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

APRIL 4, 2019

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

TABLE OF CONTENTS

EXECUTIVE SUMMARY

On February 8, 2018, the California Department of Managed Health Care (Department) notified Western Health Advantage (Plan) of its scheduled Routine Survey to be conducted 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 5, 2018 through June 7, 2018.

The Department assessed the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Access to Emergency Services and Payment
Prescription (Rx) Drug Coverage
Language Assistance

The Department identified **seven** deficiencies during the Routine Survey. The 2018 Survey Deficiencies Table below notes the status of each deficiency.

2018 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	QUALITY ASSURANCE	
1	**The Plan failed to establish public policy participation procedures and maintain a compliant public policy body.** Section 1369; Rule 1300.69(a), (d), (h) and (i)	**Not Corrected**
2	**The Plan does not document that it monitors the adequacy and utilization of its pathology and other laboratory facilities for quality, efficiency, and appropriateness of laboratory procedures.** Section 1370; Rule 1300.70(a)(3) and (b)(1)(B); Rule 1300.80(b)(5)(H).	**Corrected**
	GRIEVANCES AND APPEALS	
3	**The Plan's standard grievance letters fail to consistently address the linguistic and disability needs of its enrollees.** Section 1368(a)(1); Rule 1300.68(b)(3); Section 1367.04(b)(1)(C)(i); Rule 1300.67.04(c)(2)(F)(ii) and (v); Section 1386(b)(1).	**Corrected**

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

SURVEY OVERVIEW

At least once every three years the Department evaluates each licensed health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975[1] through a routine survey that covers major areas of the plan's health care delivery system. Surveys are conducted pursuant to Section 1380 and include review of the overall performance of the plan in providing health care benefits and meeting the health care needs of enrollees in the following areas:

Quality Assurance – Each plan is required to have a quality assurance program directed by providers and designed to monitor and assess the quality of care provided to enrollees, and to take effective action 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 – Each plan is required to have a grievance system that ensures a written record and adequate consideration of grievances, appropriate and timely processing and resolution, continuous review to identify any emergent patterns of grievances, and reporting procedures to improve plan policies and procedures.

Availability of Services – Each plan is required to provide or arrange for the provision of access to health care services in a timely manner, appropriate for the enrollees condition and consistent with good professional practice.

Utilization Management – Plan and delegate 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. Plans must also ensure that utilization functions satisfy access and quality requirements.

Continuity of Care – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Access to Emergency Services and Payment – Each plan is required to ensure that emergency medical and behavioral health services are accessible and available, and that reimbursement for these services are made as appropriate. Plans

[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.

must also have post-stabilization procedures to ensure timely authorization of care or transfer of enrollees who are stabilized following emergency care.

Prescription (Rx) Drug Coverage – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescription drugs, benefits and services, and ensure benefit coverage is communicated to enrollees.

Language Assistance – Each plan is required to implement a language assistance program to ensure interpretation and translation services are accessible and available to enrollees.

The Department issued the Preliminary Report to the Plan on December 31, 2018. The Plan had 45 days to file a written statement with the Director identifying each deficiency and describing the action taken to correct each deficiency and the results of such action.

This Final Report describes the deficiencies identified during the survey, the Plan's compliance efforts, the status of each deficiency at the time of the Department's receipt of the Plan's 45 day response and actions for outstanding deficiencies requiring more than 45 days which will be reassessed at a Follow-Up Survey.

PLAN BACKGROUND

The Plan is a Sacramento-based full-service, not-for-profit, mutual benefit corporation, classified as a Group Model HMO. The Plan was founded by Mercy Medical Group (now Dignity Health), NorthBay Healthcare System, and UC Davis Health System. The Plan received its Knox-Keene license in 1997. At issuance of this report, Dignity Health and NorthBay Healthcare System remain the Plan's corporate owners, while UC Davis Health System terminated its membership in June 2017.

The Plan offers individual, small, and large group products within Placer, Sacramento, Solano, Sonoma, Yolo, Colusa, Marin, Napa, Sonoma, San Francisco, San Mateo, Alameda, and Contra Costa counties. As of December 31, 2018, the Plan served 125,882 enrollees.

The Plan's provider network includes 1,646 primary care physicians and 5,347 specialty care physicians. The Plan has no direct contracts with any individual providers. The Plan establishes its provider network is established through delegated agreements with medical groups, independent physician associations (IPAs), and Knox-Keene licensed specialty plans.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On December 31, 2018, 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 within 45 days of issuance of the Preliminary Report:

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

The following 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 establish public policy participation procedures and maintain a compliant public policy body.

