DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

WESTERN HEALTH ADVANTAGE

JANUARY 3, 2024

Behavioral Health Investigation
Western Health Advantage
January 3, 2024

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The California Department of Managed Health Care (Department) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the Department licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975 and regulations promulgated thereunder (collectively, Knox-Keene Act).[1] The Department is conducting focused Behavioral Health Investigations (BHI) of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with California laws and to assess whether enrollees have consistent access to medically necessary behavioral health care services. The full-service commercial health plans will be investigated in phases. The investigation of Western Health Advantage (Plan) is included in Phase Two.

On April 11, 2022, the Department notified the Plan of its BHI covering the time period of April 1, 2020 through March 31, 2022. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.[2] The investigation team interviewed the Plan, its behavioral health delegate, Human Affairs International of California dba HAI-CA,[3] and its Pharmacy Benefits Manager (PBM) OptumRX on August 10 and 11, 2022.

The BHI uncovered one Knox-Keene Act violation in the area of Claims Submission and Payment for failure to pay a claim for previously authorized services.

Additionally, the Department identified five barriers to care not based on Knox-Keene Act requirements in the areas of Cultural Competency, Health Equity and Language Assistance, Grievances and Appeals, and Enrollee and Provider Experience:

1. Neither the Plan nor its delegate has developed and implemented a comprehensive plan to identify and address disparities across its enrollee population in accessing behavioral health services due to age, race, culture, ethnicity, sexual orientation and gender, income level and geographic location.
2. The system used by HAI-CA for customer service inquiries does not track repeat callers.
3. HAI-CA's grievance and appeals process does not identify, track and report behavioral health services that are disproportionately denied.
4. Providers are increasingly dissatisfied with network access.

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[1] The Knox-Keene Health Care Service Plan Act of 1975 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.

[2] For purposes of this Report, the term "behavioral health" or "behavioral health services" refers to mental health as well as substance use disorder conditions, and the services used to diagnose and treat those conditions.

[3] Effective January 1, 2023, the Plan changed its behavioral health delegate from HAI-CA to OptumHealth Behavioral Health Solutions of California. However, because the review period of the Plan's BHI is April 1, 2020 through March 31, 2022, when HAI-CA was the Plan's behavioral health delegate, the investigation and this Report address HAI-CA as the Plan's delegate.

5. Enrollees experience difficulties obtaining appointments.

This BHI Report also includes Plan initiatives or operations, if any, identified as potentially having a positive impact on the Plan's provision of and/or enrollee access to behavioral health services. In this case, the investigation identified no Plan initiatives or operations that result in positive impacts on the Plan's provision of and/or enrollee access to behavioral health services.

The Plan is hereby advised that the findings and violations noted in this BHI Report will be referred to the Department's Office of Enforcement. The Department's Office of Enforcement will evaluate appropriate enforcement actions, which may include corrective actions and assessment of administrative penalties, based on the Knox-Keene Act violations.

FRAMEWORK FOR THE BEHAVIORAL HEALTH INVESTIGATIONS

I. Background

Both California and federal laws require health plans to cover services to diagnose and treat behavioral health conditions. Senate Bill (SB) 855 (Wiener, 2020) made amendments to California's mental health parity law and requires commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. Health plans must also provide all covered mental health and substance use disorder benefits in compliance with the Mental Health Parity Addiction Equity Act (MHPAEA). The MHPAEA requires health plans to provide covered benefits for behavioral health in parity with medical/surgical benefits.

Other Knox-Keene Act provisions and corresponding regulations establish standards for access to care, requiring health plans to provide or arrange for the provision of covered health care services, including behavioral health services, in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.[4] Plans must ensure enrollees can obtain covered health care services, including behavioral health services, in a manner that assures care is provided in a timely manner appropriate for the enrollee's condition.[5]

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. This included analysis of benefit classifications, cost sharing requirements and non-quantitative treatment limitations to determine if health plans were meeting parity requirements under MHPAEA. As a result of this focused compliance review, many

[4] Rule 1300.67.2.2(c)(1).
[5] Rule 1300.67.2.2(c)(2).

health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA. Since the initial compliance review, the Department conducts ongoing review of MHPAEA compliance when plans make changes to policies or operations, or when licensing new health plans. Additionally, the Department has incorporated into routine surveys review for compliance and the enforcement of requirements of SB 855 (Wiener, 2020) that expanded the scope of access and coverage for behavioral health benefits.

