided inside or outside the service area which are medically required for the alleviation of severe pain or the immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. WHA follows the prudent layperson perception of what constitutes an emergency.[16]

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it updated its *Emergency & Urgent Care Services* policy to include the correct legal standard when reviewing the medical necessity of emergency services. The Plan explained the updated policy was approved by its UM Committee on June 22, 2022.

Supporting Documentation:

- Corrective Action Plan Response Form (July 1, 2022)
- *Emergency & Urgent Care Services* (June 2022)
- *Out-of-Area Emergency Hospital Admissions* (June 2022)

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is corrected. The Department reviewed the Plan's *Emergency & Urgent Care Services* and *Out-of-Area Emergency Hospital Admissions* policies and found both now apply the subjective standard required by Section 1371.4(c).

Deficiency #7: The Plan failed to demonstrate it maintains a compliant post-stabilization care authorization process.

[15] *Out-Of-Area Emergency Hospital Admissions* policy, page 2.
[16] *Emergency & Urgent Care Services* policy, page 4.

Statutory/Regulatory References: Section 1262.8(d)(1) and (2); Section 1371.4(j)(1) and (j)(2)(B); Rule 1300.71.4(b)(1) and (2).

Assessment: Based on review of the Plan's policies, the Department found the Plan fails to maintain compliant processes for reviewing authorization requests for post-stabilization care.

Upon receipt of a request for post-stabilization care, Section 1371.4(j)(1) requires the Plan, "within 30 minutes of the time the hospital makes the initial telephone call..., either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital." Similarly, Rule 1300.71.4(b)(1) requires the Plan to "approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request." If the Plan fails to inform the requesting facility of its decision within this timeframe, Section 1262.8(d)(2), Section 1371.4(j)(2)(B) and Rule 1300.71.4(b)(2) require the Plan deem the request authorized.

To assess the Plan's compliance with these requirements, the Department reviewed the Plan's *Out-of-Area ER Hospital Admissions* policy, which outlines its procedures for authorizing post-stabilization care. The policy requires that, "[i]f WHA or [a Delegated Medical] Group fails to approve or deny a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request, the necessary post-stabilization medical care shall be deemed authorized."

The Plan's policy goes on to describe its process for reviewing post-stabilization authorization requests, which varies according to whether the Plan or its delegates are at risk for the requested services. If the Plan's delegate is responsible for authorizing post-stabilization care, the Plan's *Out-of-Area ER Hospital Admissions* policy states:

> If admission is determined to be within the Group's service area, and/or the Group's financial responsibility/risk (ie elective admissions) [the Plan] notifies the Group's UM department **within one (1) hour of determination**.... (**Emphasis added**.)

The Department found the process described above fails to comply with the Plan's legal obligation to make an authorization decision and inform the requesting facility within 30 minutes of receipt.

If the Plan is responsible for authorizing post-stabilization care, the Plan's *Out-of-Area ER Hospital Admissions* policy states:

> If admission occurs outside the Group's service area and is WHA's risk [the Plan] calls the UR/CM department of the OOA facility **the same day** to request clinical information....
>
> If the [Plan] is unable to obtain timely information on the member's status, *Authorization of Post Stabilization* letter is sent **the same day** via FAX to

> the OOA hospital Admitting and/or UR departments, indicating that authorization is required for continued hospital stay.[17] (**Emphasis added**.)

The Department found this process fails to require the Plan render an authorization decision within one half hour of receipt. Instead, the process only requires the Plan contact the requesting facility the same day, which far exceeds the 30 minute timeframe required by Section 1371.4(j)(1) and Rule 1300.71.4(b)(1).