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

Assessment: Based on review of Plan documents, interviews with Plan staff, and written statements by the Plan, the Department determined that the Plan failed to establish procedures for permitting subscribers and enrollees to participate in establishing the Plan's public policy. Further, the Department also found that the Plan did not maintain a compliant public policy body during the survey review period.

A. Public Policy Participation Procedure

Section 1369 requires the Plan establish procedures to permit subscribers and enrollees to participate in establishing the Plan's public policy. Rule 1300.69(h) and (i) mandates the Plan incorporate its public policy participation procedures in the Plan's bylaws as well as include a description of its public policy participation procedures in the Plan's combined evidence of coverage (EOC) and disclosure form.

The Department asked the Plan if it maintained public policy participation procedures during the survey review period of March 1, 2016 through March 1, 2018. In a written statement submitted to the Department on October 23, 2018, the Plan stated that it "did not have procedures for providing subscribers and enrollees (other than Board members) to participation in establishing public policy of the Plan during the audit period."

Having failed to establish public policy participation procedures as mandated by Section 1369, the Department determined the Plan was also out of compliance with Rule 1300.69(h)'s requirement that it incorporate such procedures into is bylaws and Rule 1300.69(i)'s requirement that it include a description of its system for public policy participation in its combined EOC and disclosure forms. In a written response to

Department, the Plan stated it "intends to adopt a Bylaws revision to incorporate the public policy provisions and will additionally include information in its 2019 EOCs describing its public policy information."

B. Public Policy Body

In addition to the mandate to establish public policy participation procedures, the Knox-Keene Act also requires health plans to establish a public policy body, as described in Rule 1300.69.

The Plan did not provide any documents demonstrating that a public policy body existed during the survey review period. The Plan submitted a *Board Resolution,* adopted on March 9, 2018 (after the Department's survey review period), that established the Plan's Board of Directors (BOD) as its public policy body. During interviews, the Plan asserted that, because over one-half of its BOD members are subscribers or enrollees, the Plan complies with Rule 1300.69(a)(1).

The Department reviewed the Plan's BOD List, reflecting the membership of the Plan's BOD from 2015 to present. The Department determined the Plan's BOD membership failed to meet Rule 1300.69(a)(1)'s requirement that at least one-third of its governing board qualify as subscribers and/or enrollees. Rule 1300.69(d) specifies that to meet the "subscribers or enrollees" requirement, these individuals "shall be persons who are not employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan." The Department found that 10 out of 11 BOD Members in both 2015-2016 and 2016-2017, and 6 out of 7 BOD Members in 2017-2018 held key management positions at medical groups and IPAs that the Plan contracts with in order to provide health care services to its enrollees. As corporate officers and directors of the Plan's delegated medical groups and IPAs, these BOD Members are representatives of the Plan's subcontractors and, therefore, fail to meet Rule 1300.69(d)'s requirements.

Alternatively, the Department found that 9 out of 11 BOD members in both 2015-2016 and 2016-2017, and 5 out of 7 Board Members in 2017-2018 held key management positions with Plan's corporate owners, Dignity Health, NorthBay Health Care System, and UC Davis Health System.[2] As officers of the Plan's corporate owners, the Department determined these individuals are persons financially interested in the Plan, and, therefore, fail to satisfy the definition of subscribers or enrollees for the purposes of a public policy body as noted in Rule 1300.69(d).

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it would implement a separate Public Policy Committee (PPC). The Plan indicated it was in the process of amending its Bylaws to establish a standing PPC, which its BOD would approve in May 2019. The Plan anticipates beginning recruitment for PPC members in approximately June 2019 with the goal of holdings it first meeting by September 30, 2019. Additionally, the Plan explained it would update its EOC to reflect the new PPC.

[2] UC Davis Health System withdrew as the Plan's corporate owner in June 2017. Representatives from UC Davis left the Plan's Board on June 23, 2017.

Supporting Documentation:

- *Amended Bylaws*
- *Public Policy Committee Charter*
- *Public Policy Committee Agenda*

Final Report Deficiency Status: Not Corrected

The Department has determined that the Plan has not corrected this deficiency. 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 progress in correcting this deficiency, and whether Plan enrollees and subscribers participate in establishing the public policy of the Plan. The Department will review the Plan's Bylaws, PPC Charter and membership, PPC meeting minutes, EOC, and conduct interviews with key staff.