II. Methods for BHIs

The BHIs involve evaluation of health plans' commercial products regulated by the Department.[6] To evaluate the Plan's operations for the review period of April 1, 2020, through March 31, 2022, the Department requested and reviewed plan documents, files, and data, and conducted interviews with Plan and Pharmacy delegate staff. The BHI involved reviewing and assessing the Plan's operations pertaining to the delivery of behavioral health services. The BHI focused on the following areas:

- Appointment Availability and Timely Access
- Utilization Management, including Triage and Screening
- Pharmacy
- Quality Assurance
- Grievances and Appeals
- Claims Submission and Payment
- Cultural Competency, Health Equity and Language Assistance
- Enrollee and Provider Experience

To further understand potential barriers to care from the perspective of enrollees and providers, the Department sought enrollee and provider participation in separate interviews concerning their experiences with the Plan. The Department reached out to stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the DMHC Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. In connection with the Plan's BHI, the Department interviewed one provider and four enrollees whose input was considered for the Plan's BHI. The interviews were conducted between April and May 2022. The four enrollees worked or lived in Marin, Sacramento, and Sonoma counties. The one provider serviced Marin County.

The issues raised by interviewed enrollees included complaints that concurrent review for intensive outpatient program and partial hospitalization program services were conducted too frequently, difficulties in obtaining appropriate services to treat eating

[6] The BHIs do not include plan products or plan enrollees covered by Medicare, California's Medi-Cal program, self-insured Administrative Services Organizations or non-Department regulated products.

disorders, including lack of coordination of care, lack of treatment plans, limited or short-term care and lack of an in-network dietitian with experience in eating disorders. Other enrollee issues involved complaints that out-of-network services were not authorized when only two in-network options were unsuitable and difficulty obtaining a provider who was accepting new patients. The interviewed provider is a medical provider who told us they sometimes refer patients for behavioral health services such as psychotherapy. The provider stated their patients often report difficulties finding and accessing behavioral health services.

PLAN BACKGROUND

The Plan received its Knox-Keene license on January 14, 1997, and operates as 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. As of March 31, 2022, the Plan's commercial enrollment included 103,148 enrollees[7] in Northern California, including Colusa, El Dorado, Humboldt, Marin, Napa, Placer, Sacramento, Solano, Sonoma and Yolo counties.

The Plan and HAI-CA entered into a delegation agreement on January 1, 2014, which was amended since that time, most recently with an effective date of January 1, 2022. Pursuant to the delegation agreement, the Plan delegates mental health and substance use disorder treatment services to HAI-CA, together with related functions, such as credentialing, utilization management, quality assurance, network management, and certain administrative functions.

[7] Source: DMHC Dashboard 2022 Q1

SECTION I: KNOX-KEENE ACT VIOLATIONS

CLAIMS SUBMISSION AND PAYMENT

#1: <u>Failure to pay a claim for previously authorized services.</u>

Statutory/Regulatory Reference(s): Section 1371.8

Supporting Documentation:

- Review of 30 Provider Dispute files (April 1, 2020 – March 31, 2022).
- Plan's Log A listing all behavioral health services requested during the review period that required prior authorization.
- Fourteenth Amendment to the Second Restated and Amended Group Subscriber Agreement Between the Western Health Advantage Plan and Human Affairs International of California: Attachment C: Delegation Agreement (effective April 1, 2020).

Assessment: Pursuant to a written agreement with HAI-CA, the Plan delegated most behavioral health care operations to HAI-CA, including utilization management and claims administration.

According to Section 1371.8, when a health plan authorizes services, it may not rescind the authorization if it later determines the enrollee was not eligible at the time the authorized services were rendered. Specifically:

> A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility.

The Department reviewed a random sample of 30 provider dispute files for behavioral health services from a universe of 647 such files for the review period. In Provider Dispute file #14, a behavioral health care provider requested and received prior approval from HAI-CA to provide 10 days of intensive outpatient treatment to an enrollee.[8] HAI-CA authorized an additional three days of services following a concurrent review request from the provider.[9] The provider submitted a claim for the services to HAI-CA after the approved services were performed. HAI-CA issued a denial letter to the provider, stating the member was not eligible at the time services were rendered. The provider disputed the denial and HAI-CA upheld its original denial decision. The provider received no payment for services. The provider rendered services in reliance

[8] Authorization number 2021022206000684-002-0002-0, issued by HAI-CA on September 30, 2021.
[9] Authorization number 2021022206000684-002-0002-1, issued by HAI-CA on October 14, 2021.

on the prior authorization provided by HAI-CA. Accordingly, the Department finds the denial of payment to violate Section 1371.8.