Further, statements made by the Plan representatives during interviews also suggested the Plan's post-stabilization authorization process does not comply with the Knox-Keene Act. When asked what is its understanding of the required timeframe to make a post-stabilization care authorization decision, the Plan's Clinical Resource Manager stated the Plan had 30 minutes to respond from the time the hospital contacted the Plan requesting admission from the emergency room. The Clinical Resource Manager explained it was the Plan's practice to contact the facility to obtain information about the treating physician and request the enrollee's medical records. The Plan's Clinical Resource Manager stated a decision would be made upon receipt of clinical information needed to determine whether post-stabilization care is medically necessary. The Department found the process described by Plan representatives during interviews failed to comply with the Knox-Keene Act's requirement that the Plan render an authorization decision within 30 minutes of receipt of a post-stabilization care request.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it revised its *Out-of-Area Emergency Hospital Admissions* policy to "clarify that the Plan is compliant with Section 1262.8(d)(1) and (2); Section 1371.4(j)(1) and (j)(2)(B); Rule 1300.71.4(b)(1) and (2)." The Plan also explained it reviewed its *Emergency & Urgent Care Services* policy to ensure it also complies with these requirements.

Supporting Documentation:

- Corrective Action Plan Response Form (July 1, 2022)
- *Emergency & Urgent Care Services* (June 2022)
- *Out-of-Area ER Hospital Admissions* (June 2022)

Final Report Deficiency Status: Corrected

Based on the corrective actions undertaken, the Department has determined that this deficiency is corrected. The Department reviewed the Plan's *Emergency & Urgent Care Services* and *Out-of-Area Emergency Hospital Admissions* policies and found both now require the Plan respond to authorization requests for post-stabilization care within one half hour of receipt as required by Section 1262.8(d)(1) and (2), Section 1371.4(j)(1) and (j)(2)(B), and Rule 1300.71.4(b)(1) and (2).

PRESCRIPTION DRUG COVERAGE

Deficiency #8: The Informational Section of the Plan's formularies does not include notice of monthly updates.

[17] *Out-of-Area ER Hospital Admissions*, pages 3 through 4.

Statutory/Regulatory References: Section 1367.205(a)(3); Rule 1300.67.205(d)(9).

Assessment: Section 1367.205(a)(3) requires the Plan display its formularies according to the standard formulary template developed by the Department. Rule 1300.67.205 outlines the requirements for displaying a formulary consistent with the Department's standard formulary template. Specifically, Rule 1300.67.205(d)(9) requires the Plan include "[n]otice that the health plan will update the formulary with any changes on a monthly basis" in the Informational Section of the Plan's formularies.

The Plan maintains two formularies, titled *3-Tier Preferred Drug List* and *4-Tier Preferred Drug List.* The Department reviewed both formularies to determine whether they complied with the Department's standard formulary template as specified under Rule 1300.67.205. The Department found both formularies failed to include notice about monthly basis in the Informational Section as required by Rule 1300.67.205(d)(9).

The Department acknowledges that the Plan's formularies include the following statement on the Cover Page: "This list is updated at least monthly and is subject to change." However, Rule 1300.67.205(d)(9) requires the Plan include such notice in the Informational Section of its formularies.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it revised its formularies to include notice of monthly updates. The Plan indicated these revisions were effective July 1, 2022.

Supporting Documentation:

- Corrective Action Plan Response Form (July 1, 2022)
- 2022 Western Health Advantage 4-Tier Preferred Drug List (PDL) (effective July1, 2022)
- 2022 Western Health Advantage 3-Tier Preferred Drug List (PDL) (effective July1, 2022)

Final Report Deficiency Status: Corrected

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

The Department finds that the Plan revised the Information Section of both of its formularies to include notice that the health plan will update the formulary with any changes on a monthly basis as required by Rule 1300.67.205(d)(9).

SECTION II: SURVEY CONCLUSION

The Department's 2021 routine survey of the Plan is complete.

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.

The Plan may elect to append a brief statement to the Final Report as set forth in Section 1380(h)(5). To append a statement, 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 Final Report:

- Click the eFiling link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the **DPS Routine Survey Document Request** titled, **2021 Routine Full Service Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.