Deficiency #2: The Plan does not document that it monitors the adequacy and utilization of its pathology and other laboratory facilities for quality, efficiency, and appropriateness of laboratory procedures.

Statutory/Regulatory Reference(s): Section 1370; Rule 1300.70(a)(3) and (b)(1)(B); Rule 1300.80(b)(5)(H).

Assessment: Based on review of Plan documents and interviews with Plan staff, the Department determined the Plan was unable to demonstrate that it monitors the adequacy and utilization of its pathology and other laboratory facilities to ensure quality of care, efficiency and appropriateness of laboratory procedures. Section 1370 requires the Plan to establish quality assurance (QA) procedures, in accordance with Department regulations, "for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs." Rule 1300.70(a)(3) mandates the Plan's QA program "monitor whether the provision and utilization of services meets professionally recognized standards of practice." Additionally, Rule 1300.70(b)(1)(B) requires the Plan ensure that "quality of care problems are identified and corrected for all provider entities."

In accordance with Rule 1300.80(b)(5)(H), the Department considered the adequacy and utilization of the Plan's pathology and other laboratory facilities, including the quality, efficiency and appropriateness of laboratory procedures. The Department reviewed Plan Policy, Ongoing Monitoring and Interventions, dated May 2017, and other Plan documents, including the *Quality Improvement Program Description*, *Quality Improvement Workplan* and Quality Improvement Committee Meeting Minutes covering the survey review period. The Department found no evidence in those documents that

the Plan monitors the quality, efficiency, and appropriateness of its network pathology and other laboratory facilities.

In interviews, Plan staff stated that the Plan relies on the delegated provider groups' credentialing departments to ensure that laboratories are Clinical Laboratory Improvement Amendments (CLIA)[3] certified and does not otherwise monitor its laboratory services. However, the Plan provided no further explanation or evidence on how CLIA certification satisfies the Plan's obligation under the Knox-Keene Act to continuously monitor the quality of care, utilization of services, and costs of its pathology and other laboratory facilities.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it updated its potential quality issue (PQI) policy to specifically outline laboratory and radiologic services as basic health care services for which its PQI Review Committee will monitor and investigate. The Plan also indicated that it now requires its delegates to verify current CLIA certification of all contracted clinical laboratories on an annual basis. Further, the Plan updated its delegated credentialing assessment procedure to include clinical laboratory facilities. Finally, the Plan explained it monitors laboratory utilization through Healthcare Effectiveness Data and Information Set (HEDIS) measures and reviews genetic testing utilization through using Informed DNA.

Supporting Documentation:

- *Potential Quality Issue Management (PQI)* (revised January 24, 2019)
- *Assessment of Organizational Providers* (revised May 23, 2018)
- *Organizational Provider – Random File Audit Tool*
- *Delegation Responsibilities Grid*
- Sample Laboratory and Genetic Testing Utilization Monitoring Reports

Final Report Deficiency Status: Corrected

The Plan changed its delegation oversight procedures and audit tool to include assessment of clinical laboratory facilities. Additionally, the Plan provided evidence that it monitors utilization of laboratory services. Based upon the corrective actions undertaken, the Department has determined that the Plan corrected this deficiency.

GRIEVANCES AND APPEALS

Deficiency #3: The Plan's standard grievance letters fail to consistently address the linguistic and disability needs of its enrollees.

Statutory/Regulatory Reference(s): Section 1368(a)(1); Rule 1300.68(b)(3); Section 1367.04(b)(1)(C)(i); Rule 1300.67.04(c)(2)(F)(ii) and (v); Section 1386(b)(1).

[3] The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the United States through the Clinical Laboratory Improvement Amendments (CLIA) of 1988. Federal regulations establish quality standards and conditions that laboratories must meet in order to be certified to perform testing on human specimens. *See* 42 C.F.R. 493 et seq.

Assessment: Based on review of the Plan's standard grievance files, the Department determined the Plan fails to consistently address the linguistic and disability needs of enrollees in its grievance acknowledgement and resolution letters. Section 1368(a)(1) mandates the Plan maintain grievance procedures in accordance with Department regulations. Rule 1300.68(b)(3) requires that the Plan's grievance system addresses "the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities" by "providing assistance to those with limited English proficiency or with a visual or other communicative impairment."

Additionally, Section Rule 1300.67.04(c)(2)(F)(v) mandates the Plan include a notice of the availability of language assistance in all non-standardized vital documents with enrollee-specific information, as specified by the Plan in its Language Assistance Program (LAP) consistent with Rule 1300.67.04(c)(2)(F)(ii).