Conclusion: Based on review of documentation submitted, the Department determined the provider rendered services in good faith when the provider submitted and received authorization for services prior to rendering the services. Accordingly, the Plan's delegate HAI-CA failed to pay a claim in violation of Section 1371.8. The Plan retains responsibility for ensuring claims are paid in accordance with Knox-Keene requirements pursuant to Section 1367(j), which states in relevant part: "The obligation of the plan to comply with this chapter shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities."

SECTION II: BARRIERS TO CARE NOT BASED ON KNOX-KEENE ACT VIOLATIONS

The following is a summary of the barriers to care the Department identified through its investigation of the Plan. Additional information on the barriers will be included in the Phase Two Summary Report.

For purposes of the BHIs, barriers to care mean those barriers, whether inherent to health plan operations or otherwise, that may create undue, unjustified, needless or unreasonable delays or impediments to an enrollee's ability to obtain timely, appropriate behavioral health services. As applied to providers, barriers refer to those barriers that result in undue, unjustified, needless or unreasonable delays or impediments to a provider's ability to provide timely, appropriate behavioral health services to an enrollee.

The barriers themselves may not arise to a violation of the Knox-Keene Act and/or Rules. The barriers may be caused by a combination of factors, such as a lack of certain provider types due to market conditions (i.e., supply of providers has not kept up with demand for services), health plan acts or omissions that do not arise to a violation of the Knox-Keene Act and/or Rules, circumstances that may not be covered by the Knox-Keene Act and/or Rules, or insufficient facts to support a finding of a violation of the Knox-Keene Act. Although barriers are not enforceable under the Knox-Keene Act, the Summary Report for each phase of the BHIs will include recommendations to reduce barriers and improve access to behavioral health services.

#1: Neither the Plan nor its delegate developed and implemented a comprehensive plan to identify and address disparities across its enrollee population in accessing behavioral health services due to age, race, culture, ethnicity, sexual orientation and gender, income level and geographic location.

Summary: The Plan and HAI-CA were asked to provide policies, processes and plans that address cultural competence in the delivery of behavioral health services designed to ensure services are delivered in a culturally competent manner. While both provided program descriptions, neither the Plan or HAI-CA provided a plan with specific, measurable goals.

The Plan and HAI-CA were also asked to produce documents reflecting how they identify and address disparities across the enrollee population for age, race, culture, ethnicity, sexual orientation and gender identity, income level and geographic location. The Plan provided its Population Health Assessments for 2020 and 2021, but these documents did not describe a plan for combating disparities among those seeking behavioral health services. HAI-CA's *Cultural Competency/Language Assistance Plan Description and Evaluation* included broadly stated guiding principles and goals, but little information about how these principles were put into practice or how specific goals were implemented to achieve measurable results.

Apart from compliance with legal requirements for language assistance programs, neither the Plan nor HAI-CA were able to identify any policy or procedure describing

practices and activities pertaining to community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and smaller populated cultural communities subject to behavioral health disparities.

Concerning cultural competence training and training content provided to contracted providers and Plan staff, the Plan requires and monitors staff training for its language assistance program and for cultural competency, but does not require or monitor cultural competency training for its providers, although cultural competency resources and training modules are available to contracted providers on the Plan's website through a secure provider portal. HAI-CA provided copies of training modules for its language assistance program, but these modules do not address the broader issues beyond language related to cultural competency. HAI-CA also does not require or monitor cultural competency training for its providers.

The Department asked the Plan and HAI-CA to provide documents that describe the oversight and monitoring of contracted providers to ensure providers meet the cultural, ethnic, racial, and linguistic needs and preferences of its membership. Minimal evidence of monitoring was provided. Based on program evaluation materials submitted by HAI-CA, it does not appear that HAI-CA does more than identify the race, ethnicity and languages spoken by providers. HAI-CA appears to rely on complaints and grievances for oversight purposes, monitoring member complaints and member satisfaction regarding cultural competency via the member experience survey. HAI-CA reported zero cultural ethnic grievances in 2020 and zero in 2021.

#2: <u>The system used by HAI-CA for customer service inquiries does not track repeat callers</u>.