Consistent with these requirements, the Plan's *Grievance and Complaint Management* policy states: "[t]he Plan shall provide no-cost assistance to those with limited English proficiency, upon their request, including interpreters and translations." The policy also affirms that the Plan will "ensure all individuals have access to and can fully participate in the Grievance system by providing assistance to those with visual or other communicative impairments." The *Grievance and Complaint Management* policy requires the Plan's grievance acknowledgement and resolution letters "address the language and disability needs of the Member by providing assistance including translation and interpretation services, access to telephone relay services and other devices to aid disabled Members."

Further, the Plan's *Translation and Interpretation Services* policy states that "Standard Vital Documents and non-standard member specific Vital Documents that are sent in English will include a notice in the Threshold Language that offers Interpretation or Translation assistance for the document." The *Translation and Interpretation Services* policy identifies "Grievance letters (acknowledgment, resolution)" and "Appeal letters (acknowledgment, resolution" letters as "Vital Documents" under the Plan's LAP.

The Plan provided the Department with a copy of its *Notice of Nondiscrimination and Language Assistance Services.* The *Notice* includes the following statement:

> Western Health Advantage:
>
> Provides free aids and services to people with disabilities to communicate effectively with us, such as:
>
> - Qualified sign language interpreters
> - Written information in other formats (large print, audio, accessible electronic formats, other formats)
>
> Provides free language services to people whose primary language is not English, such as:
>
> - Qualified Interpreters
> - Information written in other languages
>
> If you need these services contact the Member Services Manager.

The Department reviewed the Plan's template grievance acknowledgement and resolution letters and found they all indicate the Plan's *Notice of Nondiscrimination and Language Assistance Services* is included as an enclosure.

File Review

To assess compliance, the Department reviewed 70 standard grievance files randomly selected from the universe of such files for the survey review period of March 1, 2016 through March 1, 2018. The Department found the Plan failed to include any information about language assistance or aids and services for people with disabilities in 16 acknowledgement letters[4] and 15 resolution letters.[5]

The Department also identified 16 acknowledgement letters[6] and 14 resolution letters[7] that failed to include the Plan's *Notice of Nondiscrimination and Language Assistance Services*, but did provide the following statement in Spanish only:

> IMPORTANTE: ¿Puede leer esta carta? Si no, nosotros le podemos ayudar a leerla. Además, usted puede recibir esta carta escrita en español. Para obtener ayuda gratuita, llame ahora mismo al Western Health Advantage (888) 563-2250 lunes a viernes de 8 a.m. – 6 p.m.[8]

The Department found that none of these letters provided information on language assistance services in English or offered assistance to enrollees with visual or other communicative impairments.

[4] File #2; File #6; File #10; File #11; File #15; File #18; File #21; File #23; File #28; File #32; File #36; File #53; File #55; File #63; File #69; File #70. Note: File #15 included no acknowledgment letter. Therefore, the Department marked it deficient.
[5] File #2; File #6; File #8; File #10; File #18; File #21; File #23; File #26; File #28; File #29; File #32; File #37; File #53; File #59; File #63; File #70. Note: File #29 included no resolution letter. Therefore, the Department marked it deficient.
[6] File #3; File #5; File #20; File #22; File #26; File #27; File #31; File #34; File #37; File #40; File #42; File #51; File #56; File #62; File #65; File #68.
[7] File #5; File #20; File #22; File #27; File #31; File #34; File #40; File #42; File #51; File #56; File #62; File #65; File #68.
[8] The Department translated the paragraph into English, which reads as follows: "IMPORTANT: Can you read this letter? If not, we can help you read it. In addition, you can receive this letter written in Spanish. For free help, call Western Health Advantage now (888) 563-2250 Monday through Friday from 8 a.m. – 6 p.m."

TABLE 1
Standard Grievance Acknowledgment and Resolution Letters

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievances	70	Acknowledgment letters address language and disability needs of the enrollee	38 (54%)	32 (46%)
Standard Grievances	70	Resolution letters address language and disability needs of the enrollee	41 (59%)	29 (41%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan explained that, starting in April 2016, it implemented a new automation process for generating grievance acknowledgment and resolution letters that was completed on February 27, 2018. Nearly all deficient files found by the Department were processed during the initial implementation phase of this project. As a result of human error, these files did not include enclosures, such as the Plan's NOLA and non-discrimination notice. However, the Plan indicated that all grievance acknowledgment and resolutions letters processed on or after February 27, 2018 would include these enclosures through the new automation process.

In addition, the Plan provided evidence that it sent a grievance acknowledgement letter for File #15 and a grievance resolution letter for File #29. The Plan acknowledged that these letters were not included in the files originally submitted to the Department as a result of an oversight by the Plan.

Supporting Documentation:

- File #15 Acknowledgement Letter
- File #29 Resolution Letter
- Standard Grievance Files (March 1, 2018 through February 14, 2019)

Final Report Deficiency Status: Corrected

To assess compliance, the Department reviewed 30 standard grievance files randomly selected from the universe of such files processed by the Plan between March 1, 2018 and February 14, 2019. The Department found that all 30 acknowledgment letters and all 30 resolution letters included the Plan's *Notice of Nondiscrimination and Language Assistance Services.* Based upon the corrective actions undertaken, the Department has determined that the Plan corrected this deficiency.

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

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

Assessment: Based on review of the Plan's grievance files, the Department determined that, upon receipt of an expedited grievance, the Plan fails to immediate notify the enrollee of their right to contact the Department.

Section 1368.01(b) and Rule 1300.68.01(b)(1) require the Plan immediately notify enrollees of the right to contact the Department regarding their expedited grievance. Consistent with this requirement, the Plan's *Exempt Grievance and Grievance Management Policy* states the Plan "shall provide immediate telephonic or verbal notification to the Member regarding their right to contact the DMHC about their Expedited Grievance without the Member having first participated in WHA's Grievance process prior to apply to the DMHC." Similarly, the Plan's *Appeal Management – Member (Expedited) Policy* notes that "upon receipt of an expedited grievance, WHA will immediately notify the member of his/her right to contact the DMHC through a documented telephone call."

During onsite interviews, Plan staff indicated it was their practice to document that they provided immediate notification to the enrollee of their right to contact the Department in the "investigation notes detail" section of the Plan's internal grievance database records for each expedited grievance case.

File Review

To assess compliance, the Department reviewed 49 expedited grievance files randomly selected from the universe of such files during the survey review period of March 1, 2016 through March 1, 2018.[9] Contrary to the Plan's statements during onsite interviews, the Department found that none of the files included any documentation of immediate telephonic or verbal notification to the enrollee of their right to contact the Department regarding the expedited grievance.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it "acknowledges the Plan's noncompliance with regard to immediately notifying the enrollee of his/her right to contact the Department via a documented phone call, per the *Exempt Grievance and Grievance Management Policy* and its *Appeal Management – Member (Expedited) Policy.*" To correct this deficiency, the Plan indicated that it increased the frequency of its grievance and appeals staff training from an annual to a quarterly basis. The Plan explained the training addresses the requirement, upon receipt of an expedited grievance, to immediately inform enrollees of their right to contact the Department.

Further, the Plan stated it would audit 100% of all expedited grievance and appeals in 2019 to ensure enrollees receive immediate notification. The Plan indicated that it would perform audits on a quarterly basis and report results to its Compliance Committee.

[9] The Department identified two expedited grievance files as withdrawn provider appeals for requested Out of Network/Out of Area treatment requests. File #17; File #21. Because the grievance was ultimately withdrawn in both cases, the Department replaced these files with File #50 and File #51, respectively.

Final Report Deficiency Status: Not Corrected

The Department has determined that the Plan has not corrected this deficiency. 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 progress in correcting this deficiency through review of expedited grievance files, grievance training documents, expedited grievance audit results, Compliance Committee meeting minutes, and interviews with key staff.

UTILIZATION MANAGEMENT

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

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

Assessment: Based on review of the Plan's medical necessity denial files, the Department determined the Plan fails to consistently include a clear and concise explanation of the reasons for the Plan's decision in denial letters sent to enrollees.

Section 1367.01(h)(4) requires that, when a Plan denies a request for health care services based on medical necessity, the Plan communicate its decision in writing to the enrollee. Section 1367.01(h)(4) further requires that the Plan's denial letter "include a clear and concise explanation of the reasons for the plan's decision." Consistent with these requirements, the Plan's utilization management (UM) policy, titled *Denial Process*, states:

> Notification letters for adverse decisions regarding original requests for services must cite specific reasons and criteria used to make the decision (either medical necessity criteria or benefit coverage limitations/exclusions listed in the member's EOC/contracts); these must be stated in clear, concise and understandable language for laypersons.