Summary: HAI-CA receives inquiries from consumers and uses a proprietary system for documenting each phone contact. The system collects relevant demographic information and allows for selection of tasks relevant to the caller's inquiry. Comments made by enrollees, providers, or provider representatives related to care and service are able to be recorded. However, the system does not generate a report that identifies and tracks instances in which a caller makes more than one call in order to resolve a concern ("repeat callers").

The Plan confirmed it does not have a mechanism to evaluate repeat caller data to determine whether callers raised the same issue repeatedly. As a result, neither the Plan nor HAI-CA is able to track instances in which callers are not getting the assistance they request and therefore cannot fully evaluate the effectiveness of customer service operations. Moreover, enrollees who call repeatedly and fail to get the assistance they need may be unable to obtain needed behavioral health care services.

#3: <u>HAI-CA's grievance and appeals process does not identify, track and report behavioral health services that are disproportionately denied</u>.

Summary: Pursuant to its Delegation Agreement with the Plan, HAI-CA is responsible for handling grievances and appeals pertaining to behavioral health services. HAI-CA produces a quarterly report called "Member Complaint Analysis" and an annual report,

"Quality Improvement-Clinical/Utilization Management Program Evaluation." These reports include grievance data which is presented to the Plan. Neither of these reports include discussion of the frequency with which specific services are denied. HAI-CA confirmed during interviews it does not identify and investigate outliers and/or high percentages of grievances by diagnosis code.

The Department requested a log of all grievances and appeals pertaining to behavioral health care services during the review period. The log data showed that 45% of all urgent appeals involved denials for services to treat alcohol dependence. In 81% of those denial instances, the decision to deny care was upheld on appeal. HAI-CA's failure to identify and report this high rate of denial information to the Plan prevents the Plan from being able to track, trend or address issues involving these specific services or understanding the experiences of its enrollees seeking behavioral health care.

#4: <u>Providers are increasingly dissatisfied with network access</u>.

Summary: Health plans are required to conduct an annual provider survey to solicit from physicians and non-physician mental health providers, perspective and concerns regarding compliance with timely access standards.[10] HAI-CA's document *Quality Improvement – Clinical/Utilization Management Program Evaluation For Western Health Advantage Health Plan* for the period January 1, 2021 through December 31, 2021 included provider satisfaction survey data results.

The 2021 Provider Survey reflected a decrease in satisfaction from 71.8% (2020) to 67.7% (2021) in rating the metric: "Access to care from providers in the network for your clients/patients in the timeframe you determined necessary." More than 30% of providers were "dissatisfied" or "very dissatisfied" with enrollee wait time for behavioral health appointments. Similarly, providers expressed dissatisfaction with the ease of referring enrollees to other network providers. In 2020, 72.9% of providers responded they were "satisfied" or "highly satisfied" with the ease of referral. In 2021, the percentage of providers who responded "satisfied" or "highly satisfied" decreased to 56.2%.

Access to Network Providers

	2021	2020	2019
Ease of referring members to other providers in the network	56.2%	72.9%	75.0%
Access to care from providers in the network for your client/patients in the timeframe you determined necessary	67.7%	71.8%	73.8%

The decrease in provider satisfaction with timely access to appointments suggests both that enrollees experience difficulty in obtaining appointments and providers are dissatisfied with their inability to provide timely, appropriate care to enrollees. Lack of

[10] A provider survey is required to be conducted annually pursuant to Rule 1300.67.2.2(d)(2)(C).

access and inability to make referrals with ease are barriers to timely care that increased in severity since 2019.

#5: Enrollees experience difficulty obtaining behavioral health services, and provider lists are ineffective.

Summary: The Department requested the Plan provide data for the review period concerning enrollees who reached out to the Plan or HAI-CA to request behavioral health appointments or assistance in obtaining behavioral health appointments. The Plan submitted HAI-CA's log of data[11] containing 246 entries, including 138 distinct callers or enrollees, some of whom telephoned HAI-CA on multiple occasions. The data demonstrated many enrollees who reached out to HAI-CA for assistance in obtaining a behavioral health provider or appointment had already attempted to identify a provider or get an appointment on their own, but experienced difficulties and were unsuccessful in doing so.

Of the 246 entries, 62[12] (or 25%) involved calls in which enrollees stated that despite their efforts, such as making phone calls and conducting searches to find a behavioral health provider or get an appointment, they were unsuccessful. Examples of problems described by enrollees and documented by customer service representatives include:

- The enrollee searched HAI-CA's website provider lists and called providers, but was having a hard time finding a provider and/or getting an appointment;
- The enrollee received a list of providers from HAI-CA, but was unsuccessful with providers on the list;
- Enrollees called providers, but the providers were not accepting new patients, were out-of-network, or did not return the enrollee's call; and/or
- Difficulty finding providers who met specific characteristics, such as:
    - experience providing a specific treatment modality,
    - experience treating children,
    - a provider that speaks a particular language, or
    - a provider of a certain gender.