File Review

To assess compliance, the Department reviewed 70 UM medical necessity denial files randomly selected from the universe of medical necessity denial decisions made by the Plan during the survey review period of March 1, 2016 through March 1, 2018.[10] The

[10] The Department determined that a number of files did not involve a decision based in whole or in part on medical necessity. These files were replaced as follows: File #3 replaced by File #71; File #5 replaced by File #73 replaced by File #74; File #8 replaced by File #75; File #11 replaced by File #76; File #12 replaced by File #77 replaced by File #78; File #16 replaced by File #79; File #19 replaced by File #80; File #22 replaced by File #81 replaced by File #82 replaced by File #83; File #23 replaced by File #84 replaced by File #85; File #26 replaced by File #86 replaced by File #87; File #27 replaced by File #88; File #28 replaced by File #89; File #30 replaced by File #90; File #34 replaced by File #91; File #35 replaced by File #92 replaced by File #93 replaced by File #94; File #38 replaced by File #95; File #44 replaced by File #96 replaced by File #97; File #47 replaced by File #98; File #51 replaced by File #99

Department determined that, in 56 of the 70 files (80%), the Plan's denial letters to enrollees failed to include a clear and concise explanation of the Plan's decision.[11]

The Department identified two issues that resulted in the lack of clarity and conciseness: First, the Plan often provided conflicting reasons for the denial. The Department found 51 files where the denial letter stated the request was "disapproved as not medically necessary or not a covered benefit."[12] The Department determined this statement was not clear because it failed to explain whether the Plan's denial was based on medical necessity or a coverage determination.

Second, the Plan frequently explained its denial decision using medical terminology that a layperson may not understand. The Department identified six files where the denial letter to the enrollee contained unclear medical terminology.[13]

Case Examples

- **File #6:** The denial letter used language that would likely be unclear to a layperson, stating:

  chart note documentation and paid prescription claims history does not support that you have tried two high-intensity statin therapies concomitantly for > or = 8 continuous weeks; AND the LDL level remains > or = 130mg/dL. Adherence to cholesterol regimen must be evidenced by consistent pharmacy claims over 8 weeks and/or in chart notes.

  The medical terms "LDL" and "high intensity statin therapies" are used without an explanation. The references to laboratory values and mathematical formulas ("LDL level remains > or =130 mg/dL") would not be understandable to a layperson. The level of language used ("Adherence to a cholesterol regimen" and "concomitantly") are unnecessarily complicated.

replaced by File #100; File #54 replaced by File #101; File #57 replaced by File #102; File #61 replaced by File #103; File #62 replaced by File #104 File #67 replaced by File #105; File #68 replaced by File #106.

[11] File #1; File #2; File #4; File #6; File #7; File #9; File #10; File #14; File #15; File #17; File #18; File #20; File #21; File #24; File #25; File #29; File #32; File #33; File #37; File #40; File #41; File #42; File #43; File #45; File #46; File #48; File #49; File #50; File #53; File #55; File #58; File #60; File #64; File #65; File #66; File #69; File #70; File #71; File #74; File #75; File #76; File #78; File #79; File #80; File #87; File #89; File #90; File #95; File #97; File #100; File #101; File #102; File #103; File #104; File #105; and File #106.

[12] File #1; File #2; File #7; File #9; File #10; File #14; File #15; File #17; File #20 File #21; File #24; File #25; File #29; File #32; File #33; File #37; File #40; File #41; File #42; File #43; File #45; File #46; File #48; File #49; File #50; File #53; File #55; File #58; File #60; File #64; File #65; File #66; File #69; File #70; File #71; File #74; File #76; File #78; File #79; File #80; File #89; File #90; File #95; File #97; File #100; File #101; File #102; File #103; File #104; File #105; and File #106.

[13] File #4; File #6; File #7; File #18; File #75; File #87. Note: File #7 also included a conflicting explanation of the basis for the decision, stating that the request was "disapproved as not medically necessary or not a covered benefit."

- **File #7:** Denial letter used language unclear to a layperson, and also contained confusing language as to whether the denial was for lack of medical necessity or because the drug was not a covered benefit:

  Coverage for this drug cannot be provided at this time for the following reason: the prescribing provider's request is disapproved as not medically necessary or not a covered benefit as you have not tried and failed oral bisphosphonates, zoledronic acid, and as a next step, Prolia.