In addition, 30 entries[13] involved calls from enrollees checking on the status of the appointment search being conducted for them by HAI-CA, or enrollees stating HAI-CA did not call them back when promised.

The data indicate enrollees who attempted on their own to obtain behavioral health services, using HAI-CA's lists, website or other search methods, were unsuccessful. The processes and tools for enrollees to self-refer and make appointments are ineffective and unavailing. Even when HAI-CA conducted appointment searches for enrollees, the frequency of enrollees calling to check the status of the search indicates

[11] Referred to as Log G.
[12] Log G, Rows 4, 6, 9, 10, 20, 22, 23, 24, 27, 31, 34, 40, 42, 46, 47, 53, 57, 60, 63, 64, 72, 74, 76, 80, 83, 84, 87, 93, 101, 103, 105, 113, 117, 118, 128, 130, 131, 134, 136, 150, 153, 157, 162, 166, 167, 168, 178, 181, 187, 196, 198, 199, 211, 214, 215, 228, 231, 235, 237, 240, 246, 247.
[13] Log G, Rows 2, 14, 33, 35, 44, 62, 71, 92, 96, 98, 109, 137, 141, 142, 174, 177, 185, 186, 209, 210, 215, 217, 221, 222, 224, 225, 227, 239, 241, 243.

enrollees did not perceive they were getting appointments when needed. The amount of effort, time and delay incurred by enrollees in attempting to secure behavioral health services indicate HAI-CA's process for enrollee self-referral and appointment assistance result in barriers to care.

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its BHI of the Plan and identified one Knox-Keene Act violation and five barriers to care not based on Knox-Keene Act requirements.

Within 10 business days of issuance of this Report, the Plan is required to notify the Department in writing of any ***factual*** errors in the Report (Response). The Plan's Response shall include all of the following:

- A detailed explanation of the Plan's perceived factual error (factual errors include, for example, a misspelled policy name, incorrectly cited document date, etc.).
- Documentation necessary to demonstrate the factual error and the Plan's asserted correct fact(s) (correct facts may be demonstrated by submission of relevant documentation, for example, the title page with correct policy name, document page with correct date, etc.). Please highlight relevant correct information in the documentation submitted to ensure the Department is able to identify and confirm the correct fact.

Information in the Plan's Response that goes beyond the identification of factual errors will not be considered for purposes of this Report.

Within 30 calendar days from issuance of this Report, the Plan is required to submit a corrective action plan (CAP) that is reasonably calculated to correct the one Knox-Keene Act violation.

The Plan may submit a statement describing actions the Plan has or will take to address the five barriers to care not based on Knox-Keene Act requirements (Barriers Statement). This separate Barriers Statement is **not** part of the corrective action plan described below, and should be submitted separately. Should the Plan wish to submit a Barriers Statement, please submit it to the Department no later than February 4, 2024, using the DMHC Web Portal process described below.

The Plan must submit its Response, if any, and CAP via the Department's Web portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

Once logged in, follow the steps shown below to view and submit the documents required:

- Click the e-Filing link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the DPS Routine Survey Document Request titled, DPS 2021 Mental Health Investigation– Document Request.

This Report, along with the Plan's submitted CAP will be sent to the Office of Enforcement for review and appropriate enforcement action, which may include

corrective actions and assessment of administrative penalties. A copy of the Report that includes any appropriate factual corrections, along with the CAP and any Barriers Statement submitted by the Plan, will be posted to the Department's website.

APPENDIX A

APPENDIX A. INVESTIGATION TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Holly Pearson	Assistant Chief Counsel
Tammy McCabe	Attorney IV
Laura Biele	Supervising Health Care Service Plan Analyst
Lezlie Micheletti	Health Plan Specialist II
Jamie Gordon	Health Plan Specialist II
CONSULTANT TEAM MEMBERS: THE INS COMPANIES, INC.	
Heather Harley	Project Manager
JoAnn Baldo	Investigator
Anita Edington	Investigator
Katie Dublinski	Investigator
Donna Lee Williams	Investigator
Trisha Crissman	Investigator
Art Kusserow	Investigator
Mary Kay Lucas	Investigator
Beth Ann Middlebrook	Subject Matter Expert
Henry Harbin	Subject Matter Expert

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: WESTERN HEALTH ADVANTAGE	
Rebecca Downing	Chief Legal Officer
Khuram Arif, M.D.	Chief Medical Officer
Kiran Biring, PharmD	Pharmacy Director
Rick Heron	Chief Experience Officer
Jessica Warshaw	Corporate Compliance Director
Abigail Luebbert	Compliance Supervisor
Jennifer Nguyen	Staff Attorney
Sherri McMahan	Clinical Resources Director
Blaire Richardson	Corporate Quality Director
Bea Pennington	Customer Services Director
Judy Baillie	Clinical Quality Manager
Syed Hamdani	Claims & Provider Relations Director
Dao Somera	Appeals & Grievances Manager
Dr. Kevin Leahy	Clinical Pharmacy Manager
Kristen Tarrell	Accreditation Program Manager
Loretta Teodecki	Claims & Provider Relations Manager
Lisa Saephan	Compliance Analyst
Emerita Roque	Compliance Analyst
Christina Titus	Member Services Supervisor
Susan Vang	Senior Member Service Representative
Becky Pyle	Delegation & Credentialing Oversight Specialist
DELEGATE STAFF INTERVIEWED FROM: OptumRx	
Chris Parrish	Manager, External Audits
Leonard “Don” Punzalan	Manager Internal Audit, Optum Legal Compliance & Regulatory Affairs
Tanea Straub	Strategic Account Executive
Nicolle Deering	Clinical Consultant, Pharmacist
DELEGATE STAFF INTERVIEWED FROM: MAGELLAN	
Dr. Andrew Sassani	VP, Chief Medical Officer, California
Chris Daher	VP, Network Development and Provider Relations
Racquel Flournoy	Compliance Manager
Joel Gluzman	VP, Associate General Counsel
Annette Sumrall	Senior Director of Clinical Care Services
Leanne Mulford	Senior Director, Provider Relations and Regulatory
Eshan Sun	Clinical Care Manager
Kim Friederich	Compliance Manager
Kristina Junio	Appeals Manager

DELEGATE STAFF INTERVIEWED FROM: MAGELLAN (continued)	
Katie Bushmann	Director of Customer Care
Sara Brown	Manager of Customer Care
Fawn Kimura	Compliance Manager
Faye Griffin	Customer Care Associate
Anita Vindiola	Customer Care Associate

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	# of Files	Case ID Number
Customer Service Inquiries (Western Health Advantage)	32	01378584 01351147 01231754 01322397 01318349 01189332 01403117 01402797 01383053 01250833 01164325 01362172 01172180 01161560 01244987 01211124 01282810 01405001 01320381 01197144 01207310 01345926 01398085 01214304 01290104 01249251 01300112 01288413 01393919 01281271 01246875 01380469

Type of Case Files Reviewed	# of Files	Case ID Number
Customer Service Inquiries (Magellan)	30	1011057115-M-0-1 1012288062-M-0-0 1011423374-M-0-0 1012538790-M-0-1 1012609927-M-0-0 1012203702-M-0-0 1011182510-M-0-0 1012236964-M-0-0 1012214278-M-0-1 1011551882-M-0-1 1012702564-M-0-1 1011053460-M-0-0 1011315207-M-0-0 1011784280-M-0-1 1010971612-M-0-1 1012592106-M-0-1 1012668795-M-0-0 1012586058-M-0-0 1012832594-M-0-1 1010988186-M-0-0 1011738946-M-0-0 1011815393-M-0-0 1012874926-M-0-1 1011596246-M-0-0 1011407971-M-0-1 1012859114-M-0-1 1011726878-M-0-0 1010961291-M-0-0 1011131917-M-0-0 1010426445-M-0-0

Type of Case Files Reviewed	# of Files	Case ID Number
Enrollee Requests for Out of Network Behavioral Health Provider	30	2021020206000686-001-0001-000 OP0007890084 2020073106000625-002-0001-000 2020071706000676-001-0001-000 2020012806000989-002-0001-000 2020073106000625-002-0001-002 2016011106000643-002-0001-000 2021030306000190-001-0001-000 2007042006001947-002-0001-001 2020101306000865-001-0007-001 2020101306000865-001-0003-000 2021051706000832-001-0001-000 2016030306000151-003-0001-000 2020101906000692-003-0001-000 2019110106000889-002-0002-000 2021030206000774-001-0001-000 2021082306000247-001-0001-000 2021092906000400-001-0001-000 2021092006000692-001-0001-000 2021082306000546-001-0001-000 2013103006000854-002-0001-000 2021030206000736-001-0001-000 2019011006001682-002-0001-000 OP0007693563 2020111106000039-002-0003-000 2021010406000655-001-0001-000 2021031806000476-001-0001-000 2020121706000494-001-0005-000 2021010206000055-001-0002-000 2021020506000365-001-0006-000