  Chart notes dated May 18, 2017 indicate that you tolerated ibandronate well. WHA covers Forteo for the treatment of osteoporosis in women who are at high risk for fracture when all the following is meet: 1) one of the following: a) one or more non-traumatic fractures as evident by chart notes, OR b) evidence of radiographic fractures, OR c) T-score less than or equal to -2.5 SD, AND 2) one of the following a) patient had a non-traumatic fracture while on bisphosphonate therapy or Prolia, OR b) patient had an inadequate response, as evidenced by documented worsening BMD, following at least one year of therapy with a bisphosphonate AND an additional year of treatment with Prolia, OR c) patient had an intolerable side effect or contraindication to both oral and IV bispbosphonate therapy AND an intolerable side effect or contraindication to Prolia. Treatment failure is defined as a statistically/clinically significant (e.g. 4-5%) decrease in absolute bone density or occurrences of osteoporotic fractures despite therapy (documentation required), or patient is intolerant to oral/IV bisphosphonate or Prolia. Treatment is not allowed for: 1) combination therapy with a bisphosphonate, Evista or calcitonin, 2) treatment of hypoparathyroidism, and 3) Non-FDA approved indications unless there is sufficient documentation of efficacy and safety in the published literature. Approvals are allowed for a maximum treatment duration of 2 years.

- **File #87:** The denial letter used language that would likely be unclear to a layperson, stating:

  The prescribing provider's request is disapproved as not medically necessary or not a covered benefit as chart note documentation was not provided to confirm you have tried two preferred ARBs or ARB combinations (e.g., losartan, irbesartan, or valsartan), or confirming you are continuing therapy with telmisartan as paid under prior health plan coverage. You have been eligible with WHA since July 1, 2013 and prescription claims history does not support prior use of any preferred ARB (e.g., losartan, irbesartan, or valsartan) or current use of telmisartin.

The denial letter uses the term "ARB" several times without defining the term. The drug names are listed without descriptions or an explanation of how current use / continuing therapy of telmisartin might be necessary for authorization.

TABLE 2
Plan's UM Medical Necessity Denial Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Plan's UM Medical Necessity Denial Files	70	Letter includes a clear and concise explanation of the reason(s) for the Plan's decision.	14 (20%)	56 (80%)

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it had begun revising its template denial letters "to improve the clarity of the language for a layperson." The Plan also conducted staff training on January 24, 2019 on denial letter language. The Plan indicated that its Clinical Resource Manager is "spot checking denials" to ensure letters are clear.

Supporting Documentation:
- Denial Letter Revision Training
- Sample Denial Letters

Final Report Deficiency Status: Not Corrected

The Department has determined that the Plan has not corrected this deficiency. 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 progress in correcting this deficiency through review of the Plan's denial letter audit results, review of UM medical necessity denial files, and interviews with key staff.

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

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

Assessment: The Department found that the Plan does not ensure that all entities to which it delegates UM functions conduct those functions in accordance with statutory requirements. The requirements of Section 1367.01(a) addresses various aspects of utilization review including denial communications, use of criteria or guidelines and decision turn-around times, among other requirements. Section 1367.01(j) requires the Plan review compliance with these requirements as part of the Plan's QA program.

A. Specialty Providers

The Plan contracts with three entities in order to provide specialty care to its enrollees: Human Affairs International of California (HAI-CA) provides behavioral health services, Landmark Chiropractic provides chiropractic and acupuncture services, and Express Scripts provides pharmacy benefits. These three specialty organizations are each accredited by the National Committee for Quality Assurance (NCQA).

The Plan delegates UM functions to all three entities. While the extent of these delegated functions vary among the three specialty organizations, each perform utilization review activities covered by Section 1367.01. However, based on document review and interviews with Plan staff, the Department found the Plan does not perform delegation oversight to ensure compliance with the requirements outlined in Section 1367.01. The Plan's policy*, Delegation Oversight – Utilization Management* states:

> Contracted entities delegated by WHA to perform UM activities that are NCQA accredited, if any, do not need to undergo a comprehensive delegation oversight audit that includes file review.

During onsite interviews, the Plan's Medical Director and UM clinical management staff confirmed that the Plan does not review or audit denial files from its NCQA accredited delegates for compliance with Knox-Keene requirements.