Type of Case Files Reviewed	# of Files	Case ID Number
Denied Claims	30	2018040406000740-002-0001-0 2021051106000242-001-0002-0 2011030206002168-004-0002-0 2017110606001235-006-0005-0 2017052506000244-001-0010-0 2011092206002152-002-0001-0 2009032606001454-002-0003-0 2018123106000584-001-0009-0 2021032206000664-001-0011-0 2021092006000692-001-0001-0 2020062606000544-002-0002-0 2021111606000216-001-0002-0 2015100806000754-002-0004-1 2020041306000560-001-0002-0 2021121706000446-001-0001-0 2021072006000209-001-0001-1 2021020206000678-001-0001-4 2020101306000865-001-0008-0 2011120506000504-003-0002-0 2018073006000082-001-0004-0 2020092306000313-001-0001-3 2021011906000337-001-0001-0 2020111706000437-001-0001-2 2020090806000854-001-0003-0 2017081706000017-002-0001-1 OP0016042547-5 2018073006000082-001-0003-0 OP0016289450-1 2019061306000167-002-0002-0 2021050606000690-001-0007-0

Type of Case Files Reviewed	# of Files	Case ID Number
Denied Claims (Rx)	29	61133753 62804901 63174528 68289926 77232075 78893454 56591728 56840321 56894125 56894125 57433215 57438571 57433215 57529084 57660389 58053314 58066358 58144777 59086546 59167108 60290533 61159495 61750944 65415943 67130878 67674012 69168632 01186646 01190096

Type of Case Files Reviewed	# of Files	Case ID Number
Grievances and Appeals	30	138694 2020092906000809-001-0003-3 2021110506000466-001-0002 2019041706000895-003-0001-4 2020060506000757-001-0013-2 139770 140298 2021041906000826-001-0002 01260171 2020092506004976-001-0001-1 144657 122749 01463689 01436191 137069 01214267 130803 2020101906000692-001-0002-1 2017092906000229-002-0001-1 127701 2020021006000438-001-0001-5 140666 2019013106000853-002-0002-1 2020111706000437-001-0001-2 01455332 127271 127893 01435740 2021020706000071-001-0002-2 2017050206001161-002-0001-4

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management	30	2020092506005022-001-0001-1 2011030206002168-003-0002-2 2018021306000410-003-0002-0 2005090906002297-004-0002-2 2021033006000683-001-0002-5 2021031606000774-001-0001-2 2020020706000617-002-0002-2 2021030406000730-001-0001-0 2021030106000855-001-0004-0 2021120206000440-001-0001-1 2019072206000871-002-0001-1 2021060306000678-001-0001-1 2010110406001299-003-0008-0 2009091306000153-003-0001-3 2021040906000671-001-0001-3 2021101406000461-001-0001-1 2020100906000188-001-0001-0 2021070106000381-001-0001-0 2006102506002308-004-0001-0 OP0007851307-5 2020070706000335-001-0005-2 2019012506000972-003-0001-1 2005090906002297-003-0001-4 2019110406001068-002-0001-0 2020041506000327-002-0002-0 2020041606000570-002-0003-0 2021020706000071-001-0002-3 2021041306000815-001-0002-5 2011110406001070-005-0001-0 2021012906000630-001-0002-3

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management Rx	29	61133753 62804901 63174528 68289926 77232075 78893454 56591728 56840321 56894125 56894125 57433215 57438571 57433215 57529084 57660389 58053314 58066358 58144777 59086546 59167108 60290533 61159495 61750944 65415943 67130878 67674012 69168632 01186646 01190096

Type of Case Files Reviewed	# of Files	Case ID Number
Provider Complaints	65	131494 143764 139352 145184 126598 130979 127954 125802 131745 137212 122602 124539 131758 131967 128163 136697 130203 143907 144271 131277 120530 127168 123687 128182 133107 129753 144737 129064 133877 138417 125977 122123 124699 144428 124083 137534 135655 134501 132199 121282 131436 142028 131440 127317 134043

Type of Case Files Reviewed	# of Files	Case ID Number
Provider Complaints (continued)		125678 139490 137345 123194 141024 137370 120246 136447 143957 132497 123112 136094 141027 121849 120157 119174 136017 130790 126076 132428

Type of Case Files Reviewed	# of Files	Case ID Number
Claims Denied	30	193996443 198563097 190925432 201754587 200083206 205077578 192558176 195394700 197651303 196384427 195519887 194926366 191550510 194899981 192222482 197343918 199423937 194491733 194487590 197343919 197485494 196737309 199693124 192925516 196986064 194926385 192222497 202718491 203465646 191550478

Type of Case Files Reviewed	# of Files	Case ID Number
Claims Paid	30	191999077 197045441 201857613 191451196 198553771 202058798 197418137 199162819 204649900 205142951 200667429 205532551 197967617 203754457 199344213 193972166 203217384 205323104 194485397 205298918 196908244 198334473 205352974 205532508 193090001 195663880 199174930 191460124 201223519 196231237

Type of Case Files Reviewed	# of Files	Case ID Number
Potential Quality Issues	35	145184 143901 141779 141695 138696 137741 135105 136670 136284 135385 135054 134645 134525 134608 133947 133097 133024 132733 132605 132248 132035 131573 131610 131162 131044 131083 130516 124045 122444 120564 119074 130615 129423 128996 127701

Western Health Advantage
Corrective Action Plan Response

DMHC File No. 933 0348
Date: February 2, 2024

BEHAVIORAL HEALTH INVESTIGATION 2022
Investigative review period: April 1, 2020 through March 31, 2022

Response to DMHC BHI Investigation Report (January 3, 2024)

CORRECTIVE ACTION PLAN (CAP)

ISSUE: Failure to pay a claim for previously authorized services:

- Provider submitted claim for authorized services for intensive outpatient treatment.
- HAI-CA denied claim, stating member was not eligible at time of service.
- Provider dispute received. HAI-CA upheld the denial although services were rendered in reliance of prior authorization.

Statutory/Regulatory Reference(s): Health and Safety Code Section 1371.8

> A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility.

Conclusion: The Plan's delegate violated Section 1371.8. The Plan retains the responsibility to ensure that claims are paid in accordance with Knox-Keene requirements. The obligation of the plan is not waived when services are delegated to another contracting entity.

Western Health Advantage ("WHA") had a plan-to-plan arrangement with HAI-CA to provide behavioral health services to WHA enrollees. This relationship ended effective December, 31, 2022. WHA is unable to implement a CAP directly with HAI-CA.

WHA entered into a new plan-to-plan arrangement with US Behavioral Health Plan, California ("OptumBH") effective January 1, 2023. OptumBH is responsible for all mental health and substance use disorder utilization management including referrals, authorizations, member grievance/appeals, claims adjudication and payment, and dispute resolution.

As part of its oversight activities, WHA receives reporting from OptumBH in accordance with the contracted statement of work and delegation agreement. Reporting includes a monthly Authorization, Referral, & Denial Log, and a quarterly Appeals & Grievance report that includes Potential Quality Issues. Reporting also includes quarterly claims reporting.

WHA has confirmed the following information with OptumBH:

- OptumBH has a documented process and procedure for paying claims that were authorized by OptumBH when a member's retroactive eligibility status is received. Claims processors will review the claim to confirm that an authorization exists that matches the provider and services billed on the claim. If an authorization is located, the member's claims history is reviewed to identify other eligible services and claims.
- Optum BH tracks appeal, grievance, and provider dispute outcomes and reviews on a routine bases to identify potential trends.

Current reporting received by WHA from OptumBH does not include this specific category (Denial of payment related to retro-eligibility). An attempt to rescind or modify an authorization for health care services after the provider renders the service in good faith and pursuant to the authorization, inconsistent with section 1371.8, would need to occur on three (3) or more occasions over the course of any three-month period. (28 CCR 1300.71(a)(8)(T)). In order to effectively monitor for such an occurrence, WHA will take following actions:

- WHA and OptumBH will review 2023-2024 claims history and provider disputes to identify any current issues related to processes inconsistent with section 1371.8.
- WHA and OptumBH will determine if adding specific tracking is valuable at this time.
- If updated reporting is needed, WHA will implement added reporting within 6 months of approval of this CAP.

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