The Department notes that the NCQA accreditation process does not address all of the requirements of the Knox-Keene Act. Although NCQA accreditation includes a review of UM policies and an audit of UM denial files, NCQA does not assess compliance with specific Knox-Keene requirements, including:

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

B. Medical Groups and IPAs

In addition to the three specialty provider organizations, the Plan also delegates UM functions to six medical groups and IPAs. Unlike the specialty providers, the Plan reviews UM files from these six organizations, as described in the Plan's *Delegation Oversight – Utilization Management* policy:

> Annual audits include file reviews (authorizations and denial files to evaluate process compliance including the use of appropriate professionals for decisions, use of criteria for medical necessity decisions, turnaround

timeliness, letter/notification compliance, appropriateness of decisions, rationale and interventions, etc.)

As evidence of its monitoring activities, the Plan submitted its *Standardized Audit Tool 2017 for Delegated Oversight,* which the Plan's UM staff uses in its annual delegate file audits. The Department reviewed the Plan's audit tool and determined it does not assess compliance with all required Knox-Keene Act elements for denial letters, including:

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

During onsite interviews, the Plan's Clinical Resources Manager confirmed that the Plan's *Audit Tool* does not assess or confirm compliance with these elements of the Knox-Keene Act.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it revised its *Delegation Oversight* policy to require the Plan to conduct an audit of NCQA accredited contracted entities for "compliance with requirements beyond or in addition to NCQA requirements." In addition, the Plan revised its delegate audit tool to assess whether provider denial letters include the name and direct telephone number of the health professional responsible for the decision.

Supporting Documentation:

- *Delegation Oversight Utilization Management (UM)*
- *Denial File Review Tool*

Final Report Deficiency Status: Not Corrected

The Department has determined that the Plan has not corrected this deficiency. While the Department acknowledges the Plan has taken steps towards resolving this deficiency, the Plan has yet to complete an audit of its NCQA accredited delegates. Therefore, insufficient time has passed for the Department to assess whether the remedial efforts corrected this deficiency.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of the Plan's delegation oversight audit results and interviews with key staff.

CONTINUITY OF CARE

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

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

Assessment: Based on review of Plan documents and interviews with Plan staff, the Department determined the Plan does not ensure timely screening of children for ASD in accordance with professionally recognized standards of practice.

Section 1374.72 requires the Plan provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, including autism. Rule 1300.74.73(a)(3)(D) requires the Plan to ensure that enrollees are receiving medically necessary autism health care services, including timely screening, diagnosis, evaluation, and treatment.

Additionally, Section 1370 requires the Plan "establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities and costs." Rule 1300.70(b)(1)(A) specifies that the Plan designs its QA program to ensure that "a level of care which meets professionally recognized standards of practice is being delivered to all enrollees."

In a review of Plan documents, the Department was unable to identify policies, procedures, or guidelines that incorporate the timely screening of children for ASD by primary care providers. The Department found no evidence the Plan performed any oversight or other QA efforts to ensure its providers conducted timely screening of children for ASD consistent with professionally recognized standards of practice.

Further, in response to the Department's request for information on the Plan's standards for timely evaluation, screening, and diagnosis of patients with ASD, the Plan was unable to provide any reports, policies, procedures, clinical guidelines, or tools that incorporate the monitoring of timely screening of children for ASD, nor did the Plan produce any documents that would be disseminated to primary care providers to guide or direct them in screening children for ASD.

During onsite interviews, Plan staff confirmed that it does not include screening for ASD and does not monitor its providers to ensure that children are timely screened for ASD in accordance with professionally recognized standards of practice.

Plan's Compliance Effort: In its response to the Preliminary Report, the Plan stated it changed its *Delegation Oversight UM Audit Tool* to include review of its delegates' policies and procedures regarding ASD screening. In addition, the Plan updated its *Preventative Care Services* policy to include guidelines on ASD screenings. Further, the Plan indicated that it intended to include an article on ASD screening in its upcoming *2019 Spring Provider Insider Newsletter*.

Supporting Documentation:

- *Delegation Oversight UM Audit Tool*
- *Preventative Health Guidelines* (Released January 2019)
- *"Primary Care Screening for ASD"* article for *2019 Spring Provider Insider Newsletter*

- Provider Web Portal screenshot – Health Screening Guidelines for Autism

Final Report Deficiency Status: Not Corrected

The Department has determined that the Plan has not corrected this deficiency. 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 progress in correcting this deficiency through review of the Plan's delegate oversight audit results, provider guidelines and educational materials, preventative health guidelines, and interviews with key staff.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Survey.

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 Review of the Plan and issue a Report within 18 months of the date of this Final Report.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web Portal, eFiling application. 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, **2018 Routine Full Service Survey – Document Request**.
- Submit the response to the Final Report via the DMHC Communication tab.